

State Commission on the Efficacy of the Certificate of Need Program Certificate of Need and its Effect on Cost, Quality, and Access in Georgia

Presented by

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The Origins of CON Theory

Cited in the establishment of many CON laws restricting the construction and expansion of healthcare facilities was the “Roemer Effect.” In their 1959 study, Roemer and Shain argued that hospital beds would be intentionally filled by providers who induce ill-informed patients into hospital stays.[1]

The Introduction of Prospective Payment Systems

Medicare and Medicaid originally paid for hospital services using a “cost plus” reimbursement basis, where hospitals were paid for all of their costs and more. Under this reimbursement system, hospital profits were directly linked with patient volumes. While the basis of the argument for this set of circumstances, i.e. “supply creating demand,” may have been valid during the “cost-plus reimbursement era” before the implementation of the prospective payment system (“PPS”) for hospitals in 1983, it is widely asserted that it has not been demonstrated to be the case today, in an era characterized by the shifting of financial risk to providers.

The Federal Mandate for CON

Beginning in the mid-1970s CON laws for inpatient medical care were enacted under a Federal mandate across the U. S. in an attempt to control the supply of expensive healthcare services.

The End of Federal Support of CON

Federal support for CON ended in 1986 with the repeal of the National Health Planning and Resources Development Act of 1974.[1] Legislators were concerned

that CON “failed to reduce the nation’s aggregate health care costs, and it was beginning to produce a detrimental effect in local communities.”[2]

[1] Carolyn W. Madden, *Excess Capacity: Markets, Regulation, and Values* 33: 6 *Health Servs. Research* 1651, 1659 (Feb. 1999).

[2] Patrick John McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a “Managed Competition” System*, 23 *Fla. St. U. L. Rev.* 141, 157 (1995).

The Federal Trade Commission CON Studies

During the late 1980s, the Federal Trade Commission (FTC) conducted the first of several studies on CON concluding that, “Market forces generally allocate society’s resources far better than decisions of government planners,”[1] and recommended that states remove their CON regulations.

The FTC expressed similar sentiments before the Georgia General Assembly. “The Federal Trade Commission staff said that a proposal before the Georgia General Assembly to relax temporarily part of the state’s “Certificate-of-Need” (CON) regulation “represents a worthwhile undertaking which may lead to greater diversity and better quality in health care services and increased price competition in the health care market.” [2]

[1] Press Release, FTC (Aug. 10, 1987)

[2] Press Release, FTC (Aug. 10, 1987).

The FTC / DOJ Hearings on Competition in Healthcare

In November, 2002, FTC Chairman, Timothy J. Muris, announced that the FTC would hold joint hearings with the DOJ on competition in healthcare in 2003.[1] On July 23, 2004, following the conclusion of the hearings lasting over six (6) months, the FTC and DOJ (“agencies”) issued a joint report, entitled “Improving Health Care: A Dose of Competition” in which the agencies recommended that states decrease barriers to entry into provider markets. The agencies encourage states to reconsider whether CON programs “best serve their citizens’ health care needs.”[2]

[1] Press Release, FTC, *FTC Chairman Announces Public Hearings on Health Care and Competition Law and Policy to Begin in February 2003* (Nov. 7, 2002) at www.ftc.gov/opa/2002/11/murishealthcare.htm (last visited Aug.

5, 2004).

[2] Fed. Trade. Comm.& Dept. of Just., Improving Health Care: A Dose of Competition” A Report by the Federal Trade Commission and the Department of Justice 22 (2004).

Following testimony at numerous hearings from industry representatives and legal, economic, and academic experts on the healthcare industry and health policy, the agencies concluded that the burdens placed on competition by CON programs “generally outweigh” its “purported economic benefits.” The agencies suggested that instead of reducing costs, there is evidence that CON programs actually drive up costs by “fostering anticompetitive barriers to entry.”[3] “More importantly, CON regulation tends to foster higher prices, lower quality and reduced innovation in health care markets.”[4]

[3] Fed. Trade. Comm.& Dept. of Just., Improving Health Care: A Dose of Competition” A Report by the Federal Trade Commission and the Department of Justice 1-2 (2004).

[4] Press Release, FTC (Mar. 9, 1988)

The agencies expressed concern that CON programs drive up healthcare costs because they depress supply and protect healthcare providers from competition. In reliance upon empirical studies that showed CON programs generally failed to control costs and may actually result in higher healthcare costs, the agencies expressed further concern that CON programs prevent entry into the market by entities that can provide higher quality care, and contended that CON programs may delay the introduction of new technology. In support of their conclusions, the agencies relied upon empirical studies that showed CON programs generally failed to control costs and actually may result in higher healthcare costs.[5]

[5] Fed. Trade. Comm.& Dept. of Just., Improving Health Care: A Dose of Competition” A Report by the Federal Trade Commission and the Department of Justice 4 (2004).

The FTC/DOJ Report Regarding
ASCs and CON

Regarding Ambulatory Surgery Centers (ASCs) (relatively new market entrants) the agencies stated their belief that ASCs are beneficial for consumers and that state CON laws pose an anticompetitive barrier to entry. In response to ASC provider allegations that CON laws may be used to prevent ASCs from entering the market, the agencies committed to “aggressively pursue” activities of anticompetitive conduct. [6]

[6] Fed. Trade. Comm.& Dept. of Just., Improving Health Care: A Dose of Competition” A Report by the Federal Trade Commission and the Department of Justice 27 (2004).

The FTC/DOJ Report Regarding Hospital Abuse of CON

The FTC has also recognized the potential for competitive abuse in CON by stating, “...state law frequently requires a hospital to obtain a “certificate of need” (CON) before it can build a new facility. The Commission has discovered that existing hospitals have sometimes opposed these CON applications, not in good faith, but merely to delay the entry of a new competitor and to burden it with heavy costs.”[7]

[7] Press, Release, FTC, Calvani Outlines FTC’s Concerns in Health-Care Competition (Feb. 21, 1986).

Earlier FTC Remarks on CON

Additionally, “‘there is near universal agreement’ among health care economists that Certificate of Need Regulation ‘has been unsuccessful in containing health care costs.’”[8] This consensus is based on several reasons, including the fact that CON restricts new firms from entering a healthcare market in competition against incumbent providers. “One reason that CON may have been unsuccessful in constraining health care costs is that it restricts the ability of new firms to enter a health care market and compete against incumbent providers.”

[8] Because it tends to protect existing providers from competition, the CON process may increase prices to consumers and interfere with improvements in the quality of care.

[8] Press Release, FTC (June 22, 1989).

THE IMPACT OF INDEPENDENT ASC’S ON HOSPITALS’ FINANCIAL STABILITY

The development of ASCs and surgical hospitals has often been cited by general hospital groups as the cause of not only declining general hospitals finances, but also of general hospital closures. Certain facts question this conclusion. The annual number of hospitals closures declined between 1987 and 1994. These years correspond with a period that saw more than a doubling of the number of ASCs [1] .

[1] “Does ambulatory surgery center development cause hospital closures?” Outpatient Surgery, Oct. 1997, p. 1.

Reasons for Hospital Closures

Numerous other factors have been cited as a cause for hospital closures which have occurred:

1. The excess bed capacity of hospitals during the enormous shift from inpatient to outpatient care; 2. Failure to adjust to managed care and large reductions in average length of stay; 3. Hospital mergers and acquisitions leading to large scale market consolidation, including closure of facilities, during the 1990s; and, 4. the costly failure of vertical integration efforts including the acquisition of physician practices.[1]

[1] "Does ambulatory surgery center development cause hospital closures?"
Outpatient Surgery, Oct. 1997, p. 2.

Reasons for the Growth of ASCs

The government has encouraged the development of ASCs, not only to improve access to, and the convenience of, healthcare services, but also as a cost saving measure that maintains or enhances quality. The 2003 HHS report determined that higher reimbursement levels for hospital outpatient departments (HOPDs) over freestanding ASCs was costing taxpayers \$1 billion dollars annually.[1] The response of hospitals was that they need to be overpaid in order to shift costs to support their emergency rooms, intensive care units, 24 hour service, and generally sicker patients.[2]

1] "Hospitals cry foul: HHS report urges reimbursement adjustments"
Modern Healthcare, Feb. 17, 2003, p. 10.

[2] "Hospitals cry foul: HHS report urges reimbursement adjustments"
Modern Healthcare, Feb. 17, 2003, p. 10.

A February 2003 report issued by the HHS Inspector General urged CMS to set consistent reimbursement levels for hospital outpatient departments ("HOPD") and freestanding ASCs.[1] In two-thirds of the procedures examined in the report, all of which can be performed in either setting, HOPDs were reimbursed more than ASCs for the same procedures. The median overpayment was \$282. This discrepancy results in overpayments to hospitals of \$1 billion dollars annually. Overpayments to ASCs for the remaining procedures accounted for \$100 million annually.

[1] "Hospitals cry foul: HHS report urges reimbursement adjustments"
Modern Healthcare, Feb. 17, 2003, p. 10.

CON REGULATIONS IN GEORGIA AS COMPARED WITH OTHER STATES

The Scope of State CON Regulations

- Thirty-six (36) states and Washington D.C. currently have some form of CON regulations.
- There are twenty-seven (27) states, including Georgia, that have CON regulations for Ambulatory Surgery Centers (ASC).

Estimating the Scope of CON Regulation in Georgia

- Georgia had CON regulations for 11 types of facilities. At this time, the average number of facilities types subject to CON in the United States is 7.9.
- Georgia regulates 19 types of services through CON. The average number of types of services subject to CON in the United States is 15.
- Georgia regulations cover 8 types of equipment, while the average number of types of equipment subject to CON in the United States is 6.5.

The Future With or Without CON

The Effect of Repeal of CON

CON Proponents say:

The repeal of CON regulations will lead to a surge in healthcare costs for patients and payers.

Counterargument:

A recent empirical study on this topic entitled, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" reviewed health spending in the period from the late 1970's and 1993, including spending before and after state CON laws were repealed.

The study stated, "The major findings about CON can be summarized as follows: first, we found no surge in expenditures after CON was lifted; second, despite a statistically significant reduction by mature programs on acute spending per capita, there was no corresponding reduction in total per capita spending (apparently due to offsetting expenditures on non-hospital services)." [1] "We found that mature CON reduced hospital bed supply per capita population, but could detect no increase in bed supply following the removal of CON." [1] The study also found that established CON programs increased cost per adjusted patient day and cost per admission. [1]

[1] Christopher Conover & Frank Sloan, Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?, *Journal of Health Politics, Policy & Law*, Vol. 23 (1998), p. 466, 469, 473-474.

CON is Anticompetitive

The central argument against CON regulatory policy is that it is anti-competitive. By intervening in the market, CON disrupts the natural market forces and serves as a barrier to new market entrants. CON is considered by most healthcare economists as a strong disincentive of the clear cost and quality benefits of the introduction and diffusion of new technologies.

CON and Innovation

“In industry after industry, the underlying dynamic is the same: competition compels companies to deliver increasing value to customers. The fundamental driver of this continuous quality improvement and cost reduction is innovation. Without incentives to sustain innovation in health care, short-term cost savings will soon be overwhelmed by the desire to widen access, the growing health needs of an aging population, and the unwillingness of Americans to settle for anything less than the best treatments available. Inevitably, the failure to promote innovation will lead to lower quality or more rationing of care – two equally undesirable results.”[1]

[1] Michael Porter, et. al., *Making Competition in Health Care Work*, Harvard Business Review, Vol. 72, no. 4 (1994), p. 131.

CON Regulatory Policy and Cost Control

The great public health experiment that is CON has been in effect, in some form, for as long as four (4) decades in much of the U.S. CON’s effectiveness and the economic and regulatory burdens of this regulatory policy have been studied extensively by both federal and state governments, academic institutions, as well as by other researchers and organizations. From the perspective of the market economy, by all measures, CON laws appear to have failed to control costs. In a review of CON and its marked impact, Patrick J. McGinley wrote,

“In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering healthcare costs.”[1]

[1] Patrick John McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System*, Florida State University Law Review, Vol. 23 (1995), p. 157.

The Benefits of Competition

There is also a continuing consensus among health economists that competition in healthcare drives improvements in quality of care and patient outcomes, while also acting as a force for greater cost efficiencies.

"there is ... agreement across all perspectives of [health economics theory] on one issue: the negative consequences of too much concentration of economic power." [1]

[1] Carolyn W. Madden, *Excess Capacity: Markets, Regulation, and Values* Health Services Research, Vol. 33, no. 6 (Feb. 1999), p. 1663.

Competition has been demonstrated to correlate with lower average costs for hospitals in more competitive markets, as compared to costs in less competitive markets.[1] Healthy competition gives economic power to patients and payers by creating consumer choices and by raising quality standards as providers and payer compete for patient loyalty, raise quality, and lower costs.

Without healthy competition and patient choice, decisions about access, quality, and beneficial outcomes can be made by monopoly or oligopoly providers in the market, who, without strong competition, can ignore patient demands and needs.

[1] J. Zwanziger, G. Melnick G, & A. Bamezai, *California Providers Adjust to Increasing Price Controls*, in *Health Policy Reform: Competition and Controls*, AEI Press, 1993, p. 241-258.

Conclusion

n CON is a complex issue as illustrated by the diversity of this commission. Factual information is difficult to obtain.

n In my comments today I have tried to present as much objective information as possible with references where appropriate.

n From the information presented it seems that CON is not critical to maintaining cost control and may be detrimental.

n Competition is certainly limited and the benefits of a free market are restricted in that environment.

n Patient access to health care, innovation created by competition, and ongoing cost control do not appear to be fostered by the present regulatory environment.