



POLICY MATTERS

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Irrational

Do Certificate of Need laws reduce costs or hurt patients?

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Summary: Certificate of Need laws, or CONs, have been set up across the country under the assumption that rationing hospital construction and expansion would limit increases in health care costs. Four decades of experience have shown that CONs do not control costs, but do provide a significant barrier to entry to innovative health care facilities and limit competition in the health care marketplace. Faced with this evidence, CON supporters have created novel arguments to justify them, but these new rationales also fall under close scrutiny. New Hampshire should end its thirty-year experiment and repeal its Certificate of Need Law.

BACKGROUND

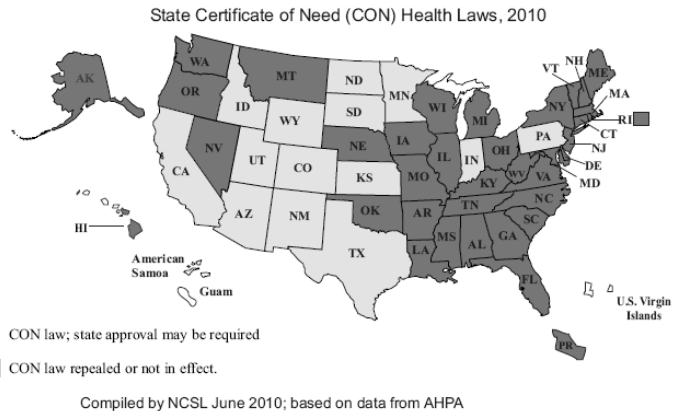
Certificate of Need laws require state government approval for health care providers looking to establish or expand their facilities. By limiting investment in capital projects, regulators hope to reduce inefficiencies in the health care marketplace. Supporters argue that excess capacity, such as hospitals with too many empty beds, results in high fixed costs being passed along to patients.

The first Certificate of Need law in the nation was in New York in 1964, when the State Legislature required that the government determine there was a need for a new hospital or nursing home before construction could begin.¹ The American Hospital Association soon supported the concept, and began a push to establish CON Boards in other states. In the Health Planning Resources Development Act of 1974², Congress required agencies in each state to centrally plan expansion in the health care industry, and authorized just over \$1 billion in grants for states to set up CON requirements over three years.

The U.S. Department of Health, Education, and Welfare touted the goals of the new law, republished in the Journal of the American Medical Association in November 1975.

The enactment of health planning legislation offers new means for achieving that coordination and of providing for the development of necessary health resources while preventing costly surpluses.³

Congress repealed these mandates and federal funding in 1987. Since then, 14 states have repealed their CON laws, leaving 36 states and the District of Columbia with CON processes. The accompanying map was compiled and published by the National Conference of State Legislatures.



CONTROVERSIAL HISTORY

From its inception, the Certificate of Need process has faced criticism as an unwarranted intrusion of well-meaning bureaucrats into the health care marketplace, and an opportunity for existing firms to place barriers to entry on would-be competitors. As early as 1976, authors David Salkever and Thomas Bice found “that CON laws do not dampen total hospital investment.”⁴

As Congress debated cutting federal funding for state CONs, several studies questioned the effectiveness of the programs over their first decade. In 1985, James Simpson found that California placed no limits on existing hospitals to expand services or purchase equipment, but placed CON requirements on competing surgical centers⁵.

The best CON law reflects the calculated risk that the benefits of public scrutiny of health facility projects will outweigh the program’s unavoidable side effect of enfranchising existing providers. Some certificate-of-need laws are structured such that the side effects seem to overshadow the benefits.

Even when CON Boards approve requested projects, the time and expense of complying with state regulations could be immense, according to a 1987 study by Roberta Roos published in Pace Law Review⁶.

For example, the CON application filed by a group of Connecticut hospitals for a magnetic resonance imaging (MRI) center was over 1400 pages, and the required supplement exceeded 1700 pages. From conception until final approval, Greenwich Hospital’s noncontroversial and unopposed request for a CON to replace its telephone system took one year, and that period was “brief” only because the hospital agreed to waive its right to a hearing.

Roos also describes a case study in which White Plains Hospital Medical Center in New York took ten years to get approval for CAT scanners. Roos found that the cost of a CON application exceeded \$100,000 for major projects, and could reach \$350,000 if litigation was required⁷.

A 1991 study of 1,957 acute care hospitals nationwide found that costs were actually higher in CON states⁸.

These findings suggest not only that CON do not really contain hospital costs, but may actually increase them by reducing competition.

In Kentucky, a restrictive CON law requires for acute care hospitals to show a need in all surrounding counties. Dr. Kevin Kavanagh points out that this prevents Jessamine County from getting a new hospital because the City of Lexington is in a neighboring county, and Lexington doesn’t need another acute care facility⁹.

Kentucky’s CON law regarding acute care hospitals virtually assures no additional facilities will be built in the State of Kentucky. It is so restrictive that one wonders whether its primary purpose is to guard the healthcare of citizens or whether it is mainly used to protect influential political interests, making the need for the appeal of Kentucky CON law even more imperative.

A comprehensive study by Conover and Sloan in 1998 showed remarkably little effect of CON laws on the cost, quality, or accessibility of health care services¹⁰.

*There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations. Mature CON programs also result in a slight (2 percent) reduction in bed supply but higher costs per day and per admission, along with higher hospital profits. CON regulations generally have no detectable effect on diffusion of various hospital-based technologies. It is doubtful that CON regulations have had much effect on quality of care, positive or negative. **Such regulations may have improved access, but there is little empirical evidence to document this.** (Emphasis added)*

A joint report from the Federal Trade Commission and the U.S. Department of Justice in 2004 recommends that states reconsider Certificate of Need laws as a way to control health care costs¹¹.

*The Agencies believe that, on balance, **CON programs are not successful in containing health care costs**, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. As noted earlier, the vast majority of single specialty hospitals – a new form of competition that may benefit consumers – have opened in states that do not have CON programs. Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns. (Emphasis added)*

In 2005, Dr. Roy Cordato authored a report calling for CON repeal while rebutting the presumption that market forces simply don't work in health care¹².

*The idea that in the area of health care services, free market competition can't work as a means of cost control, is not grounded in either economic theory or empirical evidence. Indeed, in areas where competition is allowed to flourish, such as optometry, the customer is well served with plenty of options and competitive pricing. Furthermore, **believing also that CON laws and the bureaucrats that administer them can do a better job than the competitive market process, is not only wishful thinking, it is the economic equivalent of believing the Earth is flat.** Somehow, legislators have convinced themselves we can have the results of open competition by creating monopolies – as Orwell said, love is hate and war is peace. (Emphasis added)*

In 2010, Dr. Michael Morrissey of the University of Alabama Lister Hill Center for Health Policy concluded that “CON is ineffective in controlling hospital costs” and “ineffective in controlling Medicaid nursing home costs.”¹³ In Hawaii, CON has prevented construction of a second hospital on the island of Maui¹⁴.

Hawaii bureaucrats held up construction of a new \$220 million private hospital on Maui for years, forcing the island's 144,000 residents to depend on a single, state-run facility or on clinics. The State Health Planning Development Agency rejected a 2007 proposal to build a new, state-of-the-art facility, denying it a certificate of need because it would negatively affect the existing government-run hospital. The agency finally granted approval in 2009, and construction is now underway, but in the meantime victims of emergencies on the island's south side must still endure a 90-minute drive on a two-lane highway to reach the Maui Memorial Medical Center.

CHERRY PICKING

As evidence mounted that CONs were not effective in holding down health care costs, CON supporters formulated a different rationale. They began to argue that policy makers had to limit the growth of for-profit hospitals, specialty hospitals, and Ambulatory Surgical Centers in order to maintain the cross-subsidization that occurs in all large hospitals.

Cross-subsidization means that patients with premium insurance pay higher rates than Medicare,

Medicaid, or emergency room patients. These patients in effect subsidize money-losing services throughout the hospital. Specialty hospitals don't have to accept Medicaid patients or operate emergency rooms. Without these affluent, and profitable, patients, existing hospitals would take a financial hit. Since policy makers have a public interest in making sure emergency rooms remain open, they could use CON laws to restrict "cherry picking."

In 2007, Mark Botti from the Department of Justice Antitrust Division testified before the Georgia General Assembly on why CON laws are not a proper mechanism to protect non-profit hospitals from for-profit competition¹⁵.

I want to address directly one of the most prominent rationales advanced for keeping CON laws, namely, that incumbent hospitals should be protected against additional competition so that they can use their profits to cross-subsidize care for uninsured or under-insured patients.(18) Under this rationale, CON laws would impede the entry of such healthcare providers as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, single- or multi-specialty physician-owned hospitals, because if these new competitors were to enter the marketplace, community hospitals could not continue to exploit their existing market power over consumers. Put another way, without CON laws, we would see new, higher-quality, low cost providers in the marketplace, which would put competitive pressure on incumbent providers.

POLITICAL INFLUENCE

Granting power to state government, particularly to unelected boards filled by representatives of the industry under review, poses a clear danger of rent-seeking and self-dealing. A 2001 study published by the National Institute for Health Care Reform found serious suspicion about the political motives behind CON decisions in several states.

In five of the six states studied – all except Michigan – the CON approval process can be highly subjective and tends to be influenced heavily by political relationships rather than policy objectives.¹⁶

In Washington, for example, a hospital respondent described CON decisions as inconsistent, given the state's latitude to interpret regulations. A more extreme case occurred in Illinois, where the CON authority was suspended in 2004 for several months after conflicts of interest were revealed among board members.¹⁷

In Illinois, the state CON process provided an opportunity for the 21st Century poster-child for political corruption, Rod Blagojevich. The case file of the convicted Illinois Governor includes an affidavit from FBI Special Agent Daniel Cain outlining how Blagojevich and his cronies used the state's Planning Board to solicit bribes.

*Rezko informed Levine that Mercy was not going to receive its CON. According to Levine, he asked Rezko **whether it would matter to Rezko if Mercy's construction contractor paid a bribe to Rezko and Levine and, in addition, make a contribution to Rod Blagojevich.** Levine testified that Rezko indicated that such an arrangement would change his view on the Mercy CON¹⁸. (Emphasis added)*

That's the Chicago way. Such outright corruption is surely not the norm for CONs in other states, nor even in Illinois today, but it does show the risks of placing such powerful control over multi-billion dollars hospitals in the hands of political appointees.

CONTRARY EVIDENCE

There have been some studies purporting to show lower health care costs or better health outcomes in states with CONs on the books. The AFL-CIO sponsored a study of the Big Three automakers showing lower costs in state with CONs¹⁹.

In analyzing their own healthcare costs, DaimlerChrysler, Ford Motor Co. and General Motors Corp.-all members of our alliance and three of the largest employers and purchasers of healthcare in the nation-reported to the Michigan Legislature about analyses of their traditional and PPO health costs. Each company examined data from states where they have many employees and retirees. They reported that in every year analyzed, they had lower per-person health costs in states with CON than in states without such laws. For example, DaimlerChrysler's per-person healthcare costs in "non-CON" Wisconsin were about triple what they were in New York, a state with a rigorous CON program.

Yet Wisconsin is a CON state, reinstating its requirements in 1993. Moreover, states may see higher medical costs for reasons other than Certificate of Need programs, and the AFI-CIO study does not control for any other variables.

A study published in the Journal of the American Medical Association found slightly lower mortality rates following Coronary Artery Bypass Graft Surgery (CABG)²⁰.

Unadjusted mortality was 5.1% in states without certificate of need regulation compared with 4.4% in states with continuous regulation, and 4.3% in states with intermittent certificate of need regulation.

This study attributes the improved health outcomes to higher surgery volume. High procedure volume improves medical performance, and this may be a secondary effect of CONs. By limiting competition, CONs may effectively concentrate certain procedures towards select hospitals and surgeons. Recent research shows that most of this effect is in fact related to surgeon volume, in that doctors become more proficient as they accumulate experience performing a specific procedure²¹. Practice makes perfect. If policy makers are willing to interfere in the health care marketplace to increase procedure volume, they would be more effective limiting the number of surgeons than the number of new hospitals.

NEW HAMPSHIRE LAW

New Hampshire began its experiment with Certificate of Need laws in 1979, with passage of RSA 151-C, which finds:

The general welfare and protection of the lives, health, and property of the people of this state require that all new institutional health services be offered or developed in a manner which avoids unnecessary duplication, contains or reduces increases in the cost of delivering services, and promotes rational allocation of health care resources in the state.²²

The Health Services Planning Review Board is made up of ten members; the New Hampshire Department of Health and Human Services Commission or his designee, five members from the health care industry, including providers, insurance companies, and a representative from the New Hampshire Association of Counties, and four public members who are not employed in the field to serve as consumer representatives. There are currently three vacant positions, all public members, slanting the current HSPR Board towards the health care industry.

A certificate of need is required to "construct or modify health care facilities, acquire new medical equipment, or offer new inpatient care beds and services, subject to statutory thresholds." Those thresholds are "\$ 2,780,012 for any acute care facility project; \$ 1,853,341 for any nursing home, ambulatory surgical facility or specialty hospital project; \$789,995 for any ambulatory surgical facility within the service area of a hospital with fewer than 70 licensed beds; and \$400,000 for equipment."²³

In order to receive permission to start a project that trips these thresholds, a hospital or other medical provider must fill out a 23-page application²⁴, describing the project's scope and purpose, and how the

plan would fit into the current health care market. The process also requires applicants to submit in-depth analysis of the primary and secondary markets that the project would serve, road networks and travel conditions in the area, as well current facilities offering similar services, utilization rates using several different metrics, and rates schedules for Medicare, Medicaid, commercial insurance, and private payer patients.

RECENT HISTORY

From 2007 to 2012, HSPR has reviewed 33 applications for hospital construction and expansion²⁵, ranging from a \$10,000 addition of 24 new beds at the Sunbridge Clipper Home in Wolfeboro to an \$84.9 million construction and renovation project for the acute care facilities at Elliot Hospital in Manchester. 28 of the projects were approved.

Position	Name	Term Expires
DHHS Designee	John Wallace	N/A
NH Ambulatory Service Center Assoc.	Nicholas Vailas	Dec. 1, 2011 (Holdover)
NH Assoc. of Counties	Robert Chase	Dec. 13, 2013
NH Healthcare Assoc.	Christopher Martin	Apr. 19, 2013
Health Care Insurers	James Tollner	Apr. 19, 2011 (Holdover)
NH Hospital Assoc.	Lori Underwood	Apr. 19, 2012
Consumer Rep.	Deb Grabowski	Apr. 19, 2013
Consumer Rep.	VACANT	
Consumer Rep.	VACANT	
Consumer Rep.	VACANT	

Two were withdrawn. Wentworth-Douglass Hospital applied for a \$67.3 million project to expand its acute care facilities in August 2008, but withdrew the application in April 2009. The hospital resubmitted a request for a \$54.9 million project in August 2009, and received approval in April 2010. Imaging Resource Alternatives applied for a \$1.6 million MRI machine in June of last year, but withdrew the application before the Board could act.

Three projects are still under formal review, all seeking permission to expand acute care facilities, at Catholic Medical Center in Manchester, Dartmouth-Hitchcock Medical Center in Lebanon, and St. Joseph's Hospital in Nashua.

Acute Care represents the bulk of hospital capital projects addressed by the HSPR over the past five years. They account for 18 of the 32 applications, counting the Wentworth-Douglas project just once. Given the increased use of acute care facilities in the American medical system, and the HSPR's track record of approval for these projects, it's hard to see how New Hampshire's Certificate of Need law is doing much of anything to hold down costs. The panel generally takes five to six months to approve an application. And it is possible that New Hampshire health care providers have simply learned to stop asking for costly projects that are unlikely to receive the Board's permission.

NEW HAMPSHIRE LEGISLATION

The debate over New Hampshire's CON law was reignited this year by efforts by Cancer Treatment Centers of America to evade the requirements of the statute in order to build a new facility in Salem. The Pennsylvania company successfully lobbied the Georgia Legislature to allow specialty hospitals without CON approval, and is seeking a similar fix in New Hampshire.

CTCA CEO John McNeill testified before the House Health, Human Services, and Elderly Affairs Committee in favor of HB 1642²⁶. "We view a Certificate of Need process as a barrier that is often used in communities by existing providers as a way of protecting their turf," McNeill said.²⁷

But current hospitals oppose this effort to circumvent the CON Board. NH Hospital Association President Steve Ahnen argues that for-profit hospitals like CTCA can cherry-pick patients with private insurance, patients who currently subsidize other parts of the hospital.

"The services that lose money are the ones that everyone wants to make sure we have. Do we have an ER and an ICU, they all lose money," Ahnen testified.

HB 1642 would not only let specialty hospitals like CTCA avoid filing a CON application. It would also require the DHHS Commissioner to provide a waiver for such facilities from the Medicaid Enhancement Tax. This controversial tax has been on the books in New Hampshire for decades as part of the state's so-called Mediscam system. Hospitals would pay the MET to the state. The state would use those receipts to receive federal Medicaid matching funds, and then effectively refund the MET payments through a separate program known as Disproportionate Share Hospitals (DSH). In effect, hospitals were left harmless under the MET, and lawmakers could skim the matching funds for other spending priorities.

New Hampshire's current budget severs the link between the MET and DSH payments, turning what was a phantom tax into a real tax. Several New Hampshire hospitals have sued the state over this change, as well as series of cuts to reimbursement rates imposed by Governor John Lynch dating back to 2008.²⁸ HB 1642 would exempt CTCA from the MET, while leaving it in place for current hospitals.

The House Health, Human Services, and Elderly Affairs Committee is also considering a bill to repeal the Certificate of Need Law entirely²⁹. HB 1617 has two key advantages from a public policy standpoint compared to HB 1642. By removing the CON process for all hospitals, rather than just a potential new facility, HB 1617 provides a level playing field in the New Hampshire marketplace. The current regulatory regime provides a significant advantage to existing firms by placing a formidable barrier to entry in the path of new entrants. But exempting one hospital or class of hospitals would also represent government interference. This bill does not address the Medicaid Enhancement Tax. Whether lawmakers continue to assess this tax on hospitals or repeal it, the tax code should provide equitable treatment for all health care facilities. Waiving state taxes in order to entice business to locate in New Hampshire would be a significant departure from past practice, and open to the door to all manner of ill-conceived tax incentives from rent-seeking politicians.

CONCLUSIONS

Four decades of experience shows that CONs have failed to control health care costs. These costs rose during a decade of national-wide CON laws, and have continued to rise in states that have repealed CON laws and states that have kept them.

There is some evidence that CONs produce better health care outcomes due to higher procedure volume, but this is at best a secondary effect of limiting health care facilities. There are surely more direct methods to increase surgical procedure volume than preventing new hospitals from being built.

The cherry-picking rationale for blocking innovative medical facilities like specialty hospitals and Ambulatory Surgical Centers does not justify continued use of CON laws. Patients choosing for-profit facilities reveal both the inadequacy of existing hospitals to satisfy their patients, and the unsustainable cross-subsidization that prop up much of the American medical industry. CONs merely serve as a way for policy makers to hide these structural problems by protecting established hospitals from the consequences of competition.

In New Hampshire, the Health Services Planning Review Board serves as an unnecessary bureaucratic hurdle to new entrants to the health care market. It has done nothing to address shortages in New Hampshire's health care infrastructure, and there is no evidence that it has lowered costs for New Hampshire patients. Lawmakers should repeal New Hampshire's Certificate of Need Law.

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ENDNOTES

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