

The Certificate of Need

An Outdated Concept in Need of Re-examination

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Abstract: The certificate of need was enacted to control health care costs. Multiple studies by academic and Federal agencies have shown it to be ineffective. Serious questions have been raised as to if the CON can serve its intended purpose with the emergence of for-profit public corporations in our health care system. The granting of monopolies with little or no oversight on charges is not good public policy. It has lead to protracted and expensive legal battles, and corruption in state government which has contributed to the downfall of state administrations.

Key Words: certificate of need, health care reform, competition, monopoly

Introduction: The Certificate of Need refers to state laws which require an applicant to prove a legally defined need before major healthcare construction is allowed or a service is provided. The basic assumption is that by eliminating duplication, the savings will be passed onto the consumer and the CON will save healthcare costs. However, this assumption has as one of its tenets that we are dealing with a truly non-profit system. As Morrissey pointed out in 2002, “the principle difference between for-profit and nonprofit organization is how the profits are spent. For-profit enterprises spend them on shareholders. Nonprofit entities are prevented by law from explicitly doing so.”(15)

State Certificate of Need laws vary widely between states and can cover over 40 services which range from hospitals, nursing homes, home health agencies to business computers, medical office buildings, swing beds and subacute services. (16) Each of these services has its own economics and set of pros and cons regarding the CON’s existence.

What “need” is, is in the eyes of the beholder or State Government. The laws are often convoluted and illogical and do not take into account the welfare of citizens. For example, in Kentucky, to build an acute healthcare facility on the basis of improving healthcare quality, all hospitals in the county and surrounding counties would have to (at the same time) have final termination of their Medicaid or Medicare provider agreement, final revocation of their hospital license, OR final revocation of their hospital accreditation, a set of conditions which would never happen.(10)

Most of the research in the literature and the emphasis of this report will concern Acute Care Facilities.

History in the United States: The first state to enact a CON was the State of New York in 1964. Soon after, the American Hospital Association started a national campaign encouraging the remaining states to enact their own CON laws. (16) In 1972, Section 1122 of the Social Security Act was enacted to require that all states review healthcare expenditures over \$100,000.(5) In 1974, the federal “Health Planning Resource Development Act” tied funding for Medicaid and Medicare to having a state agency

to oversee the building of major medical facilities and purchasing of major medical equipment.(15) By 1975, twenty states had enacted a CON law. (15,16) By the mid-1980's all states and the District of Columbia had CON laws.(2) In 1987, the federal government repealed the Health Planning Resource Development Act, "in part because it was ineffective in controlling costs."(15) In 2008, the National Conference of State Legislatures listed 27 states plus the District of Columbia on its website as having CON laws for acute hospital beds.(16)

History in Kentucky: Coinciding with the passage of Section 1122 of the Social Security Act, the State of Kentucky enacted a CON in 1972. The stated statutory purpose of the CON (KRS 216B.010) is as follows:

"Therefore, it is the purpose of this chapter to fully authorize and empower the Cabinet for Health and Family Services to perform any certificate-of-need function and other statutory functions necessary to improve the quality and increase access to health-care facilities, services, and providers, and to create a cost efficient health-care delivery system for the citizens of the Commonwealth." (KRS 216B.010)

The Kentucky's law mandates that all sides of the iron triangle be improved. The three sides of the triangle are cost, quality and access. It is commonly held in medical economics that it is virtually impossible to improve all three sides. Kentucky, is mandated to do so but at the same time its regulations, regarding construction of acute care hospitals, has virtually shut the process down by setting the bar too high and requiring all hospitals in a county and surrounding county to be shown to be in need.(10)

How Well has the CON Worked in the United States?

The State of Washington has extensively studied the CON. The Washington State Joint Legislative Audit and Review Committee (1999) and the Seattle's Mercer Human Resource Consulting Group (2005) both found the CON neither reduced the cost or increased access to healthcare. (2)

One of the changes in the medical economic landscape is the emergence of large corporations, many of which are for-profit. The CON of the 1970's was not created in this type of business environment.

Some for-profit hospital corporations have on past SEC reports stated:

“We target hospitals in growing, non-urban and select urban healthcare markets for acquisition because of their favorable demographic and economic trends and competitive conditions. Because these service areas have smaller populations, there are generally fewer hospitals and other healthcare service providers in these communities and generally a lower level of managed care presence in these markets. We believe that smaller populations support less direct competition for hospital-based services.”(6)

The certificate of need has given these companies a virtual monopoly in rural areas. Kentucky is a prime example of this and there is little to no state oversight on charges to patients as there is with utility companies.

There have been numerous academic studies regarding the effects of the CON on the price of healthcare. Virtually no studies have shown that the CON lowers costs.(2,15) One study performed by Conover and Sloan in 1998 found that “mature CON programs resulted in a slight (2 percent) reduction in bed supply but higher costs per day and per admission, along with higher hospital profits.”(7)

In July 2004, an extensive study was conducted by the Federal Trade Commission and Department of Justice.⁽¹⁴⁾ Testimony from 250 panelists compiled over 27 days along with independent research concluded that:

“States should decrease barriers to entry into provider markets.” “States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs.” The report further stated: “The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anti-competitive risks that usually outweigh their purported economic benefits.”

In February of 2007, Mark Botti, Chief of the Litigation I Section US Dept of Justice, Antitrust Division, testified before a joint session of the Georgia State House and Senate Health and Human Services Committee regarding the Certificate of Need.⁽³⁾ He emphasized that competition benefits health care and “harm is caused by regulatory barriers to entry”. In addition, his written testimony stated that “CON laws create barriers to beneficial competition” and stressed the following:

- “Original Cost-Control reasons for CON laws no longer apply.”
- “Protection of revenues of incumbents does not justify CON laws.”
- “CON laws impose other costs and may facilitate anti-competitive behavior.”
- “CON laws lead to less competition and higher prices.”

In September of 2008, the FTC and Dept. of Justice reaffirmed the 2004 report on the certificate of need in testimony given to the Illinois Task Force on Health Planning reform.⁽¹⁸⁾ By issuing a joint statement that “CON Laws Undercut Consumer Choice, Stifle Innovation and Weaken Markets' Ability to Contain Health Care Costs.”⁽⁸⁾ Illinois is part of a growing list of states that have either repealed or are reexamining the Certificate of Need. As of 2008, fourteen states have repealed the CON and two others have limited its scope, Ohio to long-term care facilities and Nebraska to long-term care and

rehabilitation facilities. In addition, Louisiana retains oversight of assisted-living facilities, long-term care facilities and intermediate-care facilities for the mentally handicapped.

In Kentucky, the CON was reviewed in June 1997 by the Kentucky Subcommittee on Health Care Costs. Legislative Research Commission staff notes of the meeting recorded comments in multiple areas that the “CON does not control costs or increase access”.(11) The final report concluded that “when Kentucky looks at its increase in the volume of outpatient services and costs, particularly outpatient surgeries, it seems evident that the CON process has fallen short (of) its intended purpose.” And “as managed care continues to develop in Kentucky and works to promote competition and cost containment, the usefulness of CON for certain services will be limited at best.”(12)

The State of Washington reviewed the CON and also “found that the CON has not controlled overall health care spending or hospital costs.”(19)

Most recently, the Institute of Health and Social-Economic Policy reported in 2005 that Kentucky had the 17th highest total gross charge-to-cost ratio 2.33 (232.90%) in the United States.(9) In 2007, one rural hospital with a CON protected virtual monopoly has a facility overall charge-to-cost ratio of 7.95 (794.91%).(1)

The CON also does not have a good track record in promoting quality. The 1997, Kentucky CON report stated that “the CON has done very little to enforce the role of quality in reducing the rate of cost increases.”(12) The Washington State Joint Legislative Audit and Review Committee reported in 1999:

“...that CON has not controlled overall health care spending or hospital costs. The study found conflicting or limited evidence about the effects of CON on the quality and availability of other health care services or about the effects of repealing CON.”(19)

State licensure laws can also be used to promote health care quality and may be another avenue to use in view of the failed CON.

The CON has also produced two other aberrations. The first, is the large cottage legal industry that has emerged to advocate for corporations requesting CONs. Legal fees can be in the hundreds of thousands of dollars and competing facilities can countersue in an attempt to prevent the granting of a CON. In one case in Mississippi, almost two million dollars was spent in a fight between a hospital and an imaging center over the awarding of a CON.(13) The longer the fight the more expensive the process, producing expenditures which would have been better spent on services to patients.

The second aberration is that the CON has fostered corruption. The lack of any clear criteria which actually lowers healthcare costs may give rise to special legislation and behind-the-scenes negotiations which may not always be legal.

It is difficult to define need and the CON does not lower costs. Thus, how does a state determine who should receive a CON? In Kentucky, one has to do the impossible, improve all three arms of the Iron Triangle of healthcare. This is an impossibility. Other states have a simpler approach:

In Illinois, Governor Blagojevich's criminal complaint alleges that a plan was devised to award a CON to an acute care facility in exchange for bribes and campaign contributions and "at least one board member was soliciting bribes for board action". (4)

In Alabama, Governor Don Siegleman was convicted for allegedly taking a \$500,000 bribe for an appointment to the Certificate of Need Review Board.(17)

Against the Repeal of the CON

In order to repeal a state's CON law, significant political force has to be mounted, usually from potential providers who have been denied access to the healthcare market. When lifted all at once, a surge in

facility construction can occur by multiple providers entering into a needed market. Surges have been observed in some but not all states that have repealed the CON.(19) The following states have experienced surges.

- Utah: Psychiatric and nursing homes.
- Arizona: Nursing homes and open heart surgery.
- Tennessee: Home Health Agencies.
- Ohio: Hospitals, ambulatory surgery centers, pediatric services and dialysis.

When surges occur they tend to decrease over time.(19)

Minnesota repealed the CON in 1984 and Wisconsin repealed it in 1987 but both states reinstated it in 1992.(15) Tennessee repealed the CON for home health agencies but after a surge in providers it reenacted the law.

Two other factors are also commonly put forth. The first is fairness. Many CONs have been resold to facilities and these CONs would become worthless if the law was repealed. Even the initial facility which was given a CON may have paid large legal fees in a protracted legal battle.

Small rural hospitals also want protection to prevent large hospital corporations from entering the market and driving them out of business with aggressive discount pricing.

Conclusion:

Nowhere else in the US economic system are monopolies assigned to for-profit corporations without regulatory oversight on prices charged to consumers. The airline industry purchases jumbo jets with a cost of over 200 million dollars and they have no guarantee of filling a single seat.

One must ask the question: If the CON has not been shown to be effective in lowering healthcare costs then why do the states cling so dearly to it? Nowhere else in society is a monopoly granted by a state with so little oversight and, unlike gaming licenses, the CON is given away for free.

There is no doubt that the CON is a valuable commodity. After it is awarded, sometimes to for-profit corporations, it is then sold. Currently, the process in most States is for a requesting organization to justify a CON and if justified it is given away for free.

Shouldn't the process be that a state determines where the need exists and if a monopoly is to be granted the CON is placed up for bid. The moneys could then be funneled back into the healthcare system with matching Federal funds. That way all hospitals and not just the big corporations receiving the CON will benefit.

If this seems crass or unethical, I would argue it is making lemonade out of lemons. The unethical part of the CON is the awarding of state-sanctioned monopolies to for-profit corporations without any oversight on prices that are charged to the patient. The preferable alternative is to eliminate the CON altogether.

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