Senate Interim Committee on Certificate of Need

August 30, 2006 - Monsanto, 800 N. Lindbergh, St. Louis, MO 63167 - 12:00 pm
Creve Coeur Campus, Intersection of Lindbergh and Olive, D Building - Quest Room

Senators: Bill Stouffer, Chairman
Jack Goodman
Delbert Scott
Frank Barnitz

Cited testimony by Jan Vest, CEO, Signature Health Services, Inc.

Economic basis for elimination of CON.

1974 – National Health Planning and Resources Development Act: At the time reimbursement was based on the cost of production. The government payment system encouraged inefficient investment because it took the risk out of the process. Costs were recouped regardless of any failure to accurately estimate demand. Indeed the so-called cost-plus system of reimbursement took away the need to consider future demand at all.

1987 – Repeal of mandate due to change in payment system, being a predetermined amount based on the kind of service.

In a market where providers need to compete for cost-conscious purchasers of services, even if the purchasers are insurance companies, higher costs cannot simply be passed along in higher prices.

In reality, CON is a cartel enforcement device that protects incumbent providers from new entrants and competition.

The continuation of CON regulations cannot be justified either theoretically or empirically. In fact, from the perspective of sound economics, the reverse is true. If one desired to devise a policy for any market whose purpose would be to reduce efficiency, raise costs and prices, and reduce product quality, the existing CON programs would be highly recommended.

State CON is an all inclusive and intrusive method to control supply of institutional health facilities

Important aspects of the production, distribution and sale of health care services has been removed from the competitive free enterprise system and placed under the control of a command-and-control bureaucracy. The market is run by government rather than entrepreneurial insight and patient preferences.

Proponents of CON laws do not refute the economics by presenting an alternative economic framework that would explain why an actual free market in medical-care facilities and equipment would not behave as economic theory would predict. Instead they suggest that standard economics should not be used for analysis at all, even though what is being assessed is at the heart of what economic science is all about – market price and output formation and the efficient allocation of scarce resources.

Findings Duke University professors Christopher Conover and Frank Sloan published in 1998 in the Journal of Health Politics, Policy and Law, *Does the Removal of Certificate of Need Regulations Lead to a Surge in Healthcare Spending*?.

CON laws resulted in a 2 percent reduction in bed supply and "higher costs per day and per admission, along with higher hospital profits," exactly what economic theory would predict.

Overall, the study found no decrease in per capita health care spending attributable to CON.

A more recent study -- Federal Trade Commission released jointly with the Department of Justice – 2004

"The Agencies believe that CON programs can pose serious competitive concerns that generally outweigh CON programs' purported economic benefits. Where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."

Hidden Tax

CON laws are used to create a hidden tax. The cost of health care and the profits to health care providers are purposefully kept high by granting monopoly privileges. If it is deemed that those who are paying for health care services should bear the burden of also paying for care given to the indigent, then an explicit excise tax should be placed as a line item on all health care inventories.

Another way CON imposes a hidden tax on the health care system relates to the resources hospitals and other health care entrepreneurs must devote to obtaining the certificate.

Breaking the Consumption/Payment Link

The reason why health care may be overpriced is that, in most cases, what economists call "the consumption/payment" link has been broken. In 2002 over 84% of all personal health care expenditures were made by someone other than the person receiving the care.

CON laws substitute bureaucratic decision-making for the market's entrepreneurial assessments. The problem is that the government decision-makers have no basis for gathering accurate market information and, furthermore, they have no incentive to make sure investment get made in the right places, at the right times, and the right amounts. Unlike the case with private entrepreneurs, if their decisions prove to be wrong, there are no personal consequences borne by the planners responsible.

As University of Pennsylvania analyst, Mark Pauly noted, CON programs "tended to be 'captured' or dominated by the hospitals they were intended to regulate, and that those hospitals used regulation to keep out competition."

*Primary source: *Certificate of Need Laws: It's Time for Repeal*, November 2005, by Roy Cordato, Ph.D - Economics. Bio highlights follows:

Roy Cordato, Ph.D. -- Vice President for Research and Resident Scholar at the John Locke Foundation. From 1987-1993 he was Senior Economist at the Institute for Research on the Economics of Taxation (IRET) in Washington, DC. He has served as full time economics faculty at the University of Hartford and at Auburn University and as adjunct faculty at Johns Hopkins University. His articles have appeared in a number of economics journals and law reviews in addition to *The Christian Science Monitor*, *The Washington Times*, *Investor's Business Daily*, *The Journal of Commerce*, *The Congressional Record*, *The Orange County Register*, *Ideas on Liberty*, *Human Events*, and many other newspapers and magazines.

Wisconsin Hospital Association newsletter – The Valued Voice (excerpt)
November 23, 2005
Volume 49, Issue 44

President's Column: CON Regulation

Seeking data to refute the auto industry's push to bring back Certificate of Need (CON) after a 20-year hiatus, the Indiana Hospital and Health Association commissioned Price Waterhouse Coopers to do an analysis based on an earlier study the accounting firm did for the American Hospital Association.

The following table shows the top 20 states ranked by per capita hospital expenses in 2004. The **bolded** states have some form of CON regulation to "control" capital spending by hospitals and physicians.

	Hospital Expense Per Capita
Massachusetts	**$2,357**
North Dakota	$2,229
New York	**$2,202**
Missouri	**$2,009**

Maine	**$1,936**
Ohio	**$1,932**
West Virginia	**$1,930**
Rhode Island	**$1,929**
Pennsylvania	$1,925
Delaware	**$1,908**
South Dakota	$1,867
Nebraska	**$1,862**
Minnesota	$1,804
Vermont	**$1,775**
Indiana	$1,750
Connecticut	**$1,745**
Michigan	**$1,731**
Iowa	**$1,720**
Wisconsin	$1,710
Illinois	**$1,709**

The results are hardly a testament to the efficacy of capital regulation. And while the chart also fails to make a strong case for "free market competition" as defined by the absence of capital expenditure regulation, perhaps the real message here is that hospital/health care cost drivers are many and varied and that simple, sound bite solutions are simply that…

Steve Brenton
President

John E. Wennberg Study, Dartmouth Medical School
Variation in use of Medicare Services Among Regions and Selected Academic Medical Centers: Is More Better?, December 2005

"For example, during the first six months following their hip fractures, patient using academic medical centers in high spending areas had 82% more physician visits, 26% more imaging exams, 90% more diagnostic tests and 46% more minor surgery. Compared to low-intensity regions, patients with hip fractures, colon cancer and heart attacks who were loyal to academic medical centers in high-intensity regions had higher mortality rates and worse "score cards" on measures of quality.

"The patients were followed for up to five years after their initial event – the hip fracture, surgery for colon cancer, or heart attack. The study showed increase mortality rates in regions with greater care intensity."