STATEMENT

of the

American Medical Association

to the

Connecticut Certificate of Need (CON) Task Force


The American Medical Association (AMA) appreciates the opportunity to provide comments regarding the Certificate of Need (CON) Task Force Draft Recommendations. The AMA strongly supports and encourages competition between and among health care providers, facilities and insurers as a means of promoting the delivery of high quality, cost effective health care and providing patients with more choices for health care services and coverage that stimulates innovation and incentivizes improved care, lower costs and expanded access. Because CON programs restrict competition, the AMA consistently advocates for CON program repeal.

I. CON programs and their failure to achieve stated goals.

The advocates of CON program frequently claim that CON programs as necessary to control health care costs and/or improve health care quality and access. The great weight of the evidence shows that CON has failed to achieve these goals.

A. CON does not control health care costs, and, in fact, may increase health care costs.

There is a compelling body of peer-reviewed academic research spanning over many years, as well as numerous state legislative-commissioned CON studies, demonstrating that CON programs have failed to achieve their purported purpose—to restrain health care costs. In fact, some studies have concluded that CON programs have actually increased health care costs. Going only as far back as 1998, two noted public policy scholars from Duke University, Christopher Conover and Frank Sloan, published a study that examined the purported cost-control claims of CON over a twenty-year period and focused on whether CON repeal led to increased health care costs. The study concluded that “[t]here is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations.”¹ Likewise, another review of CON research concluded that “[a]t a minimum, it seems fair to conclude that direct CON effects on costs are not negative.”²

Similarly, in 2000 a noted CON economist, Michael Morrisey, PhD, stated that:

[CON] has attracted many empirical studies. They find virtually no cost containment effects. However, they do show higher profits and restricted entry by for-profit hospitals, hospital systems, and contract management firms. The rather exhaustive literature on CON yields virtually no evidence that it has controlled health care costs.

Dr. Morrisey’s article also found that “[t]he [CON] mechanism serves to prevent or delay the entry of new sources of supply. The empirical evidence suggests that as a result of CON, hospital costs are no lower and may be higher. Prices are higher.”4 Another study by Dr. Morrisey, along with David Grabowski, PhD and Robert Ohsfeldt, PhD, stated that “[s]tate legislators have little to fear in the way of cost consequences from the repeal of CON laws. […] CON laws are not an effective means of limiting Medicaid expenditures.”5 Another article in 2007 found that “CON laws had a positive, statistically significant relationship to hospital costs per adjusted admission.”6 Still more recent researched, published in 2013, in Medical Care Research Review, concluded that:

[S]tates that dropped CON experienced lower costs per patient for [certain cardiac procedures]. Average Medicare reimbursement was lower […] in states that dropped CON. The cost savings from removing CON regulations slightly exceed the total fixed costs of new [cardiac surgery] facilities that entered after deregulation.7

In addition to the findings of this peer-reviewed evidence, a litany of state CON studies demonstrates that CON not only does not control costs, but may actually increases costs. A 2007 report from the Lewin Group, entitled An Evaluation of Illinois’ Certificate of Need Program, concluded that “review of the evidence indicates that CONs rarely reduce health care costs, and on occasion, increase costs in some states.”8 In 2006, Georgia State University provided a report to the Georgia Commission on the “Efficacy of the Certificate of Need Program” pursuant to a request from the state legislature, which created the commission. This report stated that “[a]cross all markets, states ranked as having the most rigorous CON regulation have statistically significantly less competition than non-CON states” and that “[l]ower levels of competition are associated with higher

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4 Id.
costs.”9 It also found that “CON regulation is associated with higher private inpatient costs” and that “increased CON rigor is associated with higher costs.”10 Another 2006 study performed by the Missouri Senate Interim Committee on Certificate of Need stated that CON “acts as an artificial barrier to entry, stifling competition and innovation in the healthcare market” and “[n]ot only does this lead to higher healthcare costs but it also limits patient choice.”11 Further, a 2003 Michigan CON study found that “[t]here is little evidence that CON results in a reduction in costs and some evidence to suggest the opposite.”12 while a 1999 Washington State CON study reached a similar conclusion, stating that “[t]he weight of the research evidence shows that CON has not restrained overall per capita health care spending.”13

There are additional academic and peer reviewed sources that can be cited demonstrating that CON programs have either failed to control, or have actually increased, health care costs. However, an article published in the economics journal Inquiry in 2003 may have summed it up best when it stated that “[s]tate legislators have little to fear in the way of cost consequences from the repeal of CON laws.”14

B. CON is not an effective quality improvement mechanism.

Because CON programs have utterly failed to control health care costs, some CON proponents have tried to support CON programs by claiming that CON can promote quality. However, these quality claims have also been closely examined, and the results are, at best, inconclusive. For example, the previously-cited Georgia CON study legislative study stated that while “[t]here is considerable variation on a number of dimensions of quality across markets […] there is no apparent pattern with respect to [CON] regulation and no statistical correlation.”15 The Lewin Group report similarly concluded that, concerning the ability of CON laws to increase the quality of care:

\[E\]ven the strongest supporters of maintaining the program agree that the area where CON can directly influence quality is narrow […]. CON laws’ impact on quality and care is limited.16

The Washington State Joint Legislative CON study discussed above likewise found that “[t]he evidence is weak regarding the ability of CON to improve quality by concentrating

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10 Id.
14 Supra, note 5.
15 Supra, note 8.
16 Supra, note 7.
volume of specialized services.” Similarly, the comprehensive 1998 Duke University CON study by Conover and Sloan stated that “[i]t is doubtful that CON regulations have had much effect on quality of care, positive or negative.” Another Conover and Sloan study, which was commissioned by the Michigan Department of Community Health in 2003 to evaluate Michigan’s CON program, concluded that:

Research findings are inconclusive regarding the ability of CON to improve quality by concentrating volume of specialized services at certain facilities. Evidence is mixed regarding CON’s effect on the market share of for-profit providers and any resulting impacts on quality. This study added that “[i]t may make little sense to rely on CON to carry out quality assurance functions that might be better approached by more direct and cost effective means such as regulation and licensing and/or outcome reporting to the public.”

More recent studies continue to demonstrate that CON programs are not quality-effective. For example, the authors of a 2016 study of CON and cardiac care wrote: “[W]e find no evidence that cardiac CON regulations lower procedural mortality rates for [cardiac surgery] interventions.” A November 2016 study of CON and its relationship to all-cause mortality found that CON programs have no statistically significant effect on all-cause mortality. Point estimates indicate that if they have any effect, they are more likely to increase mortality than decrease it. (Emphasis added).

C. CON does not improve access to care.

There is little evidence that CON positively affects access to care. For example, the 2003 Conover and Sloan Michigan CON study found that “CON has a limited ability to impact the overall cost of health care or to address issues raised by care for the uninsured and underinsured.” The Georgia legislative commission study found that CON’s effect on access was no more than “mixed.” The Washington State CON study concluded that not only had Washington’s CON law “had no effect on improving access,” but “[i]n some instances, CON rules are used to restrict access by preventing the development of new facilities.”

CON programs can also impair patient access by reducing the availability of medical providers, according to January 2016 study, published by the George Mason University.

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17 Supra, note 12.
18 Supra, note 1.
20 Id.
21 Vivian Ho, Meei-Hsiang Ku-Goto, & James G. Jollis, Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON, 44 Health Services Research 2, 483-500 (Apr. 2009).
23 Supra, note 18.
24 Supra, note 8.
25 Supra, note 12.
This study found that CON laws reduce the overall number of medical providers, suggesting less availability of imaging services in CON states, and that residents of CON states are more likely to travel out of state to obtain imaging services than are residents of non-CON states.\textsuperscript{26} Also, by delaying facilities from offering the most advanced equipment to patients and staff (because obtaining CONs for new technology may take upward to 18 months), CON “reportedly affect[s] providers’ ability in some states to recruit top-tiered specialist physicians.”\textsuperscript{27}

\section*{II. Competition, not CON, is the right prescription to controlling costs, improving health care quality and access.}

Competition, not CON programs, is the right prescription for lowering health care costs, improving health care quality, increasing patient access to health care physicians, providers and services and fostering the development and implementation of innovative alternatives to integrated delivery systems (IDS)—alternatives that will benefit patients. In addition to their failure to control costs, increase quality and improve patient access, CON programs can stifle competition by protecting incumbent hospitals and IDS from competition. One state study found that:

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CON acts as an artificial barrier to entry stifling competition and innovation in the healthcare market. The onerous cost and process of undergoing CON review has a distinct chilling effect on those seeking to undertake modernization, specialization and efficiency in healthcare.\textsuperscript{28}
\end{quote}

Recent research has also noted that while “hospitals initially had mixed views about the benefits of CON, but banded together to support the process after realizing it was a valuable tool to block new physician-owned facilities.”\textsuperscript{29} This research is supported by a 2016 finding that “CON laws are negatively associated with services provided by nonhospital providers, but not with services by hospital providers.”\textsuperscript{30}

CON’s effect of insulating hospitals and integrated delivery systems from competition reduces the incentive of hospitals to compete on cost and quality factors such as the hospital’s level of investment in modernizing and maintaining its physical plant and equipment, the quality and experience of the nurses and other professionals who practice there and the resources it makes available to physicians.

Protecting hospitals and IDS from competition reduces the incentive of hospitals to compete on these factors, allowing incumbent hospitals and IDS to provide potentially sub-optimal care for patients. By restricting the entry of competitors, such as physician-

\begin{footnotesize}
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\item Thomas Stratmann & Matthew Baker, \textit{Are Certificate-of-Need Laws Barriers to Entry? How They Affect Access to MRI, CT, and PET Scans}, working paper, Mercatus Center, George Mason University (Jan. 2016).
\item Tracy Yee et al., \textit{Health Care Certificate-of-Need Laws: Policy or Politics?} Research Brief 4, National Institute for Health Care Reform (May 2011).
\item Supra, note 11.
\item Supra, note 27.
\item Supra, note 26.
\end{itemize}
\end{footnotesize}
owned facilities, CON laws have weakened the market’s ability to contain health care costs, undercut consumer choice and stifled innovation. Facilitating competitive entry into hospital and IDS markets is the best means of ensuring that patients reap the many benefits of competition.

One crucial means of facilitating entry is to eliminate, or at least restrict, CON, which is a significant barrier to entry into hospital markets. According to the National Conference of State Legislatures, the existing CON programs concentrate activities on outpatient facilities because these tend to be freestanding, physician-owned facilities that constitute an increasing segment of the health care market.\(^{31}\) Many of these physician-owned facilities are ambulatory surgical centers (ASC) that, as a class of provider, have been found in numerous studies of quality to have complication rates that are low and patient satisfaction rates that are high.\(^{32}\) For example, a recent study published in *Health Affairs* concluded that ASC “provide a lower-cost alternative to hospitals as venues for outpatient surgeries.”\(^{33}\) Instead, CON has taken on particular importance as a way to claim territory and to restrict the entry of new competitors. It should go without saying that competition requires competitors. By restricting the entry of competitors, such as physician-owned facilities and services, including but not limited to ASCs, CON laws have weakened the market’s ability to contain health care costs, undercut consumer choice and stifled innovation, such as the creation of value-based payment initiatives.

There is another strong overriding policy reason for eliminating or restricting CON so as to encourage the entry and development of competitive alternatives to IDS. One of the most important ways to reduce healthcare costs is to prevent the need for hospitalizations through more effective prevention programs, early detection, improved chronic disease management and other proactive measures. These programs are achieved primarily or exclusively through the actions of physician practices, not by hospitals themselves. Moreover, to the extent that these initiatives are successful, they will not only reduce the hospitals’ revenues, but they may have a negative impact on the hospital’s margins, assuming hospital revenues decline more than their costs can be reduced. Thus, when CON protects hospital owned IDS from competition, the hospital may be more likely to resist physician efforts to reduce the need for hospitalizations.

**III. Conclusion.**

The AMA greatly appreciates the opportunity to provide comments regarding the Certificate of Need (CON) Task Force Draft Recommendations. A wealth of studies show that CON has failed to achieve its goals, whether those goals pertain to cost control, quality of care or patient access to care. In fact, by insulating incumbent hospitals and IDS from competition by physician-led and other initiatives, CON has fostered price increases, limited patient choice and stifled innovation at a time when it is universally

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recognized the swift development of innovations, such as value-based purchasing initiatives, is imperative. Further, even if there were a time when CON had effectively addressed excess supply issues, the shift to value-based purchasing now obviates CON, particularly given CON’s anticompetitive effects. The AMA therefore urges that any Connecticut CON program be structured so that it does not inhibit in any way entry by physician-led and other potential hospital competitors into hospital or IDS markets.