INSTITUTE FOR JUSTICE

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Kentucky Certificate of Need Task Force
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To Chairman Douglas, Chairman Webber and members of the Task Force:

My name is Jaimie Cavanaugh and I am an attorney and legislative counsel with the Institute for Justice. For over a decade, Institute for Justice has been working to repeal and reform certificate of need laws around the country. Over the past few years, I have become the national policy expert on certificate of need. I have litigated a certificate of need case here in Kentucky, supported repeal efforts across the country, and published a comprehensive report comparing each state's CON laws in 2020.[1] More recently, I published a report specific to certificate of need laws here in Kentucky.[2]

My presentation today will have three parts. First, I'll explain the original intent behind certificate of need laws. This will help us understand how these laws affect access to healthcare today. Second, I want to dispel some common myths about certificate of need laws. And third, I will talk about the real-world implications of using certificate of need laws to suppress the supply of healthcare facilities and services.

I. BACKGROUND

In 1972, Kentucky adopted its certificate of need laws. A lot has changed in the healthcare landscape in the past five decades, yet certificate of need laws remain largely the same. As we think about how certificate of need laws operate today, it is important to remember why they were adopted in the healthcare industry in the first place. In the 1970s, the federal government promoted certificate of needs laws as a way to *decrease* its spending on healthcare.

At that time, healthcare providers were reimbursed by government payors on a "cost-plus" basis. Under the cost-plus system, hospitals were reimbursed for their actual expenses, instead of the negotiated rates they receive today. Congress believed that these reimbursements incentivized hospitals to open and expand without risk at the government's expense.[3] Thus, the purpose of certificate of need laws was to decrease the number of hospitals and the number of hospital beds in order to control costs. By their nature, certificate of need laws cannot increase access to care. That's the exact opposite of what they were designed to do.

Healthcare reimbursements are different today. Hospitals and healthcare providers are typically reimbursed on a fee-for-service basis. They aren't reimbursed

based on their actual costs. Instead, providers are reimbursed based on rates set by the government. So, the reimbursement rates, which may have incentivized the rapid growth of healthcare facilities in the past no longer exists. And even before reimbursement methods were updated, Congress disavowed certificate of need laws in the 1980s, correctly recognizing that they failed to decrease healthcare spending. In other words, the entire basis for enacting certificate of need laws is gone.

Today, agencies of the federal government like the Department of Justice, the Federal Trade Commission, and the U.S. Department of Health and Human Services continue to urge states to repeal certificate of need laws.

II. DISPELLING CERTIFICATE OF NEED MYTHS

I often hear *post hoc* arguments for why we should keep certificate of need laws, but certificate of need laws harm patients, increase costs, decrease access to care (as they were intended to do), and decrease the quality of healthcare. I'm going to walk through some of the arguments for keeping certificate of need laws and explain why evidence dispels those arguments.

A. Certificate of Need Laws Do Not Prevent Rural Hospital Closures

Many people believe that certificate of need laws are necessary to protect or improve rural healthcare options. But if you think about the purpose of certificate of need laws, it's hard to imagine how that can be true. Remember, certificate of need laws were intended to limit the growth of new facilities, so we know they discourage development of new facilities in rural areas. In fact, in 2019, the General Assembly acknowledged the burden that certificate of need laws place on rural communities when it enacted legislation to remove rural health clinics from the list of facilities that require a certificate of need. Kentucky joined eight states that have certificate of need programs, but exclude certain rural facilities. Those eight states are: Alabama, Indiana, Montana, Ohio, Oregon, South Carolina, Tennessee, and Washington. Specifically, Alabama, Oregon, South Carolina, Tennessee, and Washington all have certificate of need laws, but exclude rural hospitals from those laws because they recognize that certificate of need laws do not prevent rural hospitals from closing. Just the opposite, they harm rural communities by discouraging new facilities from opening.

In addition to preventing many facilities from opening in rural communities, certificate of need laws harm rural communities by preventing existing rural hospitals from adapting to meet the needs of their communities. Rural hospitals can't re-allocate beds, buy new equipment, or add needed services without going through the expensive certificate of need application process. And because we know that process takes months,

if not years with appeals in the state courts, it is often not worth the time and expense to apply in the first place. As a result, patients suffer.

Certificate of need laws simply do not prevent rural hospital closures. With certificate of need laws in place, Kentucky has experienced four rural hospital closures since 2005.[4] Another ten rural hospitals face an immediate risk of closure. Again, this is all with certificate of need laws in place. In contrast, several states without certificate of need laws have had zero rural hospitals closures since 2005. Examples are Colorado, Idaho, Utah, and Wyoming.

B. There Is No Evidence That Hospitals Rely On Cost-Shifting

When we break down the reasons why rural hospitals are closing, it typically comes down to finances and reimbursement rates. Certificate of need laws don't address reimbursement rates and were in fact designed to decrease healthcare spending, not to increase costs. Nonetheless, I know that many people fear that if certificate of need laws go away, new facilities like surgery or imaging centers will open and privately insured patients will use those facilities, leaving the rural hospitals with the poorest or sickest patients. Some people call this cherry-picking. This phenomenon is known to economists and researchers as "cost-shifting." Again, this boils down to a problem with reimbursements—not an issue certificate of need laws can address.

The good news is that this Task Force should not be worried about cost-shifting. This argument is a red herring. Although it sounds intuitive, researchers haven't been able to find any credible evidence that hospitals cost-shift in the ways they claim. If healthcare facilities were as reliant on the profits from privately insured patients as they argue, then we would expect that the facilities in poorer or more rural areas would charge privately insured patients higher rates. But the research finds no correlation between the percent of government payors in a geographic area and the rates hospitals charge patients. Likewise, if hospitals relied on cost-shifting, we would expect to see hospitals raise prices with some uniformity when the government lowers reimbursement rates. Again, there is no evidence of that either. Similarly, if cost-shifting were necessary, we would also expect to see hospitals lower prices when the government raises reimbursement rates, but that also doesn't happen. If anything, the research shows that hospitals in states with certificate of need laws are able to inflate prices because of the lack of competition. Thus, certificate of need laws distort healthcare costs, which leads to a lack of access because people avoid seeking medical treatment because it costs too much.

If the General Assembly is interested in helping rural communities, it should seriously consider repealing certificate of need laws. The data reveal that states without certificate of need laws have more rural hospitals per capita *and* more rural surgery

centers per capita. If hospitals were reliant on cost-shifting, this could not be true. We would expect to see more rural surgery centers, but fewer rural hospitals. But instead, we see more of both facilities because the competition makes everyone do better. Also, we would have plenty of examples of rural closures in states that have more recently repealed their certificate of need laws like Florida, Pennsylvania, Indiana, or New Hampshire, but again that isn't the case. Instead, the numbers expose the weakness in the cost-shifting argument. That argument assumes there are only a fixed number of patients in a given area. But since there are more rural hospitals and more rural surgery centers per capita in states without certificate of need laws, we know that by increasing access to care, more people will seek treatment. The number of patients before and after certificate of need laws are repealed will not remain static.

C. Certificate of Need Laws Increase Healthcare Costs

It is also confusing that the cost-shifting argument comes up because simultaneously, many people continue to argue that certificate of need laws lower healthcare costs. The data dispel that argument, but by sticking to the cost-shifting argument and admitting that they charge privately insured patients exorbitant rates, healthcare providers admit that certificate of need laws allow them to *increase* healthcare costs. In other words, accepting the cost-shifting argument (which lacks any evidentiary basis) is an admission that certificate of need laws have failed to control costs and instead make healthcare more expensive.

This is a huge problem in a state like Kentucky where more than 18% of the population is saddled with medical debt.[5] That is significantly higher than the national rate of 13%. And 12% of adults in the Commonwealth have reported not seeing a doctor because of cost.[6] It might sound attractive to say that privately insured patients are on the hook for losses caused by low government reimbursement rates, but even if that is what's happening, it's crippling the 60% of Kentuckians who have private health insurance.[7] That's the majority of the state. They deserve better too.

I have also heard the argument that Kentucky doesn't have a problem with healthcare costs, because some of its costs are lower than its neighbors.' Ignoring the high percent of the population that carries medical debt, even if Kentucky's healthcare rates are competitive, costs would improve further if certificate of need laws were repealed. We know that many Kentuckians, especially in northern Kentucky, are forced to leave the Commonwealth to seek care. Instead of forcing Kentuckians into neighboring states, if Kentucky could make its healthcare costs more accessible, maybe it could attract patients and healthcare dollars from neighboring states.

D. The Federal Courts Have Not Found That Kentucky's Certificate of Need Laws Achieve Any Of Their Stated Purposes

I'd like to briefly talk about the case I litigated challenging Kentucky's certificate of need law for home health agencies. Dipendra Tiwari and Kishor Sapkota wanted to open a home health agency to serve the sizable Nepali speaking community in the Louisville-area. After the Cabinet denied their certificate of need application, we challenged the certificate of need law and brought claims under the federal Due Process and Equal Protection Clauses. In 2022, the Sixth Circuit U.S. Court of Appeals ruled against Dipendra and Kishor.

The courts, however, never made any findings of fact about whether certificate of need laws achieve their purposes. Neither the district court, nor the Sixth Circuit reviewed the Cabinet's stated purposes for the certificate of need laws and found that the laws were achieving those purposes. Instead, under U.S. Supreme Court precedent, federal courts are required to uphold laws "no matter how unfair, unjust, or unwise" as long as the government provides "any plausible reason" to justify the law.[8] This means the government can assert the certificate of need laws are necessary to decrease healthcare costs without providing any evidence and the court is required to accept that statement, despite the mountain of evidence showing that certificate of need laws do not lower healthcare costs; they increase healthcare costs.

Because the court was required to follow this deferential standard of review, called rational basis review, Chief Judge Jeffrey Sutton called on lawmakers to address this problem. On behalf of a three-judge panel, Judge Sutton wrote that "the judgment that [certificate of need laws are] a failed experiment has the ring of truth to it. Were we Kentucky legislators ourselves, we would be inclined to think that certificate-of-need laws should be the exception, not the rule, and perhaps have outlived their own needs."[9]

III. THE CONSEQUENCES OF ARTIFICIALLY LIMITING THE SUPPLY OF HEALTHCARE

We know that certificate of need laws were designed to reduce the number of healthcare facilities being built. Research confirms that they have achieved this. Patients in states with certificate of need laws must wait longer and drive farther for healthcare. States with certificate of need laws have fewer hospitals, fewer hospital beds, fewer psychiatric care facilities, fewer dialysis clinics, and fewer medical imaging devices. Decades of purposely limiting the supply of healthcare has led to emergency situations today. We saw that during pandemic surges Kentucky was forced to suspend its certificate of need laws to give hospitals the flexibility they needed to respond. States with certificate of need laws were 27% more likely to run out of hospital beds during COVID surges.[10]

But certificate of need laws have dire consequences even outside a pandemic. Twice in 2023, Governor Andy Beshear has been forced to override existing certificate of need regulations with emergency regulations. First, in March 2023, Governor Beshear adopted regulations in response to what he called an "ongoing mental health crisis." But the certificate of need laws directly contributed to this crisis. For example, in 2013, the Cabinet for Health and Family Services commissioned a study on Kentucky's healthcare capacity. The Capacity Report pointed out many areas where certificate of need laws were choking off supply of facilities and services in a way that was harming Kentuckians. Notably, the Report warned that Kentucky needed more psychiatric facilities because "utilization of inpatient psychiatric case [was] about 50% higher than the national benchmark."[11] This means the Cabinet has had a decade to encourage the development of inpatient psychiatric beds and facilities.

Instead, the Cabinet has denied a certificate of need application for a Louisville hospital that wanted to address this problem. In 2021, Mary & Elizabeth Hospital filed an application to convert 33 of its existing licensed acute care beds to psychiatric beds. The Cabinet denied the application despite the applicants warning of the urgent need for services. An existing provider, with on the ground information, was trying to meet the needs of the community. But certificate of need laws stood in its way. Less than two years later, Governor Beshear's emergency regulations will allow Mary & Elizabeth to apply again to convert some of its existing acute care beds to psychiatric care beds, but it should not have come to this. The state would have been so much better off if those 33 beds had come online in 2021.

Then, in May 2023, Governor Beshear signed a second set of emergency regulations to address the "ongoing shortage of ambulance services available across the Commonwealth."[12] Disturbingly, since 2021, the Cabinet has denied at least 11 certificate of need applications to provide ground ambulance service. Those are 11 providers that could have been alleviating this critical shortage over the last two years.

The ground ambulance certificate of need law was also ruled partially unconstitutional earlier this month.[13] The Sixth Circuit ruled that Kentucky cannot prohibit out-of-state ambulance providers from operating in Kentucky, so long as those providers comply with safety regulations. The plaintiff in that case, Legacy Medical Transport, is an Ohio-based ambulance service that was allowed to drive patients from Ohio to Kentucky under the certificate of need laws, but was prohibited from turning around and driving those same patients from Kentucky back to Ohio. Specifically, the court ruled that the economic protectionism for incumbent in-state providers created by the certificate of need laws is unconstitutional.

Under this ruling, the Cabinet is free to continue enforcing certificate of need laws against in-state ambulance providers, but can't restrict out-of-state providers from

entering and working in Kentucky. Given this ruling, it makes little sense not to repeal the ground ambulance certificate of need requirement. The Court also noted that the "human costs [of certificate of need laws]," such as inflated prices, limited access, and decreased quality, are "costs that the Kentucky legislature has inflicted on its own people."[14] This Task Force should recommend that the General Assembly stop inflicting these harms on Kentuckians.

Thank you for allowing me to participate in this process. Please let me know if I can provide additional information or answer any questions.

Sincerely,

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[1] Jaimie Cavanaugh, *et al.*, *Conning the Competition A Nationwide Survey of Certificate of Need Laws* (Aug. 2020) https://ij.org/report/conning-the-competition/.

[2] Jaimie Cavanaugh & Matthew Mitchell, *Striving for Better Care: A Review of Kentucky's Certificate of Need Laws* 15 (Aug. 2023), https://ij.org/report/striving-for-better-care/.

[3] Grace Bogart, *Iowans Need Change: The Case for Repeal of Iowa's Certificate of Need Law*, 45 J. Corp. L. 221, 232 (2019).

[4] Austin Schick, *Sizable chunk of rural hospitals face closure in Kentucky*, Spectrum News (Aug. 10, 2023), https://tinyurl.com/22x7b53r.

[5] Garrett Wymer, *Great Health Divide Accumulation of medical debt a growing crisis experts say*, WKYT (Apr. 21, 2022), https://tinyurl.com/2t75wsvw.

[6] Medicaid's Role in Kentucky (July 5, 2017), https://tinyurl.com/29787ttf.

[7] *Health in Kentucky*, USA Facts https://tinyurl.com/yry9e85n (last viewed Sept. 14, 2023).

[8] *Tiwari v. Friedlander*, 26 F.4th 355, 361 (6th Cir. 2022).

[9] *Id.* at 365.

[10] Cavanaugh & Mitchell, n.2, *supra* at 15.

[11] *Id.* at 9.

[12] *Id.* at 16.

[13] *Truesdell v. Friedlander*, 2023 WL 5663239 (6th Cir. Sept. 1, 2023).

[14] *Id.* at *11.