Policy Report

Promoting Health Care Transparency and Value

Moving Towards Consumer Driven Health Care

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It is widely stated that health care does not respond to the same economic forces as other industries, but what else can be expected when certificates of need all but assure customers and that meaningful price and quality information is hidden from consumers?

Health Watch USA

Promoting Healthcare Quality, Access & Affordability

I. The State of Health Care in the United States

The United States is not even rank in the Top 10 nations for life expectancy, according to the 2007 annual report of the Organisation for Economic Co-Operation and Development[1], a multinational cooperative organization formed by an international treaty in 1960 that tracks economic data from 30 major industrialized and European nations. In fact, it says, we are below average.

Despite being the richest country, the Untied States spends the largest percentage of its Gross Domestic Product, 15%, on Health Care, spending 36% more than the next highest countries of Switzerland and Germany.[2]

To make matters worse, we have the most expensive health care in the world, spending the most per capita in health care than any other industrialized nation, 138% more than the average OECD Nation, 20% and 50% more than the next two highest OECD Nations of Luxemburg and Switzerland. And we spend twice as much in the private sector in relationship to our country's total health care expenditure as the next highest country, Switzerland.[3] Despite this, the United States has an infant mortality rate which is higher than the average OECD Nation. This may be partiality due to variations in reporting; however, the US infant mortality rate is higher than Canada and Nordic Countries which have similar methods of reporting.[4]

Private insurance in the United States is an expensive line item comprising about 35 percent of total health-care spending, which is more than twice the percentage of total health-care spending than the next-highest country.[5]

A corresponding skyrocketing rate in private insurance premiums has taken place. According to Kaiser Family Foundation, the average cost of family coverage is over $11,000 per year. Since 2000, premiums for family coverage have increased 87%. The dollar amount the average worker pays has increased correspondingly while the inflation rate has increased only 18% and the average wage only 20%. [6]

Some people have attempted to blame the high cost of health care on the technology used in the U.S. System. But Japan, the country with the longest life expectancy -- 82.1 years[7] -- also has more CT scanners per capita than any other county in the world. In 2002, Japan had more than seven times the CT scanners per capita as the United States.[8]

Up to one in four Japanese receive a CT scan each year.[9] Despite this, Japan expends 63 percent per capita less on health care than the United States.[10]

There is general agreement that we are pouring money into a system which is not producing health care of high value. In fact, many are starting to argue that the health care in the United States is poor. McGlynn, et.al.[11] studied the quality of care for patients with 30 acute, chronic medical conditions along with preventative care. They found that 45% of patients did not receive recommended care

The Commonwealth Fund summarized a detailed study of OECD Data by Gerald Anderson. The study found that the major factor in increased health care spending was higher prices.[12] And yet in 2002, the United States had fewer hospital beds, physicians, nurses and CT scanners per capita than the average OECD Nation.[13]

The above is an example of how in non-competitive markets high expenditures and charges do not assure high quality. In the United States there is not only a lack of competition but a lack of health care transparency regarding quality and prices. If something is not done, Secretary Leavitt, Dept. of Health and Human Services, predicts that one out of every five dollars produced in the United States will be spent on Health Care.[14]

In response to this, a new industry is emerging that of outsourcing medical care to foreign countries. Not only has the outsourcing of x-rays interpretation to foreign countries become commonplace over the last several years, but the transporting of patients for performance of major surgery at foreign hospitals is starting to emerge. According to the American Medical News,[15] sixteen of these hospitals are accredited by the Joint Commission, the largest hospital accrediting agency in the United States. The countries include among others: Italy, India, Rio de Janeiro, Singapore and the Bahamas. And the savings are huge. A hospital in Thailand is offering an average savings of 76% on a heart bypass, 86% on a vascular bypass and shunt and 69% on a liver transplant.

II. Transparency

In February of 2007, Dept. Health and Human Services' Secretary Mike Leavitt sent a letter[16] to the heads of major industries requesting support of the four "cornerstone" actions of a recent Presidential Executive Order calling for the – interoperable health IT; transparency of quality; transparency of price; and incentives for high-value health car. Letters of support for transparency have been received from over 240 major corporations including Wal-Mart, 3-M, McDonalds, Xerox, Kodak, IBM, Intel, GE, GM, Ford, Proctor and Gamble, Caterpillar, Cisco and ATT. [17]

Transparency in Quality

Presently, the only decision most Kentuckians can make in the purchasing of health care is whether or not to obtain care. They cannot effectively shop for the best quality of the service at acute care hospitals.

Nursing homes have extensive quality data regarding pressure ulcer formation, urinary tract infections, weight loss, and decrease in mobility, along with other data posted online by the Department of Health and Human Services on their "Nursing Home Compare" website.[18] Acute care hospitals have 21 measures most of which center around patient education and administration of certain medications, measures which the hospital can easily meet by 'teaching to the test'. Meaningful measurements such as infection rates, patient falls, incidence of pressure sore formation and nursing staffing ratios are absent.[19]

The State of Kentucky posts on the web hospital mortality and procedure volume information,[20] data which may also be indicative of the quality performance of doctors rather than hospitals.

Joint Commission: The Joint Commission is the largest organization in the United States that accredits hospitals and health care facilities. It only posts summary data of their accreditation findings within 90 days of an accreditation visit. The Joint Commission's initial and complete findings are not released to the public. In a letter sent by a Kentucky State Senator requesting complete information, he received a response which stated:

> "Unfortunately, the Joint Commission is unable to provide you with a copy of the accreditation report. The Joint Commission has an obligation to its accredited organizations to keep accreditation related information confidential, including the accreditation report." [21]

Health Watch USA finds this unacceptable. After all, restaurants have their health department deficiencies published regularly in the newspaper. The same standards should apply to health care facilities. The Joint Commission's primary responsibility should be to the public. In a recent lawsuit by the American Nursing Association against the Department of Health and Human Services[22] for not assuring adequate nursing care in American hospitals, it is pointed out that the Joint Commission is funded by the organizations it accredits. In addition, the basis of the lawsuit is that the Joint Commission in not assuring adequate nursing care in acute care hospitals.

> "JCAHO's nursing standards are totally devoid of standards and requirements concerning the immediate availability of a registered nurse to render bedside care to the patients."[23]

One would assume that the Joint Commission accreditation findings and reports would be submitted to the federal office for the Centers for Medicare and Medicaid Services (CMS) in Baltimore, MD. Health Watch USA has requested this information under the Freedom of Information Act. CMS was not able to find any reports. This brings into question the quality of oversight CMS has over the Joint Commission and the quality of our health care.

HealthGrades: HealthGrades is a for profit internet company which ranks hospital quality. Its methodology was analyzed in 2002 by Krumholz et. al.[24] in an article published in the Journal of the American Medical Association. The authors found that the quality measurements used by HealthGrades did identify groups of hospitals that when taken together did differ in quality of care and outcomes but "poorly discriminated between any 2 individual hospital's process of care or mortality rates during the study period." Hospitals in Kentucky have used HealthGrades' rankings to advertise the quality at their institution.

Other States: Only two states provide meaningful quality data to consumers for acute care hospitals. They are Pennsylvania and Florida. Pennsylvania provides hospital infection rates which are posted online.[25] Pennsylvania hospitals differ widely with their infection rates. For example, in Erie, PA one hospital has an infection rate which is twice as large as the rate found in a competing facility.

The State of Florida has the most comprehensive website which it launched in November 2005.[26] Using this site, a consumer can easily obtain and compare information on hospital quality. Data on readmission rates, mortality rates along with complications and infections can be obtained. Complication data includes the incidence of: Post operative infections, bed or pressure sores, infections due to medical care, post operative hip fractures and post operative embolism and sepsis (a severe blood infection).

The one short coming is that the methodology for the bed and pressure sores eliminates high risk patients with hemiplegia, paraplegia, or quadriplegia, patients in MDC 9, obstetrical patients in MDC 14, and patients admitted from a long-term care facility or transferred from an acute care facility. Thus, it does not analyze patients admitted from nursing homes.[27]

This is unfortunate, since an important parameters to monitor is the frequency and progression of bed sores and ulcers in patients returning to nursing homes after hospitalization. Nursing homes already track this data, it only needs to be reported. This would allow the monitoring by a second party and does not rely solely on a system of self reporting.

Nursing Staffing: Nursing care is the primary function of an acute care hospital. Home health agencies, outpatient treatment centers and surgery centers can provide care where 24 hour nursing staff is not needed. Thus, one of the best indicators of hospital quality is the number of registered nurses it provides to take care of its patients. This number needs to be acuity based or adjusted for the sickness of the patients. Several states have introduced legislation to require the public disclosure and posting of nursing staffing ratios in hospitals.[28] California has enacted mandatory nurse to patient ratios, mandating a 1 to 5 or higher ratio on general medical and surgical floors and a 1 to 2 or higher ratio in the intensive care unit.[29]

One of the best things a Kentuckian can do is to ask their registered nurse how many patients he/she is taking care of and if they are overworked. If a patient is on a general medical or surgical floor and his registered nurse is taking care of eight or more patients, a dangerous situation may exist. It has been reported in the Journal of the American Medical Association that the patient death rate increases over 30% as the number of patients a registered nurse is responsible for doubles from four to eight.[30]

Investigated Incidents and Complaints: Public access to this information is very important. However, in Kentucky, freedom of Information requests must now be filed with the Kentucky Office of Inspector General (OIG) to obtain a facility's OIG investigative report. Health Watch USA has been told that investigative reports cannot be obtained from the Department of Community Based Services. Calls have been made in the editorial sections of the news media to release and post OIG reports on the internet.[31,32] However, unlike the Kentucky Board of Medical Licensure's website[33] where under the physician profile section investigative and disciplinary actions against physicians can be immediately viewed, the Office of Inspector General facility investigatory reports must still be requested in writing using the freedom of information act. A further delay in public access to these reports is caused by their release only after the investigation has been completed and a final disposition has been determined. Theoretically, this could possibly take years.

Non-Investigation of Reported Incidents: Governmental oversight has an important role in assuring quality of health care. Concerns about health care should be made immediately to the provider and egregious infractions can be reported at the same time to the State Office of Inspector General, Cabinet for Health and Family Services. By Kentucky state law, ANYONE who suspects abuse or neglect of an adult or child must immediately report or cause a report to be made to the Department for Community Based Services. Anyone includes everyone and not limited to physicians, nurses, law enforcement officers and cabinet personnel. The Cabinet is then required to investigate and notify appropriate agencies. It if does not, it would be a severe infraction of the Cabinet's responsibility in the protection of the health care of Kentuckians.

Health Watch USA has received reports of non-investigation of whistle blower retaliation. Retaliation against whistleblowers is prohibited under the Kentucky Patient Safety Act.[34] Although these reports have not been investigated by Health Watch USA regarding their validity, the Kentucky Patient Safety Act has no regulations written for it or penalties enacted for its violation.

CON and Quality: The State of Washington Joint Legislative Audit and Review Committee found that the "evidence of CON's effect on quality is mixed".[35] Morrisey[36] also reported mixed evidence on the effects of the CON on technology diffusion and hospital mortality. The Kentucky Subcommittee of Health Care Access and Cost Oversight[37] concluded that the "CON has done very little to enforce the role of quality in reducing the rate of cost increases". "There is no mechanism for enforcing (facilities to follow nationally accepted standards of care) aside from somewhat limited licensure laws." Conover and Sloan concluded that "it is doubtful that CON regulations have had much effect on the quality of care, positive or negative".[38]

The Fletcher Administration initially proposed the following quality criterion for the granting of a Certificate of Need (see below).[39]

> "A documented history of uncorrected quality control problems which threaten the life, health and safety of the hospital's patients. Examples may include higher than normal rates of preventable hospitalization, medication errors, or hospital acquired infections."

This criterion was removed from the final regulations adopted on May 12, 2006 (see below).[40]

> "All licensed acute care hospitals located within the planning area (includes all the adjacent counties) have experienced one or more of the following:

i. Final termination of their Medicare or Medicaid provider agreement;

ii. Final revocation of the their hospital license issued by the Cabinet for Health and Family Services' Office of Inspector General; or

iii. Final revocation of their hospital accreditation by the Joint Commission on Accreditation of Healthcare Organizations."

The new criteria is virtually impossible to meet since final termination or revocation is an extremely rare event and all hospitals in all surrounding counties must meet a criterion at the same time.

Transparency in Costs

Before a hospital service is rendered, consumers may wish to find and compare charges. This however is very hard to do. Hospital administrators will argue that "price means nothing" and that "no one pays the same price for the same service". There are two charges, the list price and the insurance contract price. The latter varies widely between insurance policies and can be discounted as much as 50%.

Consumers have limited access to information about the cost of a service before they receive it. The Kentucky Hospital Association posts the median hospital charges for various groups of diseases treated at Kentucky hospitals on their website.[41] This average information can serve as a guide but does not help individual patients, since charges can vary widely between different insurance contracts with the highest price often being charged to those who do not have health insurance. In addition, some institutions give customers without health insurance discounts off of their list price for prompt and full payment. Customer's that have health insurance have difficulty in comparing insurance contract prices between institutions. Some insurance companies, for example Humana,[42] are starting to post contract prices on their website for their policy holders. However, this information is also needed for consumers with Health Savings Accounts who are shopping for an insurance policy. These customers need to know which company has the lowest contract prices before they purchase their policy.

Another difficulty is that unlike other purchases, a consumer does not know exactly what needs to be bought. Will a stomach pain be treated with an antacid or with emergency surgery? Thus, global costs and average costs for procedures is also vital information for consumers.

Many insurance companies and hospitals have non-disclosure clauses regarding insurance prices. This is proprietary information which in the past was beneficial for the insurance company to protect. The insurance company would be placed at a disadvantage if a hospital found out that another hospital was paid a higher rate for a service. However, with consumer driven health care, the reverse occurs. Thus, it is advantageous for the insurance company's policy holders to know the contact price of a service. Customers will then be driven to competing institutions that have a lower contract price and put market pressure on the higher price institution to lower their prices.

Transparency of the cost of prescription medications is starting to develop. There is one State run on-line prescription drug price comparison website. My Florida Rx, "The Florida Prescription Drug Prices" website, provides pricing information for the 100 most commonly used prescription drugs in Florida." [43] This site is an excellent aid to consumers to locate the least expensive pharmacy within their city or county.

Certificate of Need: There is little evidence that the Kentucky certificate of need protects customers from high medical costs. Governor Fletcher proposed CON regulations on Dec. 20, 2005 that had a criterion which addressed high insurance contract prices at some institutions.[44]

> "A historically and significantly higher negotiated rate for providing identical services as similar licensed hospitals."

However in the adopted regulations on May 12, 2006 [45] changed the criterion from a "higher negotiated rate" to "adjusted revenues"

> "The adjusted revenue of each licensed acute care hospital located within the planning area exceeded one-hundred and fifty (150%) of the state mean adjusted revenue, for acute care hospitals, during each of the previous three (3) fiscal years."

Because of the averaging effect of Medicare and Medicaid on revenues, this criterion is extremely had to meet by any single hospital. In addition, all hospitals in all adjacent counties would also have to meet this criterion at the same time before a CON for construction of another hospital could be awarded. This second provision makes this criterion virtually impossible to meet.

In an article published in the Commonwealth Journal on July 2, 2006,[46] The editor reported that the county's hospital was well within the State pricing guidelines. However, the State was using "revenues" not "consumer prices" to determine cost-effectiveness. Because of the averaging effect of Medicaid and Medicare on hospitals revenues, Health Watch USA projected that "consumer prices" would have to be three times the State average before this criterion is meet. (Note: It would also have to be met by all hospitals in all surrounding counties.)

Using revenues instead of prices is an example of decreasing *Cost Transparency,* which is to the determent of the consumer.

Government Oversight: In Kentucky, the Public Service Commission is charged with guarding consumer interests and approving utility pricing. A recent editorial published in the Lexington Herald Leader commented that the Kentucky Legislature introduced legislation concerning utility companies that would "strip consumers of protections against unjustifiable rate increases" and gave the utility companies the "benefits of monopoly pricing while effectively freeing them from regulatory oversight and enable(d) the utilities to shift all their risk onto consumers". This legislation was defeated.[47]

There is not a Public Service Commission for hospitals. Currently, the Kentucky Certificate of Need grants the benefits of monopoly pricing with no public protections.

Profitability: Profitability is an indirect measure of cost. Although, hospital administrators may argue that profits mean nothing, the Institute of Health and Socio-Economic Policy disagrees. They have shown a significant relationship between the hospital list price and profitability.

All hospitals must file an extensive financial document with Medicare. It is hundreds of pages long and is called a Medicare Cost Report. From what Health Watch USA can determine, hospitals in large hospital chains can vary the amount to be reported as Net Income (on Worksheet G-3) and do it legally. Most hospital financial websites post this fudge number which cannot necessarily be trusted.

If one back tracks through four sections of the Medicare Cost Report, the origin of "Net Income" on worksheet G-3 can be shown to be derived from the declared home office expense. The Medicare Allowed Home Office Expense and Declared Home Office Expense are both reported on Worksheet A-8-1**.** However, it is the Declared Home Office Expense that is used to calculate Net Income. One could argue that the difference between the declared and allowed Net Income should be added back into the hospital's Net Income.

In Kentucky, this discrepancy may amount to tens of millions of dollars. If our state government was not adjusting for

III. Competition and Certificate of Need

The concept of certificates of need was born in the 1970s to help control health care costs by eliminating costly duplication of health care services. In many states, CON laws were enacted when the 1974 National Health Planning and Resources Development Act tied state certificate-of-need legislation to participation in Medicaid and Medicare. At that time federal government was reimbursing on a cost-plus basis. But in 1987, the federal mandate was repealed, and the government switched to a system of payment based on each patient's diagnosis.[48]

By 2005, 14 states, comprising 35% of the United States Population, had dropped their certificate-of-need laws.[49] In addition, Ohio only regulates long-term care facilities, Nebraska only regulates long-term care facilities and rehabilitation facilities and Louisiana has never enacted CON Regulations.

Kentucky law proports that the purpose of the State's Certificate of Need policy is "to improve quality and increase access to health-care facilities, services and providers, and to create a cost-efficient health-care delivery system". A certificate of need (CON) is required to build or open a new hospital, imaging center, surgery center, cardio-vascular and transplant program, hospice agency, home health agency, psychiatric facility, adult day health care program, megavoltage radiation equipment, positron emission tomography along with other health care programs.[50,51]

The premise behind the CON law is that health care economics are not affected by competition and costs can be lowered by controlling hospital growth and duplication of services. However, the CON laws are old and were enacted before for-profit hospitals were commonplace. Some for-profit hospital chains have had in their SEC 10K reports business plans that targeted rural communities to obtain a favorable markets with less competition. This attests that the premise of health care economics not being affected by competition is no longer valid. Community Health Systems has three Kentucky Hospitals. Here was what their December 31, 2005 SEC 10K report stated:

> "We target hospitals in growing, non-urban healthcare markets because of their favorable demographic and economic trends and competitive conditions. Because non-urban service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services. Also, we believe that non-urban communities generally view the local hospital as an integral part of the community." [52]

The institute of Health and Socio-Economic Policy compared the charge to cost ratio of for-profit and non-profit hospitals using 2003-2004 Medicare Cost Report data.[53] The institute reported a significant increase in Charge to Cost Ratios in Proprietary for-profit than non-profit hospitals.

Type of Hospitals	Number	Total Charge to Cost Ratio
Proprietary Corporation	686	365.81%
Voluntary Nonprofit, Church	580	256.96%
Voluntary Nonprofit, Other	1953	227.00%
Government	910	180.48%

The high cost and inefficiencies of for-profit medicine was reviewed by Woolhandler and Himmelstein.[54] The review found that there was a 19% increase in cost between for-profit vs non-profit institutions and poses the question: "Why does investor ownership increase costs? (answer) Investor owned hospitals are profit maximizers, not cost minimizers." Devereaux, et.al.[55] combined 8 studies comprising 350,000 patients and 324 hospitals. They found a higher cost of care in for-profit as compared to non-profit hospitals.

One should remember that Value equals Quality plus Cost. The above is only part of the equation and the studies on quality versus type of hospital corporation have been mixed. [56, 57, 58, 59]

The CON regulations in Kentucky have been made more restrictive by the Fletcher Administration. Expansion of existing hospitals is based upon conditions which exist at only that facility, as for a new facility to enter into a market, a stringent criterion has to be met by at the same time by all hospitals in all surrounding counties.[60] This "Existing Hospital Protective Clause" along with stringent criteria makes it is a virtual impossibility for an additional competitor to enter into most markets in Kentucky.

Unlike, utilities companies, there is not Public Service Commission to over see charges of hospitals. They have virtual monopolies whose charges are unchecked by governmental oversight or by market forces. One should not assume that a publicly traded for-profit company will pass on its income it has secured, by holding a state sanctioned monopoly, to the customer and not to its stock holders.

Multiple studies have failed to show that CON regulations result in any significant cost savings for acute hospital care. One study,[61,62] in 1998, by Conover and Sloan of longstanding CON programs in other states found that:

> "Mature CON programs also result in a slight (2 percent) reduction in bed supply but higher costs per day and per admission, along with higher hospital profits." [63]

Morrisey noted that in a 1991 Study which he co-authored that "Hospitals in states with CON had costs that were 20.6% higher" [64]

In 2004, the Federal Trade Commission and Department of Justice compiled an extensive report after 27 days of testimony from 250 panelists, coupled with independent research, reached the following as one of their conclusions:

> "States should decrease barriers to entry into provider markets. States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs. The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. As noted earlier, the vast majority of single-specialty hospitals – a new form of competition that may benefit consumers – have opened in states that do not have CON programs. Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns." [65]

Kentucky's new certificate-of-need regulations for acute care hospitals are among the most restrictive in the United States. They not only prevent competition but also foster monopolies where competition is needed. Theses CON policies may actually increase the price tag of health care – particularly in rural markets where state-sanctioned, for-profit monopolies exist.

The effectiveness of Kentucky's Certificate-of-Need law was reviewed in 1997. Legislative Research Commission (LRC) staff notes included the following comments regarding the law: [66]

> "CON does not control costs or increase access."
>
> "In attempts to control costs CO(N) actually limits access"
>
> "CON has been effective in creating barriers (and) has slowed growth which has slowed cost increases."
>
> "CON is a barrier, By doing away with the CON will increase access."

> "What we have now is not creating competition. Instead it is creating monopolies."

Managed care was also given credit for controlling costs, and the certificate-of-need law was given credit for creating barriers.

The final subcommittee report concluded: [67]

> "When Kentucky looks at its increases in the volume of outpatient services and costs, particularly outpatient surgeries, it seems evident that the (certificate-of-need) process has fallen short of its intended purpose."
> "As managed care continues to develop in Kentucky and works to promote competition and cost containment, the usefulness of CON for certain services will be limited at best."
> "CON has done very little to enforce the role of quality in reducing the rate of cost increases."

Economic Perversions Caused by the Certificate of Need:

Some acute care hospitals in the State have entered the outpatient service market and use the CON process to prevent other lower priced providers from entering the market. Some have justified this practice by citing the indigent care they provided and the necessity of cost shifting to cover expenses. This is a reprehensible practice for the following reasons.

> 1) To create a system which underpays for indigent care is wrong, but to correct this by overcharging working patients just compounds the problem. Instead of society paying for indigent care, the payment will fall on the uninsured working poor. This is the segment that has the resources to pay out-of-pocket for the service but not the insurance to protect them from price gouging. Why should they get stuck with a bill for an MRI scan which costs twice as much as those who have insurance?
>
> 2) Hospitals are not the only health care providers that provide indigent care. Doctors do too and in southeast Kentucky they are also in a crunch to make end meet. They are faced with a large influx of patients without insurance and little resources to pay their medical bills. Why shouldn't doctors be able to compete for this market on a level playing field?

3) Hospitals can still provide their services to patients admitted to the Hospital and in their emergency room. In this setting, the Hospitals have a captive audience and it is known that services in this setting cannot be provided as inexpensively as in an out-patient setting. This is the whole reason why outpatient services came about.

4) Finally the premise of the statement is not valid. Hospitals do get paid for indigent care. Hospitals receive payment for Kentucky residents that are at or below the poverty level and not covered by Medicaid through the Kentucky Disproportionate Share Hospital (DSH) Program.[68] This program only covers outpatient and inpatient hospital care. It does not cover physician services.

Effects of Eliminating the CON:

In an extensive review of the literature the State of Washington Joint Legislative Audit and Review Committee reported that repeal of the Certificate of Need resulted in surges in providers in some but not all states.[69] These surges lessened with time and there was no pattern observed between states. The following States experienced surges.

> Utah: Psychiatric and Nursing Home.

Arizona: Open Heart and Nursing Home.
Tennessee: Home Health (only removed for home health and because of the surge reinstituted in the early 1990s) [70]
Ohio: Hospitals, Ambulatory Surgery, Dialysis, and Pediatric Services.

Grabowski, et. al. reviewed state data from 1981 through 1998 and found that repealing their CON laws did not cause a significant growth in nursing home or long-term care Medicaid expenditures.[71]

An analysis of charge to cost ratios in States with and without CON's for acute care hospitals revels that there is little difference using 2003-2004 Medicare Cost Report data. Charge to Cost ratios in States without a CON is only 3.5% smaller that states with a CON (t-test, p value 0.694).[72]

There are examples of healthcare markets in Kentucky that have competing providers but still have high costs. However, when a consumer does not know the price or quality of the service he is buying competition cannot exist. There is little market resistance to new providers, since there are no quality or price benchmarks which they have to match. One can argue that transparency in healthcare costs and quality must first take place before the CON is removed. This stepwise process may help in the prevention of initial surges in providers once the CON is repealed.

Another problem is that in Kentucky there is no longer a citizens board to oversee the administration of the CON.

IV. Iron Triangle of Health Care:

Costs: Acute Hospital care in Kentucky is expensive, and Kentucky is a poor state. According to the Institute of Health and Social Policy, Kentucky has the 17th highest charge-to-cost ratio in the United States using data from fiscal years 2003-2004.[73]

Quality: Conover, Sloan also stated that **"**It is doubtful that CON regulations have had much effect on quality of care, positive or negative."

As pointed out in the June 1997 LRC Staff Notes and in the report on Certificate of Need in Kentucky, if the certificate of need was abolished, better quality could be enforced through licensure. Quality can also be promoted by market pressure in a competitive health care environment.[74]

The Fletcher Administration originally proposed CON quality Criteria of: [75]

a. Medicare or Medicaid certification was revoked;

b. Accreditation from the Joint Commission on Accreditation of Health Care Organizations was revoked;

c. A documented history of uncorrected quality control problems which threaten the life, health and safety of the hospital's patients. Examples may include higher than normal rates of preventable hospitalization, medication errors, or hospital acquired infections

However, these criteria were eliminated and replaced with criteria which required the final loss of licensure, accreditation or Medicare/Medicaid funding in all hospitals in the county and surrounding counties. [76]

It is argued by some that the CON improves quality. However, one of the main principles of a free market economy is that competition promotes quality. Without competition, prices may soar and quality can fall, resulting in a reduced Value

of health care. State which do not have CONs include: Texas, California, Ohio, Indiana, Pennsylvania and Minnesota. Certainly, one can argue that the Cleveland Clinic and Mayo Clinic are thriving in this environment. They thrive because of their reputation and quality.

Access: The 1997 LRC notes repeatedly referenced that the Kentucky CON reduced access. This seems to be in direct conflict with the Statutory purpose of the CON as described in KRS 216B.010. Recently, Sen. Tom Buford stated that Certificate-of-Need's main effect is to limit Medicaid access and increase the cost in underserved areas by creating monopolies.

V. Conclusion

The goals of the Kentucky CON are clear improving the cost, quality and access of health care – often referred to as the "Iron Triangle" of health care. The theory asserts that increasing emphasis on one of the three usually decrease the outcome of the other two. But it is becoming more evident that the Kentucky's CON regulations actually reduce the size of the entire triangle. It is widely stated that health care does not respond to the same economic forces as other industries, but what else can be expected when certificates of need all but assure customers and that meaningful price and quality information is hidden from consumers? Transparency in healthcare costs and quality should first take place before the Certificate of Need is removed. This stepwise process may help in the prevention of initial surges in providers that have been observed in some, but not all, States once CON regulations are repealed.

Resources:

The Commonwealth Fund: http://www.cmwf.org/index.htm

Depart of Health and Human Services Call for Value Drive Health Care: http://www.hhs.gov/transparency/

The Kaiser Family Foundation: http://www.kff.org/

Health Watch USA: www.healthwatchusa.org

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Policy Report

Promoting Health Care Transparency and Value

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