Testimony before Kentucky General Assembly
Special Committee Certificate of Need Task Force
Monday, August 21, 2023

Thank you, Mr. Chairman, and thank you to the members of this committee for the opportunity to speak.

As mentioned, my name is Melissa Fausz and I am here today representing Americans for Prosperity (AFP).

AFP Kentucky partners with hundreds of grassroots advocates across the state to inform and influence public policy matters that are close to heart for liberty-minded Kentuckians.

One issue that we have been working on as an organization for over a decade now is Certificate of Need (CON), which is why I'm so pleased to be here today to talk about our perspective on this important issue.

It is timely, necessary, and laudable that this committee has taken on the work of evaluating the state's Certificate of Need laws and their impact on your health care marketplace.

No doubt, this week and in the coming months you will hear from economists, hospital finance experts and administrators, providers, patient advocates, and lawyers who have litigated on Certificate of Need issues.

So, I will stick to the perspective I think AFP can best provide, which is the insights we've gained from working with key stakeholders on Certificate of Need repeals and significant reforms across the country, quite literally from Florida to Alaska.

With that said, first and foremost - why are we even involved in advocacy on what many might view as a kind of esoteric health care regulation? Well, quite simply, we believe in order for everyday Kentuckians to be able to achieve their personal version of their American Dream, they need access to a health care system that is patient-centered and market-driven. When patients have true purchasing power, and providers are unleashed to do the work they were trained for and are so passionate about doing, market forces are remarkably effective at balancing the desire for affordability with the need for quality, access, true choices, and the kind of innovation in treatment and cures that is the hallmark of the American health care system.

And that's where Certificate of Need comes in. In a misguided attempt to control rising health care costs, the federal government required states to put in place these anti-competitive measures. The theory was this: when health care facilities are in the same geographic regions and competing for the same patients, they will buy the latest gadgets, build the fanciest buildings, and

do many costly things to try and grab the attention of consumers - all while passing along the buck for these bells and whistles to the patients (and their insurance providers) - thereby driving up the cost of care. They also figured that, by limiting competition, they could create a cross subsidization effect that would help pay for indigent care. Cross subsidization is a wonky term, that basically means, if heavily insured and/or self-insured folks have no other option but to go to the same facility as uninsured or underinsured folks who can't pay for the full price of care, the rate that the facility can charge their better-insured patients can help cover the costs of those who can't pay the full rate - allowing facilities to serve these patients while still staying out of the red.

On paper, this sounds nice. And I'm sure you've heard from a few incumbent facilities in or around your district who maintain that Certificate of Need does indeed serve these functions. But here's the truth of the matter - decades of research does not find significant, systemic effects that validate this claim. And what's more, from a purely anecdotal perspective, having been directly involved in Certificate of Need repeals and significant reforms in Florida, Montana, Tennessee, North Carolina, and most recently South Carolina - the sky hasn't fallen in those places. We've seen more capital investment, especially in suburban areas, but across the board - and hospitals have not been failing any faster than they were before the laws were changed.

And, for what it's worth, the federal government realized that Certificate of Need did not have the intended effect. They reversed course, but for a majority of states, it was already too late. Incumbent facilities were not eager to give up their new competitor's veto and have fought tooth and nail to preserve CON laws ever since. The Federal Trade Commission throughout multiple, successive administrations - both Democrat and Republican - has begged states to stop engaging in this anticompetitive practice.

It's been really hard working on this issue - most people don't even know CON laws exist. They know that they lack options, they know something's wrong when they get sent to a hospital further away from their home because the one nearby was full, they can feel it when management at the facilities they're seeking treatment from don't seem too worried about patient satisfaction with their own care.

When a Virginia mom lost her baby because the hospital where her child was born lacked an incubator, she didn't find out until later that her hospital had applied years before to purchase incubators, only to have another hospital further away successfully argue that they had incubators and a neonatal intensive care unit (NICU), so it was unnecessary for that hospital to build a NICU. The State Department of Health, which administers the state’s Certificate of Provider Need, agreed. And families suffered.

When a doctor in Georgia wanted to start providing a less invasive version of colon screenings using new, innovative technology, the hospital nearby argued that they provide old school colonoscopies that were sufficient. The state’s Department of Community Health agreed. Never mind that the old school colonoscopy required more time off work for patients, more discomfort in the preparation for the procedure, and more risk to the patient - which is always the case when you choose a more invasive procedure over a less invasive one. Patient convenience, comfort, and time away from their other activities were not considered as part of the CON decision-making process. And that's unacceptable.

When a health care company asserted there was a need to build an additional hospital facility in South Carolina, its competitor objected. These two companies were tied up in litigation for a decade before the decision was made that yes, there was a need for another hospital facility. By the time the state was able to make that decision over the objections of a very litigious incumbent facility, the people of South Carolina went 10 years without access to additional health care capacity that the state finally decided had been necessary all along.

These are just a few stories; we've learned of so many others over the years. I started personally lobbying on CON repeal for AFP nine years ago. When I first started I, like most people, had never heard of it. And it was only once I learned about what it was and was able to start looking at what facilities, equipment, and types of treatment my state's CON board had denied that I started to see the fingerprints of CON on some of the issues I and my family had dealt with in accessing timely, local care. Every year I work on this issue I hear more stories, I see more research get done, and I only become more and more convinced that CON laws do not serve their purpose. At best, they don't do what they were designed for. And at worst, they actually hurt people.

In a review of 128 papers that tested the effects of CON laws - 89% of the research tests conducted showed neutral to negative effects as an outcome of CON laws, and those negative effects are 500% more common than the neutral results. This literature review was produced very recently by the Institute for Justice, and we're happy to provide copies to any of your offices.

My sister organization, Americans for Prosperity Foundation, put out a report called Permission to Care, which details many of the individual stories I just shared. I know some of y'all have already read our report, but I would be happy to make sure anyone else who'd like to give it a read is able to.

I have no doubt that the folks who grant certificates of need in states that still have these laws are doing their best. But the fact of the matter is, no one has a crystal ball. States with CON laws can ever only play catch up to their community's health care needs. No matter how sophisticated your methodology is for deciding what types of facilities, equipment, and treatments are necessary, it will never be accurate enough to predict the future. We learned this during COVID. When successive waves of the virus hit different states at different times, many states' health care facilities were strained to their limits and beyond. For states without CON laws, hospitals were able to move faster in adding beds and converting say, surgical recovery beds into additional infectious disease wards. In most CON states, thankfully governors realized the issue and waived the rules for a time. Unfortunately, even with the rules waived, states with CON laws were 27% more likely to run out of hospital beds during those COVID surges.

We might be tempted to think that was a unique situation, but unanticipated needs come along all the time. Some states' populations are growing faster than expected. Many didn't see the opioid epidemic coming and the need for additional substance abuse recovery treatment options. Breast cancer and colon cancer incidence is on the rise in 30 to 39 year-olds, prompting discussion that we may need to start regular screenings for these diseases sooner in life - meaning we need more

capacity, more equipment to run these tests. Who knows what other challenges we'll face with an aging population?

Take Kentucky specifically. You'll probably hear more about this story when the Institute for Justice provides comments during the next meeting, but a sizable Nepali-speaking community has grown in the Louisville area. A Nepalese immigrant, Dipendra Tawari and his business partner, Kishor Sapkota attempted to open a small home health agency to serve this community, specifically geared towards their cultural needs, to include speaking their language. Their application was rejected when Baptist Health objected, saying that there was sufficient care in the region. The Cabinet for Health and Family Services agreed, based on a rigid formula that did not take into account the fact that Baptist could not provide the same level of culturally appropriate care. (Source: Institute for Justice Report, hyperlinked above)

It is not possible for any group, no matter how well informed, to be able to say with confidence what level of health care provision is or isn't adequate. And it becomes even less accurate of a prediction when incumbent businesses are given the power to chime in on whether their would-be competitors are "necessary" or not.

Incumbent facilities often wring their hands about "boutique" providers coming in, drawing off wealthier, healthier patients, and leaving critical access hospitals that are already in a precarious financial situation with the sickest patients that are the least likely to pay. It's a bleak picture, to be sure. We can look at this concern from a couple different angles.

First off, as I've already mentioned, research shows that we don't see a big subsidization effect with more uncompensated care being provided when more fully insured patients come to a facility and pay full freight.

Secondly, this is a boogeyman that we hear about a lot that just doesn't seem to come to pass. Now certainly you get your occasional facility that only accepts direct payment, not third-party payers, but these are few and far between. A plurality of Americans are on government health plans, be it Medicaid, Medicare, Tricare, or government employee plans. And so most facilities accept most or all of these payers. Any facility accepting Medicare and that has an emergency department is required to stabilize every person that comes through their door, regardless of ability to pay. And in my experience, every single provider I've talked to who runs a surgery center or any other type of non-emergency facility provides a significant amount of uncompensated care.

I think of an outpatient surgery center in North Florida, whose doctors provide needed procedures to the inmates at the local women's prison, free of charge or at very low cost to the state, well below market rate. They weren't required to provide that care, and they were doing it long before Florida changed its laws to give them the ability to grow their facility.

Finally, as I also mentioned before, patient comfort, convenience, and outcomes matter. Surgery site infection rates are lower when patients receive elective surgeries at dedicated surgery centers, rather than hospital facilities that are also treating trauma cases and infectious diseases. Do we limit some patients from accessing care in a venue that provides them with a better

outcome as a means of providing financial support to a critical access hospital? This is a backwards way of trying to ensure access to quality care options for everyone.

The data back up our experiences with CON laws. States without CON laws have more hospital beds per capita, including in rural areas, and costs for patient care are lower across the board. And very rural states with no CON laws - Colorado, Idaho, Utah, and Wyoming - have had zero rural hospital closures since at least 2005. (Source: Institute for Justice Report, hyperlinked above)

None of this is to say that there are not real challenges with hospital financial viability. There absolutely is a real struggle in some places to keep the lights on - and it is a matter that this body should be treating with the utmost gravity. However, Certificate of Need is not the appropriate vehicle through which to address these challenges, and in many cases, it is doing more harm than good. It is my sincere hope that this committee thoroughly considers these points, alongside all the other excellent information you have received and will continue to receive from stakeholders across this issue. Thank you very much for your time and I'll be happy to answer questions.

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