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Certificate of Need Laws: A Prescription for Higher Costs

BY MAUREEN K. OHLHAUSEN

AMERICA HAS STRUGGLED WITH THE cost of health care for decades. Health care costs are excessive for many reasons, and there are inherent trade-offs between among quality, cost, and access that make reducing costs in isolation a daunting exercise. Although there are no silver bullet solutions, we must still pursue many avenues to foster and maintain competition among providers, which helps keep down costs and improve quality for health care consumers. State certificate of need (CON) laws—which require state approval for new entry and expansions by health care providers—stand out as an example of regulation that squelches the beneficial effects of competition in health care markets without delivering valuable public benefits in return. Yet, even the repeal of these outdated laws is controversial in some quarters. The current debate over CON laws has been long on theory but relatively short on practical analysis.

The antitrust toolkit provides a useful framework to guide the way toward more health care competition, cost savings, and quality improvements. Of course, the sovereign, direct actions of the states in our federal system are not subject to the antitrust laws.[1] Yet, state CON laws are restraints of trade all the same, and we would do well to analyze them as such when determining whether they constitute sound public policy. Once you look at these laws through the eyes of an antitrust lawyer, the case for repeal comes into sharp focus.

What the antitrust perspective provides is the insight that these laws do not operate in a vacuum, but rather that larger market dynamics will mediate their effects. In practice, CON laws funnel benefits of indeterminate size to some incumbent health care providers, often without any meaningful political oversight or public transparency. The quality of the provider or the magnitude of the social benefits they provide to the community will not determine the size of this windfall. In fact, there are good reasons to suspect that some of the least deserving providers may be benefiting the most from these laws.

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Regardless of one's perspective on the proper balance between state and federal power, there are some very good reasons to repeal state CON laws.

History and Original Intent

CON laws typically establish requirements for state approval before a new health care provider can enter a market or an existing provider can make certain capital improvements.[2] For example, if a hospital wants to build a new wing and add additional beds, it must seek approval from the state. The state will determine whether there is sufficient public "need" for the capital improvement and either grant or deny the provider's application.

Normally, states are not directly involved in the market entry or capital improvement decisions of private firms. If a business wants to build a new factory, the state may require the business to conform to local zoning laws and other generally applicable regulations, but the state does not second-guess management's decisions about the business need for the new facility. Instead, the free market mediates those decisions. If a company makes unwise capital investments, it will lose business to its more skillful rivals. Market forces will naturally push firms to optimize their capital expenditures without any need for state intervention.

So why did states start regulating decisions that they would normally leave to the private sector? It turns out that there is a long history here that commentators often ignore or sweep under the rug in the current debates over CON laws. Yet that history is critical to understanding not only how we got to where we are today on this contentious issue, but also whether these laws should continue to remain in force.

The story of CON laws stretches all the way back to the mid-1960s. At that time, there was a view that high health care costs were driven largely by wasteful, over-investment in duplicative health care facilities.[3] A brief hypothetical best explains the concern that legislatures originally sought to address through CON laws.

Imagine that Metropolis is a city with four major hospitals of roughly equal size. Hospital A decides that it needs to buy a new, expensive MRI machine. Patients in Metropolis now have access to a brand-new diagnostic tool they did not have before. So far, so good, at least for Hospital A.

Things are not quite as rosy over at the other hospitals. Hospitals B, C, and D are now suddenly at a disadvantage

because their competitor, Hospital A, has important new capabilities they lack. Fearful that they will lose patients and prestige to Hospital A, the other three hospitals each decide to buy an MRI machine of their own. Unfortunately, Metropolis does not have enough people to utilize all four MRI machines fully. In fact, just one machine might adequately serve all the MRI needs of Metropolis. Thanks to the "me too" purchases by the rival hospitals, all four of these very expensive machines are now frequently idle.

Governments passed CON laws so that they could step in and effectively mandate that Metropolis only have one, fully-utilized MRI machine. Once Hospital A had an MRI, there would be no public "need" for the additional machines and so the state would reject each remaining hospital's application to buy one for competitive reasons.

Importantly, at the time states enacted these CON laws private health care expenditures tended to be reimbursed on a "cost plus" basis, and many thought that there was little incentive for providers to control costs and avoid excessive, unnecessary spending. Proponents viewed state intervention as a necessary check on a perceived market failure created by the existing reimbursement structure.

New York State adopted a CON law restricting new hospital construction back in 1964.[4] As the idea gained favor, the American Hospital Association began to lobby for other states to adopt CON regimes.[5] Eventually, the federal government got involved. In 1974, Congress passed a mandate for all states to establish a CON program as part of the National Health Planning and Resources Development Act.[6] By 1980, every state except Louisiana had a CON law on the books.[7]

Original Cost-Saving Rationale Fails to Deliver

Ever since states enacted these laws, economists and policy makers have been studying how well they work. The majority of studies fail to establish any definitive link between CON laws and lower unit costs.[8] Although a small number of studies identify some very modest benefits from CON laws, these studies suffer from significant methodological problems.[9]

The lack of success in controlling costs is understandable. CON laws are simply output restrictions mandated by the government. Normally, if you want the price of something to decline, creating an artificial shortage of it is not the way to achieve that. There is no clear reason to expect that the basic laws of supply and demand would not apply, either when the states enacted the CON laws or today.

Even worse, although the states originally enacted these laws to address a perceived problem with the "cost plus" reimbursement system, health care is generally no longer reimbursed that way. Instead, the federal government establishes universal reimbursement rates for Medicare and Medicaid, and private insurers negotiate payments procedure by procedure rather than by provider cost. In this environment, providers have little incentive to make unnecessary capital improvements. In effect, the purported market failure that CON laws were designed to fix no longer exists. Thus, we should not be terribly surprised that it has proven difficult to demonstrate the benefits of a legislative scheme designed to fix an issue overtaken by subsequent events.

Finally, CON laws reflect an expectation that governmental central planning is more efficient than the actions of private actors who have a direct interest in the outcome. Although the MRI hypothetical discussed in the previous section may sound simple, things in the real world are far more complex. Government actors respond to political pressure, often exerted by special interests that seek to place their own, narrow interests ahead of the general public welfare. History amply demonstrates that central economic planning is inefficient and deeply harmful to the societies that practice it. In short, there are some very good reasons why the government typically stays out of this kind of private economic activity in other parts of the economy. None of those general concerns disappears simply because we are talking about health care.

CON Laws Inhibit Socially Beneficial Competition

Although establishing actual benefits from CON laws has proven elusive, the downsides of these laws are much easier for economists and antitrust lawyers to understand. By restricting expansion and new entry, CON laws help to insulate incumbent providers from competition.

To understand just how these laws inhibit competition, consider how they might work in another industry. If Burger King wants to build a new restaurant just down the street from an existing McDonalds, it does not have to go before a state board and demonstrate a "need" for another restaurant. It does not have to fight for the right to open in a lengthy, expensive, and contested proceeding where McDonalds can successfully object to its entry on the ground that it is already providing all the hamburgers the area requires. Yet this is exactly how states administer CON laws, with the incumbent provider weighing in on whether there is a need for it to face competition.[10] As one might imagine, there are powerful reasons for incumbent firms to oppose such an application that have nothing to do with the public welfare. In effect, a market intervention originally designed to remedy a perceived market failure actually renders markets for health care services less competitive.

Normally, we want firms to face additional competition, so that customers can play firms against one another and obtain lower prices and better service. Competition also pressures firms to innovate, and beneficial innovation further improves our collective standard of living. In fact, ensuring that markets remain competitive so they can continue to provide these benefits to the public is so critical that both the Federal Trade Commission and Department of Justice devote considerable resources to identifying anticompetitive agreements and conduct. For example, we look at every merger of a certain size and challenge the ones that create excessive concentration precisely because free market competition is such a powerful force in benefitting the public.

By contrast, CON laws actively restrict new entry and expansion. They displace free market competition with regulation and tend to help incumbent firms amass or defend dominant market positions. If government is going to displace the well-proven and socially beneficial forces of free market competition in favor of economic regulation, those regulations should provide some clear public benefit that outweighs the consumer harm they create. Placed against that yardstick, CON laws do not measure up.

Fortunately, many policymakers eventually figured this out. At the federal level, the failed experiment in trying to control health care costs by regulating capital expenditures ended in 1986, when Congress repealed the National Health Planning and Resources Development Act.[11] In the wake of the federal repeal, a number of states followed suit and repealed their own CON laws. Unsurprisingly, subsequent studies did not show a massive explosion in health care costs in the states without CON laws.[12]

The Repurposing of Certificate of Need Laws

If the significant cost-savings promised by CON laws never materialized, subsequent market developments rendered the original purpose of these laws moot, and the federal mandate was repealed almost 30 years ago, why are we still talking about all of this in 2015?

The short answer is that these laws remain on the books in 36 states through a combination of legislative inertia and the fact that incumbent providers benefit when the state protects them from competition. CON laws insulate politically powerful incumbents from market forces, and those providers naturally are loathe to give up the special government preferences that CON laws bestow. Of course, it is not particularly palatable for providers to argue to the state legislature that they continue to deserve special treatment that benefits them at the expense of the broader public interest. Instead, the supporters of CON laws came up with a far more sympathetic argument that at least tries to look like a legitimate public policy concern.

Implicitly acknowledging the competitive concerns discussed above, today's supporters of CON laws argue that those laws should be maintained because they allow providers to improve the care of the indigent. CON laws, these supporters argue, allow providers sheltered from competition to charge insurance companies more. In other words, the laws operate as a kind of cross-subsidy, where comparatively wealthy patients with private insurance subsidize the care of poor patients without any insurance. Some CON laws even include express mandates requiring beneficiaries to provide care of the indigent, and CON supporters argue that these mandates ensure that providers who are able to charge supracompetitive rates must use windfalls they receive to benefit the indigent. If CON laws were repealed, the argument goes, then the poor would suffer because providers could no longer provide the indigent with the same level of care they receive today.

Are Certificate of Need Laws Well Suited to Promote Care for the Indigent?

First, we need a little background. The antitrust laws generally focus on undesirable market effects, not necessarily on the conduct of individual firms divorced from competitive effects. Because antitrust laws worry about harm to the competitive process, the current structure of the market matters a great deal in how those laws will treat any particular practice. For example, a company that holds a dominant position in a particular market is going to face more antitrust constraints on how it conducts business than a company with an infinitesimally small market share. The different legal results are not arbitrary; rather, they reflect the reality that two firms engaging in identical conduct can have very different impacts on the market.

As is the case with some of the private conduct that antitrust lawyers and economists regularly grapple with, CON laws will have different effects on indigent care based on the markets in which they operate and on differences among providers. Ignoring the market dynamics in which CON laws operate does not make those dynamics irrelevant. Although CON laws will have very different effects across providers, the laws overlook these important variances. Moreover, various aspects of the external market structure will drive those differing effects—even though those differing market structures have nothing to do with delivery of care to the indigent.

For example, consider how demographic trends can alter the expected impact of CON laws. In areas where the population is steady or has declined over time, one would normally not expect CON laws to provide much benefit to incumbent providers. The likelihood of new entry is low if the number of people living in the area is stable and demand for health care services has not materially increased since CON laws were passed. Thus, providers in a city like Detroit, which has lost significant population since the 1960s, are less likely to reap much of a windfall from CON laws.

On the other hand, in areas of strong growth in population or demand for health care, where an unfettered market would likely produce significant levels of entry, incumbent providers are probably obtaining a valuable benefit from their state's CON laws. By deterring new entry and creating artificial scarcity, CON laws likely are increasing health care prices and giving providers a material windfall in these growth areas.

In competitive markets, new entry can occur when the size of the market increases, but it can also occur when inefficiency or excessively high prices among the firms already operating in the market present an opportunity. CON laws short-circuit this market correction mechanism and protect existing incumbents. That means the weakest providers—the ones that are inefficient and would have drawn entry that may have spurred them to improve—are likely to benefit more from the shelter of CON laws. On the other hand, high-quality providers that already face significant competition in their local markets likely benefit far less from CON

laws because they are less likely to be challenged by new entrants.

How aggressively states enforce these laws also matters a great deal. In states where relatively few health care services are subject to CON requirements or the programs are not strictly enforced, the corresponding windfall to incumbent providers is likely to be less substantial. On the other hand, where CON laws are comprehensive and aggressively enforced, they probably generate a much larger windfall for providers. None of these variables—scope of the CON law, degree of enforcement, probability of new entry or expansion in the absence of a CON law—exist in isolation. Some may matter more than others in particular markets, but all of them can materially influence the size of the windfall that a given provider receives from a CON regime.

This discussion about who benefits and suffers from CON laws omits one important variable: how effectively and efficiently each provider cares for the indigent patients who arrive on its doorstep. Given that the argument for retaining these laws is that they help the indigent, that omission is telling. It is almost certain that some providers that do a relatively poor job of taking care of the indigent will benefit from CON laws while others that do an excellent job gain little or nothing from them. This is because the benefits of CON laws flow to providers unevenly, and the most important variables for determining how much benefit each provider will receive have no relationship to how well that provider handles indigent care. A poorly performing provider in an area where CON laws exclude entrants and drive up prices will benefit much more than a top-tier provider in an area with flat demand and plenty of existing competition.

Even for those CON laws with express mandates requiring beneficiaries to provide care for the indigent, the problem is that nobody knows which providers are obtaining windfalls (or how much) through the operation of CON laws and which are not—and thus are essentially on the wrong end of an unfunded state mandate to provide indigent care. Without knowing how much benefit each favored provider derives, there is no principled way to ensure that all or even most of the CON windfall will be dedicated to indigent care. Neither do we know the costs to providers to comply with the indigent care mandates relative to the value of CON protections, either in total or to each provider. Instead, all of this operates in the dark, without any opportunity for meaningful evaluation or oversight.

Certainly, a society may deliberately decide that it would like to pay for the care of the indigent by raising prices on wealthier patients with private insurance. However, using laws passed over 40 years ago and designed to achieve something completely different is not the most direct or efficient way to achieve that end. Granting providers even a limited exemption from the competitive process is an exceptionally poor and nontransparent way to achieve any public policy goal, much less one as important as indigent care. In a democracy, when the government takes money from the people to fund public works, those actions should be transparent so that the government is ultimately politically accountable for its actions.[13] CON laws use the power of government to shift funds from private payers to providers, but where and how much money is transferred remains opaque. Because the cost of CON laws is never disclosed or even evaluated, this informal and imprecise funding mechanism violates fundamental norms of good government.

Conclusions

CON laws were originally enacted by people of good will with the best of intentions. They wanted to help society by reducing the cost of health care. Unfortunately, as we now know, the methods they chose were flawed and ineffective.

We also know that these laws are actually restrictions on output, and output restrictions restrain the social benefits of free market competition. Among those lost benefits is the pressure to reduce prices and innovate. Ironically, a government program originally aimed at reducing health care prices is likely inflating them, at least in some situations.

Regardless of these drawbacks, the modern defenders of CON laws argue that the windfalls some providers receive are actually socially beneficial because the money is being used to fund indigent care. Given the poor fit between the goal of providing indigent care and the CON laws, the indigent-care claims appear to be little more than an argument of convenience by politically powerful special interests attempting to protect their historical government perquisites.

As a society, we can certainly do better. States that still have CON laws on the books should repeal them. States that deem indigent care mandates necessary should fund them directly and publicly, rather than through an opaque transfer of those costs onto the insured public. Good government demands both transparency and political accountability.

The position advocated here is not novel. Rather, there has been a lengthy, bipartisan consensus at the FTC that state CON laws should be repealed. The FTC has tirelessly advocated for the repeal of these laws for many years, with strong support from Commissioners of both parties.[14] These efforts are likely to continue as appropriate opportunities arise.

Repealing CON laws will not suddenly make health care affordable all by itself. In some markets, CON laws likely exert only a modest drag on the economy, and so their repeal should not create immediate, dramatic results. That said, health care providers should earn their customers every single day just like every other economic actor. Competition lowers prices and improves quality, and inefficient or inferior health care providers should lose business to better rivals. Government regulations that undermine these socially beneficial competitive process without returning any offsetting benefits simply cannot be justified.

[1] Parker v. Brown, 317 U.S. 341, 351–52 (1943).

[2] CON laws vary significantly across the states in terms of the scope of serv-

ices and products covered and the severity of the approval requirements.

[3] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION ch. 8, at 2 (2004) [hereinafter DOSE OF COMPETITION], https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice.

[4] Nat'l Conf. of State Legislatures, *Certificate of Need: State Health Laws and Programs* (Sept. 2015), http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.

[5] *Id.*

[6] *Id.*; Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k–300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

[7] DOSE OF COMPETITION, *supra* note 3, ch. 8, at 1.

[8] *E.g.*, David Salkever, *Regulation of Prices and Investment in Hospitals in the U.S.*, *in* 1B HANDBOOK OF HEALTH ECONOMICS 1526–27 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) ("At a minimum, it seems fair to conclude that direct CON effects on costs are not negative."); Patrick A. Rivers, Myron D. Fottler & Jemima A. Frimpong, *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 J. HEALTH CARE FIN. 1, 11 (2010) (finding that CON laws "may actually *increase* costs").

[9] *See, e.g.*, Michael D. Rosko & Ryan L. Mutter, *The Association of Hospital Cost-Inefficiency with Certificate-of-Need Regulation*, 71 MED. CARE RES. & REV. 280 (2014) (finding lower hospital cost-inefficiency in CON states than non-CON states but not controlling for the possibility that the observed differences are caused by the many other differences between states with and without CON laws). Analyzing the impact of CON laws on costs, prices, quality, or levels of indigent care is a very challenging empirical task. States that adopt (or repeal) CON laws may differ in many ways from states that do not. More importantly, those differences may influence which states decide to adopt or repeal CON laws. Although there are methods to control for these differences, those methods all have significant drawbacks.

[10] *See* Maureen K. Ohlhausen & Gregory P. Luib, *Brother, May I?: The Challenge of Competitor Control over Market Entry*, J. ANTITRUST ENFORCEMENT (forthcoming 2015), https://www.ftc.gov/public-statements/2015/09/brother-may-i-challenge-competitor-control-over-market-entry.

[11] Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k–300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

[12] Christopher J. Conover & Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL., POL'Y & L. 455, 458 (1998) (finding "no evidence of a surge in acquisition of facilities or in costs following removal of CON [regulations]"). *See also* Vivian Ho & Meei-Hsian Ku-Goto, *State Deregulation and Medicare Costs for Acute Cardiac Care*, 70 MED. CARE RES. & REV. 185, 200 (2012) (finding "removal of cardiac CON regulations is associated with a reduction in mean patient costs for CABG [coronary artery bypass graft] surgery").

[13] *See, e.g.*, FTC v. Ticor Title Ins. Co., 504 U.S. 621, 636 (1992) ("Federalism serves to assign political responsibility, not to obscure it. Neither federalism nor political responsibility is well served by a rule that essential national policies are displaced by state regulations intended to achieve more limited ends.").

[14] Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice to the Virginia Certificate of Public Need Work Group (Oct. 26, 2015), https://www.ftc.gov/policy/policy-actions/advocacy-filings/2015/10/joint-statement-federal-trade-commission-antitrust; Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform (Sept. 15, 2008), http://www.justice.gov/atr/competition-health-care-and-certificates-need-joint-statement-antitrust-division-us-department; Federal Trade Commission, FTC Staff Comment Before the Virginia Commission on Medical Care Facilities, Certificate of Public Need, Concerning Reform of Certificate of Public Need Regulation or Health Facilities (Aug. 6, 1987), https://www.ftc.gov/policy/policy-actions/advocacy-filings/1987/08/ftc-staff-comment-virginia-commission-medical-care.