Matthew Mitchell, PhD
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MERCATUS CENTER
George Mason University

FLORIDA'S CON LAW

LESSONS FROM THREE DECADES OF RESEARCH

Florida House of Representative
Health Market Reform Subcommittee

February 6, 2019

WHAT IS A CON LAW ?

A permission slip to compete

Not a quality gate

Designed to assess “need”

Unusual in a market economy

A barrier to entry that restricts supply

Anticompetitive

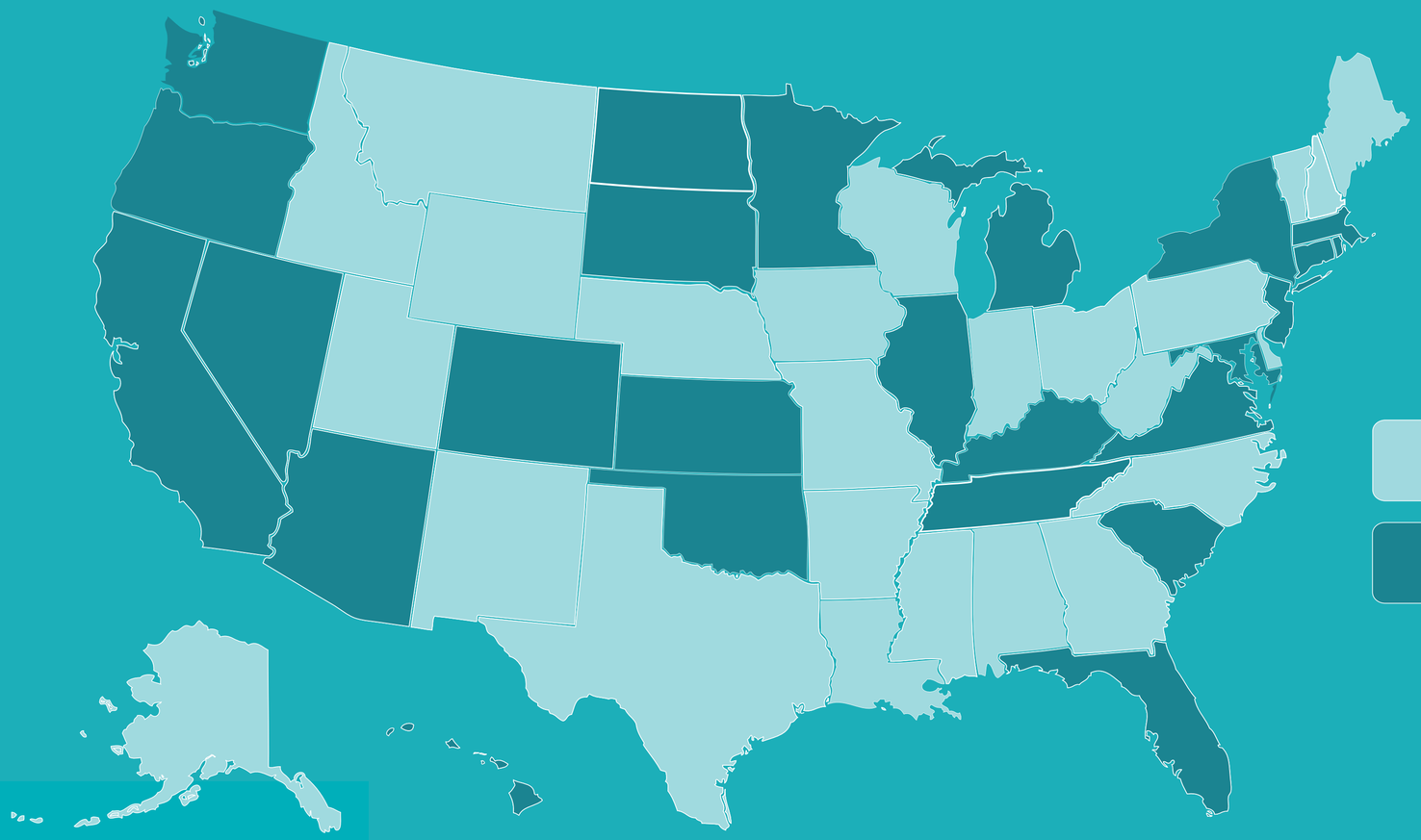
A SHORT HISTORY OF CON LAWS

1974
National Health Planning and Resources Development Act

Ensure an adequate supply of HC
Ensure rural access to HC
Promote high quality HC
Promote charity care
Encourage hospital substitutes
Restrain the cost of care

A SHORT HISTORY OF CON LAWS

1974



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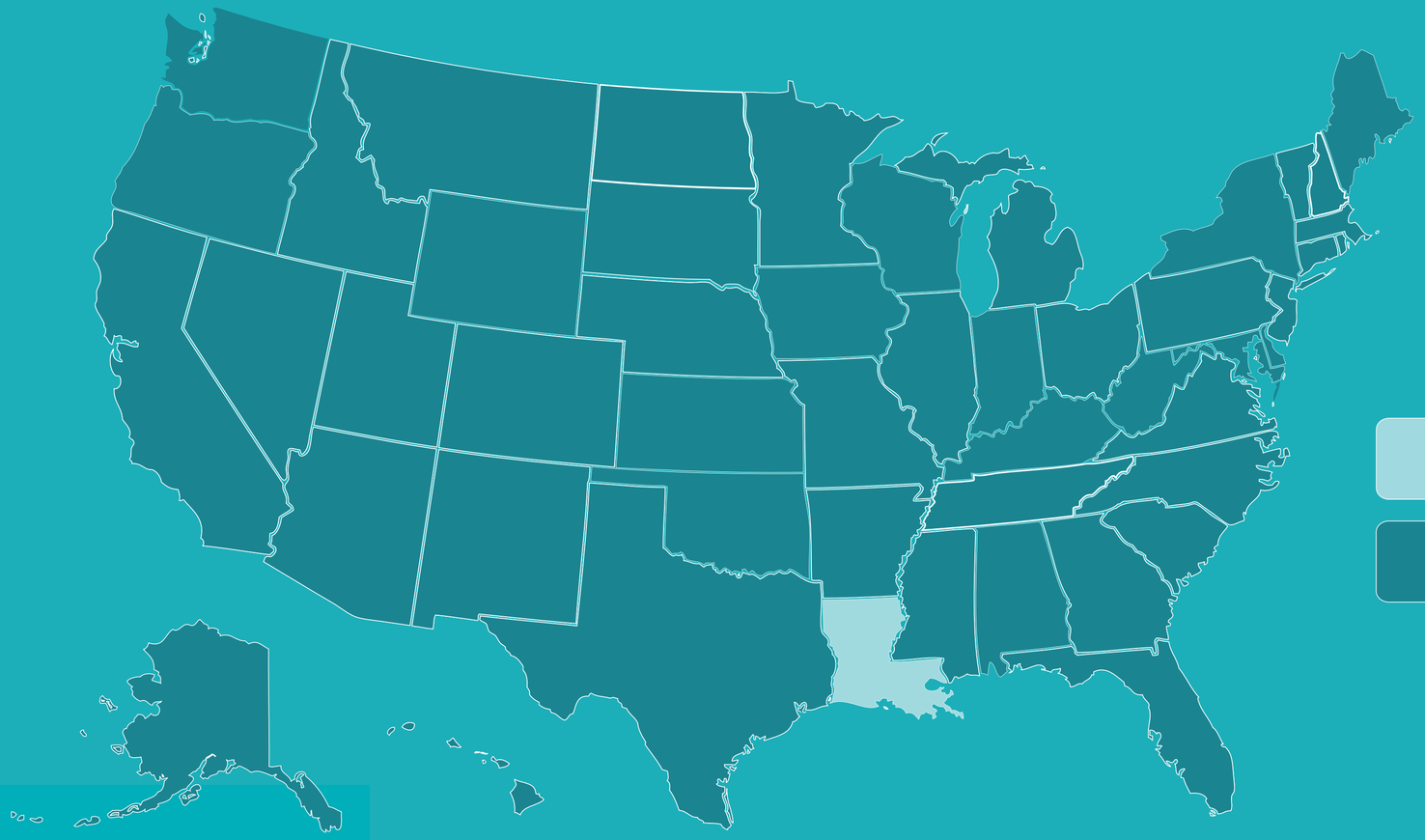
A SHORT HISTORY OF CON LAWS

1980



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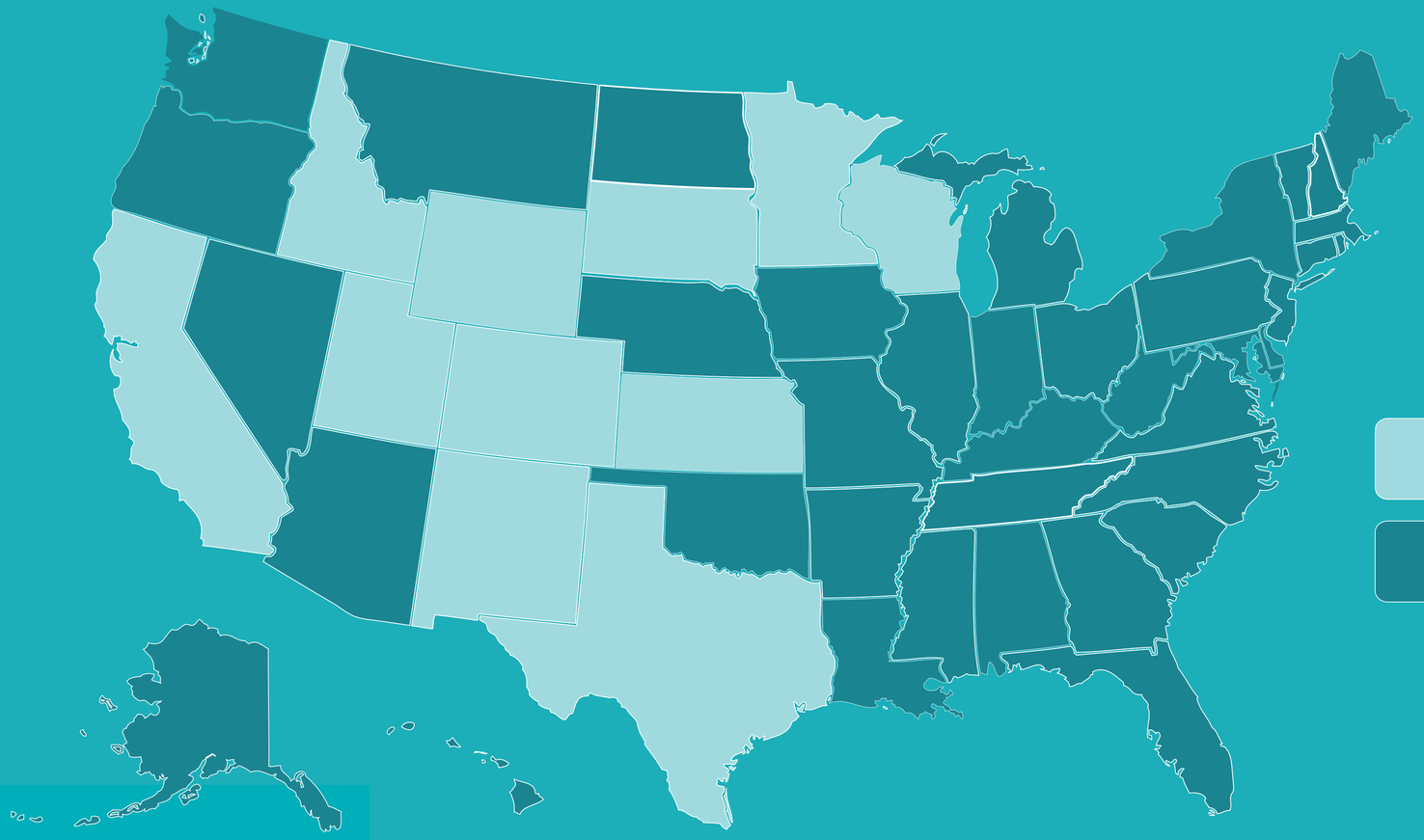
A SHORT HISTORY OF CON LAWS

1990



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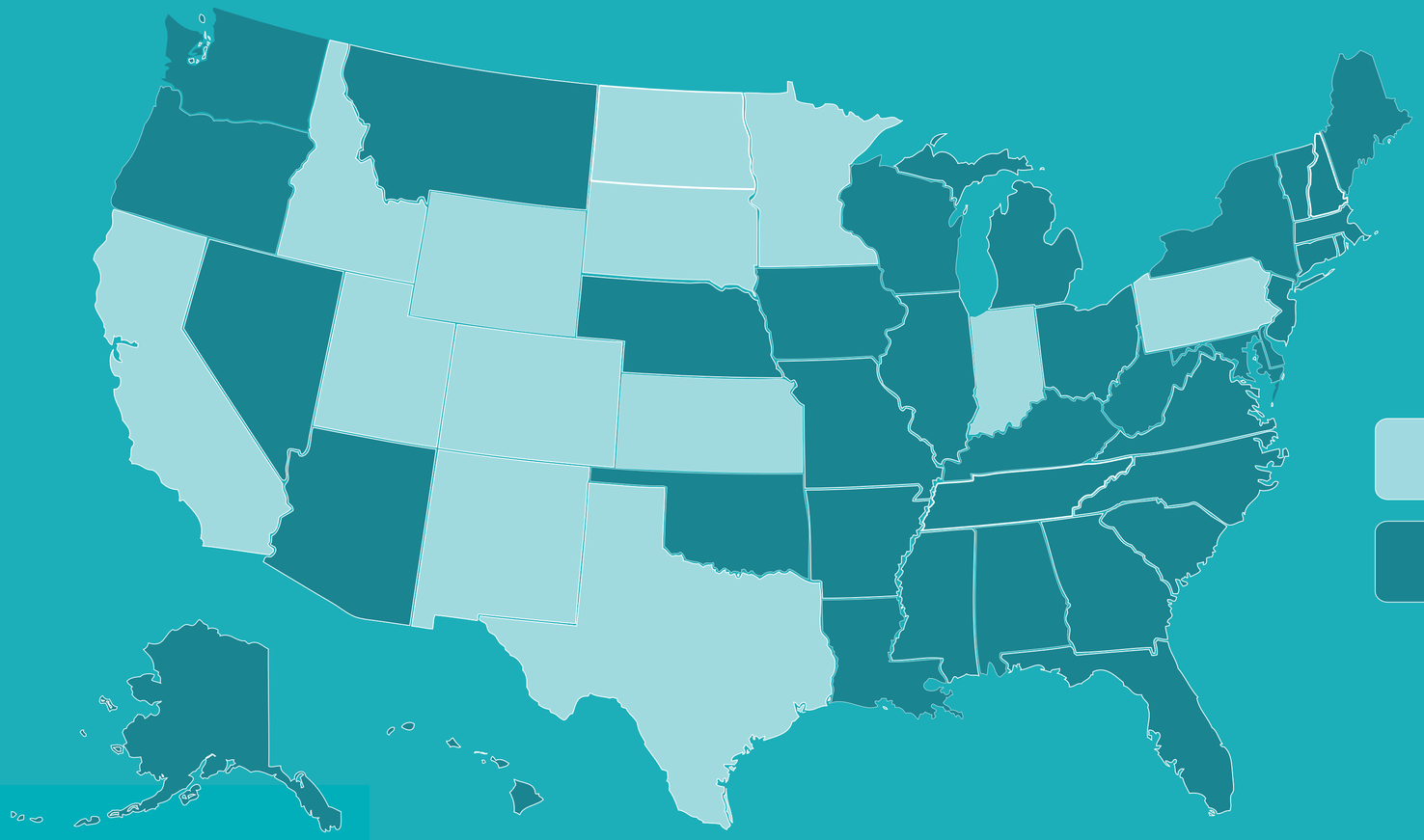
A SHORT HISTORY OF CON LAWS

2000



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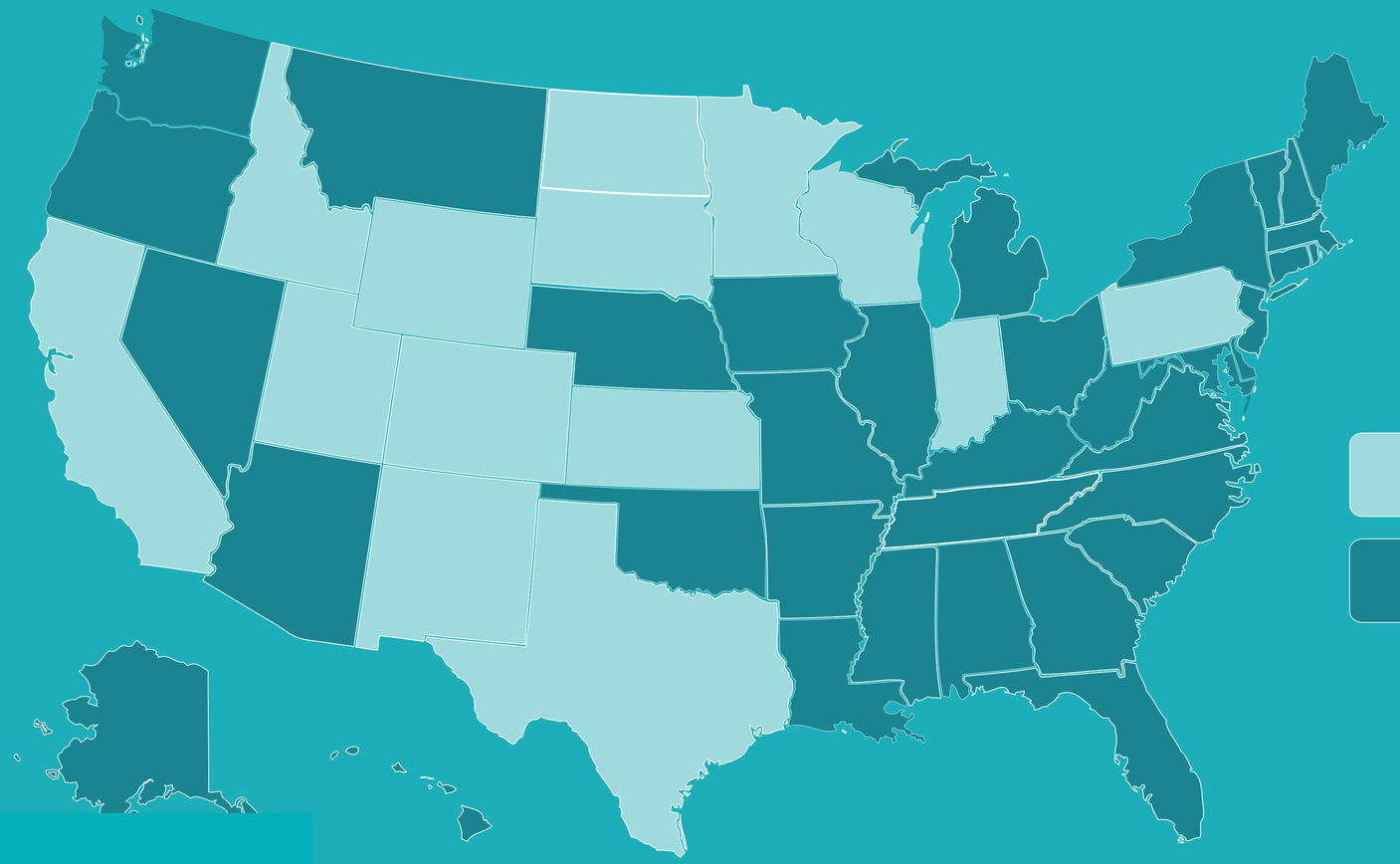
A SHORT HISTORY OF CON LAWS

2015



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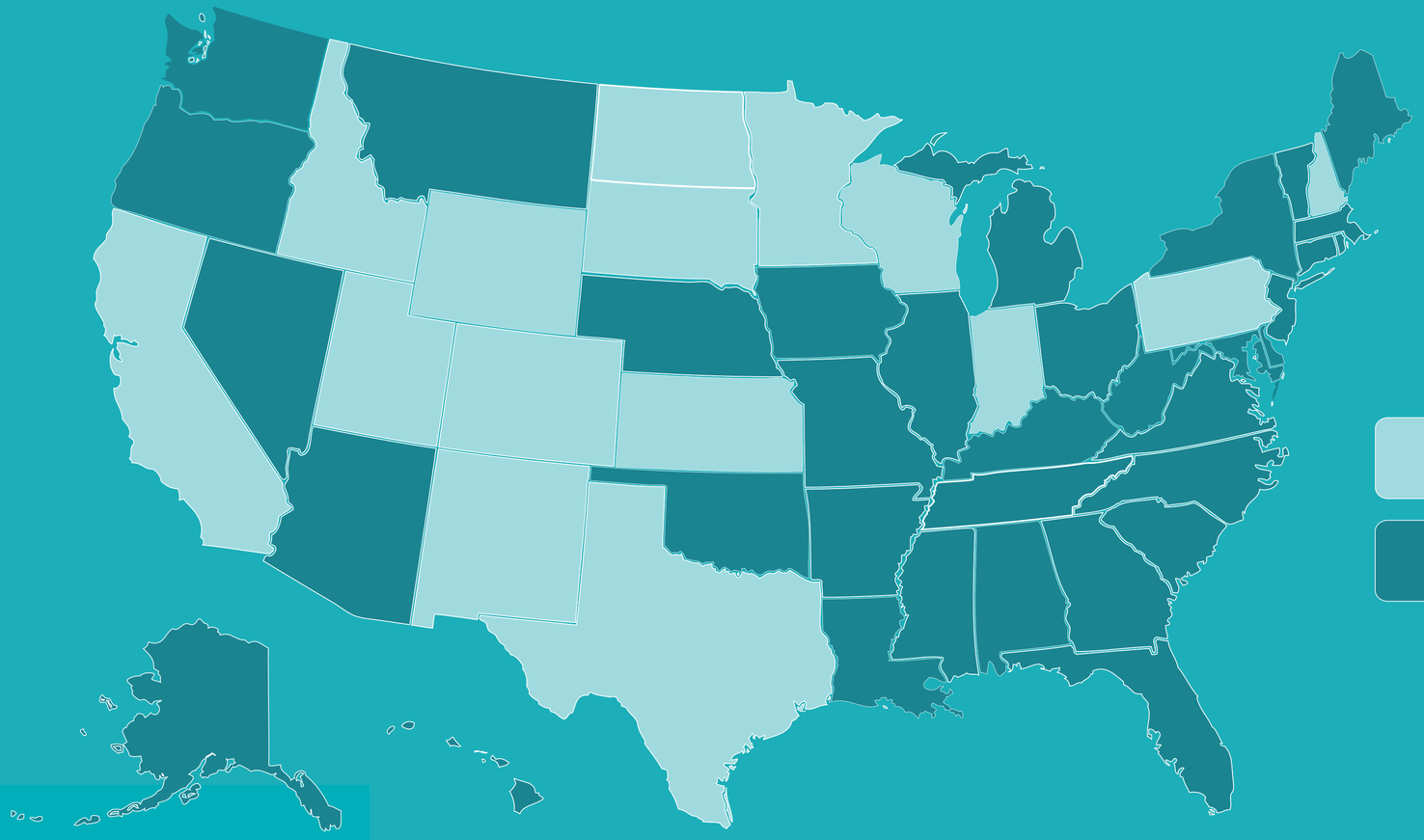
A SHORT HISTORY OF CON LAWS

2019



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CON Regulation

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FLORIDA'S CON LAW

intermediate care facilities / mental disabilities

organ transplants

home health

burn care

Nursing home beds

psychiatric services

substance / drug abuse

NICU

open-heart surgery

rehabilitation

cardiac catheterization

hospice

swing beds

long-term acute care

acute hospital beds

subacute services

assisted living / residential care facilities

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THE STATED GOALS OF CON LAWS

1974
National Health Planning and Resources Development Act

Ensure an adequate supply of HC

Ensure rural access to HC

Promote high quality HC

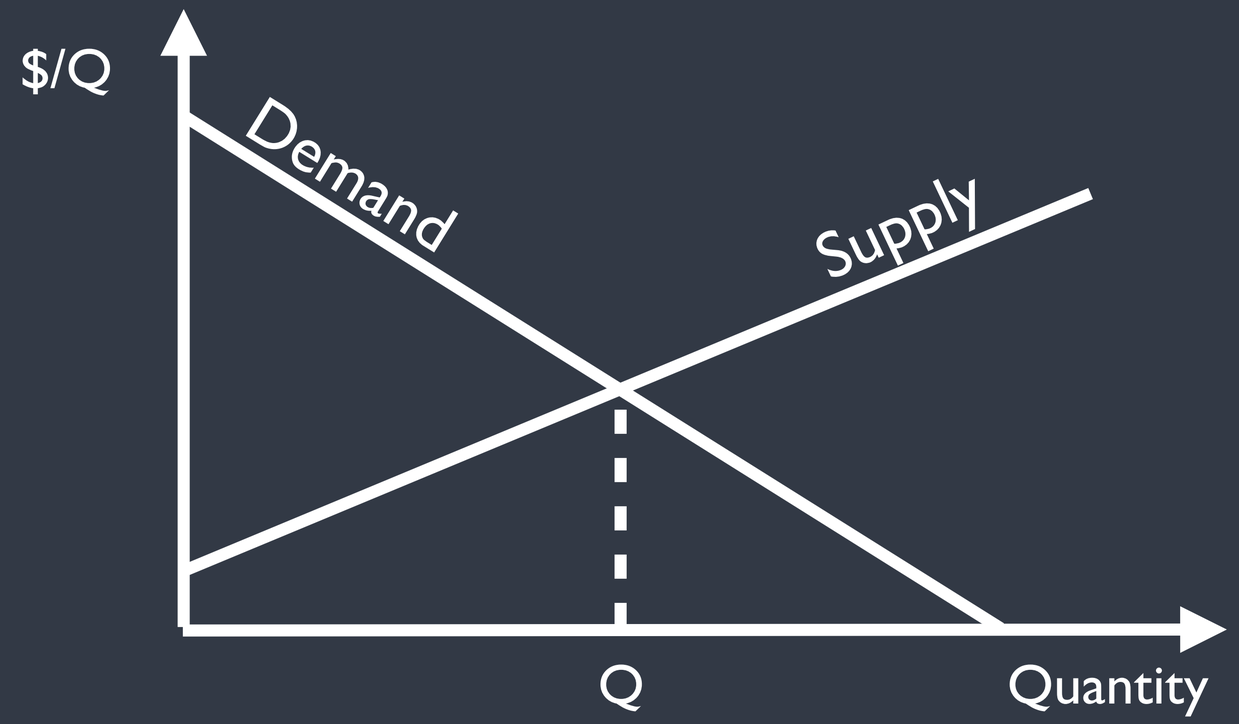
Promote charity care

Encourage hospital substitutes

Restrain the cost of care

THE REALITY OF CON LAWS

Ensure an adequate supply of HC?



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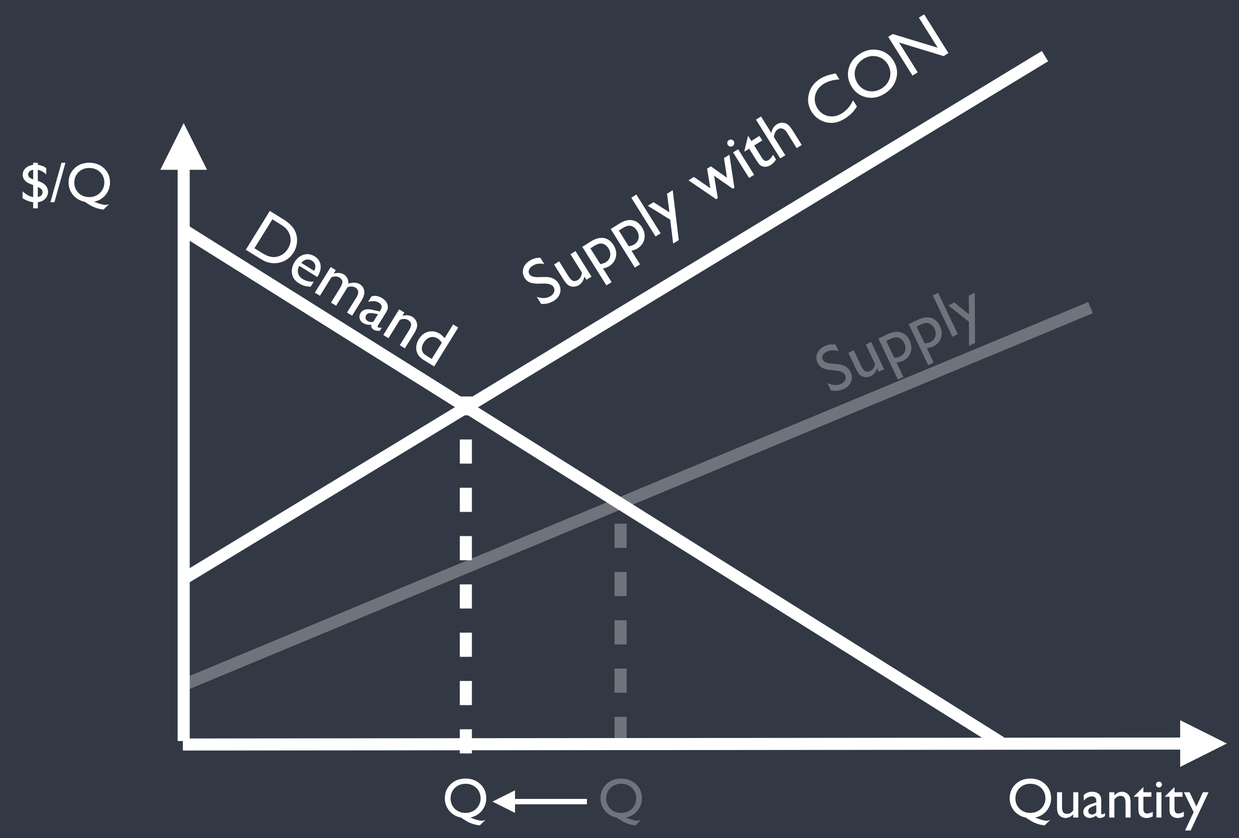
THE REALITY OF CON LAWS

Ensure an adequate supply of HC?



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THE REALITY OF CON LAWS

Ensure an adequate supply of HC?

Limited supply of dialysis clinics (Ford and Kaserman, 1993)

Limited supply of hospice care (Carlson et al., 2010)

Fewer hospitals per capita (Stratmann and Russ, 2014)

Fewer hospital beds per capita (Stratmann and Russ, 2014)

Fewer hospitals with MRIs (Stratmann and Russ, 2014)

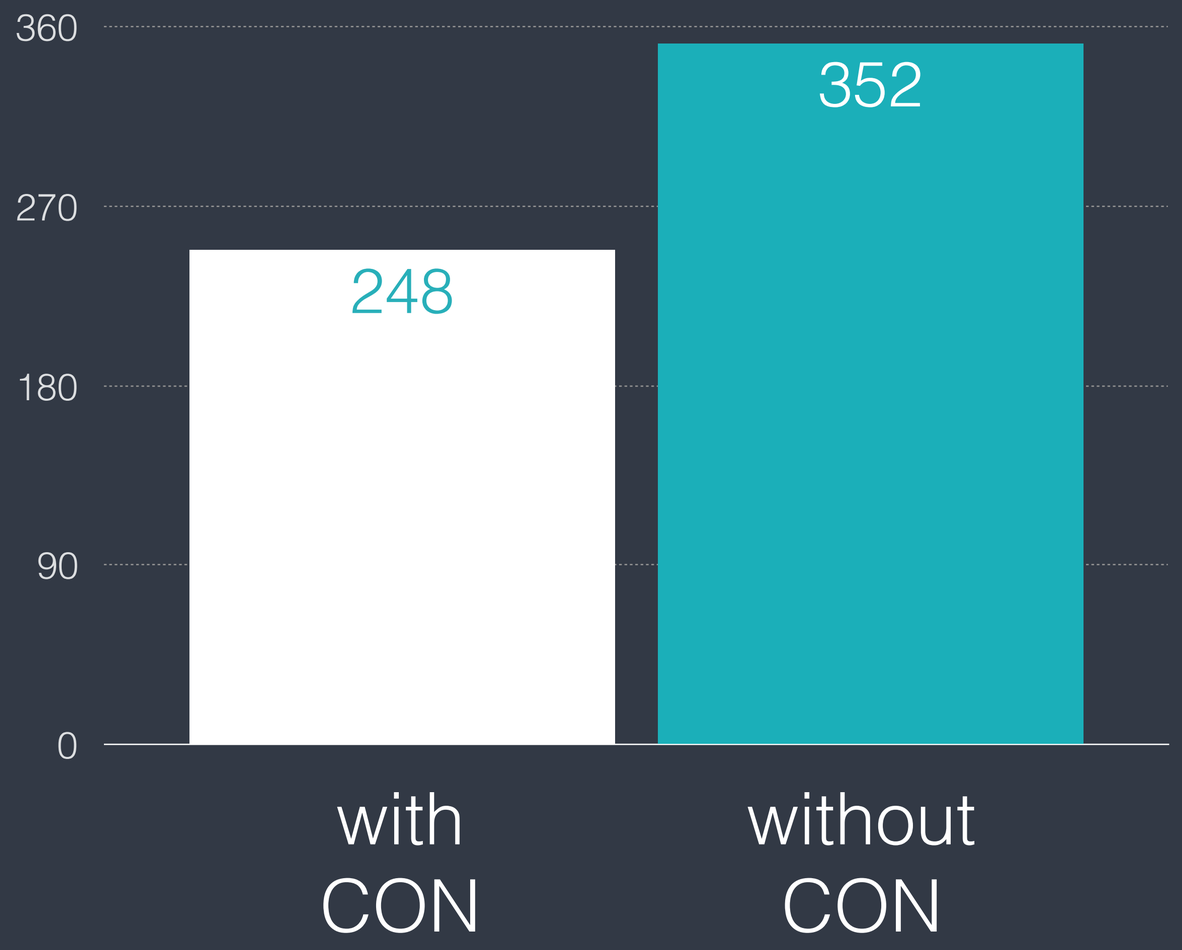
Fewer CT, MRI, PET scans (Stratmann and Baker, 2017)

More out-of-county CT, MRI, PET scans (Stratmann and Baker, 2017)

THE REALITY OF CON LAWS

Ensure an adequate supply of HC?

Estimated number of Florida hospitals without CON



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THE STATED GOALS OF CON LAWS

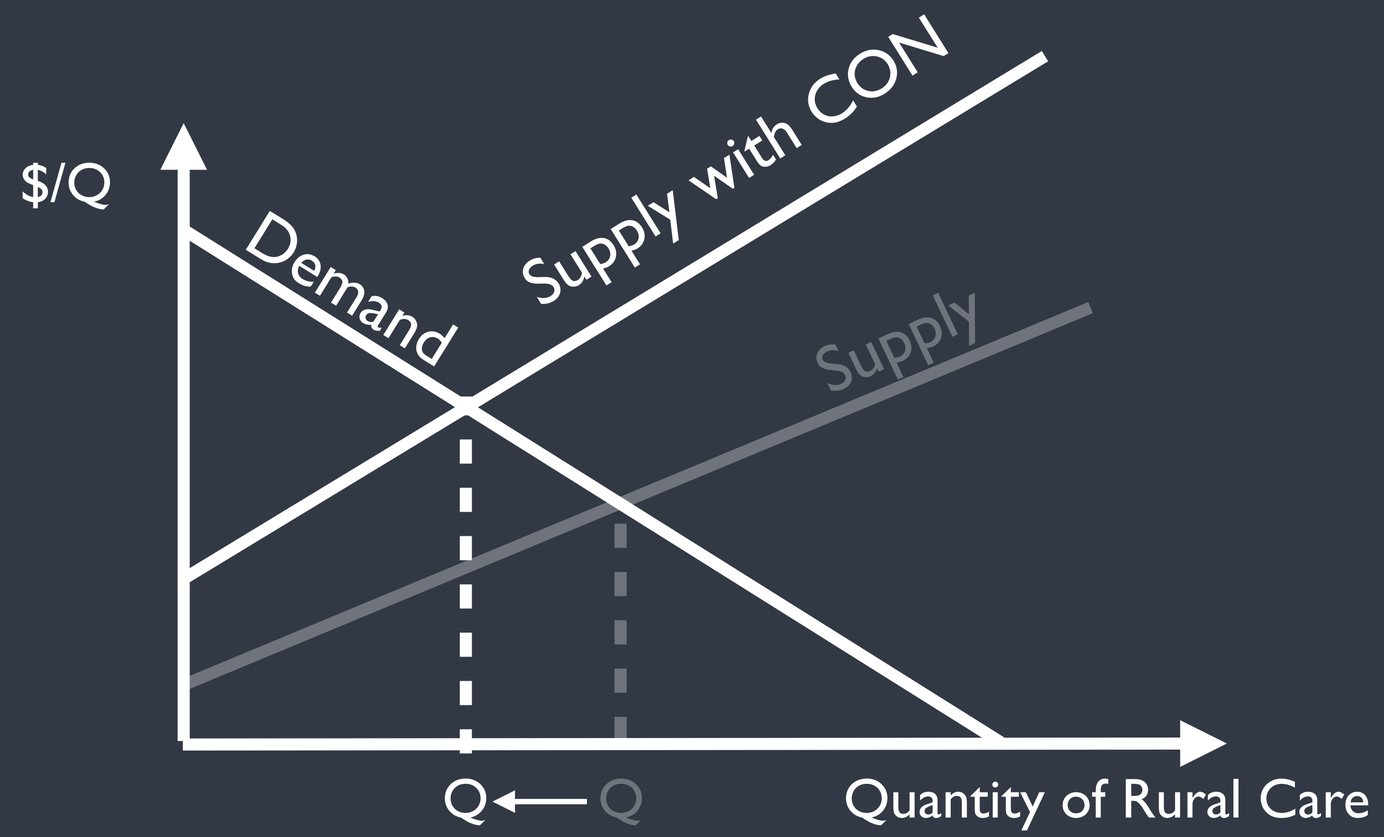
1974
National Health Planning and Resources Development Act

Ensure an adequate supply of HC

Ensure rural access to HC

THE REALITY OF CON LAWS

Ensure rural access to HC?



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THE REALITY OF CON LAWS

Ensure rural access to HC?

30% fewer rural hospitals (Stratmann and Koopman, 2016)

Less access to rural hospice (Carlson et al., 2010)

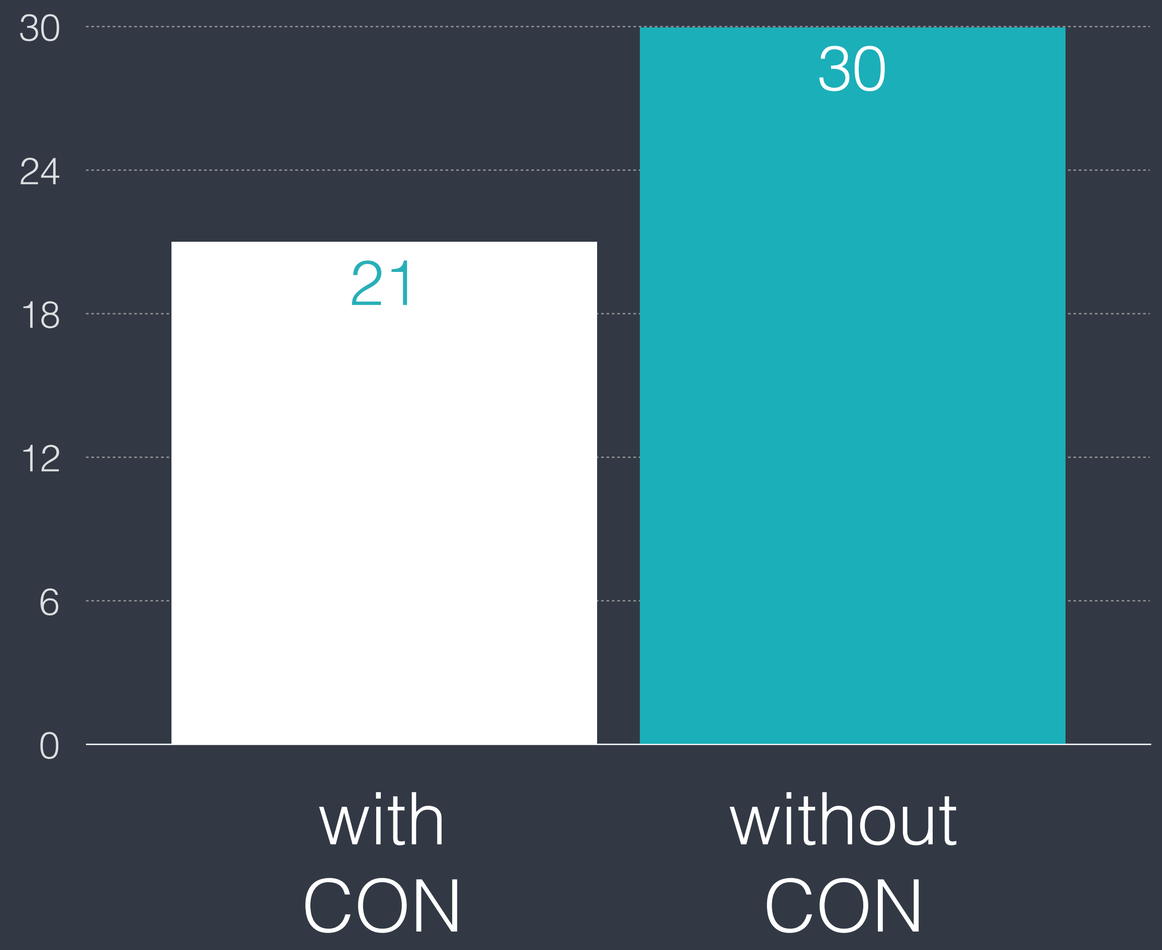
Longer travel distance to care (Cutler et al., 2010)

More out-of-county CT, MRI, PET scans (Stratmann and Baker, 2017)

THE REALITY OF CON LAWS

Ensure an adequate supply of HC?

Estimated number of *rural* Florida hospitals without CON



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THE STATED GOALS OF CON LAWS

1974
National Health Planning and Resources Development Act

Ensure an adequate supply of HC

Ensure rural access to HC

Promote high quality HC

THE REALITY OF CON LAWS

Promote high quality HC?

scale competence vs. less competition

Mixed early research on particular conditions

No effect on all-cause mortality (Bailey, 2016)

Higher mortality rates following heart failure, pneumonia, heart attacks (Stratmann and Wille, 2016)

Higher rates of post-surgery complications (Stratmann and Wille, 2016)

Lower levels of patient satisfaction (Stratmann and Wille, 2016)

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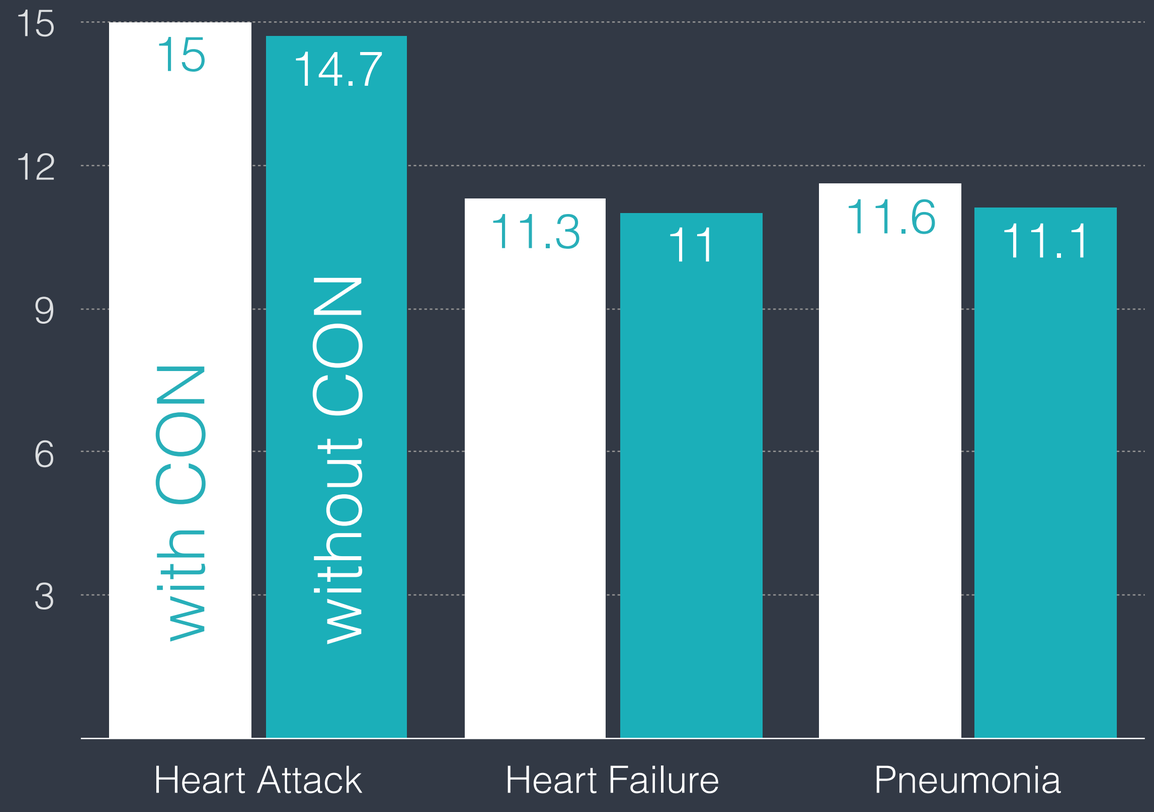
THE REALITY OF CON LAWS

Promote high quality HC?

Estimated mortality rates in Florida



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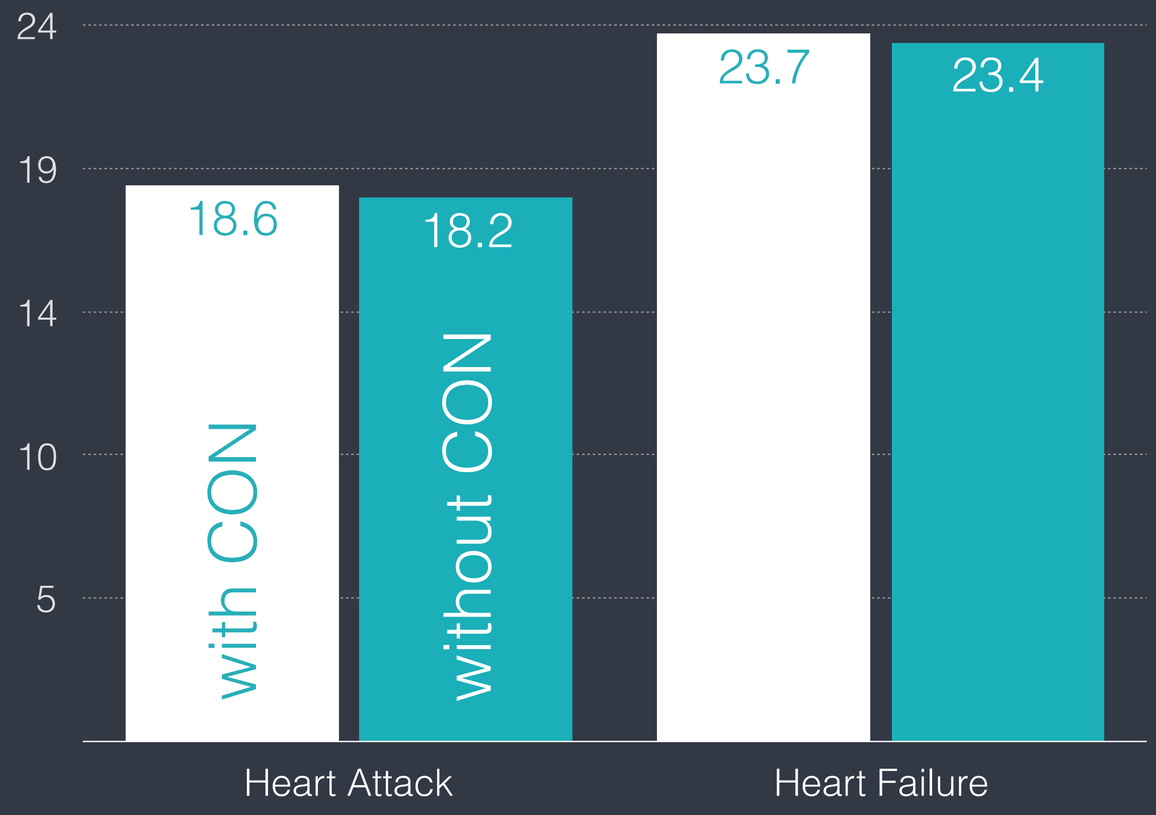
THE REALITY OF CON LAWS

Promote high quality HC?

Estimated readmission rates in Florida



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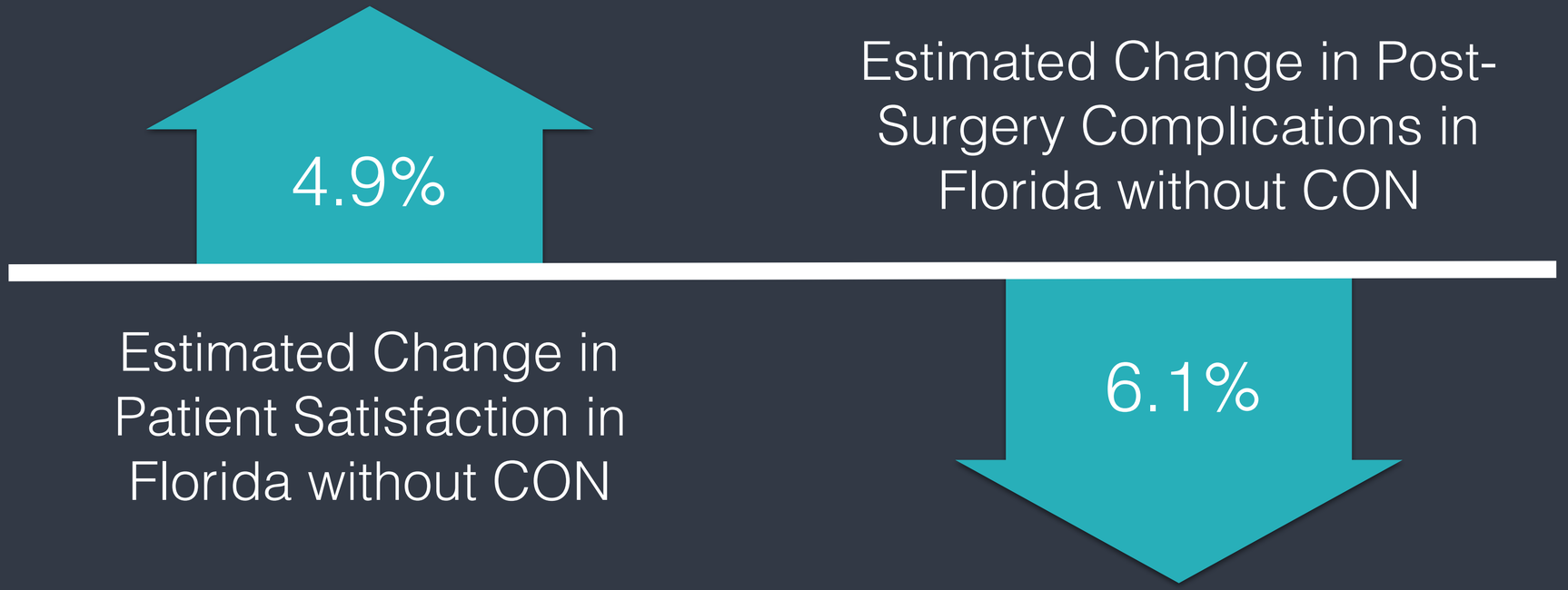
THE REALITY OF CON LAWS

Promote high quality HC?



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THE STATED GOALS OF CON LAWS

1974
National Health Planning and Resources Development Act

Ensure an adequate supply of HC

Ensure rural access to HC

Promote high quality HC

Promote charity care

THE REALITY OF CON LAWS

Promote charity care?

No evidence of higher rates of charity care (Stratmann and Russ, 2014)

Greater racial disparity in the provision of services (DeLia et al., 2009)

THE STATED GOALS OF CON LAWS

1974
National Health Planning and Resources Development Act

Ensure an adequate supply of HC

Ensure rural access to HC

Promote high quality HC

Promote charity care

Encourage hospital substitutes

THE REALITY OF CON LAWS

Encourage hospital substitutes?

ASC-specific CON states have 14% fewer ASCs per capita (Stratmann and Koopman, 2016)

ASC-specific CON states have 13% fewer rural ASCs per capita (Stratmann and Koopman, 2016)

CON limits use of *new* hospitals and *non*-hospital providers, but not existing hospitals (Stratmann and Baker, 2017)

1974
National Health Planning and Resources Development Act

THE STATED GOALS OF CON LAWS

Ensure an adequate supply of HC

Ensure rural access to HC

Promote high quality HC

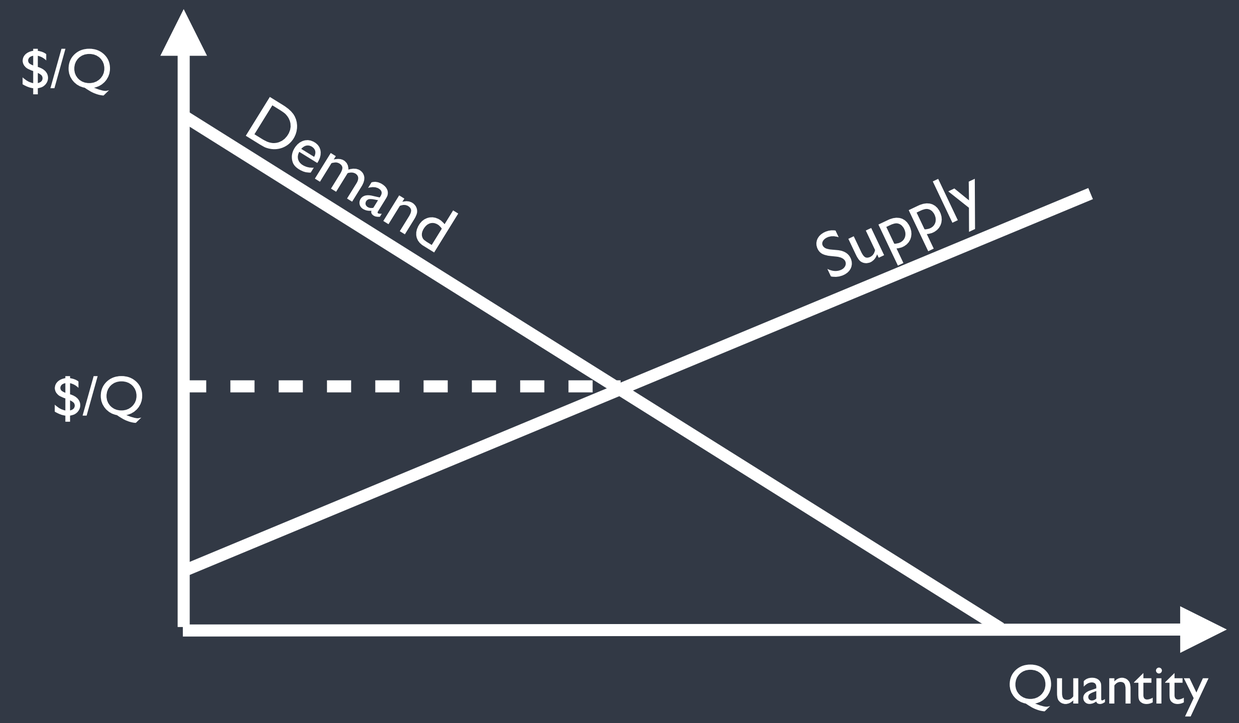
Promote charity care

Encourage hospital substitutes

Restrain the cost of care

THE REALITY OF CON LAWS

Restrain the cost of care?



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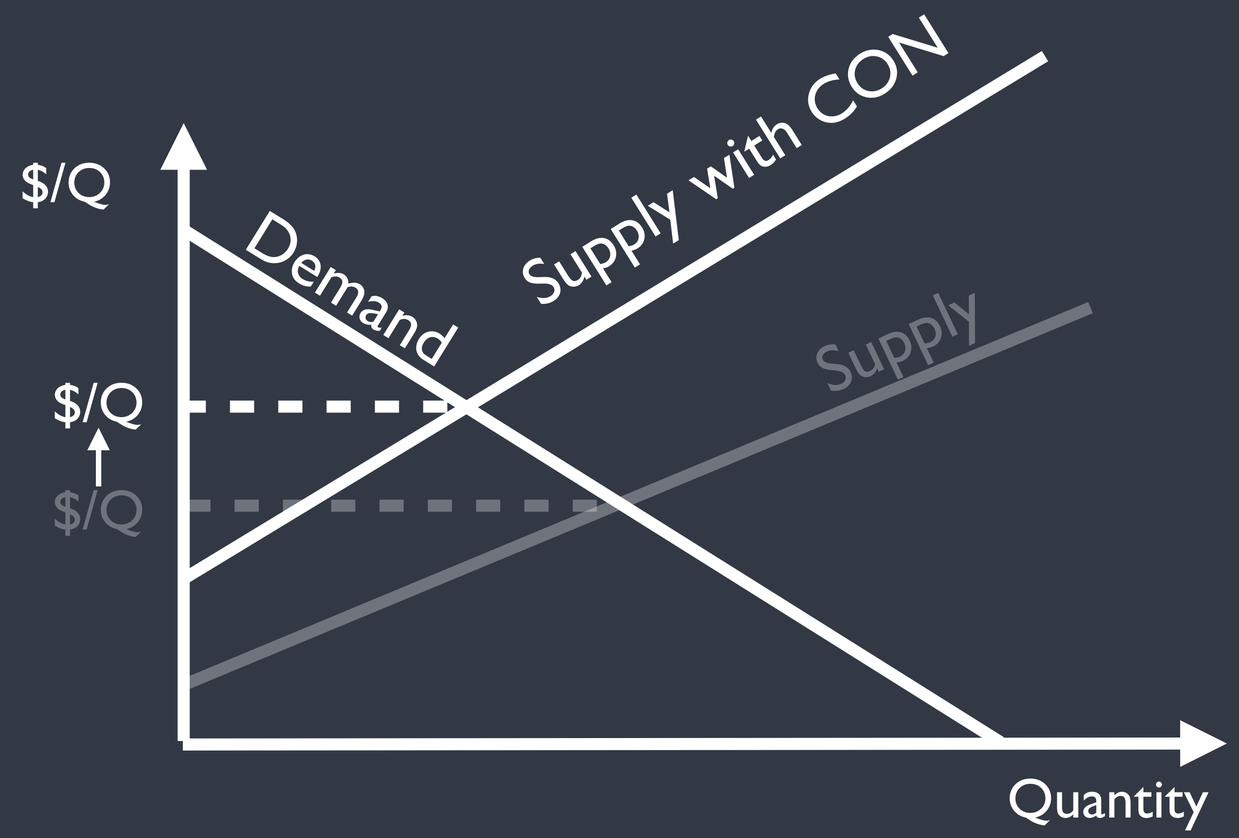
THE REALITY OF CON LAWS

Restrain the cost of care?



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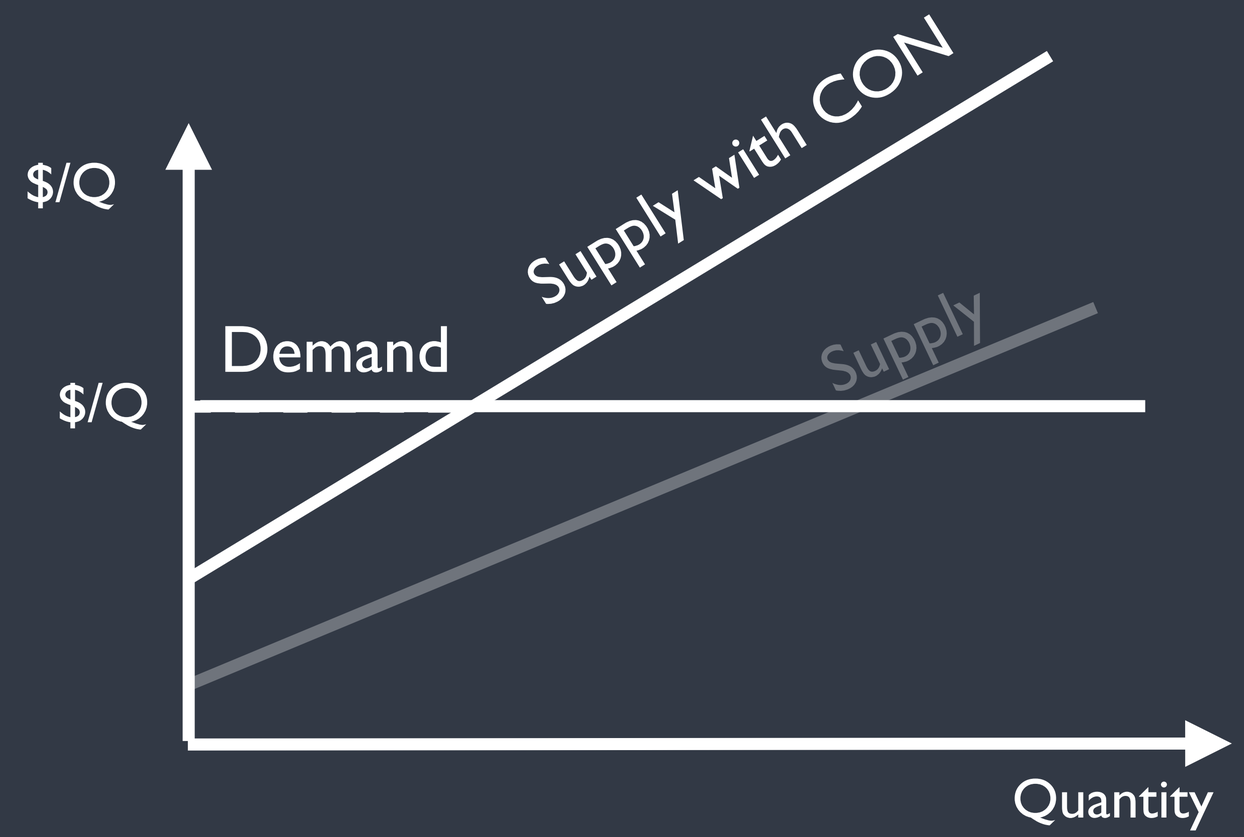
THE REALITY OF CON LAWS

Restrain the cost of care?



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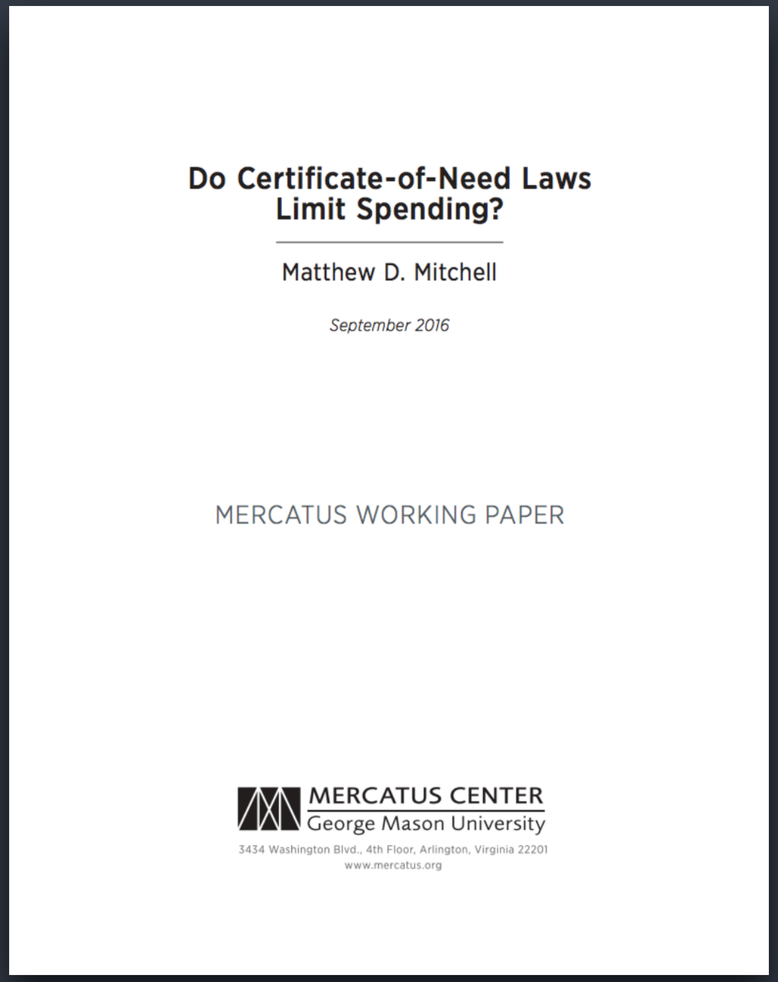

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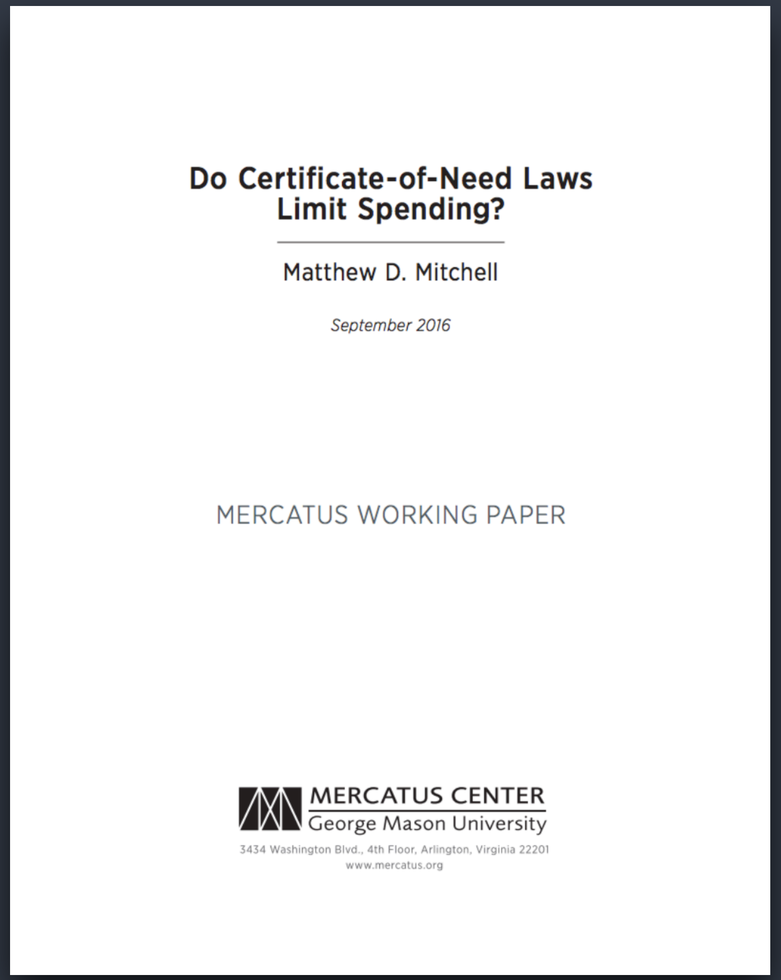

A review of 20 peer-reviewed academic studies finds that CON laws have worked largely as economic theory predicts and that they have failed to achieve their stated goal of cost reduction. The overwhelming weight of evidence suggests that CON laws are associated with both higher per unit costs and higher total expenditures.

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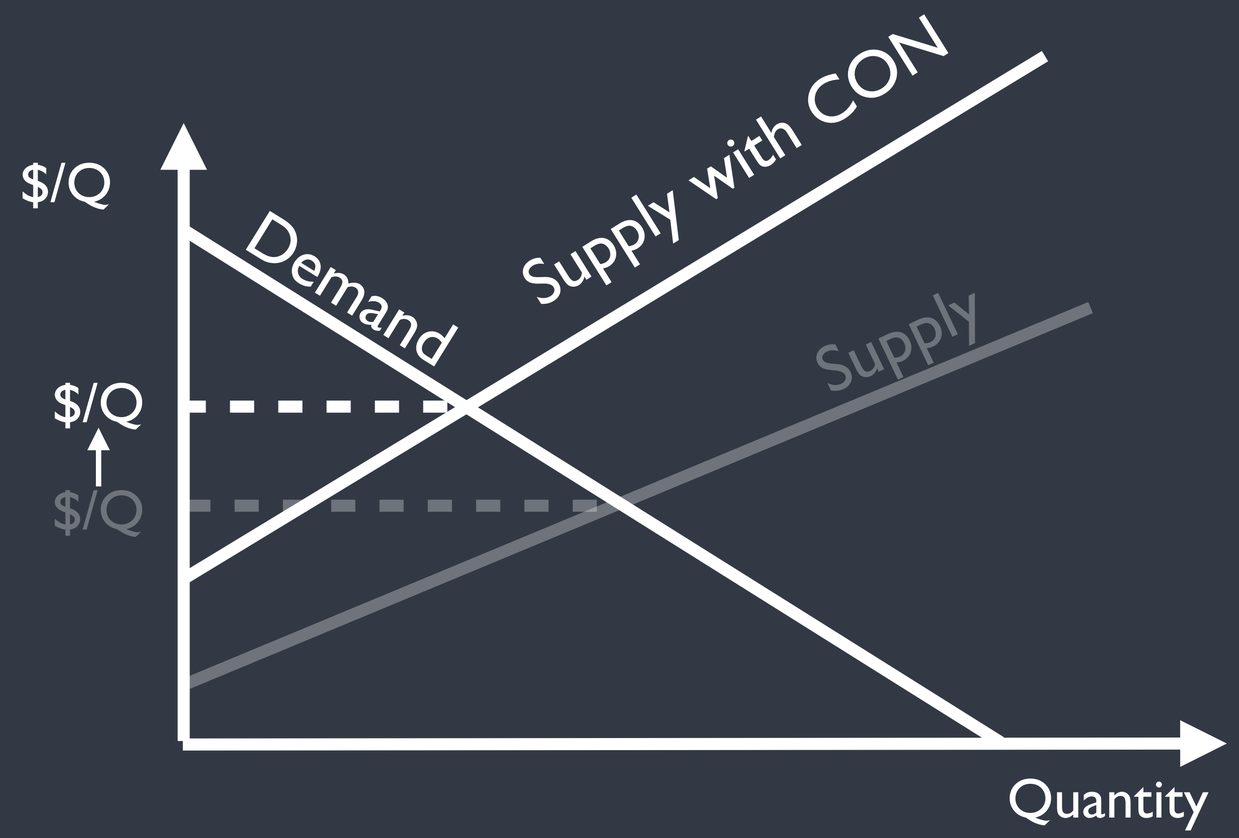
Appendix

WHY WOULD ANYONE THINK CON LAWS

Restrain the cost of care?



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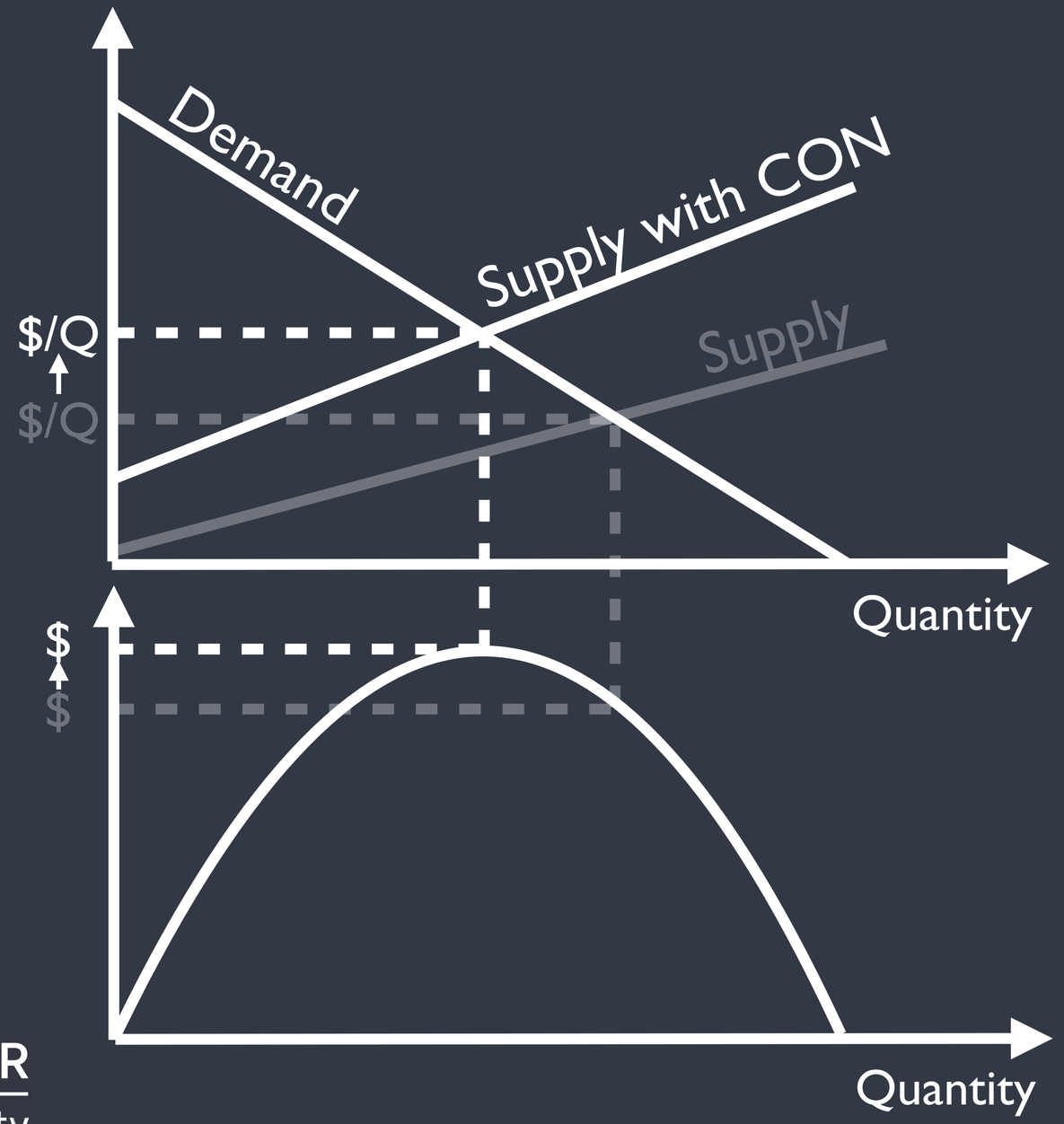

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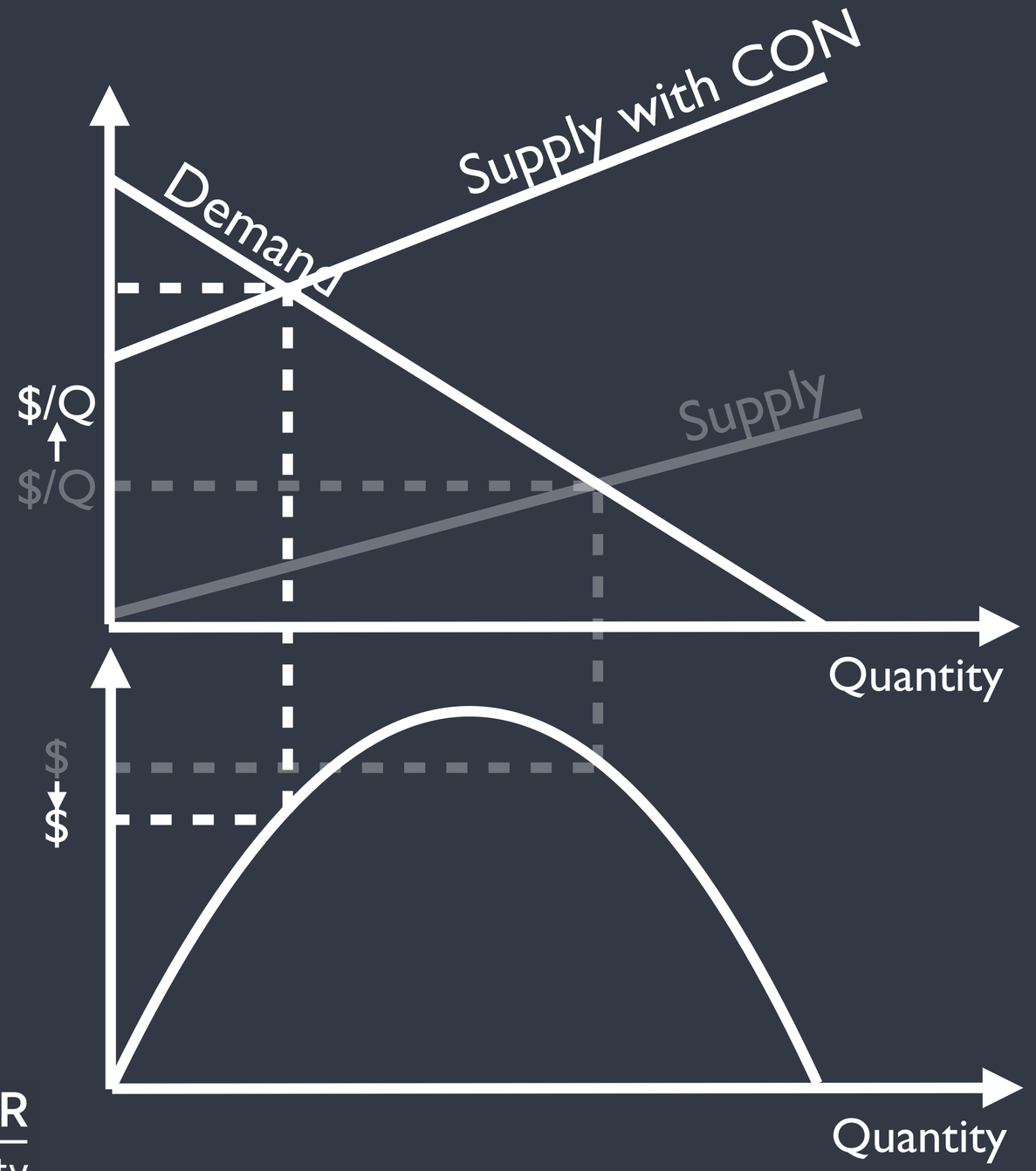

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THE REALITY OF CON LAWS

Restrain the cost of care?

4 decades of research

20 studies

only peer reviewed

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THE REALITY OF CON LAWS

Restrain the cost of care?

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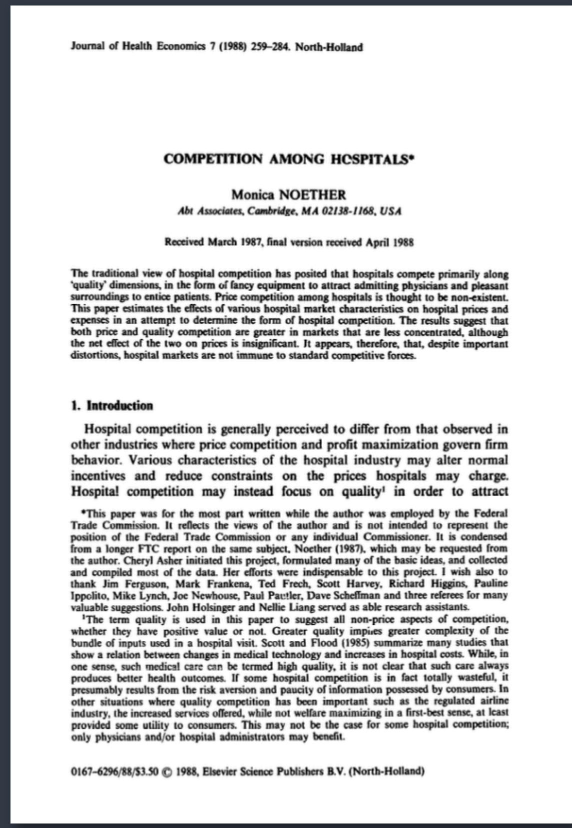
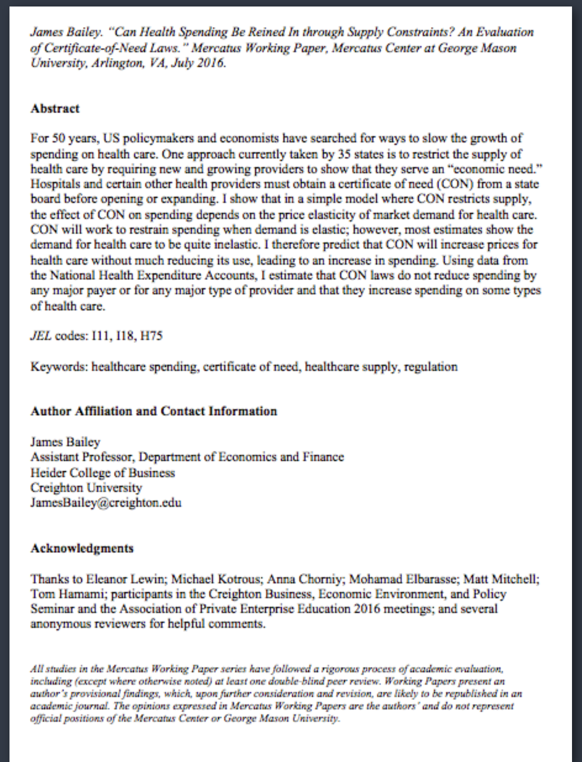
THE REALITY OF CON LAWS

Per unit cost

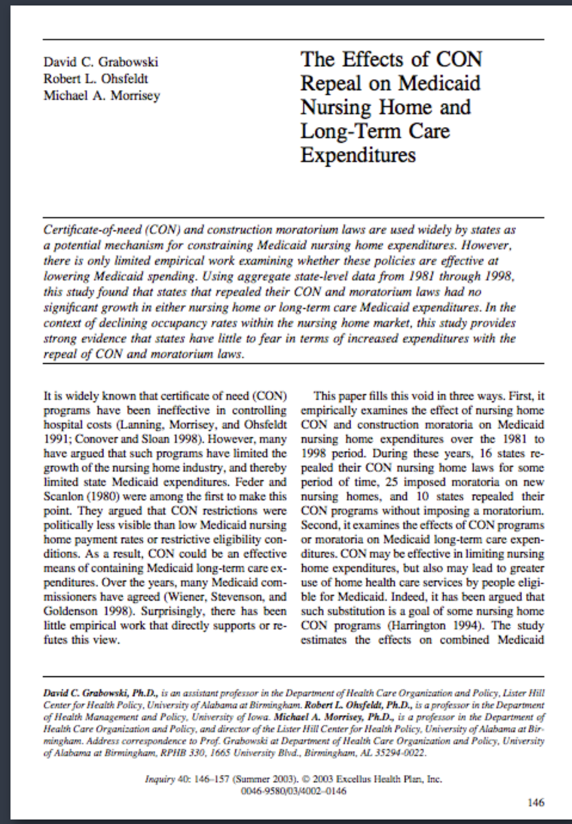

Journal of Health Economics 7 (1988) 259–284. North-Holland

COMPETITION AMONG HOSPITALS*

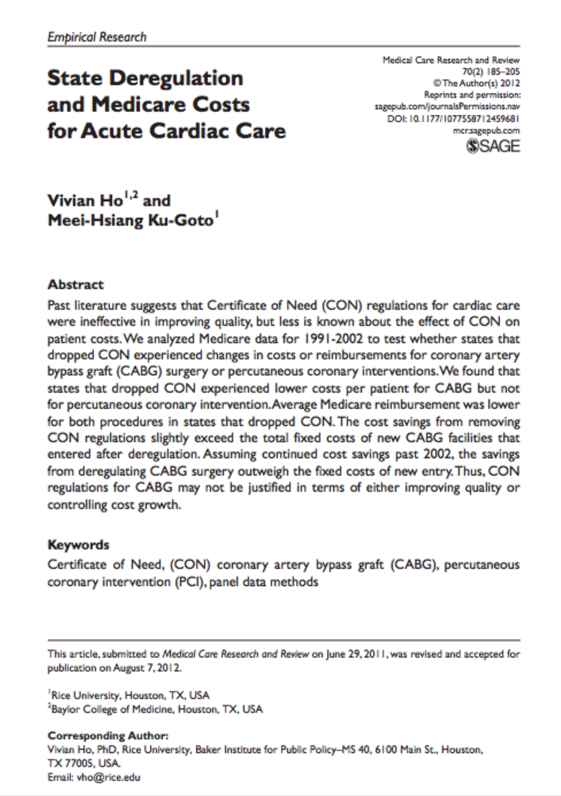
Monica NOETHER


James Bailey. "Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate-of-Need Laws." Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, July 2016.

Abstract


David C. Grabowski
Robert L. Ohsfeldt
Michael A. Morrisey

The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures


Empirical Research

State Deregulation and Medicare Costs for Acute Cardiac Care

Vivian Ho and Meei-Hsiang Ku-Goto

Abstract

3 studies: CON associated with higher cost

1 study: No detected effect on Medicaid costs

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THE REALITY OF CON LAWS

Restrain the cost of care?

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THE REALITY OF CON LAWS

Per patient expenditure

7 studies: CON increases expenditures

2 studies: No statistically significant effect

2 studies: Increases some expenditures and reduces others

1 study: Reduces the number of beds

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THE REALITY OF CON LAWS

Restrain the cost of care?

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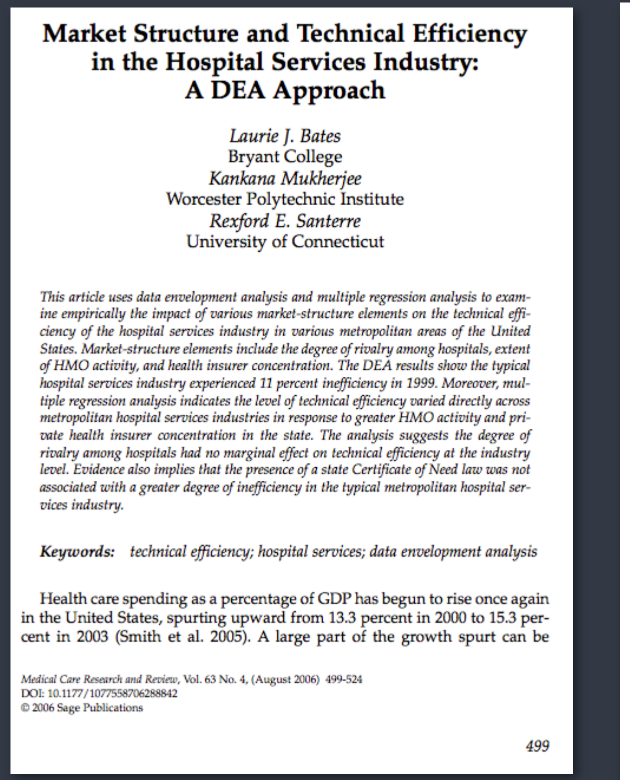
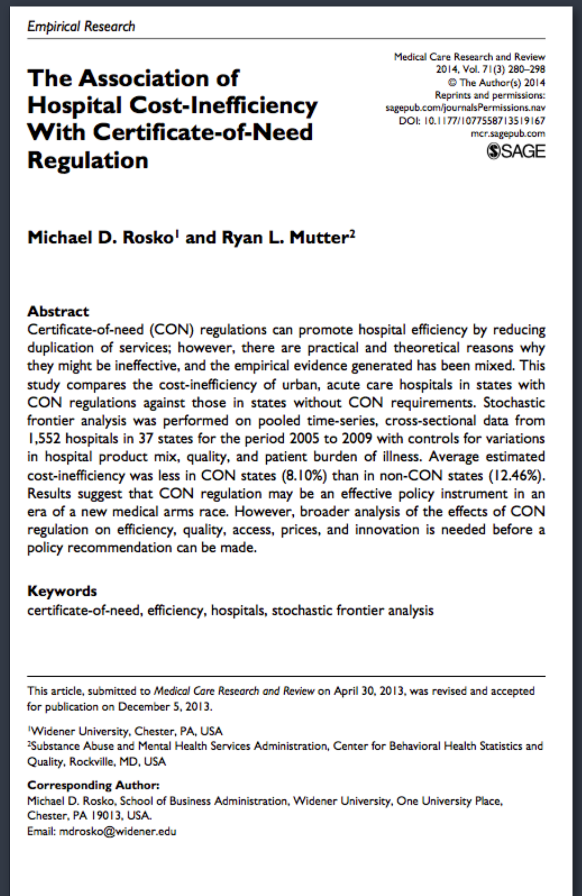
THE REALITY OF CON LAWS

Hospital Efficiency



Market Structure and Technical Efficiency in the Hospital Services Industry: A DEA Approach

Laurie J. Bates, Bryant College; Kankana Mukherjee, Worcester Polytechnic Institute; Rexford E. Santerre, University of Connecticut



The Association of Hospital Cost-Inefficiency With Certificate-of-Need Regulation

Michael D. Rosko[1] and Ryan L. Mutter[2]

Allocative Inefficiency in the Production of Hospital Services*

B. KELLY EAKIN, University of Oregon, Eugene, Oregon

The impact of CON regulation on hospital efficiency

Gary D. Ferrier · Hervé Leleu · Vivian G. Valdmanis

2 studies: CON increases some measures of efficiency

1 study: CON has no effect on efficiency

1 study: CON reduces efficiency

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THE REALITY OF CON LAWS

Restrain the cost of care?

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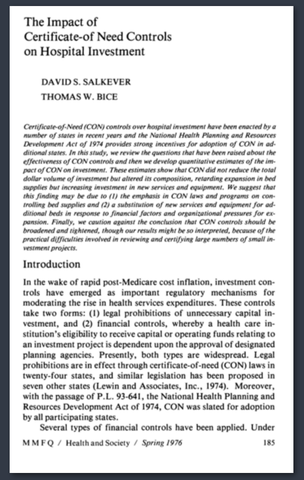
THE REALITY OF CON LAWS

Investment



The Impact of
Certificate-of Need Controls
on Hospital Investment

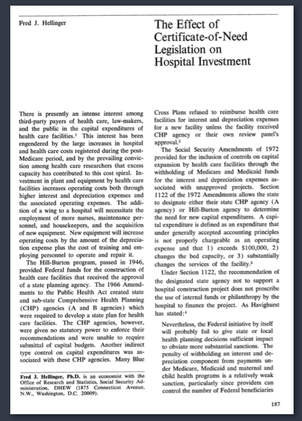
DAVID S. SALKEVER
THOMAS W. BICE

Certificate-of-Need (CON) controls over hospital investment have been enacted by a number of states in recent years and the National Health Planning and Resources Development Act of 1974 provides strong incentives for adoption of CON in additional states. In this study, we review the questions that have been raised about the effectiveness of CON controls and then we develop quantitative estimates of the impact of CON on investment. These estimates show that CON did not reduce the total dollar volume of investment but altered its composition, retarding expansion in bed supplies but increasing investment in new services and equipment. We suggest that this finding may be due to (1) the emphasis in CON laws and programs on controlling bed supplies and (2) a substitution of new services and equipment for additional beds in response to financial factors and organizational pressures for expansion. Finally, we caution against the conclusion that CON controls should be broadened and tightened, though our results might be so interpreted, because of the practical difficulties involved in reviewing and certifying large numbers of small investment projects.

Introduction

In the wake of rapid post-Medicare cost inflation, investment controls have emerged as important regulatory mechanisms for moderating the rise in health services expenditures. These controls take two forms: (1) legal prohibitions of unnecessary capital investment, and (2) financial controls, whereby a health care institution's eligibility to receive capital or operating funds relating to an investment project is dependent upon the approval of designated planning agencies. Presently, both types are widespread. Legal prohibitions are in effect through certificate-of-need (CON) laws in twenty-four states, and similar legislation has been proposed in seven other states (Lewin and Associates, Inc., 1974). Moreover, with the passage of P.L. 93-641, the National Health Planning and Resources Development Act of 1974, CON was slated for adoption by all participating states.

Several types of financial controls have been applied. Under



Fred J. Hellinger

The Effect of
Certificate-of-Need
Legislation on
Hospital Investment

There is presently an intense interest among third-party payers of health care, law-makers, and the public in the capital expenditures of health care facilities.[1] This interest has been engendered by the large increases in hospital and health care costs registered during the post-Medicare period, and by the prevailing conviction among health care researchers that excess capacity has contributed to this cost spiral. Investment in plant and equipment by health care facilities increases operating costs both through higher interest and depreciation expenses and the associated operating expenses. The addition of a wing to a hospital will necessitate the employment of more nurses, maintenance personnel, and housekeepers, and the acquisition of new equipment. New equipment will increase operating costs by the amount of the depreciation expense plus the cost of training and employing personnel to operate and repair it.

The Hill-Burton program, passed in 1946, provided Federal funds for the construction of health care facilities that received the approval of a state planning agency. The 1966 Amendments to the Public Health Act created state and sub-state Comprehensive Health Planning (CHP) agencies (A and B agencies) which were required to develop a state plan for health care facilities. The CHP agencies, however, were given no statutory power to enforce their recommendations and were unable to require submittal of capital budgets. Another indirect type control on capital expenditures was associated with these CHP agencies. Many Blue Cross Plans refused to reimburse health care facilities for interest and depreciation expenses for a new facility unless the facility received CHP agency or their own review panel's approval.[2]

The Social Security Amendments of 1972 provided for the inclusion of controls on capital expansion by health care facilities through the withholding of Medicare and Medicaid funds for the interest and depreciation expenses associated with unapproved projects. Section 1122 of the 1972 Amendments allows the state to designate either their state CHP agency (A agency) or Hill-Burton agency to determine the need for new capital expenditures. A capital expenditure is defined in an expenditure that under generally accepted accounting principles is not properly chargeable as an operating expense and that 1) exceeds $100,000, 2) changes the bed capacity, or 3) substantially changes the services of the facility.[3]

Under Section 1122, the recommendation of the designated state agency not to support a hospital construction project does not proscribe the use of internal funds or philanthropy by the hospital to finance the project. As Havighurst has stated:[4]

Nevertheless, the Federal initiative by itself will probably fail to give state or local health planning decisions sufficient impact to obviate more substantial sanctions. The penalty of withholding an interest and depreciation component from payments under Medicare, Medicaid and maternal and child health programs is a relatively weak sanction, particularly since providers can control the number of Federal beneficiaries

Fred J. Hellinger, Ph.D. is an economist with the Office of Research and Statistics, Social Security Administration, DHEW, 1875 Connecticut Avenue, N.W., Washington, D.C. 20009.

1 study: CON fails to reduce investment but changes its composition

1 study: CON backfires, increasing investment

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