HOUSE RESOLUTION

WHEREAS, Hospital construction is booming, according to the USA Today news report (January 3, 2006) that the United States is "in the middle of the biggest hospital-construction boom" in more than 50 years, a trend that likely will increase use of "high-tech medicine and add fuel to rising health care costs"; the report indicated that the hospital industry has spent almost $100 billion in inflation-adjusted dollars in the past 5 years on new facilities, a 47% increase from the previous 5 years, with spending likely to reach a record $23.7 billion in 2005, according to the Census Bureau; and

WHEREAS, State and federal authorities have historically expressed alarm about spiraling health care costs and implemented various strategies to contain those costs, including "Certificate of Need" programs aimed at controlling excessive capital expenditures by health care corporations that contribute to higher health facility operating costs; and

WHEREAS, Concerns about health care inflation caused New York to enact the first "Certificate of Need" law in 1966 in response to health insurers' and business leaders' concerns about an excessive number of hospital beds contributing to increasing costs; and

WHEREAS, Rising health care costs also prompted the United States Congress to enact the Comprehensive Health Planning Act in 1966, which required the establishment of local and state health planning agencies; states that already had planning agencies were required to expand the scope and authority of these agencies; and

WHEREAS, Federal authorities began to recognize that the major infusion of federal funds into the existing health care system and payment methodologies of the Medicaid and Medicare

programs contributed to inflationary increases in the cost of health care; the system provided little incentive for cost reduction; state and federal policy makers believed then that excess facility supply led to increased costs of business, and that those increased costs would be passed on to patients; health planning and strict "Certificate of Need" laws were supposed to constrain supply and therefore control prices; and

WHEREAS, Policy makers also believed that the tremendous growth in federal health care spending was a major factor that contributed to the poor distribution and utilization of health care facilities; early health planning and "Certificate of Need" laws were supposed to control the geographic distribution of health care and ensure more efficient and full utilization of health care facilities and equipment; and

WHEREAS, These concerns resulted in the 1972 amendments to the federal Social Security Act that required all states to review health care capital expenditures in excess of $100,000; non-compliance would result in the denial of Medicare and Medicaid reimbursements for capital expenditures; this federal law effectively became the national "Certificate of Need" law; and

WHEREAS, The U.S. Congress passed the National Health Planning and Resources Development Act in 1974, which directed each state to examine proposed health care facilities and "make findings as to the need for such services"; federal financial participation in the cost of Medicaid and Medicare would be withheld if a state did not comply; and

WHEREAS, Every state and the District of Columbia enacted "Certificate of Need" laws and regulations to comply with federal law; and

WHEREAS, The federal government in 1986 reversed course and

repealed the federal mandatory health planning law; since that time, 14 states repealed their laws; 36 states and the District of Columbia still have "Certificate of Need" laws; and

WHEREAS, Proponents argue that "Certificate of Need" laws regulate surplus capacity in health care facilities so that there is less duplication of services and lower operating costs; the higher cost of excess capacity is passed on to insurance companies and patients in the form of higher prices; by regulating the supply, surplus will be avoided; and

WHEREAS, Opponents argue that the law has not controlled costs, improved quality, or increased access to health care; it may block access to health care choices and to modernized health care facilities; opponents also claim that "Certificate of Need" laws constitute over-regulation and are harmful to the economy, and that health care should be subject to the same market forces that determine the quality, availability, and price of other goods and services; and

WHEREAS, The Federal Trade Commission (FTC) and the Department of Justice (July 2004) reported: (a) that "Certificate of Need" programs pose serious competitive concerns that generally outweigh their benefits; (b) that there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry; (c) that this process has the effect of shielding incumbent health care providers from new entrants, which can increase health care costs, as supply is depressed below competitive levels; (d) that these programs can retard entry of firms that could provide higher quality services; and (e) that these programs have been ineffective in controlling costs because they do not put a stop to "supposedly unnecessary expenditures" and merely "redirect any such expenditures into other areas"; and

WHEREAS, The American Health Planning Association refuted

the FTC criticism of "Certificate of Need" programs, claiming that there is little analytical or factual basis for the criticism or for the recommendation to eliminate them; little evidence is presented to demonstrate that market forces have had, or are likely to have, the positive effects in the health care system; the argument that planning and "Certificate of Need" regulation result in higher costs and prices, inferior quality, reduced access, less innovation, and lower operating efficiency, though repeatedly made, is not supported by demonstrated facts; "Certificate of Need" regulation, with related community-based planning, is one of the few tools that policymakers, health system officials, and ordinary citizens have available for use in trying to compensate for known weaknesses and deficiencies in the existing health care system; these decision-making processes provide a unique forum where all interested parties, and ordinary citizens, can express their views and state their needs; this oversight identifies critical quality, cost, and access concerns that are important to consumers; and

WHEREAS, The Illinois Health Facilities Planning Act (20 ILCS 3960/) became effective in 1974; it created a 13-member Health Facilities Planning Board to review the necessity of capital expenditures for the establishment or modification of health facilities and the procurement of medical equipment; entities subject to the Illinois Health Facilities Planning Act include licensed and state-operated hospitals, long-term care facilities, dialysis centers, ambulatory surgery centers, and alternative health care delivery models; facilities operated by the federal government are exempt; under current law, transactions requiring a permit include any construction or modification by or on behalf of a health care facility exceeding the expenditure minimum ($7,167,063) for projects that result in a substantial increase in a facility's bed capacity, for projects that result in a substantial change in the scope or functional operation of a facility, and for

projects that establish or discontinue a facility or category of service; in addition, the acquisition of major medical equipment (valued at more than $6,573,026) or health and fitness centers (valued at more than $3,267,766) requires a permit or exemption; and

WHEREAS, Proposals to repeal Illinois' law have not been enacted, but there has been a substantial reorganization of the Board; proponents have successfully argued that, although the Board has not historically denied many projects, the review process requires applicants to more carefully develop and scale their projects to established criteria and standards of need; many existing hospitals and the communities they serve have generally supported the "Certificate of Need" law, because elimination could jeopardize their economic vitality by a radical proliferation or expansion of unnecessary facilities; and

WHEREAS, The 93rd General Assembly restructured the Board; Senate Bill 1332 (P.A. 93-0041) was enacted after extensive debate about the history and performance of the Board and in response to proposals for its complete elimination; the new law replaced the 13-member board with an entirely new 9-member board appointed by the Governor with no requirements that they represent particular interests; the law also changed various operating policies and procedures of the Board and established a "Sunset" (repeal date) of July 1, 2008; and

WHEREAS, A major scandal involving conflicts of interest and criminal indictments of a Board member for "influence peddling, kickbacks, and other corrupt actions" by parties involved in applications subject to review prompted the Governor and General Assembly to reduce the size and makeup of the Board and to impose more strict membership requirements; to prevent conflicts-of-interest, the law now provides that no person can be appointed, or continue to serve as a member of

1 the Board, who is, or whose spouse, parent, or child is, a
2 member of the Board of Directors of, has a financial interest
3 in, or has a business relationship with a health care facility;
4 provisions were also added restricting ex parte communications
5 by board members and staff to protect against influence
6 peddling; the 93rd General Assembly enacted House Bill 7307
7 (P.A. 93-889) to restructure the Health Facilities Planning
8 Board again; the membership was reduced to 5 members and all
9 members were completely replaced; the status of the entire
10 "certificate-of-need" law was also going to be subject to
11 reconsideration under a new "Sunset" date of July 1, 2006; this
12 date was set to allow more time for evaluation of the Board's
13 operations, to provide an opportunity for the Board to
14 implement major rule changes intended to streamline and clarify
15 the existing review process, and to develop and report
16 meaningful data regarding its performance and effectiveness;
17 and

18 WHEREAS, The 94th General Assembly subsequently enacted
19 Senate Bill 2436 (P.A. 94-983) that extended the "Sunset" date
20 once again to April 1, 2007, so that the status of the Board
21 and the "Certificate of Need" program can be subject to
22 further, and more intensive, evaluation, given the
23 acceleration of health facility capital expenditures, the
24 national trends of such health care regulation, continuing
25 concerns about increasing health care costs, the need for more
26 effective cost containment, and the controversial history of
27 Illinois' current system; therefore, be it

28 RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE
29 NINETY-FOURTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that
30 the Illinois Commission on Government Forecasting and
31 Accountability shall conduct a comprehensive evaluation of the
32 Illinois Health Facilities Planning Act, including a review of
33 the performance of the Illinois Health Facilities Planning
34 Board, to determine if it is meeting the goals and objectives

1 that were originally intended in the enactment of the law and
2 the establishment of the Board, and as the law has been amended
3 and the Board policies and procedures revised since that time,
4 with special consideration for its affect on controlling
5 unnecessary and excessive capital expenditures that may be
6 contributing to health care inflation; the Commission shall
7 determine the criteria, standards, and procedures for this
8 independent evaluation; the Commission must conduct an
9 objective analysis of the impact of the "Certificate of Need"
10 program since its inception 32 years ago; and be it further

11 RESOLVED, That the Commission issue a report to the General
12 Assembly of its findings by February 15, 2007, together with
13 any recommendations for change to the Illinois Health
14 Facilities Planning Act and the structure, function, policies,
15 and procedures of the Illinois Health Facilities Planning
16 Board.