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President's Message – Summer 2005

Magnetic Resonance Imaging:
Subject of Debate

by Dean Montgomery

Advanced diagnostic imaging technologies, specifically computed tomography (CT), magnetic resonance imaging (MRI) and positron imaging tomography (PET) scanning, are the subject of a broadening policy debate. CT and MRI scan volumes, use rates, and aggregate costs have grown much more rapidly than other health services over the last decade. Service volumes and use rates have increased at compound annual double-digit rates in many communities for the last five years. The economic and potentially system-distorting implications of the continued growth in MRI scanning, for example, are increasingly and appropriately viewed with concern.[1]

There is general agreement that MRI scanning represents a substantial advance in medical technology, as well as considerable evidence to suggest that its clinical benefits outweigh the high

[1] See David Armstrong, "MRI and CT Centers Offer Doctors Way to Profit on Scans," *The Wall Street Journal*, May 2, 2005; Gina Kolata, "Rapid Rise and Fall of Body-Scanning Clinics," *The New York Times*, January 23, 2005; Maureen Glabman, "Health Plans Strain to Contain Rapidly Rising Cost Imaging," *Managed Care*, January 2005; and *TrendWatch: Impact of Limited-service Providers on Communities and Full-service Hospitals*, American Hospital Association, September 2004.

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Health Planning TODAY

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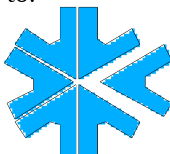

MRI: Subject of Debate
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costs. Nevertheless, the rapid diffusion of this service poses difficult questions of how best to "afford" the burgeoning costs, assure reasonably equal access to the service by the medically indigent, and limit the system-distorting effects of the shift of this highly profitable service from community hospitals to competing freestanding imaging centers.

In this context, the question arises as to whether health planning and Certificate of Need (CON) regulation are helpful in addressing these concerns. There are no definitive studies, and certainly no consensus. There are some data, however, that suggest the potential value of planning and regulation in managing the diffusion of MRI services (Table 1).
Nineteen states and the District of Columbia regulate, at least nominally, the establishment and expansion of MRI services under CON. There are no capacity controls in the other 31 states. National 2002 MRI service survey data are arrayed by state and state regulatory status in Table 1. This array and related analyses of the data show that the range in average use rates does not differ greatly between states with CON programs and states without CON programs; however:

- ✓ States with CON have fewer MRI scanner services per 1,000 persons than states without CON programs;
- ✓ Residents of states with CON have lower MRI use rates (both state median and group mean) than residents of states without CON programs; and
- ✓ Community hospitals in states with CON programs have a larger share of MRI services market than hospitals in states without CON programs.

These are commercial survey data for a single year. Thus, they are descriptive, and suggestive, not definitive or determinative. It is worth noting, nevertheless, that the data point in one direction, suggesting community hospitals, the public they serve, and the medically indigent are likely to be better served in CON states than in states without regulation.

It is also worth noting that these data are consistent with the studies of U.S. auto-makers who report lower MRI costs, both inpatient and outpatient, in states with CON programs than in states without CON regulation. The data are also consistent with the observed and widely-acknowledged pattern or niche service providers, a large number of whom offer MRI scanning, locating disproportionately in states without CON programs.

At a minimum, these data suggest areas for investigation and research by planners and regulators. Those with questions about these data, or how to make use of it, are invited to contact AHPA at ahpanet@aol.com.

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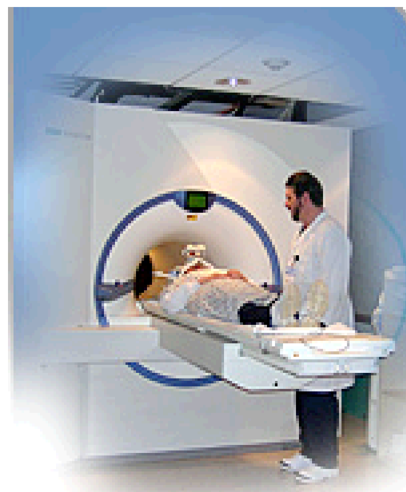

MRI: Subject of Debate

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Table 1
MRI Services
Distribution and Use by State
2002

States Regulating MRI Services Under CON

State	Hospital Services	Free Standing Centers	Total	Percent Hospital Based	MRI Scans [All Sites]*	Use Rate [Scans/1,000 Persons]	Population
Alaska	7	5	12	58.3	38,282	59.7	641,240
Connecticut	28	28	56	50.0	231,340	67.4	3,432,344
District of Columbia	9	3	12	75.0	77,218	136.0	567,779
Georgia	126	72	198	63.6	583,422	69.1	8,443,155
Hawaii	16	2	18	88.9	72,762	59.2	1,229,088
Kentucky	71	27	98	72.4	300,578	73.2	4,106,257
Maine	32	5	37	86.5	98,536	76.4	1,289,738
Massachusetts	60	28	88	68.2	487,702	76.1	6,408,699
Michigan	101	25	126	80.2	579,065	57.5	10,070,696
Mississippi	49	7	56	87.5	188,540	65.2	2,891,718
Missouri	107	38	145	73.8	512,699	90.1	5,690,333
New Hampshire	22	1	23	95.7	68,338	54.1	1,263,179
New York	147	245	392	37.5	1,621,041	84.4	19,206,647
North Carolina	109	44	153	71.2	588,806	71.0	8,293,042
Rhode Island	10	10	20	50.0	87,497	82.7	1,058,005
South Carolina	47	27	74	63.5	259,579	63.0	4,120,302
Tennessee	100	31	131	76.3	549,578	94.1	5,840,361
Vermont	12	1	13	92.3	31,365	50.7	618,639
Virginia	79	22	101	78.2	407,316	56.1	7,260,535
West Virginia	40	2	42	95.2	127,863	70.5	1,813,660
Total (CON States)	***1,172***	***623***	***1,795***	***65.3***	***6,911,527***	***74.2***	***94,245,416***
States Not Regulating MRI Services Under CON							
Alabama	68	34	102	67	402,933	89.1	4,522,256
Arizona	43	55	98	43.9	208,227	73.2	2,844,631
Arkansas	55	13	68	80.9	395,637	76.1	5,198,909
California	274	251	525	52.2	2,055,864	59.1	34,786,193
Colorado	56	24	80	70.0	261,413	58.5	4,468,598
Delaware	7	11	18	38.9	91,445	113.7	804,266
Florida	159	284	443	35.9	1,802,754	108.6	16,599,945
Idaho	29	7	36	80.6	71,633	53.4	1,341,442
Illinois	155	92	247	62.8	858,883	68.3	12,575,154
Indiana	99	47	146	67.8	473,430	76.6	6,180,548
Iowa	104	16	120	86.7	219,354	74.4	2,948,306
Kansas	86	18	104	82.7	199,950	73.3	2,727,831
Louisiana	85	35	120	70.8	358,509	79.2	4,526,629
Maryland	35	76	111	31.5	497,372	91.8	5,417,996
Minnesota	112	29	141	79.4	363,720	72.2	5,037,673
Montana	22	7	29	75.9	58,021	62.9	922,432
Nebraska	64	10	74	86.5	136,065	78.3	1,737,739
Nevada	19	22	41	46.3	171,166	80.2	2,134,239
New Jersey	48	144	192	25.0	830,172	97.3	8,532,086
New Mexico	25	7	32	78.1	94,036	50.1	1,876,966
North Dakota	23	3	26	88.5	46,376	71.8	645,905
Ohio	151	111	262	57.6	1,004,413	87.7	11,452,828
Oklahoma	51	22	73	69.9	227,714	64.9	3,508,690
Oregon	45	13	58	77.6	244,119	69.2	3,527,731
Pennsylvania	150	120	270	55.6	1,236,850	100.1	12,356,144
South Dakota	33	1	34	97.1	58,376	76.1	767,096
Texas	273	201	474	57.6	1,722,767	79.7	21,615,646
Utah	30	14	44	68.2	133,865	57.2	2,340,297
Washington	51	46	97	52.6	383,596	63.2	6,069,557
Wisconsin	101	31	132	76.5	383,548	70.3	5,455,875
Wyoming	18	4	22	81.8	37,265	74.4	500,874
Total (Non-CON States)	***2,471***	***1,748***	***4,219***	***58.6***	***15,029,473***	***77.4***	***193,424,484***
Total (U.S.)	***3,643***	***2,371***	***6,194***	***58.8***	***21,941,000***	***76.3***	***287,669,899***

Source: Data, IMV, Medical Information Division, 2004; Calculations and Presentation, Hobgoblin Research & Analysis, 2005
**Volume estimates based on 78% site response rate.*

Policy Perspective

by John Steen, Consultant, Health Planning and Health Policy

Angioplasty and CON

One of the many controversial regulatory policies in the states is that of either permitting or prohibiting high-risk cardiac catheterization known as percutaneous coronary intervention (PCI), or angioplasty, without on-site open-heart surgical backup. Pennsylvania is among the states that have prohibited it out of concerns for safety, but also entertained the arguments of community hospitals in rural and medically underserved areas for increasing access in their areas, especially for minority populations. For three years now, the Pennsylvania Department of Health (DOH) has been quietly conducting a pilot demonstration project of limited scope under which 11 such hospitals were approved through a waiver of department regulations. Participating hospitals are required to adhere to certain operating conditions that are largely based on American College of Cardiology (ACC) guidelines. This includes a formal written agreement for immediate (within 1 hour) transfer of a patient to a cardiac surgical facility should the need arise. Furthermore, the hospitals' informed consent form must state that the PCI procedure is being done under a waiver from the DOH's regulations and is not completely supported by the ACC guidelines. Patients considered for elective PCI must also undergo careful screening and risk stratification. Those who cannot meet the selection criteria and may be more likely to have an adverse outcome are transferred to a cardiac surgical facility for PCI. The project has allowed the hospitals to treat coronary artery blockages by inserting stents, a simpler, lower cost procedure than the CABG surgery performed at major medical centers.

As a specialized, high-risk procedure, stenting is subject to the now familiar volume-quality-cost proficiency/efficiency dynamic. The ACC and the American Heart Association (AHA) recommend that hospitals do 400 therapeutic catheterizations a year in order to achieve mortality rates of 1.35 percent or less. The highest volume cath labs in the largest medical centers commonly have rates under 1 percent. The hospitals in this pilot project have fallen far short of the recommended 400 procedures in their first and second years.

In April, the state's Legislative Budget and Finance Committee issued a report critical of the project. The report outlined serious patient safety concerns and lapses in hospital reporting of complications, and even of deaths ensuing from the procedures that were never reported to the DOH. It also found that the hospitals don" have standardized informed patient consent forms, raising serious questions about whether patients having these procedures at the hospitals fully understand the risks. And it found that most cardiac caths were not done within two hours of patient arrival at the hospital as recommended by the ACC and the AHA and mandated by the state DOH. On May 23, the DOH decided to suspend hospital enrollment in the project.

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Specialty Hospitals

After consideration of the MedPAC report (described in my previous column), CMS delivered its own report to Congress on May 11. It outlined four essential steps CMS plans to take to correct system problems that may unfairly advantage physician-owned specialty hospitals:

- Reform payment rates for inpatient hospital services through changes to the DRG system. CMS wants to make the adjustments by the end of 2006;
- Reform payment rates for ambulatory surgical centers;
- Closer scrutiny of whether facilities meet the definition of a hospital. If a facility fails to meet that definition, then it could be classified as an ambulatory surgical center, which gets lower reimbursement rates than hospitals; and
- Review of procedures for approval for participation in Medicare.

The last two recommendations may take as long as six months to accomplish. A copy of the full report to Congress is available on the CMS Web site: http://www.cms.hhs.gov/media/press/files/052005/RTC-StudyofPhysOwnedSpecHosp.pdf.

Sen. Charles Grassley (R-Iowa) and Sen. Max Baucus (D-Montana) introduced a bill on May 11 that prohibits physicians from referring Medicare and Medicaid patients to new specialty hospitals in which they have an ownership interest, and set the effective date of the bill at June 8, 2005, when the current moratorium expires, regardless of when it is enacted. Though passage appears unlikely, there will be a de facto moratorium by CMS. Mark McClellan, the administrator of CMS, said his agency will stop processing specialty hospital applications – which are needed for Medicare reimbursement – while it considers changes to payment rules for the facilities. By the time such changes are made, they should govern the process through redrawn financial incentives, obviating the need for further process restrictions.

Senator Tom Coburn (R-Oklahoma), chair of the Senate Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information and International Security, on May 24 held a hearing to address whether the federal government should regulate physician-owned specialty hospitals. Coburn said that the hearing is just the first on the issue, adding that he wants to establish a record to address the matter.

According to a Government Accountability Office report scheduled for release in the second week of June, an additional 37 specialty hospitals could open within the next one to two years without action by the federal government. The report, prepared for Grassley and Baucus, also found that CMS approval of the specialty hospitals under development would double the current number of facilities. Currently, there are about 130 specialty hospitals in the nation.

Meanwhile, a peer-reviewed research study concluded that “the lower unadjusted mortality rate after cardiac revascularization in specialty cardiac hospitals is accounted for by their healthier patients and higher procedural volumes,” and “our study provides no definitive evidence that cardiac specialty hospitals provide better or more efficient care than general hospitals with similar procedural volumes.” Cardiac Revascularization in

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Specialty and General Hospitals, Peter Cram, M.D., M.B.A., Gary E. Rosenthal, M.D., and Mary S. Vaughan-Sarrazin, Ph.D. *NEJM* 352: 1454-1462 (April 7, 2005), pp.1454, 1461. Accessible at http://content.nejm.org/cgi/content/abstract/352/14/1454.

Universal Health Care Revisited

That is the title of my article in the current newsletter of the Community Health Planning and Policy Development Section of the American Public Health Association (APHA). For APHA members, it may be accessed at http://www.apha.org/newsletter/. In it, I make the point that cost issues are the stumbling blocks that prove insurmountable for state initiatives, as well as a determinant of the feasibility of true reform on a national level:

> Can there be any solution to this short of a federal takeover of the financing of health care? With its own rapidly growing costs for an expanded Medicare program and over half the costs of Medicaid, how else but by realizing the administrative efficiencies of a single-payer health care system can the federal government accomplish it? By consolidating federal, state, and private health insurance programs under one administration, the savings could be more than sufficient to fund a true universal health care program.

On May 23, 2005, the National Coalition on Health Care issued a press release, "New Projections From Nation's Largest Health Care Coalition Show Health Care Reform Would Produce Huge Savings," accessible at
http://www.nchc.org/news/press_releases/2003/2005_05_23.pdf.
Its projections show that system-wide health care reform would save much more money than it would cost. In four scenarios for reform analyzed by Professor Kenneth Thorpe of Emory University, the investment needed to achieve universal health coverage would be more than offset by savings. In each case, the cost of a reformed system would be much less than the cost of continuing with the current "system." Thorpe projected the total change in spending for years 2006 through 2015 under four scenarios (in comparison with the status quo):

- Employer mandate supplemented by individual mandate: $320 billion reduction.
- Expand existing programs to expand coverage: $320 billion reduction.
- Develop new program modeled after the FEHB (federal employees' program): $370 billion reduction.
- Universal publicly-financed program ("single payer"): $1136 billion ($1.136 trillion) reduction.

Quality of Care Now Focus of Incentives

by Robert Vogel, Vice President
Managed Care, Sisters of Mercy Health System

Although "risk/reward" designs and modest incentive programs have been around for decades, generally they have been linked to overall financial performance of an insured population and the underlying incentive to manage utilization of health care resources. Following release of the Institute of Medicine's (IOM) "To Err is Human" and "Quality Chasm" reports, and the activity they incited, measuring and monitoring quality of care is no longer the elephant in the room.

Most importantly, as called for in the IOM reports and highlighted in the most recent MedPAC report to Congress, the Centers for Medicare and Medicaid (CMS) is taking a lead role by developing expected measures and requiring quality reporting for the Medicare program. Hospitals are required to report on ten "core measures" (soon to be seventeen) at the risk of losing part of their market basket increase. Physicians will soon participate in the Doctors Office Quality program, also presumably at risk for some of their Medicare fee adjustments. It is this quiet, but forceful, direction from CMS that will reform, in part, how we compensate providers in conjunction with the quality of care they deliver. Employers and health plans have been tinkering with quality incentives as well, but it is CMS' breadth, depth and clout that will drive widespread demonstration and adoption.

Although the incentive is in fact a penalty, it's a start. In reality, the least expensive care is always the care achieving the most appropriate outcome with the most appropriate resource mix. While many barriers remain, including common definitions of outcomes and efficient measurement tools and technology to make the process feasible, the measurement of quality is here to stay, will drive us toward better and more efficient care, and is probably the only thing that has changed materially in the modern history of U.S. healthcare.

Don't Tread On Us!

by John Steen

At the beginning of this year, the American Health Planning Association (AHPA) posted a critique of the Federal Trade Commission/Department of Justice (FTC/DOJ) policy entitled, **The Federal Trade Commission & Certificate of Need Regulation, *An AHPA Critique***, on its website. To access it, go to: http://www.ahpanet.org/Images/AHPAcritiqueFTC.pdf. See especially pp.12ff, also published in the 4th Quarter, 2004 issue of *Health Planning TODAY*, pp. 6-8.

The State of Vermont offers an illustration of what can be at stake when the federal government tries to impose its doctrines on state prerogatives in planning and regulation, including Certificate of Need (CON). Since November, Vermont's 12 health agencies that provide in-home care for the elderly and infirm have been under scrutiny by the DOJ for possible violation of anti-trust laws and conspiring to keep other firms from providing similar care.The wide-ranging federal probe is part of the DOJ's effort to examine CON laws and if they are being used as a way to curb competition in health care.

Background: Home Health Care in Vermont

The strength and resiliency of Vermont's home health system have been well-demonstrated in recent years. Vermont's community-based, non-profit home health agencies have been highly successful in assuring that all Vermonters have access to comprehensive, high quality, low cost, medically necessary home health services and hospice services, regardless of ability to pay or location of their residence. Vermont is the only state where no agency closed as a result of the federal changes to Medicare reimbursement known as the Interim Payment System (IPS), changes that shut-down over 3000 agencies in the other 49 states.

Federal data show that Vermont's 12 non-profit agencies treat more patients per capita than any other state, and Vermont has the lowest cost-per-visit for home health care of all fifty states. Nearly 80 percent of the state's home health care revenue is in the form of Medicaid and Medicare reimbursements, with only 6-10 percent covered

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by private insurance. In 2002, Vermont served 108 per 1,000 Medicare eligible people compared to the national average of 61 per 1,000 and the New England average of 81 per 1,000 (Source: Vermont Assembly of Home Health Agencies [VAHHA]) It also had the lowest cost per episode (60 days of care) of the 50 states in 2002, according to the National Association for Home Care (Washington, DC).

The state's 1999 CON guidelines, backed up by the State Health Plan, support the retention and protection of this system from competition by new for-profit and not-for-profit agencies. Vermont's CON law contains a provision that any home health service other than those non-profit agencies in existence at the time of the law – the home health agencies named in the DOJ probe – would need to undergo a CON review. Several private, Vermont-based nursing and home health providers have attempted to gain approval from state regulators, but the state has refused to grant them one on the basis of unnecessary service duplication. One firm, Professional Nurses Service (PNS), has just been granted such approval, the first in 25 years. However, the existing 12 non-competing visiting nurse agencies can thwart PNS' efforts if they can show by July 9 that they can provide enough services to ensure that no one is left on a waiting list in Vermont.

DOJ Prompts Legislative Initiative

At the end of May, the Vermont legislature enacted new legislation in response to the DOJ's intervention. The legislation establishes an explicit and clearly articulated state policy permitting and regulating the existing cooperation and coordination currently investigated by the Justice Department. It codifies the existing system of home health agencies in Vermont as reflected in Vermont's State Health Plans of 1980-1985, 1985-1990 and 1990-1993, Health Resources Management Plans of 1993-1996 and 1996-1999, and the CON Guidelines that have been in effect since 1999. The state policy enunciated in these plans favors the delivery of home health services by a community-based and supported non-profit home health agency system, and expressly favors collaboration among these agencies over a competitive, market-driven system. It expressly designates geographical areas to be served by each of the existing non-profit home health agencies. It makes a clear statement of state policy that supports the existing non-competitive community-based non-profit model for delivery of home health services, and reiterates the responsibility of the existing home health agencies to meet the needs of their respective communities. It continues the present standards for approving new competing home health agencies. It continues state collection of data on cost, access, and quality.

The legislation was approved by the House by a unanimous 132-0 vote, and by the Senate on a 24-2 vote. It enables the existing 12 visiting nurse agencies to serve patients within the state's existing service territories (largely county boundaries). That practice, among others, is precisely what has been under investigation since last November by the DOJ for possible violations of federal anti-trust laws.

"We don't want the federal government dictating how we deliver care in this state more than they already do. This bill is intended to protect a Vermont solution to providing care for the home bound that works," said State Senator Jim Leddy, the Chair of the Senate Health and Welfare Committee. Senator Leddy said the current system that fosters cooperation helps keep costs down. He said the investigation interferes with state's efforts to efficiently and effectively deliver health care. The legislation started in Leddy's committee and received a 6-0 vote there. The House Health Committee also voted unanimously for the legislation as did both the House and Senate Appropriations committees. Republican Gov. James Douglas indicated he would sign the bill into law.

What Is at Stake?

Vermont's community values are manifest throughout the state, and are evident in its forty-year history of state planning in long term care. That was well described in a statement made by VAHHA to the Governor's Bipartisan Commission on Health Care Availability & Affordability (appointed by Gov. Howard Dean in January, 2001):

> *The current market structure, although not a competitive one, does achieve the desired*

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goal of competition: universal access, low cost, and high service quality. Proponents of the totally open market argue that competition would drive costs down, give consumers more choice, and assure greater access to home care services. Data suggests otherwise.

Repeatedly during the past decade, we have invited these proponents of competition to identify one single state that has competition which they believe has a better home health system than Vermont. So far not a single state has risen to this "Pepsi Challenge." In fact, in the wake of critical stressors in the Medicare funding of home health during recent years, the resiliency and strength of Vermont's system has been amply demonstrated: there has not been a single closing in Vermont, patients with "high cost" needs have not been "dumped;" patients who have fallen through the cracks and become ineligible for Medicare funding have continued to be served.

With the current nonprofit system, Vermonters are much more likely to get needed home health services than other Americans. Health care, including home health services, is not a commodity, nor is it available to consumers in the same competitive market structures as other services. Competition simply for the sake of competition is not a valid goal in health care. What is important is assuring that all Vermonters, regardless of income and place of residence, have access to comprehensive, high quality, reasonably priced care. Vermonters have that now.

State Action Immunity vs. Competition

The legal issue here is whether the state is protected under the doctrine of "state action immunity," a protection arising from a United States Supreme Court decision affirming the authority of states to approve and regulate activities within their borders. It applies, for example, to state health planning policies to foster collaborative arrangements in order to create rural provider networks where markets cannot support more than one or two and must be stabilized to permit efficient delivery of healthcare. Here CON meets the legal tests for "clearly articulated and affirmatively expressed" state policies and "active state supervision" through state regulation. However, Vermont has not "clearly articulated and affirmatively expressed" its home health care policies until now, so the question is whether such immunity applies *retroactively*. That leaves open a 'back-door' through which the federal doctrines may challenge state authority.

Ironically, a study prepared for the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services documents what Vermont's state health planning for community-based home health care has achieved. Entitled *Promising Practices in Long Term Care Systems Reform: Vermont's Home and Community Based Service System*, by Diane Justice of Medstat, September 8, 2003
It is accessible at
http://www.cms.hhs.gov/promisingpractices/vthcbss.pdf.

Wizard's Corner

Florida Explained

"Why do elderly Floridians use more health care services than their peers in the other states and have lower mortality rates?"[1]

Undoubtedly you, like your faithful servant, have spent much of the last two years pondering the enigma that is Florida.

Fuchs, Wennberg, and others, report that adjusted health services use among white Floridians 65 to 84 years of age is about 25% higher than the comparable population nationally. In a number of South Florida communities (east and west coasts), standardized use rates are about 50% higher than the comparable national level. This extraordinary variance is not explained by greater demand resulting from higher morbidity or mortality. Mortality among these elderly Floridians is, on average, about 10% less than the comparable national rate.

Conventional explanations, e.g., physician-induced excess demand, benign climate, selective migration, healthier lifestyles, and greater social interaction, are not convincing, individually or in combination.

Health policy wonks having failed, less orthodox analysts are exploring alternative explanations, including:

- → ***Ponce de Leon Effect:*** The quixotic conquistador is redeemed.
- → ***Excessive Cat Scans:*** With the highest CT scan rate in the nation, elderly South Floridians now have nine lives. They actually die more frequently than their peers elsewhere, but bounce back.
- → ***Castro Effect:*** Cuban-American Floridians insist on out-living Fidel, if not Raul.
- → ***Ozone:*** Lightning-induced ozone, the life-enhancing drug of choice among elderly Floridians, abounds and is free.
- → ***Statistical Orthodoxy:*** The variances reported are not anomalies, no more aberrant than vote counts.
- → ***Managed Mortality:*** No one dies in Florida unless a Bush OKs the execution or removal of life support.
- → ***Political Mortality:*** Only Republican votes and Democratic deaths are counted in Florida.
- → ***Forensic Backlog:*** The good Drs. Frist and Delay are still working their way through autopsy videotapes, so death takes a holiday.
- → ***Excess MRI Scans:*** With the highest MRI scan rate in the nation, elderly Floridians have acquired magnetic powers heretofore only dreamed of by L. Ron Hubbard.

Not convinced the conundrum will be solved? Have a more convincing explanation? Submit your hypothesis and supporting analysis to ahpanet@aol.com. The most convincing explanation will awarded.

[1]Victor R. Fuchs, "Floridian Exceptionalism," *Health Affairs Web Exclusive*, August 13, 2003.