

Certificate-of-Need and Health Care Costs: What the State Can Do

Stacie Beck, Associate Professor of Economics, University of Delaware and member of CRI Advisory Board

Costs in any market, including health care, are reduced by raising productivity. The best way to achieve this is to release the forces of competition inherent in free markets. Proposed reforms of the Affordable Care Act (aka Obamacare) seek to do this on the demand side by incentivizing patients/consumers to shop for the best and lowest-priced care via i.e., health savings accounts (HSAs) and cross-state-border sales of health insurance. However, less attention has been paid to supply side reforms.

When suppliers in any market are protected from competition they can charge higher prices. They are also less efficient, adopt cost-saving technology more slowly and provide lower-quality services. Thus, the project of freeing the demand side is likely to backfire unless the supply side is also freed. A certificate-of-need program is an anti-competitive supply-side barrier under state control.

What is a Certificate-of-Need Program?

Under these programs applicants must establish to the state that there is a need for additional capacity before a certificate is granted to build additional health care facilities or make major equipment purchases. This was due to a mistaken idea that excess capacity raises prices, a plausible possibility under Medicare cost-plus pricing. Medicare reimbursement has since been reformed. Moreover, there was no evidence that health care costs were, in fact, restrained. For these reasons the federal government eliminated the incentive to establish certificate-of-need (CON) programs in 1987 after creating it in 1974. Nevertheless, state CON programs linger on in 34 states, including Delaware.

This planned-economy approach to health care supply is equivalent to denying a grocery store (like Walmart) a permit to build because there is already adequate grocery store supply in the area. A new, more efficient store enters because it can underprice existing stores. This creates excess capacity which forces less efficient stores to close. Even the threat of a new store will force existing stores to become more efficient, in order to deny the new entrant a market opportunity. This is how Walmart drove productivity gains in the retail sector throughout the US in the 1990s.¹

Clearly, it is advantageous to existing health care providers to convince lawmakers to retain CON programs. One justification is that providers are required to provide free care to indigents. However, this is very inefficient. Just as we provide EBT (food stamp) cards so families can shop at the best value grocery store, it would be more efficient and fair to switch to an explicit tax on health care providers to fund health care vouchers/HSAs for the indigent.

¹ The income gain through lower prices, especially to lower income families, has been established in the economic literature (Hausman and Leibtag, 2007)

Otherwise this anti-competitive barrier reduces the threat of entry, and insulates existing providers from price competition.

Delaware's Certificate of Public Review (CON) Program²

Title 16, Chapter 93 of the Delaware Code establishes the program. It covers the construction or establishment of any health care facility, the acquisition of a nonprofit health facility, the expenditure of more than \$5.8 million by a health care facility (with some exceptions), a change in bed capacity of 10 beds or more than 10% of licensed capacity (whichever is less), and the acquisition of major medical equipment (excluding replacement and with some exceptions). The review process considers the 'need of the population', the effect on existing providers, the effect on cost and quality of health care, and the availability of less costly/more effective alternatives in-state or out and co-ordination with the Delaware Health Resources Management Plan (§9304-6).

In the application kit, applicants are asked to provide demographic data, utilization rates of existing providers, and impacts on existing providers. They also get the opportunity to describe the impact of the project on cost and quality of health care in the service area. There are even some irrelevant questions (e.g. Has the Applicant evaluated alternative uses to which these monies...could be used...? Does the Applicant intend to employ energy conservation principles..?). Extensive financial data are expected and any other studies/analysis that Applicants may have conducted to reach the decision to file the application. More serious hurdles lurk in the Delaware Health Resources Management Plan.

The Plan (last updated in 2014) explicitly prohibits the establishment of hospitals in Delaware for 5 years based on current versus projected capacity needs. Capacity needs are calculated using explicit formulas in the Plan. CPR applicants' requirements for indigent (charity) care are laid out. While there is some discussion of other considerations, the major consideration appears to be whether additional capacity is justified based on demographic data and current capacity (existing providers). However, it is not really possible to determine how much weight is given to any one factor, including cost.

It is fair to conclude that Delaware's CPR program is an anti-competitive barrier. Undue weight is given 'current capacity', i.e., existing providers. Applicants must provide highly detailed data, which will be made public thereby possibly giving away competitive advantage. Applications can be denied on a wide range of factors. Although only two applications of 47 were denied (2005-2016), there are no data on withdrawn and deterred applications.

Evidence of Effects

Statistical studies on the impact of CON programs such as Delaware's CPR program on health care costs indicate that costs are not reduced. There is some evidence that costs are

² This information is available at dhss.delaware.gov/dhss/dhcc/hrb/cprpinfo.html

increased.³ Studies on quality are mixed. However, it is difficult to measure the true impact of CON programs statistically because they are widespread (small control group) and their effect is through the deterrence of cost-saving activity which is hard to measure. Anecdotal evidence is easier to come by. The Federal Trade Commission and the Anti-Trust Division of the US Department of Justice make a very strong case for elimination of state CON programs, and cite specific instances of anti-competitive behavior by health providers that was facilitated by CON regulations.⁴

Conclusion

It is impossible to see any upside for health care consumers or insurers to Delaware's Certificate of Public Review program, other than to ensure that providers are qualified and licensed to provide care. Excess capacity should not be a consideration, indeed, it is the mechanism through which new entrants to the market puts pressure on suppliers to reduce price. Nor should the financial/economic viability of new entrants or existing suppliers be a factor since it is better for consumers if inefficient providers are driven from the market. Right now, most care is paid for by third parties such as the State itself, or Highmark Blue Cross-Blue Shield. This may account for the failure to eliminate this program already. However, demand side pressure is likely to intensify as health care costs increase and the Affordable Care Act is reformed, as it must be to remain viable.

Two alternatives are possible. Political pressure could be brought to encourage the state legislature to repeal the law. Alternatively, CRI could investigate the possibility of suing to overturn the law. In the last two years, the Institute for Justice has brought cases in Iowa and North Carolina on behalf of market entrants who were blocked under CON laws.

³ See National Conference of State Legislatures at www.ncsl.org/research/health/con-certificate-of-need-state-lasws.aspx and Mitchell, Matthew "Do Certificate-of-Need Laws Limit Spending?" Mercatus Working Paper, September 2016.

⁴ Joint Statement of the Federal Trade Commission and the Anti-Trust Division of the US Department of Justice to the Virginia Certificate of Public Need Work Group, October 26, 2015.

