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HOW STATES CAN REFORM HEALTH CARE TODAY

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CHAPTER 4

Welcome Competition

Scale Back Certificate of Need Laws

Matthew D. Mitchell, PhD

KEY TAKEAWAYS

- In much of the country, state regulations have monopolized local health care markets.
- Certificate of need (CON) laws have been widely studied, and the evidence is overwhelming that they reduce access, limit competition, and increase costs.
- State legislators could improve health care quality, lower prices, and—above all—make it easier for millions of Americans to obtain care by repealing CON laws.

PROBLEM

The Origins of CON

Much like today, federal lawmakers of a half century ago were worried about skyrocketing health care expenditures, so, in 1975, Congress passed, and President Ford signed, the National Health Planning and Resources Development Act (NHPRDA). Congress lamented the "massive infusion of Federal funds into the existing health care system [that] has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources."[1] The solution, they believed, lay in a regulation pioneered by New York about a decade earlier.[2]

The regulation requires a "certificate of need" (CON), meaning that providers that wish to open or expand their facilities must first prove to a regulator that their community "needs" the service in question. Congress threatened to withdraw federal health care funds from any state that refused to enact such a program. Because of repeated postponement, it was a threat that never actually materialized.[3] Nevertheless, by the early 1980s, nearly every state in the country had created at least one CON program.

The Rationale(s) for CON

Unlike other varieties of regulation, the CON process is not supposed to assess a provider's qualifications, safety record, or the adequacy of their facility. Instead, the entire process is geared toward second-guessing the provider's belief that their community would benefit from the service they would like to offer.

Certificate of need is an unusual regulation. In most other industries, need is assessed by the entrepreneur, based on his or her expectation of profitability. Since providers are either risking their own capital or capital that they have promised to repay, they have a strong incentive to carefully weigh the financial viability of the venture. But given the third-party payer problem in health care, lawmakers worried that patients could be induced to agree to expensive hospital stays and unneeded procedures.

In encouraging CON, lawmakers hoped hospitals would acquire fewer beds, fill them with fewer patients, and spend less money. The main purpose of CON was therefore to reduce health care expenditures by rationing care. The authors of the NHPRDA also thought that they could reduce health care costs by encouraging "the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care."[4]

Beyond costs and expenditures, the authors of the NHPRDA also hoped to ensure an adequate supply of care, especially for "underserved populations," including "those which are located in rural or economically depressed areas."[5] Finally, they hoped to "achieve needed improvements in the quality of health services."[6]

These goals—cost containment, adequate and equitable access, and quality improvement—remain widely shared aims of health policy and are laudable goals. The preponderance of evidence suggests that CON fails to achieve them. In fact, CON likely increases costs, limits access, and undermines quality.

CON's Evolution

Early research suggested that CON did not work. One study found that hospitals anticipated CON and actually increased their investments before it took effect.[7] Another found that while the regulation did change the composition of investments, "retarding expansion in bed supplies but increasing investment in new services and equipment," it had no effect on the total dollar volume of investment.[8] As a result, early evaluations found that limited CON programs had no effect on total expenditures per patient, while comprehensive programs were associated with higher spending.[9]

As this evidence was emerging, Congress was also making important changes to Medicare reimbursement. Medicare had originally reimbursed hospitals on a "retrospective" and "cost-plus" basis. "Under this system," explained health care researchers Stuart Guterman and Allen Dobson in 1986, "hospitals were paid whatever they spent; there was little incentive to control costs, because higher costs brought about higher levels of reimbursement."[10] Recognizing the problem, Congress switched to "prospective" reimbursement in 1983.[11]

Mark Botti of the Antitrust Division of the Department of Justice noted the implications of this change in testimony before the Georgia State Assembly in 2007, saying, "In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis."[12]

Indeed, three years after Congress switched from retrospective to prospective reimbursement, it elected to do away with the CON mandate.[13] Almost immediately, 12 states eliminated their CON programs. Representative Roy Rowland (D-Ga.), a physician representing the largely rural center of Georgia, captured the sentiment of his colleagues, noting a few years after repeal that, "At first glance, the idea [of certificate of need] may have looked pretty good. In practice, however, the effect of certificate-of-need on health care costs has been dubious, at best. And the program has certainly been insensitive in many instances to the true needs of our communities."[14] Representative Rowland urged his colleagues to go further, asserting that "it's now time to abolish it throughout the nation."[15]

He did not get his wish. Still, without the federal incentive, 15 states have eliminated CONs for most or all aspects of health care as of 2021.[16] The most

recent full repeal was in New Hampshire in 2016. Several other states, however, have pared back their programs. Florida, for example, enacted significant reforms in 2019, eliminating CONs for most technologies and investments.[17] For reasons that are not entirely clear, nursing home CONs seem to be particularly difficult to eliminate, so states like Florida that enact sweeping reforms often leave these CONs untouched.[18]

The global COVID pandemic touched off keen interest in eliminating barriers to health care and, as evidence mounted that these rules were associated with projected bed shortages and higher mortality, 24 states eased or suspended their CON regulations.[19] In 2021, CON reform or repeal was considered in 18 states. Modest reforms were passed in Tennessee, Washington, and Virginia, while Montana eliminated every CON except that for nursing homes.

CON Today

A survey in 2020 found that among 35 CON-regulated services, the most common CON requirements are for nursing homes (34 states), psychiatric services (31 states), and hospitals (29 states).[20] Hawaii regulates the most services at 28, with North Carolina (27 services) and the District of Columbia (25 services) falling close behind. Meanwhile, Indiana and Ohio each regulate just one service (nursing homes). With its reforms, Montana will soon join this group. Arizona and New Mexico have only ambulance service CON requirements (which, to my knowledge, have not been studied).

It is common for states to require CONs for expenditures above a certain threshold, although these thresholds vary across states. In New York, for example, projects undertaken by general hospitals in excess of $30 million necessitate a CON, while in Iowa projects in excess of just $1.5 million require a CON.[21] In a reflection of the political power of hospital associations, the thresholds that trigger a CON review are typically lower for non-hospital providers than for hospitals. In Maine, for example, hospitals must obtain a CON when they undertake capital expenditures in excess of $12.365 million, while ambulatory surgery centers must obtain a CON for expenditures in excess of $3 million.[22]

Application fees also vary, ranging from $100 in Arizona to $250,000 in Maine, though some states structure fees as a percentage of the proposed capital expenditures.[23] There is no systematic data on compliance costs, but we know that providers can spend months or years preparing their applications

and waiting to hear from the regulator. Because the process can be cumbersome, providers often hire boutique consulting firms to help them navigate it. Employees of existing hospitals and other incumbent providers typically sit on CON boards, and in all but five CON states, incumbent providers are allowed to object to a CON application of a would-be competitor.[24] In some states, Mississippi and Oklahoma, for example, competitors are allowed to appeal a CON decision after it has been made, further dragging out the process.[25]

These compliance costs and the revenue providers forgo as they await the verdict can amount to tens or even hundreds of thousands of dollars.[26] In many states, a CON can be denied if a regulator believes that the new service will duplicate an existing service, all but ensuring a local monopoly. There is, again, no systematic data on approval rates. Available data, however, suggests that approval is far from guaranteed. From early 2014 to early 2017, for example, about 55 percent of Florida CON applications were rejected.[27]

DOES CON WORK AS ADVERTISED?

The stated goals of CON regulation are to contain costs, ensure adequate and equitable access to care, and improve quality. The evidence shows CON fails to achieve these laudable goals and is an expensive barrier to entry.

CON Increases Costs

Given the potentially anticompetitive effects of the regulation, it may give providers some degree of pricing power, insulate them from the incentive to contain costs, and encourage wasteful efforts to seek and maintain the privilege.[28]

In a 2016 survey of 20 peer-reviewed studies, I conclude that "the overwhelming weight of evidence suggests that CON laws are associated with both higher per unit costs and higher total expenditures."[29]

CON Reduces Access

The theoretical prediction that CON will backfire regarding health care access is stronger. The most straightforward expectation is that a supply restraint will limit quantity supplied, and the evidence is abundant that CON does just that. Controlling for other factors, researchers find that the average patient in a CON state has access to fewer hospitals,[30] fewer hospice care facilities,[31]

fewer dialysis clinics,[32] and fewer ambulatory surgery centers (ASCs).[33] There are fewer beds per patient in these states[34] and fewer medical imaging devices.[35]

Nor does CON seem to distribute care where it is most lacking. The average rural patient has access to fewer rural hospitals and fewer rural ASCs in CON states,[36] and patients must travel farther for care and are more likely to leave their states for care.[37] Despite the hope that CON regulators might condition approval on the provision of care to vulnerable populations, there is no greater incidence of charity care in CON states relative to non-CON states.[38] Repeal of CON can increase equity as disparities among racial groups in the provision of care disappear when CON is eliminated.[39]

CON Reduces Quality

Theory suggests that competition will tend to enhance quality, though it is possible that in some settings (surgery, for example) high-volume providers may be able to offer better care through mastery of their craft. Early studies tended to focus on specific procedures and offered mixed results.[40] The most recent research, however, suggests that patients in CON states have higher mortality rates following heart attacks, heart failure, and pneumonia.[41] Moreover, patients in states with four or more CON requirements have higher readmission rates following heart attack and heart failure, more post-surgery complications, and lower patient satisfaction levels.[42] Certificate of need laws appear to have no statistically significant effect on all-cause mortality, though point estimates suggest that, if anything, they may increase it.[43]

PROPOSAL

State legislators should repeal their CON requirements. Short of full and immediate CON repeal, reform-minded legislators have several options.[44] Policymakers could schedule repeal to take effect at some future date (perhaps calibrated to give CON holders time to recover their costs on long-lived assets), or they might phase in repeal by requiring that the CON authority approve an ever-larger percentage of applications over time.

Alternatively, policymakers could eliminate specific CON requirements, such as those that restrict access to facilities and services used by vulnerable populations. Prime candidates include CONs for drug and alcohol rehabilitation, for psychiatric services, and for intermediate care facilities serving

those with intellectual disabilities. Policymakers could also take steps to ease the administrative and financial costs of applying for a CON.

Alternatively, they might mitigate the most egregiously anticompetitive aspects of CON. For example, they could bar employees of incumbent providers from serving on CON boards or, following Indiana, Louisiana, Michigan, Nebraska, and New York, they could no longer solicit and consider the objections of a competitor when a provider applies for a CON. Furthermore, no CON should be rejected on the basis that entry would create a duplication of services, as this guarantees an incumbent a local monopoly.

These and other steps could permit more Americans, especially vulnerable populations, greater access to lower-cost and higher-quality care. We know this because researchers have spent decades studying outcomes in states where policymakers have already done away with these anticompetitive rules.

ABOUT THE AUTHOR

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