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More Competition, Better Value for Patients:

**HOW SURGERY & RECOVERY
CENTERS CAN SAVE PATIENTS,
EMPLOYERS AND TAXPAYERS
BILLIONS**

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EXECUTIVE SUMMARY

For too long much of the attention related to health policy has been focused on Washington, D.C. and the details of ObamaCare. This focus is largely misplaced; state policymakers can often play a more immediate role in lowering costs for patients by promoting competition and transparency among health care providers. One place to start is to allow for greater flexibility for patients needing elective surgery.

Ambulatory surgical centers (ASC) and recovery care centers (RCC) have proven to be lower-cost, high-quality care for patients and their employers. According to the U.S. Inspector General at the Department of Health and Human Services, taxpayers would save \$15 billion and patients would save \$3 billion, for those enrolled on Medicare, if surgeries were paid for at ASC rates, with no impact on quality. We estimate that in the private marketplace, the average family of four would save \$525-\$874 a year if all outpatient surgeries was paid for at ASC rates.

In addition, research has shown that the care at ASCs, on average, result in faster recovery times, more patient-friendly attention, with many doctors preferring them to an outpatient surgery department at a hospital. Yet, numerous hospitals have engaged in targeted campaigns against ambulatory surgery centers and single-specialty hospitals lobbying for stronger, more restrictive Certificate-of-Need statutes.

Legislators should ignore these efforts, and instead modernize their states' regulatory framework to reflect the advances in surgery care, and promote a more patient-centered health system. They should exempt ASCs and RCCs from CON, if they are currently restrained, and set up licenses that allow for freestanding and affiliated RCCs if they do not exist. Any new regulations should narrowly address patient safety and protection, and allow for competition to flourish.

INTRODUCTION

Over the last four years much of the attention related to health policy has been focused on Washington, D.C. and the details of ObamaCare. This focus is largely misplaced; state policymakers can often play a more immediate role in lowering costs for patients by promoting competition and transparency among health care providers. Specifically, they can revisit the role of care settings such as ambulatory surgical and recovery care centers to unlock lower-cost, high-quality care for patients and employers.

The federal government's long history of meddling in health policy has created a hodgepodge system that often rewards inefficient and ineffective care. As a result, state lawmakers find it increasingly difficult to address all of the distortions currently present in the market, but there are "low-hanging fruit" reforms proven to help local employers and patients better afford their health care. Put simply, governors and state legislators do have powerful tools to unleash a more affordable and patient-friendly health care system.

To accomplish this, state leaders must review the antiquated, restrictive regulations that fail to reflect current medical technology or appreciate the needs of patients. These regulations are insidious; while often justified as necessary for "patient-protection," they primarily serve instead as barriers that protect incumbent players and block new and innovative provider options from entering the market. In many cases, these regulations have not only protected patients, then have done the opposite, resulting in worse health outcomes and further straining patients' finances.

HOW GOVERNMENT POLICY PREVENTS LOW-COST, HIGH-QUALITY CARE

ObamaCare regulations are beginning to drive up premiums for millions of Americans, but health care costs have experienced inflationary growth for decades. This is largely due to the onerous regulations that are preventing the next "Southwest Airlines of health care" to emerge.¹ Yet there is hope—a handful of areas within the field of medicine (i.e. LASIK eye and plastic surgery) have experienced the "holy grail" of lower costs and better quality.²

For too long, "consumer protection" regulations have been used as a form of protectionism to keep innovative, lower-cost options out of the health care marketplace for patients. By contrast, in LASIK eye and plastic surgery, areas in which government regulations have simply focused on consumer safety, federal Medicare or Medicaid reimbursement policy has not been distortive. As a result, the quality of care throughout these procedures has increased while costs have dropped. This narrow focus is needed in many other areas of medicine.

State policymakers must continue to think outside the box to make health care as affordable and flexible as possible, particularly for patients enrolled in private plans. This involves continuous and comprehensive examinations of state regulatory environments, including Certificate of Need (CON) regulations. A successful effort to unravel these regulations allows for a more consumer-oriented health care system that will drive patient costs down.

WHAT IS CERTIFICATE OF NEED?

A government-run process in many states and some federal jurisdictions that results in a legal document that allows or prevents an acquisition, expansion or creation of a medical facility.



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CON LAWS DRIVE COSTS HIGHER

Between the 1950s and the 1970s, policymakers faced the same issue we face today: health care costs rapidly growing, outpacing inflation by a wide margin.³⁻⁴ Some policymakers believed back then that limiting the capital expenditures of health care providers would allow states to control these costs more effectively.⁵

In 1964, New York enacted the first Certificate of Need law.⁶ This new law granted state bureaucrats the authority to determine whether new medical facilities, such as hospitals and nursing homes, were needed.⁷ If the government did not believe the facilities were needed, it would not grant those facilities approval for construction.⁸

Not long thereafter, the American Hospital Association (AHA) began lobbying state and federal lawmakers to adopt CON laws.⁹ The AHA was lobbying for a regulation that kept new competitors from entering the markets of their members under the guise of “protecting patients” from rising health care costs. Although the current hospitals could raise their prices at will with no competitive pressure from new hospitals. In 1974, Congress enacted the National Health Planning and Resources Development Act.¹⁰ The new law mandated that states either operate CON programs or lose federal funding for state and local health programs.¹¹ By 1980, every state except Louisiana had created a CON program.¹²

But, unsurprisingly, CON laws failed to deliver on their promise of controlling health care costs. Instead, evidence suggests that CON programs actually increase prices by reducing competition within the marketplace.¹³⁻¹⁵ This is no surprise, as CON laws essentially create government-protected monopolies and oligopolies. To fully appreciate the detrimental impact of CON regulations, one must understand their technical nature.

OVER TIME CON WEAKENED IN SOME STATES, BUT NOT KILLED

After it became clear that CON laws were driving up the cost of care, the federal government repealed its CON mandate in 1986.¹⁶ Since then, 15 states repealed their laws altogether.¹⁷ Yet many states have continued to operate CON programs, albeit with less regulation than in the 1970s.¹⁸

In 2008, the Federal Trade Commission (FTC) testified before the Florida Senate about the state’s Certificate of Need laws.¹⁹ The FTC noted that Florida had one of the most restrictive and wide-ranging CON laws in the nation.²⁰ For example, Florida is one of just 13 states that regulate sub-acute care and one of just 18 states that regulate hospice through CON rules in 2011.²¹

In its testimony, the FTC noted that Certificate of Need laws can create barriers for new health care competitors to enter the market.²² The FTC concluded that these laws “are not successful in containing health care costs,” but rather “pose serious anticompetitive risks” detrimental to health care consumers.²³

CON LAWS HARM PATIENTS

Recent academic literature has shown the direct impact of CON laws on patients’ health. Nationally-recognized CON expert Vivian Ho, of Rice University, for example, has found that eliminating CON regulations can actually reduce mortality rates for certain procedures like CABG (coronary artery bypass grafting) for heart surgery.²⁴ This makes sense. CON restricts new players that have incentives to increase quality and lower costs in order to attract patients away from established hospitals. Established hospitals with CON face no such quality and cost pressure.

REPEALING CON CAN REDUCE COSTS

Professor Ho also found that CON regulations appear to raise the volume of procedures and the average cost for specific services like cardiac and cancer care.²⁵ She and others have noted that states without CON regulations have experienced lower patient-care costs.²⁶ After dropping CON regulations for open-heart surgery, for example, costs for bypass surgery patients fell 4 percent in those states.²⁷ Competition fuels quality and cost control. CON eliminates competition giving patients little choice but to continue going to established hospitals that may be too costly or face no competitive consequence of performing unnecessary procedures.

CON REDUCES PATIENT CHOICE

There are many examples of how CON laws reduce competition, thereby increasing taxpayer and consumer costs. In 2005, for example, the U.S. Department of Justice (DOJ) discovered that two Vermont home health agencies had parlayed the federal CON law to enter into an agreement giving each other exclusive geographic markets.²⁸ As a result, Vermont consumers were paying prices that were much higher than those paid in states where home health agencies faced competition.²⁹ In 2006, the DOJ found that a hospital in West Virginia threatened a competitor with an objection during the CON process in order to force it to abandon its application for permission to build an open-heart surgery program.³⁰

CON laws not only increase prices, they reduce quality and innovation. CON laws create barriers for new competitors who could provide better services than current market players.³¹ Without competition, providers have few incentives to improve quality, operate efficiently, and innovate. With competition, providers must improve services in order to satisfy patients' individual needs and preferences.

Both the FTC and the DOJ recommend that states with CON programs critically reconsider whether their programs are actually serving the needs of patients and citizens. One place to start with changing the overall system is to allow for greater flexibility for patients needing elective surgery. A less restrictive CON program opens doors for innovative and entrepreneurial companies to emerge, such as the Surgery Center of Oklahoma and the Valley Ambulatory Surgery Center & Valley Medical Inn in St Charles, Illinois. (More on these companies later.)

AMBULATORY SURGICAL CENTERS AND RECOVERY CARE CENTERS: THE EVOLUTION OF SURGERY

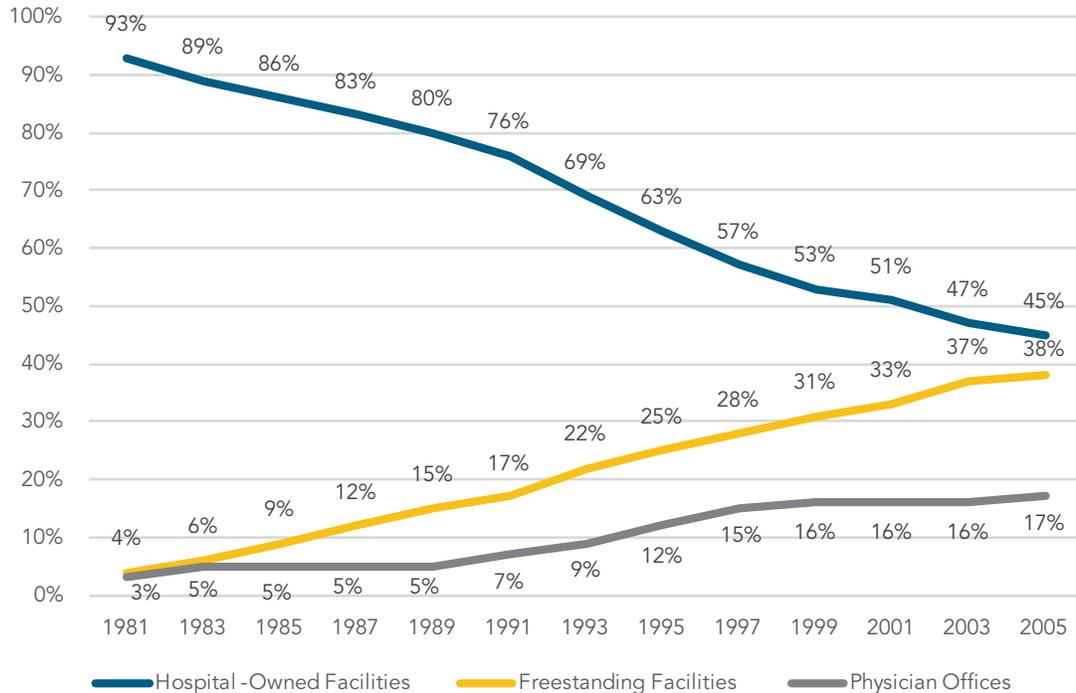
Innovations in medicine during the last 25 years have changed the face of surgical care. These advances, in both technique and the use and quality of anesthesia, have resulted in roughly 60 percent of all surgeries being performed in outpatient settings.³²⁻³³ For historical context, 63 percent of all surgeries nationally in 2005 did not require an inpatient overnight stay at a hospital, compared to 51 percent in 1990 and 16 percent in 1980.³⁴ Paired with changes in reimbursement policy, the number of outpatient surgery care visits has grown from 3.5 million in 1981 up to 17 million in 2010.³⁵ Major players driving this progress have been ambulatory surgical centers.

WHAT IS AN AMBULATORY SURGICAL CENTER (ASC)?

An ASC is a health care facility focused on providing same-day surgical care, including diagnostic and preventive procedures.



Percent of Outpatient Surgeries by Facility Type



Source: AHA, Trendwatch Chartbook, 2008, Supplementary Data Tables, Organizational Trends

In 2011, there were approximately 5,344 Medicare-certified ASCs in the United States.³⁶ California, Florida and Texas have the highest concentration of ASCs in aggregate terms. ASC growth has continued but has been significantly impacted, both positively and negatively, by changing Medicare reimbursement policy over the years.³⁷ Medicare changes reverberate into the private insurance market, as many private insurers index their reimbursements to Medicare payment levels.

Despite all these changes, a recent report from the U.S. Office of the Inspector General calculates that taxpayers will reap the benefit of lower costs for outpatient surgeries performed at ASCs:

"Medicare saved almost \$7 billion during calendar years (CYs) 2007 through 2011 and could potentially save \$12 billion from CYs 2012 through 2017 because ASC rates are frequently lower than outpatient department rates for surgical procedures. In addition, Medicare could generate savings of as much as \$15 billion for CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs."³⁸

Taxpayers would save \$15 billion and Medicare patients would save \$3 billion if surgeries were paid at ASC rates, with no impact on quality.

The IG also noted that beneficiaries save additional out-of-pocket expenses due to lower cost-sharing:

"Beneficiaries saved approximately \$2 billion during CYs 2007 through 2011 and could potentially save an additional \$3 billion for the next 6 years because the ASC rates are frequently lower than outpatient department rates. In addition, beneficiaries[TB2] could potentially save as much as \$2 billion to \$4 billion more during the 6 years through CY 2017 if CMS reduces outpatient department payment rates for ASC approved procedures to ASC payment levels."

This record of success has led the U.S. Office of the Inspector General, as far back as 1999, to endorse “greater utilization of ASCs because of the substantial cost savings to Federal health care programs when procedures are performed in ASCs rather than in more costly hospital inpatient or outpatient facilities.”³⁹

The potential savings for the private marketplace could be even greater if all outpatient surgeries, regardless of where they were performed, were paid for at a similar rate as those performed at ASCs. Conservatively assuming savings of 30-50 percent at ASCs, we estimate that the average family of four would save \$525-\$874 a year if all outpatient surgeries was paid for at ASC rates.⁴⁰

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PATIENTS AND TAXPAYERS BOTH WINNING WITH ASCS

Research has started to validate the many benefits that ASCs are associated with for patients and doctors. They include:

- **Less Costly Care**

ASCs receive lower reimbursements than hospitals; therefore outpatient surgery is less costly in ASCs for those who are insured. They are also often significantly less expensive for the uninsured. (See Oklahoma Surgery Center case study.) This increased affordability is remarkable given that many ASCs often have the most cutting-edge technological advances, provide highly-personalized care and boast higher nurse-to-patient ratios.

- **Better Health Outcomes**

Economists Elizabeth Munrich at the University of Louisville and Stephan Parente at the Carlson School of Management found in a recent study of ASCs that,

“...treatment in an ASC is associated with better health outcomes, holding patient risk constant; in fact, high-risk patients treated in an ASC are less likely to be admitted to a hospital within 7 days of an outpatient surgery, and less likely to visit an ER on the same day as an outpatient surgery.”⁴¹

Other scholars have noted that improved outcomes may be the result of specialization and repetition at ASCs. For this reason, some have referred to ASCs as a “focused factory.”⁴²

- **Faster Recovery Times**

Munrich and Parente also find that, “After controlling for patient characteristics, patients spend nearly 26 percent less time in ASCs than in hospitals for outpatient procedures.”⁴³

- **More Patient Friendly**

A 2009 MedPAC report noted that ASCs may also be gaining in popularity as they often “offer more convenient locations, shorter waiting times, and easier scheduling for patients”.⁴⁴

- **Doctor Friendly**

ASCs offer predictability and efficiency in scheduling that outpatient departments at hospitals rarely do. Doctors say they are often frustrated that scheduled surgeries are delayed or moved due to an emergency department intake in a hospital setting. In addition, doctors express gratitude for the short turnaround time and specialized focus among nurses and other support staff at ASCs.



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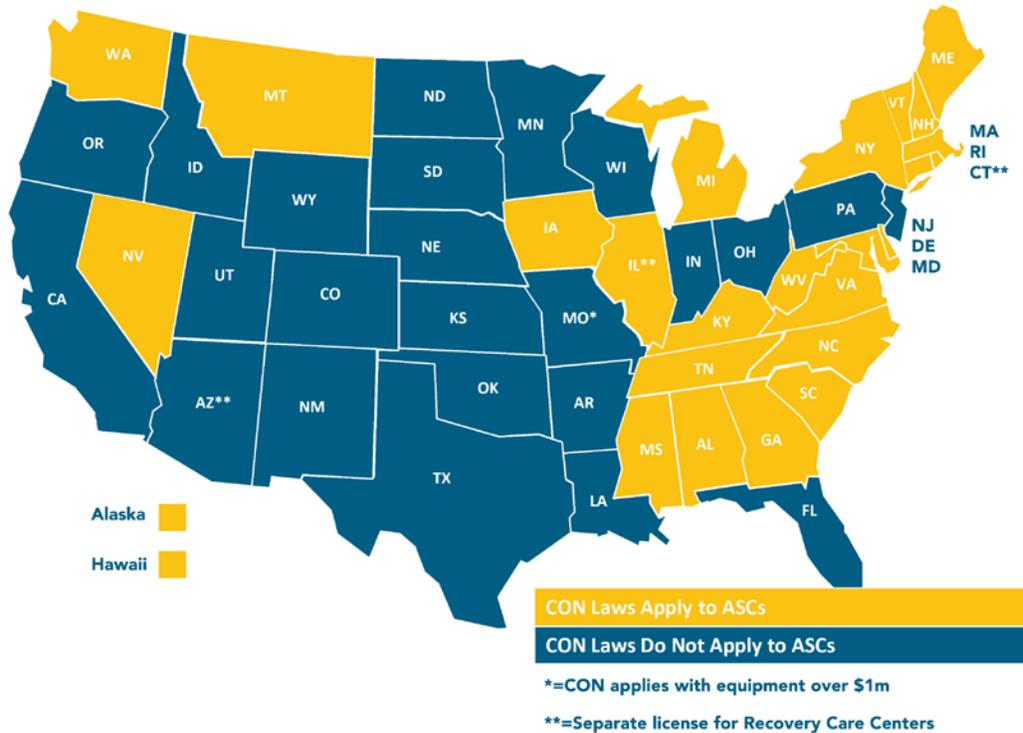
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Yet politics have often played a role in reimbursement policy for ASCs. Munrich and Parente highlight that, “In response to arguments that ASCs face lower costs than hospital outpatient departments, the Centers for Medicare and Medicaid Services (CMS) froze ASC payment rates in 2003 and has steadily reduced ASC payments, while increasing payments to hospital outpatient departments, since 2008.” The result of this change, along with increased provider consolidation in the health care marketplace, has stunted the growth of ASCs compared to just a few years ago.⁴⁵ In addition, incumbent hospital players have been aggressive in lobbying to protect the status quo, and their place in it, as the financial stakes are very high.

For those with private insurance, the growth of hospital services has become a leading cost driver. While hospital services paid by private insurance were less than \$37 billion in 1980, by 2012 these hospital costs had skyrocketed eightfold to \$321 billion.⁴⁶ Revenue lost to ASCs and doctors’ offices are seen as a direct threat to hospitals.

As a result, numerous hospitals have engaged in targeted campaigns against ambulatory surgery centers and single-specialty hospitals lobbying for stronger, more restrictive Certificate-of-Need statutes. Some have characterized actions by the American Hospital Association (AHA) as, “a full scale attack on niche providers” primarily through direct lobbying of elected policymakers and regulatory bodies.”⁴⁷ The result in many states has been regulations that deter new entrants and limit competitor organizations from investing in infrastructure and/or broadening the range of services offered at their facility. This outcome denies patients positive health and cost benefits explained above.

Certificate of Need (CON) Laws by State for Ambulatory Surgical Centers (ASC)



Source: Author's analysis based on CON data from KNG Health Consulting & National Conference of State Legislatures (NCSL)⁴⁸

Differing state regulatory requirements have led to varying penetration of ASCs in the states. ASCs are more prevalent in states lacking CON requirements. In 2009, there were 27 states with CON laws that covered freestanding ASCs; 10 with CON laws that do not include ASCs; and 14 with no CON laws. In Florida, there are currently 633 ASCs, with two-thirds being freestanding entities.



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RCCS AND ASCS WORKING IN TANDEM

RCCs are a lower-cost alternative to hospital- or nursing home-based recovery time. According to a 2003 New York Times article on a RCC in Connecticut, for example, “The charge at the [RCC] medical hotel is \$350 to \$750 a night in comparison with \$1,800 to \$2,500 a night for some hospital stays...”⁵⁰

WHAT IS A RECOVERY CARE CENTER (RCC)?

A RCC is a facility with a primary purpose of providing recovery care services.

Services often include postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected.⁴⁹ But RCCs can be used for a wide variety of treatments that do not require prolonged acute medical care, such as more intensive rehabilitation services.

Connecticut was near the vanguard on RCCs, setting their regulations to allow for them back in 1995.⁵¹ The Temple Recovery Center highlighted in the NYT article started in 2002, in leased space in the New Haven Hotel. Admissions were 50 percent from its associated ASC and 50 percent from the large academic medical center in the city, Yale New Haven Hospital. The RCC was pitched to regulators as both a cost-savings mechanism, but also as a way to free up licensed and staffed beds at Yale New Haven Hospital.⁵² In perhaps a sign of how much of a threat the lower-cost option ended up to be, Yale New Haven Hospital has since purchased both the ASC and RCC. Just like hospitals used CON to reduce competition, hospitals have incentives to buy up the competition by purchasing ASCs and then raising costs for patients to hospital-level rates for the hospital-owned ASC.

Presently only three states, Arizona, Connecticut, and Illinois, have specific licenses for “recovery care centers.”⁵³ In 2014, the Florida House of Representatives passed legislation allowing similar licensing, but the Senate did not take up similar legislation.⁵⁴ Other states license RCCs-like entities as nursing facilities or hospitals.⁵⁵ And some, like Colorado, have a separate license for RCC-like entities called convalescent centers.⁵⁶

RCCs are currently ineligible for Medicare reimbursement. However Medicare is reexamining its reimbursement policies in relation to observational status, or when patients remain in the hospital in outpatient status as they are not well enough to go home but not sick enough to be admitted. Medicare guidance recommends that observation care should not last longer than 24-48 hours, but it often does. The federal government is considering presuming that, “hospital services spanning fewer than two midnights should be considered outpatient observation.”⁵⁷ Under such a circumstance, the reimbursement rate would be adjusted accordingly, a change that may offer an opportunity for RCCs to play a more active role in treating patients if they were to win Medicare reimbursement status.

In many states, RCCs typically treat healthy patients who have had elective surgery, but a select few allow for a more flexible care model. RCCs can be either freestanding, attached to an ambulatory surgical center or a hospital. In practice, RCCs most often care for patients that are being transferred from ASCs following surgery, which allows ASCs to offer even more care options that can include more complex procedures.⁵⁸ RCCs are usually required to have emergency care and transfer protocols, including transportation arrangements and referral or admission agreements with at least one hospital.

Eighteen states permit RCC-like entities to keep patients for longer than 24 hours, usually with a maximum stay of 72 hours.⁵⁹ Connecticut allows patients to stay up to 21 days and leave the door open for a much wider variety of care than most other states. Arizona similarly does not limit the number of days a patient may recover in a RCC. This sort of flexibility increases the care choices for patients and permits more complex cases to be treated at ASCs as well.

Given the aging demographics of the United States and the continued rise in surgical procedures related to older-age, like knee and hip replacements, RCCs should be an important lower-cost option.

A more accommodating regulatory approach would allow ASCs to perform additional procedures and RCCs to care for patients receiving those procedures; such as hysterectomies, sinus surgeries, many types of spine surgery, gall bladder surgery, and abdominoplasties; that will result in greater competition for patient business. This level of flexibility has been available in Illinois for almost 18 years as a pilot, allowing ASCs to compete for 93% of surgeries, which means more and lower cost options for patients needing surgery.⁶⁰

CASE STUDY:

VALLEY AMBULATORY SURGERY CENTER & VALLEY MEDICAL INN (ST. CHARLES, IL)

The state of Illinois passed legislation in 1994 (the Alternative Health Care Delivery Act) authorizing the establishment of recovery care centers.

The Valley Ambulatory Surgery Center/ Valley Medical Inn in St. Charles, IL is a nine-bed facility that allows for patients to recover up to 72 hours in its RCC. The Inn was opened in 1997 and is connected with the Valley ASC. They have served 5,900 patients for a total of more than 7,600 days of patient care since opening the RCC.⁶¹ And the ASC advertises procedures that cost 50+ percent less than costs at local area hospitals. For example, a total knee replacement along with follow up care would cost roughly \$9,000-\$10,000 (not including doctors' or anesthesiologists' time), while local hospitals are paid at least \$21,000 for the same procedure.

According to recent testimony by the Center & Inn's Administrator, Deborah Lee Crook, the practice has some impressive health outcomes for patients. Over the past year, the infection rate has been less than 0.38 percent.⁶² For comparison, in 2011 the CDC reported that surgical site infection rates are established as high as 5 percent.⁶³

One reason for the high quality of care, cited by Ms. Crook, is the nurse-to-patient ratio at Valley ASC and Valley Medical Inn. The ratio is kept around 3 to 1 at the RCC, whereas the equivalent care setting in a hospital is between 8 and 13 to 1. This difference allows for more energy and time from nurses devoted to helping patients move more quickly after surgery and a greater emphasis on patient education to prevent future complications. It also can have the added benefit of a lower burnout rate among nurses.

As a result, the RCC has only had to transfer 0.58 percent of patients to a hospital as their care ended up requiring recovery exceeding the permitted 72 hour window.

As standard procedure, the ACS follows up with all patients the day after discharge, at two weeks and again one month following the procedure. Overall, patient satisfaction has been an extraordinary 99.1 percent.

Perhaps most encouraging is that a recent retiring hospital executive admitted, upon his retirement, that the Valley ASC and Inn had improved their own level of service as well due to the introduction of competition.



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CASE STUDY:

SURGERY CENTER OF OKLAHOMA (OKLAHOMA CITY, OK)

The Surgery Center of Oklahoma is a state-of-the-art, doctor-owned, Accreditation Association for Ambulatory Health Care (AAAHC)-certified facility located in Oklahoma City.

The Surgery Center has attracted lots of attention for the fact that it has been listing its prices for patients for the last six years. The Center has received praise from both sides of the political aisle and has stimulated price competition with local hospitals.

The Surgery Center is illustrative of the power of changing Certificate of Need laws to unlocked innovation, with results that benefit patients, employers and taxpayers alike.

Founders Dr. Keith Smith and Dr. Steven Lantier determined that the Center's costs for 112 procedures were 1/5- 1/10 the cost at other local hospitals.

A local television station in Oklahoma City, KFOR-TV, confirmed some examples of the price differences. "...a \$3,500 breast biopsy at Surgery Center of Oklahoma will cost \$16,244 at nearby Mercy Hospital. A hysterectomy jumps from \$8,000 at Surgery Center to \$37,174 at Integris Baptist Hospital. And the OU Medical Center consistently charges about \$15,000 more than what the Surgery Center does for common procedures like open fracture repairs and gall bladder removal."⁶⁴

Patients are now traveling from out-of-town and even from out-of-state to take advantage of the much lower bills at the Surgery Center. Other hospitals are taking notice. At least five other Oklahoma City-area medical facilities started posting their own prices online and some of them have lowered costs to price-match the Surgery Center.

Dr. Smith commented in the local press that, "Hospitals are having to match our prices because patients are printing their prices and holding that in one hand and holding a ticket to Oklahoma City in the other hand and asking that hospital to step up."

More recently, the Surgery Center has made news by saving the Oklahoma County government more \$150,000 on just 10 scheduled surgeries, after signing a contract to offer their services as an optional benefit to workers.⁶⁵ An additional benefit of the agreement was that patients saved \$30,000 in out-of-pocket costs compared to if they had received care elsewhere. The contract the Surgery Center signed directly with the local government produced immediate results, savings taxpayers significant money in the form of lower health claims for public workers, and saved the worker-patients thousands at the same time by granting them this optional benefit.

RECOMMENDED ACTIONS FOR STATE LAWMAKERS

Legislators should reexamine the regulatory framework in their state, and reform should embrace the following criteria:

1. Exempt ASCs and RCCs from CON, if they are currently restrained, or would be under a new license.
2. Set up licenses for freestanding and affiliated RCCs if they do not exist.
3. Pulling from best practices in AZ, FL, CT and IL, set a regulatory framework for RCCs that addresses:
 - a) Administrative requirements, such as organizational bylaws;
 - b) Protocols for routine discharges and emergency care transitions;
 - c) Inspectional procedures;
 - d) A process to handle patient complaints; and
 - e) Discipline practices for those that break the law.

A state should be careful to not be overly prescriptive as some other states have been.

A state should aim to set the ground rules and hold practitioners accountable for high-quality care, but should avoid stifling innovation at ASCs and RCCs for the care they provide, or restricting the number of days patients can stay for non-acute care.

4. States should consider leveling payments in the Medicaid program to hospital outpatient facilities to be in line with ASC market prices. The move could save taxpayers millions while ensuring beneficiaries lower-cost, high-quality care.
5. At minimum, states should require hospitals that purchase an existing ASC to maintain a pricing structure similar to other area ASCs, instead of switching to inflated hospital rates once ownership changes.



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CONCLUSION

A basic economic principle holds that as you increase demand, but fail to grow supply, prices will rise. For decades, many states have artificially held down the supply of surgery options for patients.

With an upsurge in coverage, as there may be under ObamaCare, states must pick up the pieces left by the federal government and end the practice of artificially restricting the flexibility of medical professionals and facilities. Recent research shows that states are only adding additional cost to the health care system and, in some cases, harming the quality of care.

University of Chicago economics professor John Cochrane has observed, “Cost control and technology improvement must come from disruptive competition from new suppliers, as it has in airlines, retail, internet, and other successful industries.”⁶⁶ Ambulatory Surgery Centers with flexible Recovery Care Centers might be the first step in this new, more cost-effective direction in health care.

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