STATE OF ILLINOIS
HEALTH FACILITIES PLANNING BOARD

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March 6, 2007

Mr. Dan R. Long
Executive Director
Commission on Government Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706

Dear Dan:

We have reviewed the report prepared by the Lewin Group, "An Evaluation of Illinois' Certificate of Need Program." Generally, the report appears well researched and written, and the CGFA should be commended for completing this assignment in such a short time frame.

However, due to constraints, the report was an exhaustive study of the very complex issues of health care distribution, regulation and the public policy matters pertaining to the same. In light of the looming repeal of the Act, we have taken the liberty of compiling additional information. This is intended to address the efficacies and public benefits of Illinois' Certificate of Need program, as well as the implications to public health in the event the Act is repealed. We hope that this will serve as supplemental information for the readers of the Lewin report.

Respectfully submitted by,

Jeffrey S. Mark
Executive Secretary

Frank Urso
Acting General Counsel

SUPPLEMENTAL INFORMATION TO "AN EVALUATION OF ILLINOIS' CERTIFICATE OF NEED PROGRAM"

Overview

On February 15, 2007, the Lewin Group issued a report, "An Evaluation of Illinois' Certificate of Need Program." This report was mandated by House Resolution 1497 and prepared under the auspices of the Commission on Government Forecasting and Accountability. While this study appears well researched and written, it is not an exhaustive study. It appears to have omitted some key and fundamental aspects and benefits of the program. We respectfully submit the following supplemental information for consideration by the report's readers.

Purpose of the Health Facilities Planning Act

The CON program has, in fact, has successfully fulfilled its specific statutory mandate -- limiting "unnecessary construction or modification of health care facilities." The fundamental purpose of the Act as stated In Section 2,

> *The purpose of this Act is to establish a procedure designed to reverse the trends of increasing costs of health care* ***resulting from unnecessary construction or modification of health care facilities****.* (20 ILCS 3960/Section2) (emphasis added)

FY2002 through February, 2007 the Health Facilities Planning Board has considered 536 applications for CON. Of these, 397 have been approved. The impact on construction and modification costs, are as follows:

$8.0 billion Project Costs Proposed

$6.4 billion Project Costs Approved

$1.6 billion Difference (Savings)

As with any regulatory program of this type, a number of potential applications are never submitted due to an inability to meet the standards and criteria established by the program. The above cost savings numbers DO NOT reflect potential applications never submitted. While it is difficult to quantify the number of applications "not received" we believe that 20 to 30 new facilities per year would be a reasonably conservative estimate of additional facilities which would be established if this program did not exist. This conclusion is based upon conversations with CON consultants.

SUPPLEMENTAL INFORMATION TO "AN EVALUATION OF ILLINOIS' CERTIFICATE OF NEED PROGRAM"

Implications of Repeal

On April 1, 2007 the Health Facilities Planning Act (20 ILCS 3960/1 *et seq.*) is scheduled to expire. The following is an analysis of the public health and legal ramifications if the Illinois Health Facilities Planning Board (Board) sunsets.

1. Lose $1 million in community benefits (see table 1)
During the last six months, several health care providers reached agreements with the Health Facilities Planning Board regarding compliance issues. The aggregate value of those agreements approaches one million dollars *based upon actually costs*. Further, the entire benefit from the agreements is directed toward vulnerable groups within the community. The agreements direct the health care providers to offer services that **would not otherwise** be provided. Dissolution of the Health Facilities Planning Board would nullify all the agreements. Therefore, vulnerable community populations would lose valuable health care services currently provided.

2. Increased health care service disparity based on social status[5, 8]
The Health Facilities Planning Act is the only legislative restraint on health care facility competition. Resulting from the heightened competition, health care providers will seek more "profitable" patients (that is, patients with insurance). Therefore, health care providers will lack interest in building facilities at locations serving "low reimbursement" patients. Typically, patients living in economically affluent areas are insured contrasted with patients without insurance who typically live in less affluent areas. Additionally, health care facilities will limit either marginally profitable or unprofitable community services in order to survive the increased competitive environment.

3. Increased service disparity based on geography[6]
When Ohio repealed its CON laws, urban hospitals disproportionately closed. Urban hospitals often treat poorer people so geographic-based disparity will exacerbate the social status-based disparity. That is, the most vulnerable and needy population will lose access to health care services.

4. Increased service disparity based on race[4, 7]
African-Americans are largely concentrated in urban areas so loss of urban hospitals reduces access to health care services. Further, less affluent areas are disproportionately comprised from African-Americans. Therefore, as geographic and economic-based disparities increase, the African-American community disproportionately suffers. Further, a recent Ford-UAW Community Health Care Initiative survey discovered that

serious health care disparities existed in the Kansas City (Kansas lacks CON laws and Missouri has extremely weak CON laws) area based on race with African-Americans having decreased access to health care.

5. Increased health care costs[1, 2, 3, 4, 5, 6, 7, 8, 9]

Inability to monitor the appropriate number of beds can lead to excess beds. A recent Dartmouth study concluded that extra bed capacity added $24.1 billion to national health care costs. The three main United States auto manufacturers discovered in a recent survey that the automakers' health care costs were **thirteen percent higher** in Indiana (recently deregulated) and **seven percent higher** in Ohio (also recently repealed CON) compared to Michigan, which has a very active CON process. In Indiana, which recently repealed its CON laws, an inability to corral increased competition between specialty and general hospitals led to loss of employer leverage over health care providers and health plans "caving in" to providers' demands for higher payments. Additionally, specialty hospitals proliferate when CON laws are repealed. Specialty hospitals are typically physician owned and several studies demonstrate that physician ownership increases utilization rates, which results in additional health care costs.

6. Reduced quality of Care [1, 5, 10]

A recent University of Iowa study demonstrated that coronary artery bypass graft (CABG) patients in states lacking CON laws experienced a **twenty-one percent higher** risk of death compared with patients in states with CON laws. Additionally, after Pennsylvania's CON laws expired, Pennsylvania hospitals dropped below the Leapfrog group's quality benchmark for the volume of open-heart cases per hospital.
Also of note, is testimony from a panel of Illinois cardiologists and cardio-thoracic surgeons during an HFPB rules development session. This panel noted that a proliferation of low volume programs may well compromise a facility's ability to retain qualified staff in highly specialized areas such as perfusionists.

7. Additional health care costs from increased utilization[2, 11]

Under Illinois law, the Health Facilities Planning Board is the only entity allowed to oversee the Health Care Worker Self-Referral Act (225 ILCS 47/). A 1989 Office of Inspector General (Department of Health and Human Services) study demonstrated that provider investment in health care facilities resulted in increased utilization of health care services. Further, the OIG found that increased utilization led to additional health care costs. Additionally, providers have a financial incentive to "cherry-pick" patients based on the patients' ability to pay. The Health Care Worker Self-Referral Act is the only state legislation that regulates this provider behavior.

8. Increased hospital closures[4]

A recent study of the effect of Ohio repealing its CON law demonstrated that a substantial number of hospitals closed after the repeal. Further, hospital closures occurred disproportionately in urban areas. Hospital closures decreases access to needed health care services. Additionally, hospitals employ many well-educated and trained personnel. When hospitals close, these employees lose their jobs.

9. Increased burden on hospital emergency rooms[6]
Cleveland hospitals, after Ohio repealed its CON laws, experienced dramatic increases in emergency room patients. After two Cleveland hospitals closed, the remaining hospitals had to cover the service loss. The greater burden on the remaining hospitals' emergency rooms increased the number of emergency room diversions, which, in turn, substantially lowers the quality of care and decreases access to necessary health care services.

10. Unnecessary duplication of health care services[1, 7]
The Health Facility Planning Board is the only state "tool" for maintaining and tracking the overall inventory of health care facilities and services. If the Board ceases to exist, no state entity will actively monitor the number of hospital and nursing home beds and dialysis stations within a health planning area. Therefore, the potential for excess beds to appear in the state increases. For example, the Kansas City area has 963 excess beds according to a recent Ford-UAW Community Health Care Initiative; as mentioned earlier, excess beds substantially contribute to additional health care costs. Further, duplication of services results in under-utilization of those services, which presents inefficiencies in health care provider

11. Decreased charity care to communities[4, 6, 10]
Boutique, or specialty, hospitals begin to enter the health care market when the only barrier (i.e., the CON law) is removed. Boutique hospitals siphon off community hospitals' insured patients forcing the community hospitals to provide a higher percentage of low-revenue procedures, which in turn substantially affects the community hospitals' ability to provide charity care to the community.

12. Lose public disclosure, review, and comment
The Health Facilities Planning Board provides the only forum for the public's access to health care facilities' plans for construction, service reduction, and ownership change. Further, the Health Facilities Planning Act provides the only "voice" with which the public, the group **most** affected by health care facilities' plans, has the ability to comment on health care facilities plans.

13. Confusion surrounding pending applications

Currently, the Health Facilities Planning Board has **fifty** pending CON applications (in addition to several change of ownership applications) totaling over **$800 million**. Applicants would be thrown into confusion regarding the necessary processes, requirements, and penalties for projects already before the Board. Further, health care facilities without current pending applications will be confused regarding their ability to move forward with projects similar to projects described in currently pending applications.

14. Impact on many state statutes and codes

Many Illinois statutes and departmental codes incorporate the Health Facilities Planning Board and the Health Facilities Planning Act. For example, section 4.5(d) of the Hospital Licensing Act (210 ILCS 85/); section 250.110 of the Hospital Licensing Requirements (77 Ill. Adm. Code 250); section 690.20 of the Nurse Agency Licensing Act (68 Ill. Adm. Code 690); section 100 of the Hospital Basic Services Preservation Act (74 Ill. Adm. Code 755); sections 3-102.2 and 3-103(3) of the Nursing Home Care Act; and sections 205.115 and 205.120 of the Ambulatory Surgical Treatment Center Licensing Requirements (77 Ill. Adm. Code 205). These statutes and codes, in addition to many others not mentioned, will require revision, with the attendant timeframes and political processes, if the Health Facilities Planning Act expires.

15. Require complete revamping of health care facility licensing process
Ambulatory Surgery and Treatment Center and Long-term-care licensing processes depend on the appropriate health care facility obtaining a permit from the Health Facilities Planning Board before the facility can receive a license.

16. Medicaid payment requires permit
Health care facilities undertaking actions where the Health Facilities Planning Act applies cannot receive payment from any State agency unless the facility obtains the required permit from the Health Facilities Planning Board.

Conclusions Regarding Implications

Losing authority and oversight over health care facility construction will create serious public health issues. The authorities and responsibilities of the Health Facilities Planning Board are unique to that Board and not addressed by any other State agency or program. Repeal of the Health Facilities Planning Act will have impacts:

- **Loss of community benefits of direct patient care resulting from settlements of compliance (approximately $3/4 million per year)**
- **Increased disparities in the provision of health care services – racially, geographically and socio-economically**
- **Additional closure of health care providers especially in inner-city and other medically underserved areas of the State**
- **Increase in health care costs from increases in construction and utilization**
- **Unnecessary duplication of health care facilities and services**
- **Decreases in charity care and "marginally profitable" health care services**
- **Loss of public disclosure and ability to provide a "voice" in the establishment, discontinuation and expansion of health care facilities and services within individual communities.**
- **Decrease in the quality of health care services due to the excess number of providers administering procedures or services that require minimum numbers of cases to maintain provider proficiencies and reach maximum benefits for the patients.**
- **Exacerbate the health care labor shortage if new healthcare facilities are built everyone.**

Submitted by:

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Table 1

HFPB/PROVIDER SETTLEMENTS FOR

SERVICES IN KIND AGREEMENTS FOR UNDERSERVED POPULATIONS

Facility	Docket Number	Services in Kind Agreement	Approximate Value
The Willow of the Fountain, Inc.	04_01	For six months the facility must perform 600 blood sugar and 600 blood pressure screenings and provide follow-up information to those patients with abnormal results. The facility must also conduct six public seminars regarding nursing home care. The facility must also provide free access to a family support website to 50 residents in the community.	$16,000
Morrison Community Hospital	04_11	Within one year from the date of the final order provide complete blood counts, metabolic counts and urinalysis free of charge to 150 patients referred from the Whiteside County Health Department, .	$20,000
Hoopeston Community Hospital	04_12	Provide all IDPH mandated vision and hearing screening tests to the school children in Hoopeston, Armstrong, Potomac and Rossville-Alvin School Districts for three years at no charge.	$10,000
Spiritus Dei Eye Surgery Center	04_15	Provide eye exams to 109 Aunt Martha Early Learning Center children. Exams should include: 1) visual acuity distance and near, 2) ocular motility, 3) stereopsis, 4) external ocular, and 5) fundoscopy. Agreed not to accept any referrals from the screenings.	$20,000
Southern Illinois Hospital Services	04_17	Replace $350,000 fine with a $50,000 grant to the Franklin Williamson Human Services to provide health services for the residents of West Frankfort, IL.	$50,000

Table 1

HFPB/Provider Settlements for

Services in Kind Agreements for Underserved Populations

Vista Health and St. Therese Medical Center	05_02	Ordered to pay $50,000.00 to Lake County Health Department for mental health services for Lake County residents; $125,000.00 to Health Reach, to be used to provide free medical and health care to poor and uninsured residents of Lake County; $60,000.00 to develop and implement at least three community-wide health fairs in conjunction with Lake County community organizations. Educational information and materials must be distributed, in addition to health screenings that include: blood pressure, blood sugar, cholesterol, prostate, and cancer prevention.	$235,000
Gottlieb Memorial Hospital	05_06	Provide $25,000.00 worth of free Emergency Care in the Emergency Department. Care will be provided on a first come first serve basis to uninsured or poor patients. A patient who receives free ED care will be provided with free care until completely discharged from the facility.	$25,000
OSF-St. Joseph's Hospital	05_08	Provide $250,000.00 of unreimbursed prenatal obstetrical care at a newly leased clinic in a predominantly Hispanic neighborhood in Bloomington IL. Patient costs are to be calculated at $134.00 per patient, which does not reflect rent or utility costs. St. Joseph's is required to conduct 1,866 visits.	$250,000
Hillcrest Healthcare Center	05_11	$1,000+ Advertise and provide three evening lectures to the community on Hospice Care, the Care and Management of Loved Ones with Mental Illness, and the care and management of High Blood Pressure.	$3,000

Table 1

HFPB/PROVIDER SETTLEMENTS FOR

SERVICES IN KIND AGREEMENTS FOR UNDERSERVED POPULATIONS

St. James Hospital and Health Centers, Sisters of St. Francis Health Services, Inc.	06_05, 06_06, 06_07	In collaboration with Aunt Martha's Healthcare Network, St. James establishes a Radiology Voucher Program. The Program will create vouchers for use by Chicago Heights, IL and Harvey IL residents who are uninsured, underinsured, or uninsurable. The Program must continue until direct costs reach $250,000.00, which do not include administrative salary and benefits.	$250,000
St. Anthony's Memorial Hospital of the Hospital Sisters of the Third Order of St. Francis (Project No. 02-068)	06_17	Submit $150,000.00 to the East Central Illinois Agency of the Illinois Breast & Cervical Cancer Program to fund an awareness/promotion initiative. Submit $100,000.00 to establish a restricted endowment fund providing fitness scholarships to underprivileged children and families residing in the area served by the Effingham Community Sports Center.	$250,000
Hartgrove Hospital (Project No. 04-020)	06_20	Must establish a non-renewable mental health services grant program by 5/1/07. Hargrove will contribute $200,000.00 to the grant, which is awarded to a Community Mental Health Service/Screening Assessment and Support Service Agency.	$200,000
		Total:	**$1,329,000**

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1. Mark J. Gendregske, Daimler Chrysler Corporation, CON Testimonial Notes March 19, 2002 http://www.ciclt.net/ul/sgh/CON%20Endorsement.pdf

"Daimler Chrysler Corporation's three lowest cost areas represent states with CON laws in place, while the two highest cost areas represent states without CON laws"

"In Kenosha, the two major hospital systems are building facilities directly across the street from each other. Lack of CON allowed the aforementioned situation to occur and will exacerbate the nursing shortage in Kenosha (as well as other areas)."

"In addition, lack of CON will add to the excess hospital beds situation in Kenosha"

"Risk adjusted in hospital mortality was 21% higher in patients in 18 states that had no CON regulation for open heart surgery during the period 1994 through 1999, compared to patients in 26 states in which there was continuous regulation for open heart surgery during this period."

"Virginia: Reintroduced its CON law four years after repeal in order to check uncontrolled growth. An oversupply of service resulted in six Virginia hospitals failing Medicare volume/proficiency guidelines."

"Kentucky: Following the repeal of CON, the state issued a moratorium on new health care construction and expansion to address a serious budget imbalance."

2. The Center for Evaluative Clinical Sciences, "The Dartmouth Atlas of Health Care" Dartmouth Medical School
http://www.ciclt.net/ul/sgh/Dartmouth_Key%20Section.pdf

"Greater hospital bed capacity per thousand residents of the hospital referral region is associated with higher expenditures per capita"

"Greater numbers of hospital employees per thousand residents of the hospital referral region are associated with higher Medicare reimbursements per enrollee"

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3.Cleverley & Associates "Comparison of Charge (Price) Differences among Georgia Hospitals (CON State) and Hospitals in Arizona/Texas (non-CON States)October10,2002

http://www.ciclt.net/ul/sgh/Price_comparison_CONvsNonCON.pdf

"Prices appear to be substantially lower in Georgia, a CON state, than in the non-CON states of Arizona and Texas."

4. *Gautam Naik "Hospital Building Boom Sparks Worry cities will be left behind" The Wall Street Journal November 22, 2006; Page A1*

http://users1.wsj.com/lmda/do/checkLogin?mg=wsj-users1&url=http%3A%2F%2Fonline.wsj.com%2Farticle%2FSB116416523653730402.html%3Fmod%3Dtodays_us_page_one

"A building boom under way in the U.S. hospital industry is sparking concern about economic and geographic disparities in health care."

"Much of the construction is occurring in fast-growing suburbs, as hospitals target the most affluent, insured patients who can afford to pay for top care. At the same time, many urban hospitals -- which often treat poorer people -- are struggling financially, and scores have had to shut their doors"

"Many hospitals- particularly public urban hospitals that handle a heavy load of charity cases have been forced to truncate services or close down entirely"

5. Improving Health Care: A Dose of Competition (AHPA Response) To the report by Federal Trade Commission and Department of Justice, July 2004.
http://www.ahpanet.org/articlescopn.html

"Empirical studies by all three major U.S. automakers show substantially lower health care costs in the states with CON programs."

"…open heart surgery mortality rates are more than 20% lower in states with CON regulation than in states without regional planning and regulation."

"CON review, and related community based planning, is distinct in that it often is the only light available to illuminate important quality, cost and access concerns that are important to consumers."

"Planning and CON controls necessarily limit the concentration of services and facilities in affluent areas at the expense of less affluent communities."

6. Michal Smith-Mello "Health care costs compel fresh look at Old Regulatory Lever" Foresight A Publication of the Kentucky Long Term Policy Research Center Vol. 10 No. 4 2004
http://www.kltprc.net/foresight/Chpt_74.htm

"Physicians are creating or becoming partners in diagnostic facilities, ambulatory care/surgery centers, and, in a handful of states, for-profit specialty hospitals. Aimed at patients who can afford them, often located in affluent suburban communities, and focused on profit centers such as cardiac care…"

"specialty hospitals effectively siphon some of the most profitable services away from general hospitals. Likewise, ambulatory surgery centers have had a measurable effect on the volume of hospital services. Gradually, the capacity of "generals" to maintain critical and often costly services and cross-subsidize less profitable basic services like emergency departments is undermined. As a result, some central city and rural hospitals have seen revenues decline or closed altogether."

"From specialty hospitals to rapidly growing physician practices, patients, key medical personnel, and health care dollars are gradually moving away from traditional hospitals to smaller, more focused enterprises. In the process, the charity care our health care system metes out, as well as jobs and community institutions, could be lost in the process."

"Ohio's experience, however, suggests that some of the fears about eliminating CON may be justified. Subsequent to its repeal of CON review except for long-term care beds, the number of hospitals and hospital beds has declined, while the number of ambulatory surgery centers and diagnostic imaging centers has risen sharply. Hospital beds have been lost mostly in urban centers…"

"In Cleveland, where two hospitals closed after deregulation, emergency rooms have seen patient loads rise sharply and, for a time, diversions to other hospitals created significant problems."

"In its community report on Indianapolis, the CSHSC concluded that, because no brakes could be applied to the all-out competition it found in there, "employers have little leverage with health care providers; health plans seem resigned to passing on providers' demands for higher payments; and state policymakers have few tools to influence expansion decisions…."

"Indiana's costs were about 13 percent higher while largely deregulated Ohio's costs were about 7 percent higher for inpatient services than Kentucky's; both states were 21 percent higher for fast-growing outpatient services."

7. ***Van Way, Charles W III "Where have all the beds gone" : Journal of Parenteral and Enteral Nutrition, May/June 2004***
http://findarticles.com/p/articles/mi_qa3762/is_200405/ai_n9366858/pg_2

"A typical study from Dartmouth looked at overall health care costs in communities with differing number of beds. Their conclusion was that extra bed capacity added $24.1 billion to national health care costs, as of 1993."

"The study also concluded that racial disparities existed, with access to health care being less for African-Americans"

"The study also concluded that racial disparities existed, with access to health care being less for African-Americans"

8. ***Keith Moore, Dean Coddington "Specialty hospital rise could add to full-service hospital woes: do physician-owned specialty hospitals adversely affect the communities they are intended to serve? Results of a recent study suggest they do.": Health Financial Management, July 2005***
http://www.findarticles.com/p/articles/mi_m3257/is_7_59/ai_n14817853/pg1

"All those identified in the study are located in states with limited or no certificate-of-need requirements……the focus of specialty hospitals on certain surgical procedures appears to correlate with an increase in the overall volume and

utilization of those procedures in at least one case-study service area, raising concerns about higher healthcare costs and over utilization"

"Focusing on serving patients with commercial insurance"

"All of the case-study specialty facilities were focusing on the types of procedures that are widely recognized as being most profitable"

"In almost every instance, specialty hospitals' patient mix comprised higher percentages of patients with commercial insurance or Medicare coverage, and lower percentages of patients accessing Medicaid coverage or lacking insurance, than did that of their full-service counterparts"

"One of the most disturbing results of the incursion of specialty hospitals into the case study service areas was the loss of some services to the communities"

9. ***Information for the Missouri Senate Interim Committee on Certificate of Need: Missouri Hospital Association August 1, 2006***

"repealing CON laws promotes the proliferation of physician-owned specialty hospitals"

"….consider the role that CON plays in helping the state maintains an inventory of facilities and services. This inventory is one of the few tools available to the state to track the supply of health care services and to understand how the market is evolving."

10. ***"Certificate of Need Program for Idaho" Idaho Hospital Association***

" CON ensures sustainability of the community hospitals who care for our citizens by restricting the development of boutique hospitals" " When boutique hospitals siphon off the community hospital's insured patients and fail to offer low revenue services, community hospitals are forced to provide a higher percentage of low revenue procedures, substantially compromising their ability to continue to provide charity care"

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"After allowing its CON law to expire in 1996, Pennsylvania experienced dramatic growth in the number of open heart surgery programs, which increased from 35 to 62. However, volume of cases per hospital dropped from 499 in 2000 to 408 in 2002."

"Researchers at the University of Iowa studying more than 900,000 cases of open heart surgery performed from 1994 to 1999 found the volume of procedures per program was 84% higher in CON states and the odds of death were 22 percent lower for patients receiving coronary artery bypass graft (CABG) surgery in states with CON regulation as compared to similar patients in non-regulated states. Mortality rates were lower in CON regulated states…."

11. ***Richard Kusserow, Financial Arrangements between physicians and health care businesses: State laws and Regulations, Managemnet Advisory Report 1989 http://oig.hhs.gov/oei/reports/oai-12-88-01412.pdf***

Financial Arrangements between physicians and health care businesses: State laws and Regulations, Report to Congress by Office of Analysis and Inspections, 1989 http://oig.hhs.gov/oei/reports/oai-12-88-01410.pdf

Gretchen McBeath, Bricker & Eckler LLP, Status Report on Ohio after Deregulation from Certificate of Need, Updated September 2001 http://www.bricker.com/Publications/articles/71.asp

12. ***Certificate of Need: State Health Laws and Programs, National Conference of State Legislatures, December 1, 2006 http://www.ncsl.org/programs/health/cert-need.htm***

This document compares the views of CON supporters and opponents.

Other sources:

13.Thomas Piper Certificate of Need, "Protecting Public Interests" August 1 2006

http://www.aaasc.org/state/documents/MO.CON.08.01.06.ppt

This study talks about CON background, Significant State Changes, Federal Trade Commission Study, Free market and competition, Business Health Studies and Rationale. It talks about the Benefits of CON.

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http://www.hca.wa.gov/contf/doc/TAC_policyreview.pdf

15.Public Health Resource Group, Inc "Certificate of Need Project Report" March 8, 2001

http://www.phrg.com/pdf/Conp.pdf

16. Certificate of Need Commission Michigan, "Performance Audit of the Certificate of Need Program" April 2002

http://www.hca.wa.gov/contf/doc/TAC_Michiganperformanceaudit.pdf

17. Newt Gingrich "A Health Threat We're Not Treating" Washington Post Saturday, November 12, 2005

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18. Christopher J Conover, Frank A Sloan, "Does Removing Certificate of Need Regulations Lead to a Surge in Health Care Spending?" Duke University Journal of Health Politics, policy and law Vol. 23 No. 3 June 1998

http://www.heartland.org/pdf/16448.pdf

19. South Carolina Hospital Association, South Carolina's Certificate of Need Program, September 16, 2005