



Putting on the **BRAKES**

Certificate of need regulations try to steer health-care supplies, but it's hard to keep them from fishtailing

BY CHARLES GERENA

Every month, members of the board of directors for the Central Virginia Health Planning Agency Inc. gather in a blue-gray meeting room. The conservative color scheme is everywhere, even in the speckled fabric of the chairs where the board members sit. Only one thing sticks out: the honey-colored wooden podium where health-care providers pitch their proposals for new facilities and equipment.

In Virginia and throughout the rest of the Fifth District, providers must obtain a certificate of need (CON) before making major capital investments. They have to demonstrate that the expenditure is necessary to fulfill the needs of the community, which are determined by state health officials and detailed in a formal plan.

At the January meeting of Central Virginia's health planning board, three groups explained why the region needs additional diagnostic imaging equipment. Their proposals faced the scrutiny of the board, which makes its recommendations to the state health commissioner. After an hour of presentations, reports, and intense questioning, two of the three CON applicants were rebuffed. A fourth applicant withdrew from consideration before the meeting.

Many economists question the necessity of regulating the health-care supply

so closely. Their view is that companies introduce goods and services only when they expect to be rewarded with higher revenue and profits. Meanwhile, consumers usually benefit from the increased competition in the form of broader choices and better prices. In short, markets tend to work pretty well by themselves.

But state health planners and other CON supporters counter that health care isn't a typical market. They believe that government must intervene to minimize unnecessary development and improve the accessibility and quality of care.

"We are coping with an imperfect system," notes Pamela Barclay, deputy director of health resources for the Maryland Health Care Commission, which reviews CON applications. Instead of consumers buying health care directly, government- and employer-provided insurance pays for it. But some medical services are reimbursed at higher rates than others and not everyone has the same level of coverage, creating distortions in the market.

The CON process is also imperfect, but states have used it to address problems in an industry that affects everyone's well being.

CON to the Rescue

Health-care planning dates back to the 1940s. During the Great Depression

and World War II, few hospitals were being built or updated, and the supply of medical facilities was inadequately distributed among and within states. Communities responded to this crisis by financing and planning hospital development themselves, sometimes with the help of government agencies. In 1946, their efforts were aided by federal subsidies.

States began regulating the supply of health care through certificate of need reviews in the 1960s and '70s, partly in response to lobbying from hospital operators who favored centralized health planning. By 1974, Congress required states to have a CON program in order to receive federal dollars for psychiatric, substance abuse, and other health services. It also approved direct funding of CON programs.

"States weren't seen as micromanaging health-care markets. It was routine for communities to be involved in planning," says John Steen, a New Jersey-based medical consultant who serves on the board of directors for the American Health Planning Association (AHPA).

Also, "states and federal officials were really concerned about rising costs," notes Frank Sloan, director of Duke University's Center for Health Policy, Law, and Management. "CON was the first major cost containment program implemented."

The idea was that by controlling the expansion of health-care supplies, fewer development costs would be placed on the shoulders of consumers. At the time, cost-based reimbursement systems — especially the massive Medicaid and Medicare programs created in the 1960s — enabled health-care providers to pass along most of the expense of new equipment and services to third parties. Since capital improvements could translate into increased revenue with little downside risk, providers were perceived as having an incentive to over-invest.

Lastly, state and federal lawmakers were concerned about health care quality and access. By using CON reviews to steer new development, they aimed to prevent providers from expanding only in affluent areas that were already well served. According to Lee Hoffman, chief of the CON program at the North Carolina Division of Facility Services, if there is no designated need for additional services in a metropolitan area, “providers prefer to take their chances in a rural area [rather than have] nothing at all. It gets their foot in the door.”

CON programs proliferated until the early 1980s when the federal government changed how it paid health-care providers. Under a new per-case prospective payment system, providers received a predetermined amount of money for each patient treated, regardless of the cost of the services required. The amount paid depended primarily on the diagnosis-related group into which the patient was classified.

Private health insurers adopted this payment system as well, which removed the incentive to over-invest that many policymakers had been concerned with. Meanwhile, market-based approaches such as managed care emerged as alternatives for containing medical costs, which were still rising despite the widespread usage of CON reviews.

In 1986, the federal government stopped funding CON programs and 14 states eventually abandoned their programs. Today, 36 states and the District of Columbia regulate health-care supplies to varying degrees. Virginia lawmakers backed off from eliminating the state’s CON regulations in 2001,

while West Virginia, Maryland, and the Carolinas have reviewed or revised their regulations over the last five years instead of eliminating them.

Why does more than two-thirds of the nation still conduct CON reviews? Part of the reason is political pressure, particularly from health-care providers with an established market presence.

State lawmakers also believe that CON reviews give communities a voice in health-care development. Public hearings are usually held before a CON application is considered and whenever a state’s health plan is being updated. “It’s a process in which providers and consumers of services can get together, examine problems, and exercise their best judgement,” says Dean Montgomery, current AHPA president and executive director of the Health Systems Agency of Northern Virginia.

States have another motive for trying to maneuver health-care supplies: They have a big stake in containing medical costs. In communities with a low concentration of businesses, a big chunk of medical services are reimbursed through Medicaid and insurance provided to state employees.

And there is reason to be worried about health-care providers gaining more pricing power and increasing their capital investments. Despite the changes in medical reimbursement, insurers have less power to negotiate lower rates with providers. “In the late ’80s and early ’90s, they were able to [reduce costs] the easy way because there was fat in the system,” says medical consultant John Steen. But managed care has reached its limits in cost reduction and people have been demanding more services.

The Verdict

Has this faith in the certificate of need process been justified? It depends on what criteria you use.

Constraining the health-care supply via CON review may have tempered growth in hospital beds and nursing home development. But it hasn’t been conclusively shown to slow growth in overall per-capita medical spending.

“While CON laws can be effective in slowing the expansion of some serv-

ices, many other factors affect health-care costs (e.g., labor, physicians services) that CON laws have not attempted to control,” noted a January 1999 study by the University of Washington. Furthermore, a 1998 study by Duke University’s Frank Sloan and Christopher Conover didn’t find a marked increase in health-care expenditures in states that dropped CON reviews.

Meanwhile, CON regulations may sometimes constrain supplies too well, making it difficult for health-care providers to respond to market changes. Let’s say an imaging center wants to buy another MRI machine because its existing equipment is operating 18 hours a day and on weekends to keep up with demand. The center may fail to get a CON because there is underutilized capacity elsewhere, even though that capacity may be in a less-populated area, inconvenient to patients, or outdated.

Additionally, hospitals can be prevented from moving capacity to high-growth areas or redesigning it for services that are in greater demand. Charlotte Lynch, manager of business planning at Gaston Memorial Hospital near Charlotte, N.C., recalls how she struggled to obtain a CON to redistribute its unused bed capacity to the hospital’s Women Center. Initially, the state wanted to de-license 40-plus acute care beds in the hospital’s inventory before it would approve the CON. Rather than relinquish capacity that was needed to accommodate future growth, the hospital eventually gave up some of its psychiatric beds.

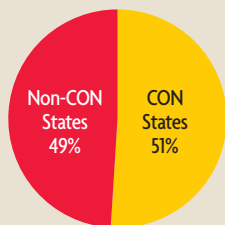
Hospitals often must obtain a certificate of need to purchase new equipment, such as MRI machines.



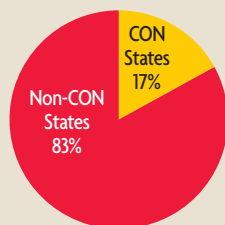
Path of Least Resistance

Specialty hospitals tend to stay away from states where medical facilities have to obtain a certificate of need to add capacity, as shown below. Is that good or bad? Specialty hospitals outperform general hospitals in terms of costs, but they are less likely to have an emergency room and they treat a smaller percentage of Medicaid patients.

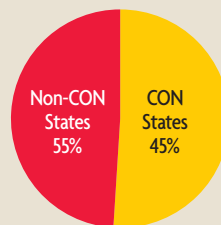
Distribution of U.S. Population



Distribution of Specialty Hospitals



Distribution of General Hospitals



NOTE: Twenty-six states and the District of Columbia were counted as “CON States” because they require a certificate of need to develop acute care beds. The total number of states with a certificate of need process of any type is much higher (36).

SOURCE: *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, General Accounting Office, October 2003

“As soon as you want to expand... and you’re not at the target occupancy, their thinking is ‘Let’s take some of this excess capacity away from them because they don’t need it,’” complains Lynch.

Health-care providers can make adjustments to the CON process or the state health plan via the public review process. But some states take at least a year to update their plan, while other states have much longer planning horizons. And there’s no guarantee that providers will get the changes they want. Lynch says it took years before North Carolina recognized a need for acute care beds.

State officials would be hard-pressed to admit these shortcomings in CON programs. Instead, they have moved cost containment down their list of policy goals and emphasized CON’s role in meeting an equally important goal: to intervene in health-care markets when accessibility and quality take a backseat to profits.

How much state governments intervene in markets depends on how many medical services they regulate and how large a capital investment must be before it is subject to CON review. Maryland and West Virginia regulate a wide range of medical services under CON and have relatively low capital cost thresholds, plus they review hospital rates. The Carolinas, Virginia, and the District of Columbia have com-

prehensive programs as well, while the latter two still have regional health planning agencies that evaluate CON applications.

An agency under the state’s department of health typically evaluates applications to determine how proposed projects meet the state’s health plan. The plan identifies the quantity and type of services needed in certain regions based on population growth, utilization rates, and other data. Then anyone can apply for a CON to meet these needs.

Other criteria are also used to determine if a proposed project is in the public interest. They include the project’s economic impact on existing facilities, the applicant’s history of providing charity care, and the geographic accessibility of the project.

With the latter, one would think that the development of health-care infrastructure should follow population growth. “In some respects that’s true,” says Ken Cook, president of Roanoke, Va.-based Vantage Healthcare Consulting Group Inc. and former executive director of southwest Virginia’s health planning agency. “But we also want to force [development] to move out into surrounding areas.” For example, Lynchburg has more nursing home beds per thousand seniors compared to the four rural counties surrounding the city.

Have these market interventions worked? A recent General Accounting Office report found that states with CON programs appear to have better access to health care because they have fewer specialty hospitals than states without CON. Such facilities are less likely to have an emergency room and to accept Medicaid patients. On the other hand, states without CON have slightly more general hospitals than non-CON states, and these facilities have to serve everyone. (See pie charts.)

On the whole, “it is very difficult to steer” the development of medical services, notes Frank Sloan. There have been some attempts to prevent hospitals from moving from the inner city to the suburbs, but they have failed to prevent health care providers from chasing population growth.

It’s Good at Playing Monopoly

Most health-care economists, consultants, and regulators would agree that certificate of need regulations have been good at one thing—producing markets with varying levels of protection. Such markets affect access and quality of medical care, both positively and negatively.

“Health care is a service where a significant portion of the population cannot afford to pay for it because they are underinsured or uninsured,” explains Lynn Bailey, a consulting economist in Columbia, S.C. By awarding a limited number of CONs for particular services in a geographic area, states essentially create franchised territories for general hospitals in exchange for them serving the entire population. “It is a social contract.”

In general, protected markets have a high cost of entry. The CON application process can take several years, especially if there are appeals, and require tens of thousands of dollars to pay for consultants, lawyers, and processing fees. But once a health-care provider gets its “franchise” for offering a certain service, it’s in a better position to charge higher prices and generate a reliable revenue stream because others can’t readily follow. “If you have a monopoly in a town, an insurer has to negotiate with

that monopolist. It's not going to get the same price as an insurer who has the ability to take its business elsewhere," explains Sloan. This probably doesn't help contain costs, but it does make it easier for providers to acquire credit and invest in new technology and staff training.

Another benefit of market protection is that it supposedly prevents a specialty facility from entering a community and cherry picking profitable outpatient services like ambulatory surgery and cardiac catheterization. While cherry picking is a savvy business move, it could hurt long-established general hospitals that use moneymaking outpatient services to pay for money-losing inpatient services like the emergency room. Hospitals must compete to hold on to their best customers while caring for the indigent and uninsured whom they are legally required to serve regardless of their ability to pay.

On the other hand, companies usually have less incentive to be innovative and efficient if they don't have to face the constant challenges of competition. So health planners perform a delicate balancing act. "If you design your CON program right so that you allow enough competitors to get in, you won't make an inefficient system. ... Providers will have to compete on quality," says Cook.

Finally, limiting the growth of new medical capacity may help build up the volume of procedures at existing facilities. This would enable providers to spread out the cost of equipment over more patients. It also would enable medical professionals to gain experience that helps them improve patient outcomes, which is why malpractice insurers often refuse to provide coverage unless providers reach a certain threshold of patient utilization.

However, CON programs have had a mixed record when it comes to increasing patient volume at facilities and their impact on outcomes hasn't been proven. Furthermore, such benefits of limiting medical capacity would have to be balanced against making services available to the greatest number of people, notes Sloan.

Watch Where You Swing That Thing!

In the final analysis, the certificate of need has been a blunt instrument of public policy. So why not let health-care markets figure out the best combination of supply and demand? Then state governments could deal with quality and access problems by establishing standards for care and expanding public medical facilities.

CON advocates argue that health-care markets can't fix themselves because they are dysfunctional. For one thing, patients usually depend on health-care providers to tell them what services they need, so providers are in the position of redirecting patient care to utilize any new capacity. "It's not like buying a car where you can determine the best quality you can get for the lowest price. We really depend on doctors to advise us what facility to go to and what services we need," says Joel Grice, director of the South Carolina Bureau of Health Facilities and Services Development, which manages the Palmetto State's CON program.

Health-care markets malfunction for a less sinister reason as well: They have little price competition, which tends to encourage overproduction. Normally, suppliers produce more as prices increase until their services become too expensive for buyers. But prices for certain medical services can continue to rise without patients demanding less.

Why? The demand for many medical services is very price inelastic. Patients care more about getting the best care available than about how much they'll pay, especially in an emergency situation or when treatment options are limited. Also, patients don't know the actual costs of their care. Market information is not readily available, plus insurers act as a third party that separates patients from providers in transactions.

Even if these market malfunctions could be fixed, broad regulation of health-care markets is more politically desirable than deregulation. If a nursing home closed down as a result of market competition, the cost of relocating former residents would make the front

page of local newspapers. In contrast, the shortcomings of CON programs impact everyone, so it's not as obvious to individuals.

Still, government regulation is considered a necessary evil to protect patients from the ups and downs of unfettered market competition. In fact, some lawmakers and health care experts believe that health care shouldn't be a profit-making business.

Notes economist Lynn Bailey, "We haven't resolved the issue of whether health care is a private good regulated by market forces—those who pay for it get it and those who can't pay for it don't—or a public good that benefits the entire community." European countries have long considered health care a public good, but following the same path in the United States—via universal health insurance or a government-run hospital system—wouldn't be cheap.

Until our society decides how health-care markets should function, CON programs will continue trying to steer supplies in the Fifth District and throughout the nation. **RF**

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