"Submission for the Record"

The Failure of Kentucky's Certificate-of-Need Laws

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To Chairs Douglas and Webber and Members of the Certificate of Need Task Force:

Thank you for the opportunity to share my recent work on certificate-of-need laws as they are applied to healthcare in Kentucky.

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INTRODUCTION

Certificate-of-need (CON) laws require healthcare providers to obtain permission by proving "need" of their services in the community before they open or expand their practices or purchase certain devices or new technologies. CON laws exist in some form in 35 states.

New York, in 1964, was the first state to pass a CON law. The goal was to contain costs. And in 1974, the federal government passed a CON law applicable to all states. Again, the justification for this law was to maintain costs. However, because CON laws did not help to contain costs, the federal government repealed its CON law in the early 1980s. Also, by the 1980s the rationale for the CON laws was gone.

Before the federal repeal, Medicare and other insurance providers used a retrospective reimbursement system, so hospitals and other medical providers were reimbursed for the full cost of whatever services were provided. So, there was some concern about the high costs because providers had some incentive to provide unnecessary services. After all, they got reimbursed for all services provided. However, by the 1980s, Medicare and many insurance providers switched to the prospective, or DRG (diagnosis-related group) system, which paid based on the patient's diagnosis. So, hospitals had an incentive to no longer over-provide services. Prospective reimbursement is the system used today. So, the original rationale for CON is gone.

However, keeping CON on the books resulted in negative consequences for patients. In four different academic, data-driven studies, my coauthors and I document these harmful effects. These studies compare economic and health measures in the 35 states with CON laws to those states that do not have CON laws.[1] These peer-reviewed studies show that CON laws:

[1] Thomas Stratmann and Jake Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2014); Thomas Stratmann and Matthew C. Baker, "Are Certificate-of-Need Laws Barriers

1. Harm patients by reducing healthcare quality.
2. Harm patients by reducing access to healthcare. They reduce the availability of medical care by making it difficult for medical providers to offer their services.
3. Harm patients by reducing the availability of medical equipment such as MRI machines and CT scanners that help diagnose illnesses and prevent premature death.

These findings are consistent with the positions of the Federal Trade Commission and the US Department of Justice under both Democratic and Republican administrations.[2] They have argued that CON laws fail to meet their stated goals and that CON laws are harmful to patients. Also, the largest association of physicians, the American Medical Association, favors repealing all CON laws.[3]

CON LAWS IN KENTUCKY

CON laws in Kentucky require already-licensed healthcare providers to obtain government permission to compete for 23 medical services (out of 28 medical services regulated across the US states by CON). Among the states with the highest number of CON laws, Kentucky ranks 6th. Some examples of CON laws are the following:

- In Kentucky, a hospital needs permission to add a new bed.
- In Kentucky, a provider needs permission to open a new hospital.
- In Kentucky, a provider needs permission to purchase an MRI machine, CT scanner, or PET scanner.
- In Kentucky, a provider needs permission to open an ambulatory surgery center.

RATIONALE FOR AND CONCEPTUAL INEFFECTIVENESS OF CON LAWS

While there are many justifications for CON laws, the typical goals include

- ensuring an adequate supply of healthcare resources,
- protecting access in rural and underserved communities,
- promoting high-quality care,

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to Entry? How They Affect Access to MRI, CT, and PET Scans" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); Thomas Stratmann and Christopher Koopman, "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).

[2] *Certificate of Need: Evidence for Repeal* (Chicago, IL: American Medical Association 2015); US Department of Justice and Federal Trade Commission, *Improving Health Care: A Dose of Competition*, July 2004, 22. See also Maureen K. Ohlhausen, "Certificate of Need Laws: A Prescription for Higher Costs," *Antitrust* 30, no. 1 (2015): 50–54; Federal Trade Commission and US Department of Justice, *Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250*, January 11, 2016; Federal Trade Commission and US Department of Justice, *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*, October 26, 2015; Letter from Federal Trade Commission Staff to Marilyn W. Avila, North Carolina State Representative, July 10, 2015; US Department of Justice and Federal Trade Commission, *Competition in Health Care and Certificates of Need: Joint Statement of the Antitrust Division of the US Department of Justice and the Federal Trade Commission before the Illinois Task Force on Health Planning Reform*, September 15, 2008; Daniel Sherman, *The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis* (Washington, DC: Federal Trade Commission, January 1988); Monica Noether, "Competition among Hospitals" (Washington, DC: Federal Trade Commission, 1987), 82.

[3] https://www.ama-assn.org/health-care-advocacy/state-advocacy/business-medicine

- supporting charity care, and
- controlling cost.

Certificate-of-need laws were well-intentioned when first introduced in states in the mid-1960s. Their effectiveness, however, should be measured by their outcomes. Even the best-intended laws might not lead to the desired results and might yield unintended consequences.

The failure of CON laws might have been expected because CON laws grant a government-protected monopoly to incumbent providers. Both basic economics and common sense tell us that government-protected monopolies have negative consequences, particularly for poor consumers.

CON laws are designed to restrict competition. Existing hospitals and other medical providers can oppose the CON application of a would-be competitor simply by claiming that there is no need for that additional medical service. This is akin to McDonald's needing permission from Burger King to open a restaurant in Kentucky.

EMPIRICAL EVIDENCE OF THE FAILURE OF CON LAWS

My colleagues and I started have analyzed data to rigorously test whether each of the stated goals of CON was achieved. Specifically, we examined the following claims by CON proponents that CON provides better access to care, higher quality care, and improves indigenous care.

We found that CON laws do not deliver on these promises. CON laws have backfired. It turns out that states with CON laws have less patient access to medical care and lower quality of medical care.

In this context, it is important to note that CON laws do not have a public health justification. CON requirements have nothing to do with public health or safety.

CON REDUCES ACCESS TO MEDICAL CARE IN FACILITIES ACROSS THE STATE

The data show *fewer* hospitals in CON states than in states without CON. In 2017, Kentucky had about 117 hospitals. A comparable state without CON has 166 hospitals. So, *a state without CON has more than 30 percent more hospitals*. This finding shows that CON *reduces* access to medical care.

And our findings also show that *states without CON have more hospital beds* per patient. Why is this important? Well, it means that patients have more choices. They are less likely to be turned away from a hospital. And it might mean that there are hospitals closer to patients.

All these estimates make apples-to-apples comparisons between CON and states without CON. This is because our estimates are adjusted by the age distribution in states, the healthiness of the population, and the percentage of the population on Medicaid and Medicare.

Kentucky also has a CON law for ambulatory surgery centers. Comparing Kentucky to statistically similar states without CON laws shows that *Kentucky likely would have over 36 centers instead of 31* if it were to repeal CON.

One important issue is the effect of CON on medical services in rural areas. CON proponents also say that CON laws increase access to medical care in rural areas. Therefore, I conducted a separate analysis, focusing on the number of rural hospitals separately. The findings of this analysis show that CON does the opposite of what is claimed by CON proponents. Kentucky has fewer ambulatory surgery centers and fewer hospitals, thus fewer choices. Kentucky residents in both urban and rural areas have fewer choices because of CON. For example, states comparable to Kentucky without CON have five additional rural hospitals instead of roughly 31 rural hospitals as of 2017.[4]

PATIENTS IN STATES WITH CON HAVE LESS ACCESS TO MEDICAL IMAGING AND OTHER SERVICES

The negative effect of CON on medical supply is not restricted to facilities. Medical inputs such as MRI, CT, and PET scans are also negatively affected. This is because Kentucky's CON laws require government permission to purchase such imaging equipment. This reduces access to medical care. For example, per year, Kentucky residents have about 28,300 MRI scans. Our estimates show that residents in states comparable to Kentucky without CON have more access to MRI scans. They receive about one-third more MRI scans—that is 38,500 MRI scans.[5] This gives us a glimpse at how access to medical care in Kentucky would improve if Kentucky were to drop its CON laws. Without CON, access is better for patients, and this better access doesn't represent an over-use of services.

QUALITY OF HOSPITAL CARE IS LOWER IN STATES WITH CON

Hospitals are incentivized to compete to attract patients in states without CON laws. Hospitals cannot compete as well on prices as most industries do because many patients are Medicare and Medicaid patients who can only be charged fixed amounts. But hospitals can compete on different margins, such as quality of service. So, there is a strong incentive for hospitals in states without CON to compete for patients by providing better quality medical services. This incentive does not exist to the same degree in states with CON laws because hospitals are shielded by law from competition in these states.

The data show that CON laws reduce hospital quality of medical services. This quality reduction is due to lacking competition among medical providers when a state has a CON law. When my co-authors and I compare states with CON laws to those with no CON laws, we find that *states with CON laws have a lower quality of service, as measured by their hospital mortality rates and hospital readmission rates*. For example, states with CON laws have:

- A 0.5 percent more deaths for surgery patients with serious complications,
- A 0.6 percentage point higher pneumonia mortality rate,
- A 0.3 percentage point higher heart failure mortality rate, and

[4] Stratmann and Koopman, "Entry Regulation and Rural Health Care."
[5] Stratmann and Baker, "Are Certificate-of-Need Laws Barriers to Entry?"

- A 0.4 percentage point higher heart attack mortality rate.

These are statistically significant differences. This evidence shows that CON is harmful to patient health and survival.

QUALITY OF INDIGENT CARE IS NOT BETTER IN STATES WITH CON

CON proponents sometimes claim that CON increases indigent care because successful applicants might commit themselves to increasing their medical services to the indigent. However, the data fail to support such optimism. It turns out that hospitals in CON states have the same amount of indigent care as hospitals in states without a CON law. Thus, *CON does not lead to additional services for the poor*.[6] In this study, we use uncompensated care to measure indigenous care.

Some states have been taking action to reverse the harmful effect of CON laws by repealing these laws. When states experienced increased population growth, the harmful effects of CON laws became more apparent. South Carolina repealed its CON law this year, in 2023. The largely rural state of Montana, also experiencing population growth, repealed its CON law in 2021. And in 2019, Florida repealed significant portions of its Certificate of Need law.

CONCLUSION

The takeaway from these findings is that CON laws are bad for Kentucky residents because they reduce the quality of medical care in Kentucky, they reduce access for Kentucky residents, and they reduce opportunities to obtain important medical services such as MRI and CT scans. Based on the research, Kentucky residents would be better off if the Bluegrass State would join the states without CON laws.

Sincerely,

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[6] Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?"

APPENDIX 1: MEDICAL SERVICES AND FACILITIES REGULATED BY CON LAWS IN KENTUCKY AS OF 2020

1. Ambulatory Surgical Centers (ASCs)
2. Assisted Living & Residential Care Facilities
3. Cardiac Catheterization
4. Ground Ambulance
5. Home Health
6. Hospice
7. Hospital Beds (Acute, General Licensed, Med-Surg, etc.)
8. Intermediate Care Facilities (ICFs) for Individuals with Intellectual Disabilities
9. Linear Accelerator Radiology
10. Long-Term Acute Care (LTAC)
11. Magnetic Resonance Imaging (MRI) Scanners
12. Mobile Hi Technology (CT/MRI/PET, etc.)
13. Neonatal Intensive Care
14. New Hospitals or Hospital-Sized Investments
15. Nursing Home Beds / Long-Term Care Beds
16. Obstetrics Services
17. Open-Heart Surgery
18. Organ Transplants
19. Positron Emission Tomography (PET) Scanners
20. Psychiatric Services
21. Radiation Therapy
22. Renal Failure/Dialysis
23. Substance/Drug Abuse

Source:
Matthew D. Mitchell, Anne Philpot, and Jessica McBirney, “CON Laws in 2020: About the Update”, February 19, 2021