Kentucky Legislature Special Committee Certificate of Need Task Force
Representative Russell Webber, Co-Chair
Senator Donald Douglas, Co-Chair
Capitol Annex, Room 171
702 Capitol Avenue
Frankfort, KY 40601

November 20, 2023

Dear Chairman Webber, Chairman Douglas, and members of the Special Committee Certificate of Need Task Force:

My name is Jeffrey A. Singer. I am a Senior Fellow in Health Policy Studies at the Cato Institute. I am also a medical doctor specializing in general surgery and have been practicing that specialty in Phoenix, Arizona, for over 40 years. Thank you for allowing me to testify before the Kentucky Special Committee Certificate of Need Task Force. I appreciate this opportunity to provide my perspective as a health care practitioner and policy analyst to assist the task force in assessing existing policies.

Roughly four decades since the repeal of the 1974 federal law that incentivized states to establish "Certificate of Need" (CON) requirements before new health care facilities can develop—or existing ones can add beds or equipment—CON requirements still exist to varying degrees in 35 states.[1] More aptly named "permission slips to compete," certificates of need are a classic example of central planning. Incumbent health care providers heavily influence CON commissions. Attempts to reform or repeal CON laws are often met by fierce resistance from the incumbents who try to make the case that they only have the interests of the public in mind.

CON laws render state health care systems sclerotic and unable to rapidly adjust their infrastructure to meet the changing demands of public health emergencies. Many governors suspended CON laws during the public health emergency. State legislators should formally repeal the CON laws in those states and in states that did not suspend them.[2]

Lawmakers enacted Certificate of Need Laws based on the theory that restricting the supply of health care services would somehow reduce demand for those services and thus restrain health care spending. However, policymakers should have noticed that private or government-run third-party payers pay for most

health care services. This insulates most patients from the actual prices of health care services, while the third-party payers absorb the costs. Consumer-patients with little skin in the game have no incentive to be cost-effective. When price signals are inoperative, demand continues despite restrictions in supply. Shortages inevitably develop while prices paid by third-party payers increase at a greater rate than would have otherwise occurred. This is basic economics.

The only way to reduce health care expenditures when health care consumers are largely insulated from price effects is to decrease availability and access to health care. In a George Mason University Mercatus Center working paper, a review of 20 academic studies found that CON laws largely failed to achieve their goal of reducing health care costs and concluded that the overwhelming evidence is that CON laws are associated with higher per-unit costs and higher expenditures.[3] The numbers speak for themselves. National per capita health expenditures increased from $2354 in 1974 to $12,914 in 2021 (in constant 2021 U.S. dollars).[4]

Despite the ineffective nature of these laws, states still have a variety of CON laws on the books today. The various states differ in the type and number of restricted facilities and expenditures. For example, Ohio restricts only long-term care services, while Kentucky restricts more than 24 different types of health care facilities.[5] The state where I reside and practice medicine, Arizona, repealed all the CON laws except for ambulance services in 1990. By 1990, California, Colorado, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah, Wisconsin, and Wyoming repealed all CON laws.[6]

The certificate-granting process effectively gives monopoly privileges to existing hospitals and facilities. When new providers petition for a certificate, established providers are usually invited to testify against their would-be competitors.[7] This means that some health care practices can openly challenge the right to exist of any practice that might hurt their bottom line. Indeed, hospital administrators openly admit that protection against competition, thanks to CON laws, has become an integral part of their business model.

Hospital administrators argue against the repeal of CON laws, claiming these laws allow them to generate enough revenue to provide 24-hour emergency services and uncompensated care. Physicians and other health care practitioners also provide uncompensated care and other services. Yet state professional organizations don’t argue for creating a certificate of need requirement before allowing additional doctors, nurses, psychologists, physical therapists, etc., to set up practices in a state. And they would be publicly derided if they did so.

New health care practitioners entering the state may provide competition to incumbents. This has not stunted the growth of the health care professions. Instead, it has benefitted health care consumers by increasing choice and access.

According to one health care journal, "hospitals tend to view CON restrictions favorably when they serve to exclude [competing] facilities from entering a market but may take steps to circumvent the CON application process where their own expansion is concerned."[8]

One of the original purposes of CON laws was to encourage hospital substitutes. Yet ironically, 28 states now restrict ambulatory care services, a common hospital substitute that competes with traditional hospitals.[9]

Both nursing homes and home health care services provide long-term care and hospice care. Many states that have repealed some CON laws retain them for nursing homes. Comparisons between states with some CON laws and those with no CON laws show hospice expenditures in states with CON laws are dominated by nursing homes rather than alternatives like home health care.[10]

A 2016 working paper by Thomas Stratmann and Christopher Koopman for the Mercatus Center at George Mason University concluded, "The presence of a CON program is associated with 30 percent fewer hospitals per 100,000 residents across the entire state," and "is also associated with 30 percent fewer rural hospitals per 100,000 rural residents."[11] A 2020 Mercatus Center working paper by Thomas Stratmann and Matthew C. Baker found that states with CON laws spend more per patient on Medicare and Medicaid in rural areas. Per-patient hospital readmission rates, ambulance utilization rates, and emergency department utilization rates are also higher in rural areas of states that have CON laws.[12]

Birthing centers have been gaining popularity as alternative venues for labor and delivery. Nurse midwives usually operate them. In some regions of the country, particularly rural areas, they enable women to give birth in culturally familiar places with more compassion than they would receive in hospitals.[13] An added benefit of birthing centers is that, in some rural areas, mothers in labor must often travel very long distances to deliver at a hospital, while birthing centers provide additional options for them. Free-standing birthing centers only take low-risk patients. The evidence to date suggests that free-standing birthing centers are associated with lower pre-term delivery rates, higher birth weights, higher breastfeeding rates, and lower rates of Caesarean sections.[14] However, Kentucky CON laws impede access to this valuable service.[15]

Women have had babies in their homes since the beginning of recorded history, and in modern times are increasingly opting for home births.[16] Fortunately, they don't need to obtain a Certificate of Need before having their baby at home.

We have seen and continue to see those countries embracing central planning fall victim to what economists call "the knowledge problem." It is impossible to predict how many ICU beds, general beds, or other health care facilities and services will be needed to serve a growing and dynamic population. Markets are the most accurate and efficient way of allocating goods and services.

With the advent of the COVID-19 pandemic, many states realized their CON laws left them unprepared for a sudden surge in demand for critical care and other health care services, and straight-jacketed by bureaucratic red tape. Therefore, 20 states suspended their CON laws, and four other states issued emergency certificates of need (thus bypassing the usually months-long certificate application process).[17] This was a tacit admission that Certificate of Need laws impede the rapid response of the health care system to sudden changes.

I encourage the task force members to heed the lessons the public health crisis provided and act now to repeal CON laws and rid their health care system of discredited central planning reminiscent of a bygone era.

Respectfully,

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[2] https://www.cato.org/blog/certificate-need-laws-will-impede-preparedness-expected-surge-covid-19-cases
[3] https://www.mercatus.org/system/files/mercatus-mitchell-con-healthcare-spending-v1a.pdf

[4] https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20per%20capita,%201970–2021

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