

**Certificate of Need Laws:**

**Analysis and Recommendations for the  
Commission on Rationalizing New Jersey's Health Care  
Resources**

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## I. INTRODUCTION

Who could object to modest federal efforts that merely empowered state and local providers and consumers to attack wasteful use of resources in a system that had undeniably grown too expensive? (Brown, 2002, 24).

Certificate of need (CON) laws arose in the 1960s as both federal and state governments began to adopt policies aimed at curbing rising health care expenditures and costs. CON regulations require providers to petition for state planning board approval before building, expanding, or closing certain services. In 1974, with the passage of the National Health Planning and Resources Development Act (NHPDA) (P.L. 93-641), Congress mandated that all states adopt CON laws.

Just ten years later, however, federal policymakers allowed this requirement to expire, based not only on increasingly conservative ideology but also on research. Although several states quickly moved to repeal their CON regulations, the American Health Planning Association (2006) calculates that about three-quarters, including New Jersey, retain the laws to varying degrees. The continuing debate over CON focuses on whether these regulations ensure access to health care, improve quality, and lower costs.

New Jersey Governor Jon Corzine's Executive Order Number 39 recently charged the Commission on Rationalizing New Jersey's Health Care Resources with examining whether the State should retain, reform, or repeal its CON laws.<sup>1</sup> This paper aims to assist the Commission with this decision by providing historical background, an overview of the debate, a literature review, economic analysis, and recommendations.

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<sup>1</sup> Although New Jersey's CON laws address a wide range of services, including psychiatric and elder care, this paper focuses on hospital and ambulatory care because these areas are the core areas addressed by the Executive Order.

## **II. HISTORY OF CERTIFICATE OF NEED**

### **A. The Rise and Demise of the Federal CON Requirement**

In the mid-1900s, the nation's aging medical infrastructure and work force was ill-equipped to adequately serve the returned soldiers and subsequent rise in population. The federal government responded by attempting to directly boost and improve supply through the Hill-Burton Act of 1946, which focused on facility capacity, and the Health Professions Education Act of 1963 (Moran, 2005, 1416). At the same time, the government expanded access to health care, for welfare recipients through the Kerr-Mills Act of 1960 and for the elderly and the poor through the 1965 Social Security Act (Moran, 2005, 1417).

By the late 1960s, health care spending was rising dramatically. Although health care spending had grown at an annual rate of 3.7 percent throughout the 1940s and 1950s, in the 1960s the rate rose to 5.8 percent. Consequently, health expenditures per capita more than tripled between 1940 and 1970 (Newhouse, 1995, 186), doubling between 1960 and 1970. Hospital expenditures, alone, more than tripled to \$27.6 billion over just ten years, 1960 to 1970 (National Center for Health Statistics, 2005, 365). Furthermore, health spending as a share of gross domestic product (GDP) had grown considerably, too, from 5.2 percent in 1960 to 7.2 percent ten years later (Centers for Medicare and Medicaid Services, undated, Table 1).

In their article on CON regulations and spending, Christopher J. Conover and Frank A. Sloan (1998, 456) explained that the spending increases were due in part to cost increases, which were caused by the confluence of several factors. First, due to the fee for service (FFS) system of payment, medical services expanded beyond, in many policymakers' opinions, the actual need. Under FFS, hospitals were reimbursed by insurers for any expenses incurred, even if the costs were inflated, services were unnecessary, or facilities were operating below capacity. Second, through Medicare or

employer-based plans, most patients had nearly full insurance for hospital treatment. Consequently, when choosing a facility, patients generally ignored the price of services – since they were not directly bearing the cost burden – and instead selected a hospital based on how diverse and advanced were its services. To attract patients, then, hospitals increasingly rushed to expand offerings and adopt the latest technology – both of which boosted costs – without regard to whether the community really needed these services. Amy Finkelstein’s (2006) research provided support for the idea that the introduction of Medicare hastened the adoption of new technology, led to more new hospitals, and boosted hospital spending.

Certificate of need regulations were intended to solve both the cost increase and over-supply problems. The precursor to CON was formed in 1964 in Rochester, New York. That year, Marion Folsom – a former Secretary of the Department of Health, Education and Welfare, Treasury official, and Eastman Kodak Company leader – brought together Kodak, other area businesses, and Blue Cross managers to establish a community health planning council. The Rochester Patient Care Planning Council, composed of insurers, patients, and providers, evaluated the community’s hospital needs, determining what services were needed and not (Piper 2003).

Both the federal government and states took notice of the Rochester effort and determined that a similar way of formally regulating health care supply would be prudent. Congress passed and President Lyndon B. Johnson signed the 1966 Comprehensive Health Planning and Services Act (P.L. 89-749), which asked states to establish planning processes that would rationally allocate federally-granted health-related funding (Moran, 2004, 1417). Spurred by this law, the state of New York established mandatory CON processes in 1966. Maryland, Rhode Island, and Washington, D.C. quickly followed suit (Piper 2003). Although lacking empirical support for the hypothesis that regulatory planning led to cost savings or other positive effects, federal policymakers

further encouraged health planning through Section 1122 of the 1972 Social Security Act. This provision allowed the federal government to deny states reimbursement for depreciation, interest, and other costs for Hill-Burton or Medicare investment projects if the effort was not approved by a state health planning agency (Salkever and Bice, 1976, 186).<sup>2</sup> The pressure of these federal regulations led about half the states to adopt CON laws by 1974 (Brown, 1992, 23).

The remaining states were required to establish CON processes by the National Health Planning and Resources Development Act (NHPRDA) of 1974 (P.L. 93-641).<sup>3</sup> The Act forced states to establish CON programs that would review and grant approvals to any facility or equipment projects that would expand health care services by any provider, not just hospitals (Choudhry, Choudhry, and Brennan, 2005, 366). As Lawrence D. Brown (1992, 23) explains in his review of federal health care regulation, the Act also established a network of Health Systems Agencies (HSAs), which were regional organizations of consumers and other community groups. Although guided by federal rules, HSAs were accountable both to the statewide planning agencies in charge of the CON processes and HSA coordinating councils (Brown, 1992, 23). Any state that failed to comply with NHPRDA by 1978 would see a sharp decline in its federal Medicaid reimbursement (Choudhry et al., 2005, 366). The NHPRDA's financial penalties for non-compliance were never necessary, as all remaining states adopted CON laws and every state formed HSAs (Piper 2003).

Only a few years after Congress mandated CON laws, the requirement came under increasingly severe criticism. David S. Salkever and Thomas S. Bice's 1976 study was one of the first to find that CON laws do not dampen total hospital investment. The

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<sup>2</sup> Brown (1992, 23) notes that the 1972 Social Security Act also attempted to regulate physician behavior by establishing Professional Standards Review Organizations (PSROs), which "deterred outlying physicians...and enshrined usual and customary practices as norms."

<sup>3</sup> The NHPRDA was passed by Congress in December 1974 but did not take effect until January 1975, when it was signed by President Gerald R. Ford.

researchers also discovered that CON processes exacerbate the medical arms race by shifting development from beds – which were closely examined by CON regulators – to services and technologies. In an analysis of CON research, Conover and Sloan (1998, 456) noted that several other studies from the late 1970s and early 1980s found that the cost of running CON equaled or exceeded the programs' savings, and did not contain overall health care costs. As inflation and unemployment contributed to increases in health care costs (Moran, 2004, 1417), federal policymakers became disenchanted with CON as a savings method. The federal CON process requirements became less stringent in 1979, when Congress amended the NHPRDA, but many states never accordingly revised their processes, as Clark C. Havighurst (2005, 374) notes in his critique of CON laws.

In the 1980s, federal policymakers became increasingly opposed to federal economic regulations, a shift that signaled the demise of the CON mandate. Brown (1992, 26) describes the development:

...the commitments to planning and capital expenditure review embodied in the planning act of 1974 came under sharp attack in [President] Ronald Reagan's first term (1981-1985) and finally lost their legislative authorization in 1986...The CON requirement for capital expenditure review was dismissed as an unjustified federal imposition on the states, a barrier to supposedly salutary competitive dynamics, and a strategy with few cost savings to show for its cumbersome bureaucratic demands.<sup>4</sup>

Indeed, national health expenditures had continued to grow at breakneck speed, regardless of CON regulations. Total expenditures, hospital care spending, and per capita expenditures each tripled between every decade between 1960 and 1980 (Centers for Medicare and Medicaid Services (undated, Table 1) and National Center for Health Statistics (2005, 365).

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<sup>4</sup> Brown (1992, 26) further remarks that regulation through PSROs was retained and actually strengthened because, unlike the CON mandate, PSROs could feasibly result in "immediate" Medicare savings.

Congress let the NPHRDA expire in 1986 (Wiener, Stevenson, and Goldenson 1998, 3), and federal funding of state CON processes ended the following year (Ho 2004, 446).

### **B. States' Choices: Repeal, Retain, or Revise?**

Within two years of the federal CON mandate lapse, ten states across the country had eliminated their CON processes, according to the American Health Planning Association, the professional organization for CON administrators (Piper 2003).<sup>5</sup> Throughout the 1990s and early 2000s, five additional states repealed their CON laws in full (American Health Planning Association 2006a).<sup>6</sup> States with CON laws comprise half the population and 45 percent of general hospitals (U.S. General Accounting Office 2003a, 15).

Although most states have chosen to keep CON processes in place, nearly all states have elected to exempt some medical services from the CON requirement. The American Health Planning Association's (2006a) annual publication of states' CON laws lists more than 30 types that states commonly choose – or not – to regulate (see Exhibit 2 below). Most states with CON laws regulate hospitals, but beyond that single category, there is huge variety in the types of services covered.

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<sup>5</sup> These states were Arizona, California, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah, and Wisconsin. Wisconsin reinstated its CON law in 1993.

<sup>6</sup> These states were Colorado, Indiana, North Dakota, Pennsylvania, and Wyoming.

## Exhibit 2: Health Services Potentially Covered by CON Laws

Air Ambulance	Lithotripsy	Psychiatric Beds
Ambulatory Surgery Centers	Long Term Acute Care	Radiation Therapy/ Linear Accelerators
Burn Care	Medical Office Buildings	Residential Care/ Assisted Living
Cardiac Catheterization	MRI Scanners	Subacute Care
Business Computers	Mobile High Technology	Substance Abuse
CT Scanners	Nursing Homes/Beds	Swing Beds
Gamma Knives	Neonatal Intensive Care Unit	Ultra Sound
Home Health	Obstetrical	
Hospice	Open Heart	
Hospitals/Beds	Organ Transplant	
ICF/MR*	PET Scanners	

ICF/MR\*: Intermediate Care for the Mentally Retarded

Source: American Health Planning Association (2006b).

Conover and Sloan (1998, 456) detailed several reasons why some states have chosen to abandon CON laws, in addition to empirical studies and ideological shifts. In addition to CON, two other types of regulation attempted to hold down costs. In the late 1980s, Medicare changed to the Prospective Payment System (PPS), which greatly weakened hospitals' incentive to inflate costs. By then, however, many states had already chosen to adopt PPS for Medicaid and also had set ceilings on prices that hospitals could charge for certain services. More than thirty states adopted rate-setting by 1980, following the lead of the Nixon and Carter administrations, both of which had advocated for increased expenditure controls (Brown, 1992, 25). As John McDonough (1997, 143) explained in his history of the topic, studies showed that before 1985 rate-setting limited growth in inpatient hospital costs. Nearly all states, however, abandoned rate-setting by the mid-1990s with mounting empirical evidence of slight or even negative effects on costs after 1985 (McDonough, 1997, 143; Solomon, 1998, 145).

Systemic change also put downward pressure in health care costs. The Health Maintenance Organization (HMO) Act of 1973 removed state barriers to and encouraged HMO growth, likely fostering the growth of HMOs through the 1980s and managed care

generally in the 1990s (Federal Trade Commission and U.S. Department of Justice, 2004, 11). Managed care pressured hospitals to lower costs by negotiating discounted rates – a practice that directly collided with and contributed to the demise of rate-setting in the late 1980s and throughout the 1990s (McDonough, 1997, 144).<sup>7</sup> Taken together, many policymakers felt that these regulations and market pressures would adequately control health care supply and costs, without CON laws. They were further encouraged to deregulate by Centers for Medicare and Medicaid Services (undated, Table 1) data that showed health expenditures holding steady at about 13 percent of gross domestic product (GDP) in the 1990s.<sup>8</sup>

The debate over CON rages on. In 2002, state legislatures across the country discussed more than 30 proposals to reinstate or repeal CON laws (Popescu, Vaughan-Sarrazin, and Rosenthal, 2006, 2141). South Carolina is in the middle of an especially contentious CON argument. Several hospitals and systems put in proposals to build a new hospital in Fort Mill. The firm that already had a facility in the area, Tenet Health Care Corporation, received CON approval; the other applicants were denied. One losing petitioner, Hospital Partners of America, wrote a letter in September to the Department of Justice (DOJ), asking for intervention on the grounds that the state's approval process violates antitrust laws (Galloro 2006). Although DOJ has not formally responded to the request, in 2004 that agency and the Federal Trade Commission recommended states consider repealing their CON laws, after studying competition in health care for two years (Federal Trade Commission and U.S. Department of Justice, 2004, 22).

One potential reason for the continuing debate is the rise of both ambulatory surgical centers (ASCs), which conduct outpatient procedures, and specialty hospitals,

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<sup>7</sup> New Jersey's attempt to prohibit HMO discounting was not effective (McDonough, 1997, 144). In 1992, the state eliminated rate-setting, as explained later in this paper. Currently, only one state continues to have rate-setting, although about five states have budget review or other control over hospital rates or expenditures (McDonough, 1997, 143).

<sup>8</sup> In the early 2000s, the share began rising (Centers for Medicare and Medicaid Services, Undated, Table 1).

which focus on one or two clinical departments. Both types of facilities are rapidly growing and could potentially threaten general hospitals and other existing providers, as Sujit Choudhry, Niteesh K. Choudhry, and Troyen A. Brennan described in their 2005 analysis. ASCs and specialty hospitals might jeopardize general hospitals because they are not obligated to provide uncompensated care – which is often a cost burden for general hospitals – and may focus on profitable services and procedures.<sup>9</sup> To ensure that health care remains accessible, some states have developed regulations. For example, New Jersey requires ASCs not owned by hospitals to pay a 3.5 percent tax of up to \$200,000 on the facility’s annual gross revenue. The tax revenue helps fund uncompensated care through the Health Care Subsidy Fund.<sup>10</sup> Many states, however, do not bolster general hospitals’ charity care through such regulations (Choudhry et al., 2005, 368).

Some states have chosen to limit the growth of ASCs and/or specialty hospitals through CON laws. CON regulations might discourage growth, as more facilities of each type are present in states without CON laws (U.S. General Accounting Office, 2003a, 15; Casalino, Devers, and Brewster, 2003, 60). In New Jersey, ASCs must apply for CON, but specialty hospitals are exempt (New Jersey Department of Health and Senior Services, 2002, 60-61).

Despite their shared potential threat to general hospitals’ solvency, however, ASCs and specialty hospitals are different. More than two-thirds of services completed by ASCs are ophthalmologic and gastroenterology procedures. ASCs grew by more

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<sup>9</sup> Opponents of ASCs and specialty hospitals also argue that such facilities – which are often for-profit and partially or wholly owned by groups of physicians – needlessly raise demand and costs. This hypothesis was supported by several studies, and led to the Stark law of 2000, which forbids physicians from referring Medicare patients for specialty hospitals or ASCs in which they have financial interest (U.S. GAO, 2003a, 6).

<sup>10</sup> Another example is found in Oklahoma, which requires ASCs and specialty hospitals to receive 30 percent of revenues from Medicare and/or Medicaid patients. If the centers fall short, they must pay a fee into the uncompensated care fund (Choudhry et al., 2005, 368).

than 50 percent between 1997 and 2003, to 3,735 facilities; during that time, Medicare payments and procedures in ASCs doubled (Choudhry et al., 2005, 362-363).

Specialty hospitals are much more capital-intensive, which may explain their relative rareness. A 2003 U.S. Government Accountability Office (GAO) study on the topic found there were only 100 such hospitals in February 2003; however, this was triple the number in 1990. Specialty hospitals were located in 28 states but 60 percent were in only seven central and southwestern states (U.S. General Accounting Office, 2003a, 13). The GAO determined that specialty hospitals do not improve access to care, as they do not tend to be built in areas with health care service shortages. Furthermore, specialty hospitals are much less likely than general hospitals to have emergency departments, treat Medicaid patients, and earn revenue from inpatient care (U.S. General Accounting Office, 2003a, 16-17). More than four-fifths of all and 96 percent of the most recently built are located in states without CON laws (U.S. General Accounting Office, 2003a, 15). However, this might be simply happenstance: specialty hospitals are most likely to be built in areas with strong population growth (U.S. General Accounting Office, 2003a, 16), and these locations might be more likely than others to lack CON processes.

Because of worries not only regarding the impact on general hospitals but also concerning the potential for excessive physician self-referral, efforts to expand specialty hospitals recently were stymied. The 2003 Medicare Act imposed an 18-month federal moratorium on developing specialty hospitals (Cram, Rosenthal, and Vaughan-Sarrazin, 2005, 1455). In addition, two states – Montana and Wyoming – passed brief moratoriums in effect from 2005 through 2006 and 2007, respectively, while a few others considered but did not adopt such measures (Choudhry et al., 2005, 367-8).<sup>11</sup>

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<sup>11</sup> In 2004, Indiana considered a temporary ban on all health facilities construction, including specialty and general hospitals, as well as ASCs (Choudhry et al., 2005, 367).

### **C. CON in New Jersey**

New Jersey first mandated CON in 1971 with the passage of the Health Care Facilities Planning Act (P.L. 1971, c.136). The state's CON laws remained largely intact for the next 27 years, even as the state adopted and abandoned another regulatory method.<sup>12</sup> Rate-setting was instituted in 1980 as it was in many other states in an effort to control costs and subsequently also facilitate financial access (Schwab, 1996). New Jersey repealed rate-setting in 1993 when the Health Care Reform Act (P.L. 1992, c.160) took effect.

For the next several years, the state's policymakers considered whether to further deregulate health care by eliminating CON laws (George, 1999). The debate culminated in relatively little change with the 1998 Certificate of Need Reform Act which gave CON process exemptions to ASCs, lithotripsy and several other technologies, basic obstetric and pediatric services, and residential substance abuse treatment programs (New Jersey Statute P.L. 1998, c.43, 10). The Certificate of Need Reform Act also called on the Governor to establish a commission to examine whether the state should regulate health care providers, and if so, how (New Jersey Statute P.L. 1998, c.43, 11). The group, which was comprised of health care professionals, recommended in February 2000 that the state retain its CON laws (Goldsmith, 2003).<sup>13</sup> This conclusion quieted New Jersey's CON debate, despite the continual upheaval of health care system mergers and closings.

New Jersey currently requires CON approval for providers that are seeking to build facilities or relocate, add, or close any of the following services: acute care, burn care, cardiac catheterization and surgery, home health, intermediate care facilities for

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<sup>12</sup> Minor amendments to the CON regulations were issued in P.L. 1978, c.83; the Health Care Cost Reduction Act, P.L. 1991, c.1987; and the Health Care Reform Act, P.L. 1992, c.160 (New Jersey Department of Health and Senior Services, 2002, 3).

<sup>13</sup> A thorough search of potential primary and secondary sources revealed that the report likely was never publicly released, only reported second-hand by the media. Consequently, no information on why the commission chose to recommend the continuance of CON laws is available.

the mentally retarded (ICF/MR), neo-natal/infant care, nursing homes, open heart services, organ transplants, pediatric care, psychiatric services, specialty hospitals, and rehabilitation (New Jersey Department of Health and Senior Services, 2002, 60-63).<sup>14</sup> (See the Appendix for a detailed list of which services must undergo CON review and which are exempt.)

The petitioner must submit the application with a \$7,500 fee<sup>15</sup> (New Jersey Department of Health and Human Services 2003) to the State Department of Health and Senior Services' Certificate of Need and Acute Care Licensure Program. The type of review varies depending on the service, but most services require full review.<sup>16</sup> (See the Appendix for the type of review required for each service.) The State Health Planning Board examines the applications for each service and recommends whether each should be approved or denied, within 90 days of receipt. The Planning Board may condition its recommendation on certain actions by applicants, such as public notice of alternate providers, in the case of a closure (Roberts, 2006). Then, the Department's Commissioner – or, when a hearing has been requested by an applicant, the Office of Administrative Law – issues a final decision no later than 120 days after the Planning Board has submitted its recommendation, or no later than 180 days if the batch includes more than 20 applications (New Jersey Department of Health and Senior Services, 2002, 36-37).

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<sup>14</sup> Many services are exempted from CON regulations, including ASCs, ambulatory care, CT scanners, gamma knives, lithotripsy, mobile high tech, MRI scanners, PET scanners, radiation therapy, substance abuse, and swing beds (New Jersey Department of Health and Senior Services 2002, 60-63).

<sup>15</sup> If the projected cost of the project will be more than \$1 million, an additional 0.25% of the projected cost must be paid.

<sup>16</sup> CON applications for most services, such as long-term care, must be submitted by a certain annual date so the Planning Board may review all proposals on the same services simultaneously. CON applications for other services may be submitted whenever the petitioner chooses (New Jersey Department of Health and Senior Services 2002, 36-37).

### **III. ANALYSIS**

The debate over CON centers on whether these regulations preserve health care access, improve quality, and lower expenditures. Each side can marshal arguments and studies to support its case. A thorough review of the literature, however, reveals that most of the literature fails to find benefits of CON regulations.

#### **A. Arguments For and Against CON**

Proponents, such as the American Health Planning Association and the American Hospital Association, generally emphasize the access argument. Economic theory states that nonprofit organizations exist because for-profit companies will underprovide unprofitable services, such as emergency departments. Supporters believe that CON is necessary because it protects nonprofit providers and the unprofitable care they provide by blocking market entry of for-profit companies. A repeal or absence of CON, then, will result in a proliferation of for-profit health care providers, driving nonprofit facilities out of the market which will lead to a scarcity of providers of unprofitable services. This will happen because nonprofit health care providers rely on well-insured patients and profitable units, called “cross-subsidization”, to support care to uninsured patients and services that do not make money. For-profit organizations will target and draw well-insured patients who need profitable services, stripping nonprofits of their financial viability. Consequently, nonprofit providers will eventually be forced to close or merge with for-profit systems, leading to a dearth of care in communities with large unprofitable uninsured or poorly-insured populations.

Supporters also argue that CON ensures high quality services and lowers costs. Quality is strongly related to volume, and CON requires applicants to demonstrate that their facilities will have a high volume of patients. CON also keeps expenditures lower than they would otherwise be, for two reasons. First, if access to the market were unrestricted, many more providers would enter. Supplier-induced demand holds that an

increase in available providers will result in more use of services – some of which may be unnecessary – and therefore boost expenditures. Second, eliminating CON would hasten the medical arms race. Providers would adopt unproven technology and make unnecessary facilities improvements in order to attract patients, passing the costs on to consumers or third-party payers.

Detractors, including the American Medical Association, argue that CON laws do not preserve access, improve quality, or keep expenditures down. Although CON was originally intended to make sure communities retained accessible health care, the regulations have had the effect of simply protecting existing providers. These providers are not necessarily of high quality. A more open market would lead to superior services by pressuring nonprofit and other existing providers to improve. In fact, ASCs and specialty hospitals that are blocked by CON are of better quality because they have higher procedure volumes.

Opponents believe CON has not lowered expenditures for several reasons. First, health care investment has simply shifted from categories that are highly scrutinized by CON regulators, such as beds, to those that are less closely examined, such as technology. Second, medical arms races that raise expenditures actually are exacerbated by CON: providers must be the first to offer a new service or procedure, otherwise their application might be denied. Third, by limiting market entrants, CON creates monopolies that drive up prices, especially since consumers who have health insurance are less sensitive to health care prices because they do not bear full costs. Fourth, if the markets were opened, specialty hospitals could lower costs through economies of scale. Fifth, supplier-induced demand does not happen, or occurs on such a small scale that total expenditures do not rise substantially.

### **B. Empirical Evidence: Few Benefits of CON**

The literature on the effects of CON is mixed.

**Access:** A few studies suggest that specialty hospitals and ASCs – which most frequently arise in the absence of CON – have the potential to drain nonprofit providers' financial resources and provide less charity care. As previously mentioned, the U.S. GAO (2003b) discovered that most specialty hospitals focus on highly profitable services and often are not located in areas of medical need. Jean Mitchell (2005), who compared specialty and general hospitals in Arizona, which lacks CON laws, found evidence to support the GAO's conclusions. She discovered that physicians with ownership stakes in specialty hospitals treated higher percentages of profitable cases, less-severe cases, and well-insured patients. Further suggesting that specialty hospitals might harm access, Jonathan Gruber (1994) found that less charity care was provided in California after it abandoned CON regulations.

More research, however, concludes that the absence of CON does not necessarily lead to more services, abandonment of cities or charity care, or a proliferation of for-profit hospitals. Gerald Anderson, Robert Heyssel, and Robert Dickler (1993) concluded that the presence of CON regulations in Baltimore and the absence of them in Minneapolis-St. Paul did not result in clearly different service offerings. However, a study that examines the effect of CON on services in cities compared to suburbs would be more useful, since most supporters of CON are wary that free exit will leave inner cities bereft of services as services shift to more lucrative suburbs. This question was addressed qualitatively by Gloria J. Bazzoli, Annaliese Gerland, and Jessica May (2006). They reviewed recent facilities construction in many markets and concluded that CON does not influence whether construction occurs in cities or suburbs. Regardless of CON regulations, more ambitious projects were launched in wealthy suburbs than in poor cities.

Stephen M. Shortell and his colleagues (1986, 106) asserted that the provision of charity care would not be threatened by eliminating CON laws because the proportion of

uncompensated care does not differ between nonprofit and for-profit hospitals. Another study, though, found that those results are not meaningful, because for-profit hospitals are unlikely to greatly increase upon the removal of CON processes (Conover and Sloan, 1998, 478).

**Quality:** As previously discussed, CON laws are intended to ensure that providers maintain high procedure volume because more than 100 studies have established that higher provider procedure volume is strongly associated with better outcomes (Conover and Sloan, 1998, 477). Robert Luft, John P. Bunker, and Alain C. Enthoven conducted the pioneering study noting this link in 1979. After another decade of research, Luft and a different set of colleagues published a book that reviewed the literature and concluded the link was solid (Luft et al. 1990). Recently, additional studies have supported the hypothesis that provider volume is strongly, negatively associated with mortality and other negative outcomes for a variety of cancer resections (Ho, 2004; Ho, Heslin, Huifeng, and Howard 2006; Schrag et al. 2003; Birkmeyer et al. 2002) and coronary procedures (Hannan, Tacz, Kavey, Quaegebeur, and Williams 1998; Birkmeyer, Stukel, Siewers, Goodney, Wennberg, and Lucas 2003). Whether the relationship is stronger for hospital or surgeon volume is unclear, although John Birkmeyer and his colleagues (2003) found that surgeon volume accounts for a substantial proportion of hospital volume's affect on mortality. David Shahian (2004), however, noted that surgeon data may not be reliable indicators of quality because, unlike hospitals, surgeons can choose to operate on less difficult cases.

The literature indicates that the presence of CON regulations impacts volume, but does not do so in a way that also improves outcomes. Verdi Di Sesa and his colleagues (2006) found that CON states have higher hospital volumes but not better outcomes for coronary artery bypass grafting. Supporting this finding, Vivian Ho (2004) and Ioana Popescu, Mary S. Vaughan-Sarrazin, and Gary E. Rosenthal (2006) both

concluded that CON states have higher hospital cardiac procedure volumes but not better outcomes, compared to states without CON laws. Stephen Shortell and Edward Hughes (1988) found that states that have stringent CON programs, rate-setting programs, or strong HMO penetration actually have higher mortality, but their study has not been replicated in recent years.

Researchers consistently find that controlling for volume and case severity, specialty and for-profit hospitals do not have better outcomes than general hospitals. The GAO (2003b, 11-12) concluded that specialty hospitals see patients who are less ill, a finding that was confirmed by Ariel Winter (2003) and Mitchell (2005). Specialty hospitals' larger share of less-severe cases appears to influence their outcome data. In a study of coronary artery bypass grafting (CABG), Peter Cram, Gary Rosenthal, and Mary Vaughan-Sarrazin (2005) found that outcomes do not differ between specialty and general hospitals, controlling for volume and case severity. The ownership of a hospital – another potential difference between general and specialty hospitals – appears to have no bearing on outcomes, cost, or efficiency (Shortell and Hughes, 1988; Sloan, Picone, Taylor, Jr., and Chou, 2001).

**Expenditures:** Most evidence suggests that CON regulations do not substantially reduce or contain health care expenditures. Neither CON laws nor other types of regulation are associated with lower costs, according to an econometric analysis of 22 years of data by John Antel, Robert Ohfeld, and Edmund Becker (1995). As previously discussed, Salkever and Bice's early (1976) study of the financial effects of CON found that these regulations did not suppress overall hospital investment but worsened the medical arms race. Although CON laws slowed bed expansion, they even more substantially sped up investment in new services and technologies, substituting a

growth in labor and services for a growth in beds.<sup>17</sup> Similarly, Conover and Sloan (1998) found that CON laws slightly lowered acute care spending but neither slowed the diffusion of hospital-based technologies nor reduced total spending. Bazzoli, Gerland, and May (2006, 790) noted that some markets are developing duplicative services and technologies, despite the presence of CON.

The only way in which research indicates CON laws might generate cost savings is through lowering the number of procedures. Both Popescu, Vaughan-Sarrazin, and Rosenthal (2006) and Ho (2006) found that CON states have lower coronary procedure rates for patients with cardiac problems. The authors suggested that this is because fewer providers are certified to perform such procedures, relative to states without CON regulations. However, the difference in procedure rates is slight, suggesting both that the effects of supplier-induced demand for these services and the potential benefit of cost savings is small.

Although research is slightly mixed, taken together studies show that CON regulations do not help states retain or foster access, improve quality, or contain expenditures.

### **C. Economic Theory: Against CON Laws**

The empirical findings explained above mostly are consistent with what one would expect from economic analysis of certificate of need laws.

CON regulations restrict the health care market by preventing health care providers from choosing the types and amounts of care they will offer – and whether they may enter the market at all. Economic theory predicts that providers already in the market will have two reactions to CON: altering their labor and capital mix, and raising prices.

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<sup>17</sup> Between 1968 and 1972, CON's impact was to reduce growth in beds by between 5 and 10 percent, and increase growth in assets – such as technology and staff – per bed by 15 to 20 percent (Salkever and Bice 1976, 197).

To produce goods, firms employ a mix of capital and labor. CON laws restrict capital investments – especially beds – but not labor. Consequently, firms that want to expand or retain their market shares will shift investment from categories that are under intense scrutiny, like enhancing facilities and adding beds, to those less closely monitored by CON regulators, such as labor and perhaps equipment. As described above, Salkever and Bice (1976) and Conover and Sloan (1998) confirmed that this is exactly what happened.

By restricting entry and exit, CON regulations effectively give firms monopoly power. Under CON laws, then, health care providers are monopolists that will charge higher prices because they do not face competition from other firms. CON laws further encourage prices to rise through limiting the amount of certain health care services that monopolists may provide to patients. These caps make services more valuable to consumers at the margin, further pushing up prices. This effect is especially likely in health care, since insurance decreases the price sensitivity of most consumers. At the same time, though, price increases might not reach their full potential because managed care firms make great efforts to lower costs. Although a thorough literature review revealed no studies that examine the effects of CON laws on pricing, economic theory strongly predicts that such regulations would raise prices. Capping prices through mandated rate-setting would be the only way to ensure that prices do not rise under CON laws.

Another likely effect of monopoly power is that a health care provider will have fewer incentives to improve or maintain efficiency and quality. Daniel P. Kessler and Mark B. McClellan's (2000) study provided some support for this argument. The

researchers found that after 1990, high levels of hospital competition both lowered costs and improved outcomes for Medicare beneficiaries.<sup>18</sup>

In New Jersey and every other CON state, the health care market is further distorted because CON regulations do not apply to all health care services. Services such as magnetic resonance imaging (MRI), which are exempt from CON laws, are free to proliferate – and do. A Switchboard.com search of “MRI” and “X-Ray” on January 3, 2007 came up with more than 20 separate facilities within 25 miles of Princeton, New Jersey that offer MRI services. Such uneven application of CON laws gives an advantage – and incentive – to firms and individual providers to supply more unregulated services, which are not necessarily needed more by the community.

Economic theorists and supporters of CON hold that if regulations were removed, allowing free entry into the health care market, those providers previously protected by the CON laws likely would suffer. For-profit hospitals, ASCs, and specialty hospitals could cherry-pick patients and services, dismantling nonprofit hospitals’ current system of cross-subsidization. However, existing hospitals would also be pressed to improve efficiency and quality. As discussed previously in the literature review, there is little empirical evidence to support either of these scenarios.

#### **IV. RECOMMENDATIONS**

Given that existing research and economic arguments find CON laws reap few if any benefits, the Commission on Rationalizing New Jersey’s Health Care Resources should recommend the State repeal its CON laws.

There are few empirical or theoretical reasons for retaining CON laws as they currently exist. Although economic theory suggests that rate-setting regulation might be

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<sup>18</sup> Before 1990, competitive hospital markets were associated with better outcomes but also higher costs, compared to less competitive markets. The authors attribute the cost shift to the rise of managed care, which they hypothesize had spillover effects on Medicare patients, who were the study’s subjects (Kessler and McClellan 2000, 610-611).

a necessary complement because it could limit price increases generated by CON laws, there is no evidence that prices actually rise more due to CON regulations. In fact, there is some evidence that rate regulations actually increase costs, and that this effect is moderated by CON processes (Antel, Ohfeld, and Becker, 1995). Given the rise of managed care, which puts downward pressures on prices, the State has little need for rate regulation. A traditional reason for rate-setting was that it helped charity care hospitals. However, upon the end of rate-setting in New Jersey, the State devised other ways to support these facilities.

Expanding CON so that all health care services are covered, which makes more economic sense than the current system, is not realistic. Opposition from providers that are not currently regulated and from proponents of deregulation would be strong. If such a proposal were enacted, the economy could be temporarily harmed as some providers of over-supplied services likely would close.

Eliminating CON, then, is the best option. However, the access, quality, and cost concerns that precipitated and have sustained CON processes should be addressed.

Removing CON processes might lead to a decline in access to care. Consequently, the State should have some rules or mechanism to ensure that poor areas continue to receive services. The State also should require acute care, psychiatric, and other critical facilities to give adequate public notice and issue referrals upon deciding to close, as the Planning Board now recommends through the CON process. With these rules and nonprofit hospitals' new ability to launch profitable services – a power they have been eager to acquire to maintain financial viability (Matteson, 2005) – the removal of CON likely would not impact access.

Because high procedure volumes are strongly associated with better outcomes, especially for coronary and cancer resection procedures, the State should continue to have procedure volume standards for these specialties. The State could set a minimum

procedure volume, backed by research and perhaps certification boards, and establish penalties for facilities which fall below that number. The State also should consider publishing annual analysis of facilities' outcomes, controlling for volume and severity, so that consumers can make more informed choices regarding their care.

Removal of CON regulations has been shown to have no effect on health care costs or expenditures (Conover and Sloan, 1998), so no State remedy should be necessary.

## **V. CONCLUSION**

Governments adopted CON laws in response to health care access, quality, and cost worries in the 1960s and 1970s. Following initial research showing that CON laws were neither cost-effective nor lowering overall costs, federal policymakers and several state legislatures opted to repeal CON laws. Additional, recent studies have demonstrated that CON regulations do not reach any of their original goals. This body of literature, combined with economic analysis, strongly suggests that New Jersey's CON laws should be repealed. The State's policymakers should consider other methods of ensuring health care access and quality.

**APPENDIX**  
**Certificate of Need Review in New Jersey**

	Type of Review
I. Bed-Related Health Care Facilities/Services	
A. New/expansion	
Adult family care.....	Exempt
Assisted living program.....	Expedited
Assisted living residence.....	Expedited
Burn center, unit, or program.....	Full
Comprehensive personal care home.....	Expedited
General hospital.....	Full
Hospital-based subacute care unit.....	Exempt
ICU/CCU beds (adult).....	Exempt
Medical detoxification program (hospital based) .....	Exempt
Medical/surgical.....	Exempt
Long term acute care.....	Expedited
Long-term care facility:	
Additions greater than 10 beds or 10 percent, whichever is less in accordance with N.J.S.A. 26:2H-7.2.....	Exempt
General long-term care.....	Full
Pediatric long-term care.....	Full
Specialized long-term ventilator care.....	Full
Specialized long-term care for behavior management.....	Full
Statewide restricted admissions facility.....	Expedited
Obstetric service.....	Exempt
Pediatric service (excluding intensive/critical care).....	Exempt
Pediatric service (intensive/critical care).....	Full
Psychiatric hospital	
Acute.....	Full
Intermediate and special.....	Full
Rehabilitation hospital (in-patient).....	Full
Residential health care facility.....	Exempt
Residential substance abuse treatment facility.....	Exempt
Special hospital.....	Full
Specialty acute care children's hospital.....	Full
B. Decrease in beds.....	Exempt
C. Replacement of beds.....	Exempt
D. Relocation of licensed beds or an entire service subject to CON review, within the same planning region in accordance with N.J.A.C. 8:33-3.4(a)3.....	Expedited
E. Relocation or replacement of an entire licensed bed related facility subject to CON review	
General hospital/within or outside county.....	Full

All other/within same planning region in accordance with N.J.A.C. 8:33-3.5(a)4.....	Expedited
All other/at the same site in accordance with N.J.A.C. 8.33-3.5(a)2.....	Exempt
F. Termination/Discontinuance of licensed beds, services, or facilities	
General hospital (all beds/services).....	Full
General hospital (some beds/services)	
No access problems.....	Exempt
Access problems.....	Expedited
All other health care facilities.....	Exempt
II. Non-Bed Related Health Care Services/Facilities	
A. New/Expansion	
Ambulatory care.....	Exempt
Ambulatory surgery facility.....	Exempt
Birth center.....	Exempt
Bone marrow transplant/harvesting including stem cell.....	Full
Cardiac diagnostic services/invasive (catheterization)	
New full service.....	Expedited
New or addition to low risk.....	Expedited
Addition of catheterization equipment to full service..	Exempt
Replacement of equipment.....	Exempt
Cardiac surgical service.....	Full
New.....	Full
Addition of operating rooms to licensed cardiac surgery service.....	Exempt
Cardiac transplant service.....	Full
Central service agency.....	Full
Comprehensive outpatient rehabilitation facility.....	Exempt
Emergency medical service helicopter.....	Full
Extracorporeal shock wave lithotripter (kidney/biliary) .....	Exempt
Gamma knife.....	Exempt
Hemodialysis and peritoneal dialysis.....	Exempt
Home health agency.....	Full
Hyperbaric chamber.....	Exempt
Kidney transplant service.....	Full
Lung transplant service.....	Full
Magnetic resonance imaging/ nuclear magnetic resonance. ....	Exempt
Megavoltage radiation oncology/linear accelerator.....	Exempt
Mobile intensive care or advanced life support service	
New.....	Full
Additions to vehicles or hours of operation.....	Exempt
Operating rooms.....	Exempt
Organ bank.....	Full
Organ transplantation/procurement.....	Full
Perinatal service: maternal and child health consortia	
New service.....	Full
Change in membership.....	Full

Perinatal service: regional perinatal center, CPC-intensive or CPC-Intermediate	
New service and designation.....	Full
Change in designation.....	Full
Increased number of intermediate or intensive bassinets.....	Full
Perinatal service: CPC-basic, CPC-birth center designation.....	Exempt
Positron emission tomography scanning.....	Exempt
Satellite emergency department.....	Exempt
Special child health clinics providing tertiary services.....	Exempt
Trauma service.....	Full
Any other new health/medical care technologies that the Department identifies as having a Statewide or regional impact.....	Full
 B. Capital improvements and renovations to health care facilities...	Exempt
 C. Replacement of existing non-bed related health care facility/service.....	Exempt
 III. Transfer of Ownership	
A. Licensed facility	
General hospital.....	Full
All other.....	Exempt
 B. Unimplemented Certificate of Need	
Less than 10 percent transfer of stock.....	Expedited
Limited partnership interests.....	Expedited
Membership of nonprofit corporations.....	Expedited
Death of applicant.....	Expedited
Change in entity without change in principals.....	Expedited
All other changes.....	Not accepted
 IV. Unimplemented Certificate of Need	
A. Change in cost in accordance with N.J.A.C. 8:33-3.9(a).....	Exempt
B. Change in financing.....	Exempt
C. Change in scope	
Increase in beds/major movable equipment/services	
Not subject to CN review.....	Exempt
Subject to CN review.....	Not accepted
Decrease in beds/major movable equipment/services.....	Exempt
D. Change of site	
Within same county in accordance with N.J.A.C. 8:33-3.9(b)1.3.....	Exempt

Within same planning region in accordance with  
N.J.A.C. 8:33-3.9(b)2.4.....Expedited

E. Extension of time.....Expedited

CPC= Community perinatal center

Source: New Jersey Department of Health and Human Services (2002, Appendix:  
Exhibit 3, 60-63)

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