Kentucky's Certificate of Need Requirements

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Co-Chairs Schickel and Koch and Distinguished Members of the Interim Joint Committee (IJC) on Licensing, Occupations and Administrative Regulation:

My name is Matthew Mitchell. I am an economist at the Knee Regulatory Research Center at West Virginia University and I have been studying Certificate of Need (CON) Laws in health care for a decade. I was pleased to see that you are interested in examining Kentucky's CON requirements.

I thought it might be helpful to share some of the research on this regulation. I will focus on the scientific study of CON and the approach to reform that others have taken in recent years.

CON laws are intended to reduce costs, increase access (especially for vulnerable populations), and improve the quality of care. Neither economic theory nor decades of empirical research suggest that CON laws achieve any of these goals. In fact, the balance of evidence suggests that the regulatory regime undermines competition, driving up costs, limiting access, and diminishing the quality of care. The case against CON is especially strong when it limits care for vulnerable populations such as those seeking psychiatric care or substance use treatment or those who live in rural communities where the supply of health services is already likely to be limited.

Standard economic theory tells us that a supply restriction such as CON will tend to shift the supply curve back, raising the costs per unit and limiting the quantity and quality of care. These effects are exacerbated by the fact that CON laws have several anticompetitive features: In most CON states—including Kentucky—the process empowers incumbent providers to challenge the applications of their would-be competitors. Competitor's objections are often dropped once the entrant agrees not to encroach on the incumbent's territory (this sort of agreement would be a violation of antitrust law if it weren't encouraged by the state). Even when a competitor has not objected to an application, he or she can use their own admission practices to influence the outcome. For example, in many states a new CON will be denied if a certain share of existing beds are unused. This incentivizes existing providers to keep their beds empty. Incumbents can also refuse to enter into direct transfer agreements with new providers, and these new providers will often be denied their own CONs without such agreements. Statutory and regulatory language often compels regulators to deny applications if a new service will "duplicate" (i.e., compete with) an existing service.

By design, then, it seems that CON laws are unlikely to achieve their stated goals.

1. The Evidence

But we don't have to rely on theory alone. We can look to the real-world experience of Americans. About one-in-three live in a state with either limited or no CON regulation in health care. Many more live in states that have reformed or pared their CON programs back. Relying on this variation across time and across geography, researchers have spent decades comparing outcomes in CON and non-CON markets.

The scientific literature studying CON laws is voluminous. To date, there have been 128 academic peer-reviewed assessments of CON laws. Together, these papers contain 458 separate tests. I have recently reviewed this literature in a paper published in the *Southern Economic Journal* (Mitchell 2024). Most tests find that CON laws undermine their stated goals. By a margin of more than 4-to-1, the regulation is associated with higher spending, less access, and diminished quality of care. The evidence is especially lopsided when it comes to spending per service (where the evidence is 9-to-1 against CON), availability of services (nearly 11-to-1 against CON), and care for vulnerable populations (where the evidence is unanimously against CON).

Among these tests assessing the effect of CON on spending, researchers find:

- CON laws are associated with 10% higher variable costs in general acute hospitals (Anderson 1991);
- Hospital charges in states without CON are 5.5% lower five years after repeal (Bailey 2016);
- In Ohio, reimbursements for coronary artery bypass grafts fell 2.8% following repeal of CON and in Pennsylvania, they fell 8.8% following repeal (Ho and Ku-Goto 2013);
- Acute care costs rise with the rigor of CON programs from the most resource-intense diagnoses (Custer et al. 2006);
- CON laws are associated with higher Medicaid costs for home health services (Custer et al. 2006); and
- There is some evidence that CON is associated higher Medicaid long-term care costs (Custer et al. 2006).

Among those tests assessing the effect of CON on access to care, researchers finds that patients in CON states:

- Have access to 30 to 48% fewer hospitals (Stratmann and Koopman 2016; Eichmann and Santerre 2011);
- 30% fewer rural hospitals and 13% fewer rural ambulatory surgery centers (Stratmann and Koopman 2016);
- 25% fewer open-heart surgery programs (Robinson et al. 2001);
- 20% fewer psychiatric care facilities (Bailey and Lewin 2021); and
- Fewer dialysis clinics and reduced capacity at existing clinics (Ford and Kaserman 1993).

Among those tests assessing the effect of CON on quality of care, researcher find that in states with CON laws there are:

- Higher mortality rates for heart attack, heart failure, and pneumonia (Stratmann 2022; Chiu 2021);
- Higher mortality rates for natural death, septicemia, diabetes, chronic lower respiratory disease, influenza/pneumonia, Alzheimer's, and COVID-19 (Roy Choudhury, Ghosh, and Plemmons 2022); and
- Lower nursing staff-to-patient ratios and greater use of physical force in nursing homes (Zinn 1994).

Among those tests that assess the effect of CON on underserved populations, researchers find:

- Substance use treatment centers in states with CON laws are less likely to accept Medicaid patients (Bailey, Lu, and Vogt 2022);
- Uninsured patients are more likely to pay out of pocket in states with CON laws (Custer et al. 2006);
- A large black-white disparity in the use of angiography disappeared when the procedures were exempted from CON (Cantor et al. 2009; DeLia et al. 2009);

- There is no evidence of cross-subsidization and no evidence that CON laws increase charity care (Stratmann and Russ 2014); and
- Safety-net hospitals in states without CON had higher margins than similar hospitals in states with the regulation (Dobson et al. 2007).

2. Options for Reform

The balance of evidence suggests that without CON laws, Kentuckians would have greater access to lower cost and higher quality care and that these effects would be especially valuable to vulnerable populations. But short of full repeal, the state has plenty of other options, including:

- Phased repeal;
- The elimination of CONs such as psychiatric care and substance use care that limit services for vulnerable populations;
- The elimination of CONs that limit low-cost alternatives to care such as hospice care, home health care, and ambulatory surgical care;
- The elimination of CONs for procedures that are unlikely to be overprescribed such as dialysis, radiation therapy, substance use care, and neonatal intensive care;
- Raising the threshold of capital expenditures that trigger a CON;
- Reducing fees;
- Altering the standards for assessing need by, for example, allowing services that duplicate existing services;
- Barring competitors from taking part in the process (as Indiana, Louisiana, Michigan, Nebraska, New Jersey, and New York have done);
- Lowering the cost of compliance;
- Requiring providers to use CONs or lose them;
- Increasing transparency in the process, by for example, reporting the share of applications that are denied as well as the share that are opposed by incumbent providers.

3. Conclusion

We need not speculate about what would happen in a Kentucky without this regulation. Decades of evidence drawn from hundreds of sophisticated empirical investigations makes it clear that Kentuckians can expect greater access to lower cost and higher quality care without CON. Vulnerable and underserved populations such as those in need of substance use treatment or psychiatric care are especially likely to benefit from repeal.

Thank you for the opportunity to offer my testimony today. I am happy to discuss my research in further detail with you or your staffs.

Sincerely,

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