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Crisis to Cure

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GOVERNMENT INTRUSION VS. FREE MARKET INNOVATION:
UNDERSTANDING MAINE'S CERTIFICATE OF NEED LAW

by Joel Allumbaugh
Director of the Center for Health Reform Initiatives
The Maine Heritage Policy Center

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INTRODUCTION

Health care spending in the United States far exceeds that of other countries, currently representing about 18 percent of the gross domestic product. If health care continues to grow at historical rates, this is expected to grow to 34 percent by 2040.[1] This is quickly eating up family budgets. From 2000-2009, health insurance premiums rose 8 percent compared to household incomes at about 2 percent. If this trend continues, health care will surpass household income by 2033.[2]

Why is health care spending such an outlier? In the overwhelming majority of markets in the U.S. economy, market competition determines prices and quality of goods and services. Companies compete to satisfy consumer demand and consumers consider price and quality to determine what goods and services they will purchase. In a well-functioning market, consumers make decisions based on good information, clear preferences, and appropriate incentives. Sellers respond by adjusting to meet consumer preferences when delivering their products and services.

What happens if sellers do not respond to consumer preferences? In most markets, they simply lose customers and either adjust to gain those customers back or ultimately go out of business. If all sellers in a market choose not to respond to customer preferences and have the luxury of keeping competitors out, prices inevitably rise and quality often suffers.

We are now beginning to describe the U.S. health care system. Health care in the U.S. flows through an extensive regulatory framework at both the federal and state levels of government, developed over decades, and further distorted by our third-party payer system. Though much of the regulatory framework arose haphazardly, it affects where and how competition takes place in health care markets.

One clear example of a regulatory barrier to competition in health care is Maine's Certificate of Need (CON) law. CON injects a bureaucratic approval process in the path of health care investment. This distorts provider responses to consumer demand and restricts access to health care services. It also dampens competition, which further exacerbates the rising cost of health care products and services.

Health care spending in the United States represents about 18% of the gross domestic product.

BACKGROUND

Maine's Certificate of Need (CON) laws have historical roots in the federal "National Health Planning and Resources Development Act of 1974" (NHPRDA).[3] To understand the purpose of the NHPRDA, it is important to understand the health care payment model in place at the time.

When Congress passed the NHPRDA, government and private insurance paid health care expenses on a cost-based, retrospective basis. Priced-based competition was absent in health care as providers could recover their full cost for provided services from Medicaid, Medicare, and most private insurers, no matter what those costs were. This combined with the general concern that patients would not be sufficiently informed to seek value in health care purchases led to the fear that providers would expand services unchecked by market forces—that supply would inevitably drive demand.

Interestingly, Congress also believed, and stated in the findings and purpose section of the NHPRDA, that "the massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources."[4] It is ironic that lawmakers at the time recognized the role government intervention played in creating a problem they proposed fixing with increased government intervention.

From 2000-2009, health insurance premiums rose 8% compared to household incomes at about 2%.

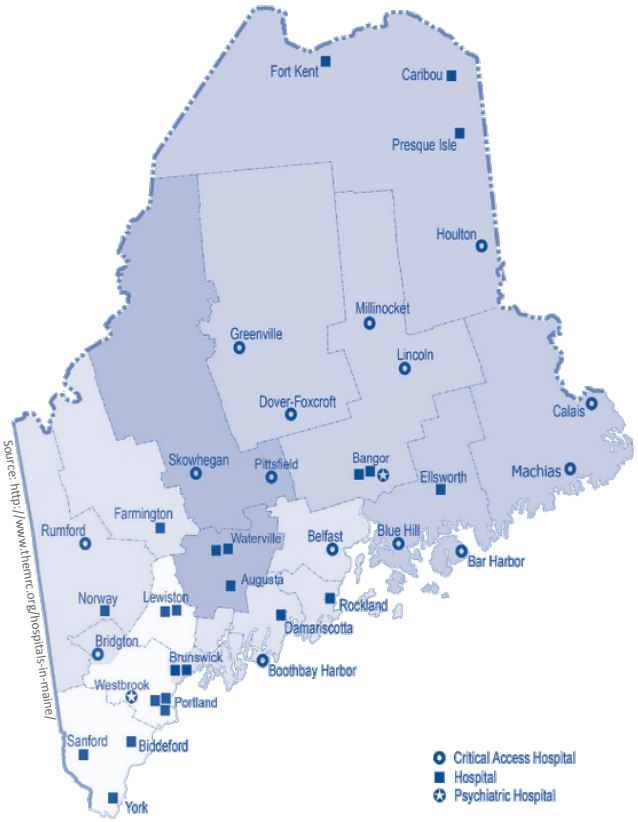
The NHPRDA required states to undergo substantial health planning activities under the threat of losing federal funding. This resulted in all states adopting CON laws of varying degrees. Though Congress ultimately repealed the NHPRDA in 1986, many state level health care planning regulations persist today.

Certificate of Need in Maine was initially passed into law in 1978[5] and was ultimately replaced with the *Maine Certificate of Need Act of 2002*.[6] The legislative findings state that "unnecessary construction or modification of health care facilities and duplication of health services are substantial factors in the cost of health care and the ability of the public to obtain necessary medical services."[7]

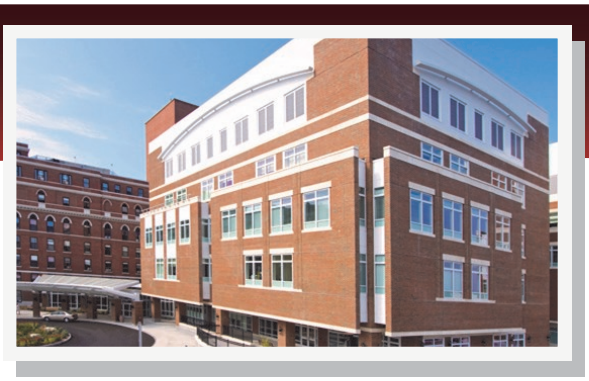
The stated purposes of the law include "support[ing] reasonable choice in health care services while avoiding excessive duplication". Other purposes listed are "support[ing] the development and availability of health care services regardless of the consumer's ability to pay" and "seek[ing] a balance, to the extent a balance assists in achieving the purposes of this subsection, between competition and regulation in the provision of health care."[8]

The Dirigo Health Reform Act,[9] passed in 2003, attempted to strengthen Maine's CON law by establishing limits on health care investment called the Capital Investment Fund (CIF), guiding CON decisions through a State Health Plan, and expanding the scope of CON's reach to encompass "any major health investment-no matter who makes it."[10]

The most recent law passed in Maine affecting our CON program is public law chapter 424.[11] PL.424 was signed on July 6, 2011, and primarily adjusts investment thresholds that trigger CON review. This law is somewhat unique in Maine's CON history as it relaxes, rather than tightening CON's grip on health care investment in Maine.



Maine's Certificate of Need law dampens competition which further exacerbates the rising cost of health care products and services.



HOW CERTIFICATE OF NEED WORKS IN MAINE

Certificate of Need in Maine requires a lengthy and complicated process for an entity interested in making a health care investment in Maine.

The first step in contemplating health care investment is to determine if the project will trigger CON review. Table 1 illustrates the dollar thresholds by category of investment that currently requires a CON application.[12]

It is worth noting that calculating investment amounts is not a perfect science, especially at the start of a project with estimates of projected expenses and the possibility of unforeseen challenges. Therefore, regulated facilities intending to initiate a project often submit a Letter of Intent to the Certificate of Need Unit (CONU) as a precaution prior to beginning a project.

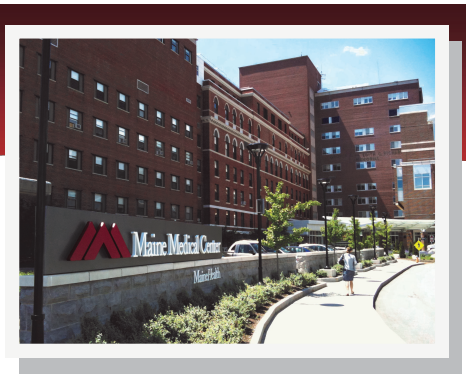
In 2011, the Government Oversight Committee asked the Office of Program Evaluation & Government Accountability (OPEGA) to initiate a limited review of Maine's CON program. They found that between 2008 and 2010 the CONU received and processed 29 CON applications. They also received another 63 Letters of Intent that the CONU determined were "not subject to review."[13]

Submissions for CON review are also subject to regulatory and statutory timelines that govern the CON review process. Many CON applications, therefore, can only be submitted at certain times of the year. The Department of Health and Human Services (DHHS) 2010 Report, *Certificate of Need Act* outlines the cycles applicants must target when making submissions.[14]

Once an application is submitted, there are a series of information requests that could follow. The CONU also accepts information from the public pertaining to a given project facilitated by a public information meeting that may or may not trigger a formal public hearing. Input is also considered from organizations such as the Maine Quality Forum, the Maine Center for Disease Control, and the Maine Bureau of Insurance.

Following its initial analysis, the CONU produces a preliminary analysis report which offers a recommendation on the application. The record is then open for additional comments and information for submission after which the CONU submits a briefing memo with its final recommendation to the DHHS Commissioner. The Commissioner then reviews the briefing memo and issues a final decision. Any person directly affected by a final CON decision may then request reconsideration of the decision from DHHS. An applicant's final recourse for an unfavorable decision is an appeal to Superior Court.

The *Certificate of Need Act of 2002* and the CON rules specify that the following are among the factors that must be considered in processing a CON application:



- The applicant is fit, willing and able to provide the proposed services at the proper standard of care.[15]
- The economic feasibility of the proposed services.[16]
- There is a public need for the proposed services.[17]
- The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State.[18]
- Ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.[19]
- Does not result in inappropriate increases in service utilization.[20]

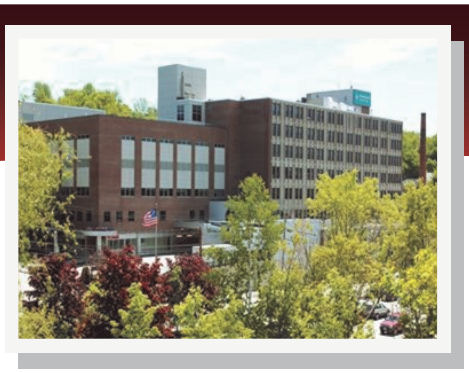
Filing fees must also accompany CON applications, though the fees likely pale in comparison to the costs incurred in completing the application itself and navigating the review process. CON filing fees alone, from 2008 through 2010, exceeded $529,000.[21]

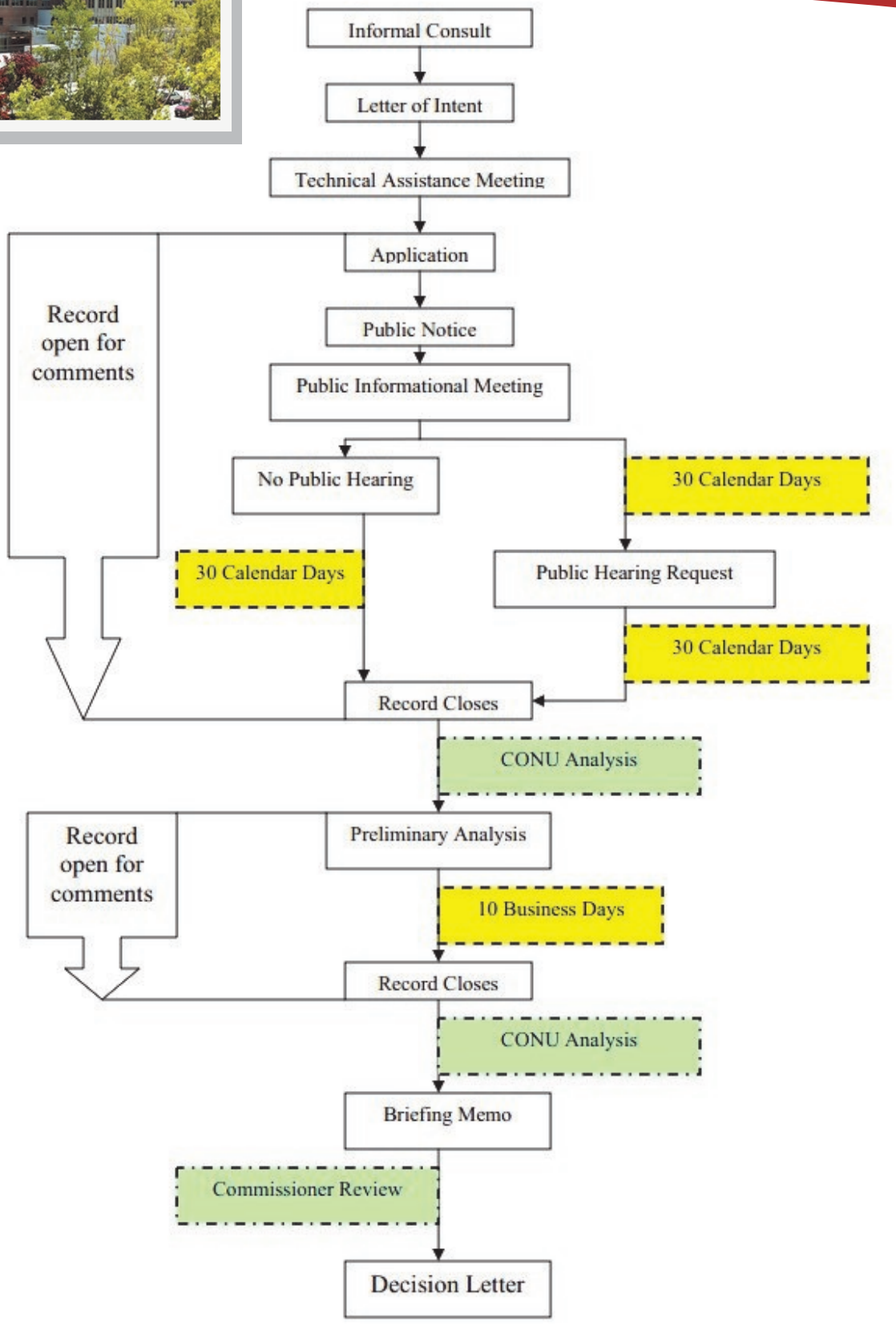
Table 1: Thresholds Triggering Certificate of Need Review

Expenditures		2/15/2012 Base	Effective 1/1/2013 2.93%
Capital Expenditures		$ 10,000,000	$ *10,293,000*
Major Medical Equipment		$ 3,200,000	$ *3,293,760*
New Technology		$ 3,200,000	$ *3,293,760*
NF Capital Expenditures		$ 5,000,000	$ *5,146,500*
New Health Service			
	Capital	$ 3,000,000	$ *3,087,900*
	3rd Year Annual	$ 1,000,000	$ *1,029,300*
New Health Facility		$ 3,000,000	$ *3,087,900*
New Health Facility - NF		$ 5,000,000	$ *5,146,500*

[1] Adjusted by Medical Care Services Index amount from January 2012 until November 2012. As of January 2012 this index was 432.583. November 2012 index is 445.278

http://www.bls.gov/news.release/cpi.t01.htm

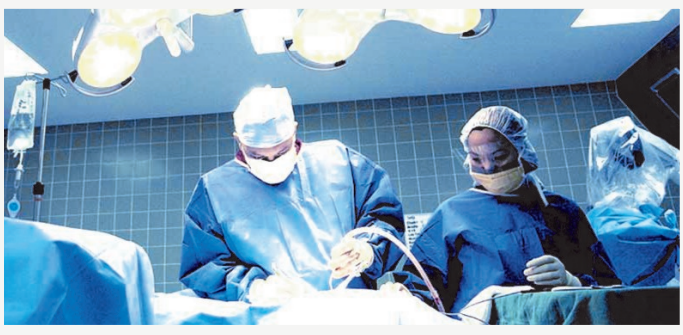



Informal Consult
Letter of Intent
Technical Assistance Meeting
Application
Record open for comments
Public Notice
Public Informational Meeting
No Public Hearing
30 Calendar Days
30 Calendar Days
Public Hearing Request
30 Calendar Days
Record Closes
CONU Analysis
Record open for comments
Preliminary Analysis
10 Business Days
Record Closes
CONU Analysis
Briefing Memo
Commissioner Review
Decision Letter

CERTIFICATE OF NEED EXAMINED

Proponents of CON laws often cite "Roemer's law" which is chronicled in a report written in 1959 by Milton Roemer and Max Shain titled *Hospital Utilization Under Insurance*.[22] Wikipedia explains Roemer's law as "in an insured population, a hospital bed built is a filled bed."[23] Stated differently, Roemer posits that in health care, supply drives demand. Regardless of the accuracy of Roemer's law, it has served as the basis of CON laws in addition to other central planning initiatives in health care, most recently the advent of Accountable Care Organizations.

There are many arguments against Roemer's Law. One of the more convincing arguments appears in John Goodman's Health Policy Blog on July 13, 2011.[24] Author Greg Scandlen points to the fact that "people are not eager to enter the hospital, even when the cost is zero." He also points out that if the "law" were true, hospital occupancy should approach 100 percent at all times. He then cites the example that from 1970 to 2000 national hospital occupancy rates dropped from 77 percent to 67 percent according to the National Center for Health Statistics. He further points to variance in hospital occupancy rates which in 2005 were 92 percent in Delaware compared to 53 percent in Idaho. It is notable that Idaho repealed its Certificate of Need law in the early 1980's.



As shown in Table 2, for fiscal year 2010 as reported by statehealthfacts.org, comparing the ten states with the fewest hospital beds per thousand residents to the ten states with the most hospital beds per 1,000 residents finds that the expense per inpatient day is $878 more in states with fewer hospital beds, $2,282 compared to $1,404. Restricting supply, as Roemer suggests, has the perverse effect of raising costs.

One notable point Roemer's law makes is the effect of third party payers in health care. When someone else pays the bill as has largely been the case both from government programs like Medicare and Medicaid and from private insurance policies, the usual tension between buyer and seller does not exist. This mirrors the recognition by Congress that "the massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care"[25] as stated in the National Health Planning and Resources Development Act of 1974. Yet both arrived at the conclusion that regulations restricting supply and government central planning are the solution rather than addressing the distortions created by regulations and our third party payer system. Roemer does note that "This analysis, moreover, represents the views of one research

If health care continues to grow at historical rates, costs are expected to grow to 34% by 2040.

group. Other students of the problem would identify other factors or cast these in another light."[26]

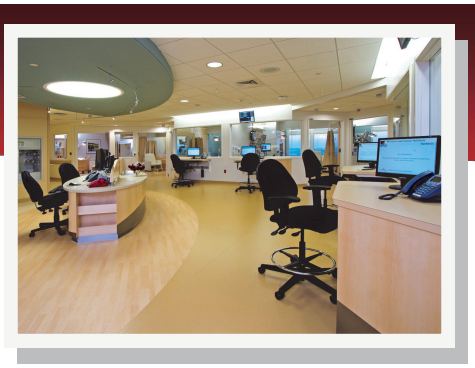
In July 2004, the Federal Trade Commission and the Department of Justice jointly published a report titled *Improving Health Care: A Dose of Competition.*[27] The report was based on 27 days of Joint Hearings from February through October, 2003; a Commission-sponsored workshop in September, 2002; and independent research. Their report states that "CON programs can pose serious competitive concerns that generally outweigh CON programs' purported economic benefits. Where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."[28]

The report closely examines the role of competitive law in health care delivery and the competitive concerns that CON programs raise. They remark that "CON regimes prevent new health care entrants from competing without a state-issued certificate of need." "This process has the effect of shielding incumbent health care providers from new entrants."[29] They go on to say that "CON programs can retard entry of firms that could provide higher quality services than the incumbents. By protecting incumbents, CON programs likewise can delay the introduction and acceptance of innovative alternatives to costly treatment methods." They provide the example that "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."[30]

Table 2:
Comparison of Hospital Expenses of the Top 10 and Bottom 10 States Based on Number of Hospital Beds
Fiscal Year 2010

State (Least)	Hospital Beds Per 1,000 People	Hospital Expenses Per Inpatient Day
Arizona	2.1	$2,173
California	1.9	$2,566
Colorado	2.0	$2,190
Idaho	2.1	$1,748
Maryland	2.0	$2,338
Nevada	1.9	$1,885
New Mexico	1.9	$2,058
Oregon	1.7	$2,818
Utah	1.8	$2,233
Washington	1.7	$2,810
Average	1.9	$2,282
State (most)	Hospital Beds Per 1,000 People	Hospital Expenses Per Inpatient Day
Washington D.C.	5.7	$2,434
Kansas	3.5	$1,304
Louisiana	3.4	$1,561
Mississippi	4.4	$1,154
Montana	3.7	$1,190
Nebraska	4.0	$1,516
North Dakota	5.0	$1,342
South Dakota	5.0	$1,113
West Virginia	3.9	$1,323
Wyoming	3.5	$1,103
Average	4.2	$1,404
Difference	**2.3**	**-$878**

Source: statehealthfacts.org and The Maine Heritage Policy Center

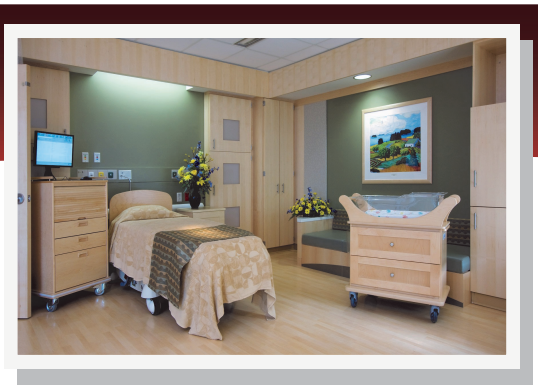


The FTC/DOJ report goes so far as to "urge states with CON programs to reconsider whether they are best serving their citizens' health care needs by allowing these programs to continue."[31] They further observe that "Remedies must resolve the anticompetitive harm, restore competition, and prevent future anticompetitive conduct."[32] The report's recommendations include:

- "Private payers, governments, and providers should furnish more information on prices and quality to consumers in ways that they find useful and relevant,"[33]
- "States should consider implementing uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish to move in-state."[34]
- "Governments should reexamine the role of subsidies in health care markets in light of their inefficiencies and potential to distort competition."[35]
- "Governments should reconsider whether current mandates best serve their citizens' health care needs."[36]

Joseph M. Miller, assistant chief, Litigation I Section at the U.S. Department of Justice, in testimony March 25, 2008 before the Florida Senate Committee on Health and Human Services Appropriations remarked that "The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat to the efficient performance of healthcare markets." "We have examined historical and current arguments for CON laws, and conclude that these arguments provide no economic justification for depriving consumers of the benefits of free markets."[37]

In discussing the benefits of competition in healthcare, Mr. Miller states: "Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services. They drive innovation and ultimately lead to the delivery of better healthcare. Government intervention can undermine market forces to the detriment of healthcare consumers."[38]



If current trends continue, health care costs may surpass household income by 2033.

EFFECTIVENESS OF CERTIFICATE OF NEED IN MAINE

In a 2004 report by Consumers for Affordable Health Care titled *When, Where and How Much: Improving Maine's Certificate of Need Program,* the authors note that "Maine's current CON statute is viewed by some as one of the more comprehensive CON statutes in the country."[39] Though there have been a series of reports and studies on Maine's CON program since its inception in 1978, all have recommended Maine maintain its CON regulation, make it more stringent, or tweak it procedurally. Few have considered any empirical evidence regarding the efficacy of Maine's CON program in its aim of containing the growing cost of health care.

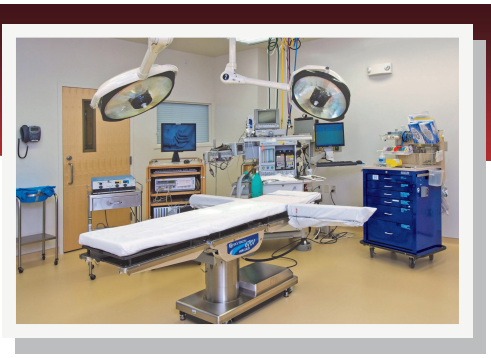
In a 2006 University of Maine Law School research paper studying CON in Maine, the author notes that a 1982 legislative committee report[40] "Curiously… refers to four articles, each of which concludes that CON is ineffective at controlling costs. The report refers to no articles or studies showing CON's effectiveness. In light of the cited evidence, the Report's recommendation to make Maine's CON program more stringent is puzzling."[41]

Perhaps the most important measure to consider in evaluating Maine's CON law is the end result in terms of health care cost containment. In *Maine's Certificate of Need: An Examination of the Empirical Evidence,* the author points out that "Capital expenditure growth rates in Maine have consistently outpaced those of other New England states, the Northeast region, and the nation. Between the years of 1998 and 2002, for example, capital expenditures in Maine grew at an average rate of 8.4 percent whereas capital expenditures in the Northeast and New England grew at an average rate of 6.6 percent. Importantly, capital expenditures in Pennsylvania, which allowed its CON law to expire in 1996, grew at an average rate of only 5.7 percent during the same period."[42]

The American Hospital Association released a report in January of 2013[43] that identifies the percent of total employment supported by hospital employment in each state. Maine leads the nation with 13.02 percent, 49 percent higher than the national average of 8.76 percent.

According to statehealthfacts.org:

- Average annual growth in health care expenditures in Maine from 1991-2009 was 7.4 percent compared to the national average of 6.5 percent.[44]
- Average annual percent growth in health care expenditures per capita in Maine from 1991-2009 was 7 percent compared to the national average of 5.3 percent.[45]
- Health care expenditures per capita in 2009 in Maine were $8,521 compared to the national average of $6,815.[46]
- Average per person health insurance premiums in the individual market in Maine were 31 percent higher than the national average in 2010 at $282 compared to the national average of $215.[47]



SUMMARY CONCLUSIONS

CON injects a bureaucratic approval process in the path of health care investment. This distorts provider responses to consumer demand and restricts access to health care services. It also dampens competition which further exacerbates the rising cost of health care products and services.

While Maine has one of the more stringent CON laws in the country, we have failed to moderate health care cost increases or capital investment. The 2011 OPEGA report states that "of the 29 CON applications filed in the three year period, 27 were approved, and over the last five years 57 of 60 CON applications were approved."[48] Meanwhile Maine leads the nation with 13.02 percent of total employment supported by hospital based employment[49] and exceeds the national average in health care expenditures per capita[50] and growth of health care expenditures both per capita[51] and overall.[52] As a result, Maine's average individual health insurance premiums are 31 percent higher than the national average.[53]

The Maine CON law protects incumbents and inhibits innovation. Among the factors that must be considered when processing a CON application is that the project "not negatively affect the quality of care delivered by existing service providers."[54] In addition, any person directly affected by a final CON decision may then request reconsideration of the decision from DHHS. This clearly tilts the playing field in the favor of incumbent providers, if for no other reason than affording them the opportunity to delay a CON decision.

Certificate of Need injects a bureaucratic approval process in the path of health care investment.

Payment models are also continuing to evolve, requiring flexibility for our health care markets to respond to consumer demand. Cost-based reimbursements have largely eroded and been replaced by prospective price negotiation. Higher deductibles and patient cost sharing responsibility have created a financial incentive for patients to seek value from health care expenditures.

Free markets lead to higher quality and lower cost, a fundamental principal that must be restored to health care. Government intervention, such as Maine's CON law, undermines market forces to the detriment of healthcare consumers.

POLICY RECOMMENDATIONS

1. Maine's Certificate of Need law should be fully repealed. The evidence that CON has not reached its intended goals is overwhelming. Health care investment should be motivated by the desire to meet patient needs, not a bureaucratic approval process that favors incumbent market participants.

2. Maine should seek opportunities to promote health care transparency. Providers should furnish information on prices and quality to consumers in ways they find useful and relevant. The State of Maine can support this effort by leveraging public payer databases to highlight cost variances and direct services to high quality/lower cost providers within government programs. The state can also enhance its efforts to promote transparency and direct care within the state employee health plan.

3. Maine should heed the advice of the Federal Trade Commission and Department of Justice and implement uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish to move in-state.

ABOUT THE AUTHOR: JOEL ALLUMBAUGH

Joel Allumbaugh
Director of the Center for Health Reform Initiatives

In addition to serving on the Board of Advisors for The Maine Heritage Policy Center, Joel Allumbaugh is MHPC's Director of the Center for Health Reform Initiatives.

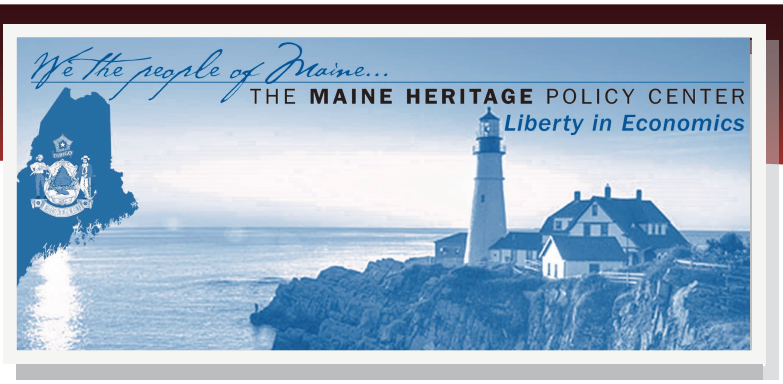
Mr. Allumbaugh is also the chief executive officer of National Worksite Benefit Group, Inc. (NWBG), a full service employee benefits insurance agency specializing in patient-centered health plan strategies. Joel co-founded NWBG in 2003.

Mr. Allumbaugh is the past director of the Maine Association of Health Underwriters where he served as President from 2002-2003 and from 2007-2011. Joel is a licensed life and health insurance consultant and continuing education instructor. Joel also hosted Inside Maine Healthcare, a television program aired on the Time Warner Cable network from 2010-2012.

Mr. Allumbaugh joined The Maine Heritage Policy Center in 2010.

Appointments:

- Appointed by Governor LePage to the Advisory Committee on Maine's Health Insurance Exchange (2011)
- Appointed by Governor LePage and confirmed by the Maine Legislature to the Maine Governmental Facilities Authority (2011)
- Appointed by Maine Superintendent of Insurance, Eric Cioppa, to the Maine Guarantee Access Reinsurance Association (2011)



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The Maine Heritage Policy Center is a research and educational organization whose mission is to formulate and promote conservative public policies based on the principles of free enterprise; limited, constitutional government; individual freedom; and traditional American values—all for the purpose of providing public policy solutions that benefit the people of Maine.

MHPC's staff pursues this mission by undertaking accurate and timely research and marketing these findings to its primary audience: the Maine Legislature, nonpartisan Legislative staff, the executive branch, the state's media, and the broad policy community. MHPC's products include publications, articles, conferences, and policy briefings.

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- **Education – The Center for Education Excellence | www.GreatSchoolsForME.org**
- **Health Care – The Center for Health Reform Initiatives | www.MaineHealthReform.org**
- **Transparency & Open Government – The Center for Open Government | www.MaineOpenGov.org**
- **Constitutional Government – The Center for Constitutional Government**

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THE **MAINE HERITAGE** POLICY CENTER
www.MainePolicy.org | www.MaineHealthReform.org
Post Office Box 7829, Portland, Maine 04112
207.321.2550 office | 207.773.4385 fax

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