



# POLICY BRIEF

## **The Failure of Government Central Planning**

Washington's Medical Certificate of Need Program

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# **The Failure of Government Central Planning**

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### **I. Introduction**

Imagine your community is home to a nursing care facility that has operated for years with optimal customer satisfaction. It provides quality care and assistance, its facilities are modern and clean, and the staff is excellent. The nursing home is exceeding capacity and its operators look at the growing demand and decide to expand the facility by adding five beds. They consult their experts, study options and projections, and, after careful consideration secure a building permit and begin construction. Sounds reasonable, right? Well, they just broke the law.

Washington is one of thirty-seven states (including the District of Columbia) that require government permission to open or expand most kinds of health care facilities. In addition to the usual building permits and zoning approval, the state must grant a Certificate of Need (CON) before such facilities can be built, expanded or modified significantly. The 14 states that do not have CON laws include large states like California, Pennsylvania, and Texas, and together comprise about 35% of the U.S. population (a full list appears on page 8).<sup>1</sup>

Washington's Certificate of Need law applies only to providers of health care. It functions as a control valve to limit the supply of health care. Hospital and clinic managers must comply with a complicated set of established procedures and formulas to prove to state bureaucrats that there is or will be a need for whatever service they seek to provide. Without successfully navigating the CON process, it is illegal to offer new health care services to Washington residents.

Public policy in Washington should focus on assuring access to affordable, high quality health care for all the people of our state. The Certificate of Need program fails to advance this fundamental goal. This study describes the history of the Certificate of Need concept, summarizes how the Washington law works, compares its stated goals with actual performance, and presents practical policy recommendations for improving access to affordable health care for the people of Washington.

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<sup>1</sup> "State and County Quickfacts," United States Census Bureau, Washington, D.C., at [www.quickfacts.census.gov](http://www.quickfacts.census.gov), accessed December 20, 2005.

## II. Background

### Origins of Certificate of Need

The roots of the Certificate of Need idea date back to 1964 in Rochester, New York. Local businesses and Blue Cross established a community health planning council composed of consumers, insurers and health care providers to study the need for hospital beds. The group decided there was a surplus and recommended that the state restrict supply in order to prevent what was then considered too many health care facilities. This effort culminated in New York's passage of the nation's first Certificate of Need law in 1966.<sup>2</sup>

### Federal Certificate of Need Law

Also in 1966, Congress enacted the Comprehensive Health Planning Act. States receiving federal funds under public health and social security programs were required to establish local and state health planning agencies. Those states that already had planning agencies were required to expand the reach and authority of these departments.

In 1972 the federal government amended the Social Security Act to compel all states to review health care capital expenditures in excess of \$100,000. Failure to comply meant a state would be denied Medicare and Medicaid reimbursements for capital expenditures.<sup>3</sup> This provision served as the skeletal beginnings of a national Certificate of Need law.<sup>4</sup>

In 1974, during a time when many lawmakers were pushing for a complete government takeover of the health care system, Congress passed the National Health Planning and Resources Development Act (NHPRDA).<sup>5</sup>

The NHPRDA law directed each state to examine proposed health care facilities and "make findings as to the need for such services."<sup>6</sup> If the states did not comply with the Act's directives, the federal government would withhold

*Federal lawmakers proposed solving a problem created by government intervention by imposing more government intervention.*

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<sup>2</sup> Citizens Research Council of Michigan, "The Michigan Certificate of Need Program," February 2005, p. 1, Lansing. See [www.crcmich.org](http://www.crcmich.org).

<sup>3</sup> Robert James Cimas, "Duped by Cries of Duplication: The Failure of the Certificate of Need Regulations," April 2002, p. 1. Article accessed at the American Association of Ambulatory Surgery Centers website, [www.aaasc.org](http://www.aaasc.org) on 19 December 2005.

<sup>4</sup> Legislative History of the 1972 Social Security Act Amendments, federal Social Security Administration, at [www.ssa.gov](http://www.ssa.gov). The provision reads, "The Secretary may withhold or reduce reimbursement amounts to providers of services under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, or other expenses related to capital expenditures for plant and equipment in excess of \$100,000, which are determined to be inconsistent with State or local health facility plans."

<sup>5</sup> National Health Planning and Resources Development Act (NHPRDA) of 1974, Section 2(a)(1), see Public Law 93-641.

<sup>6</sup> *Ibid.*, Section 1523(a)(5).

funding.<sup>7</sup> This created strong incentives for states to implement far-reaching health care planning regulations.

The NHPDA law recognized that “the massive infusion of Federal funds into the existing health care system” had severely distorted the health care market by “contribut[ing] to inflationary increases in the cost of health care.”<sup>8</sup> Ironically, federal lawmakers proposed solving a problem created by government intervention by imposing more government intervention.

### **Distortions Created by Cost-Based Reimbursement**

At that time, health care was built on a cost-based reimbursement system. Price-based competition had little, if any, role in health care because providers were able to recover full cost from Medicare and Medicaid, no matter how high. The system provided little incentive for cost reduction. “There are presently inadequate incentives for the use of appropriate levels of health care,” lawmakers said.<sup>9</sup> They believed that excess facility supply led to increased costs of business, and that those increased costs would be passed on to patients. They intended top-down health planning and strict Certificate of Need laws to constrain supply and therefore control prices.

Along with price inflation, federal lawmakers believed that a market distorted by the infusion of federal tax dollars led to poor distribution of health care facilities. Thus another purpose of early health planning and Certificate of Need laws was to control the geographic distribution of health care. Lawmakers believed that “one efficient and fully-utilized piece of equipment was better than two that were under-utilized.”<sup>10</sup>

In the years following the passage of the NHPDA, states began adopting Certificate of Need laws. The primary goal of these laws was to contain rising health care costs. Eventually every state and the District of Columbia adopted Certificate of Need regulations.

### **Repeal of Federal Law**

In 1982, the federal government acknowledged the failure of its Certificate of Need law to reduce health care costs and repealed the mandatory health planning law.<sup>11</sup> In the years following federal repeal, 14 states eliminated their medical facility control laws as well. Thirty-six states and the District of Columbia retained their Certificate of Need laws. Washington is one of these. Figure 1 shows the number of states having Certificate of Need laws from 1966 to today.<sup>12</sup>

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<sup>7</sup> Ibid., Section 1612(b)(1).

<sup>8</sup> Ibid., Section 2(a).

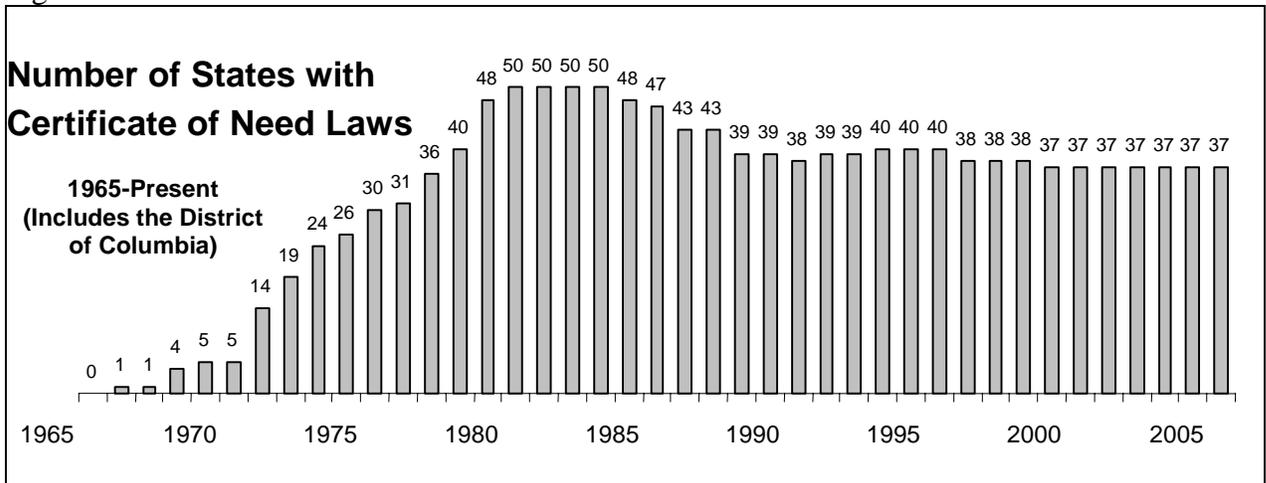
<sup>9</sup> Ibid., Section 2(a)(4).

<sup>10</sup> Terree Wasley, “Certificates of Need: Poor Health Care Policy,” Mackinac Center for Public Policy, Mackinac, Michigan, 1993.

<sup>11</sup> Michael D. Tanner, “Ending the CON Game,” The Heartland Institute, Chicago, 1996.

<sup>12</sup> Source of chart data is, Citizens Research Council of Michigan, “The Michigan Certificate of Need Program,” February 2005, p. 3. The figures include the District of Columbia.

Figure 1.



### III. Overview of Washington’s Certificate of Need Program

Washington imposed its first Certificate of Need requirements in 1971.<sup>13</sup> Later the program was changed to adapt to the requirements of the 1972 Social Security Act amendments and the 1974 NHPDA law. With these early adjustments, the program as created in the 1970s remains in force today.

The Certificate of Need program forms the backbone of centralized health planning in the state. The five stated purposes of health planning are:<sup>14</sup>

- “To promote, maintain, and assure the health of all citizens in the state, to provide accessible health services, health manpower, health facilities, and other resources while controlling excessive increases in costs, and to recognize prevention as a high priority in health programs, as essential to the health, safety, and welfare of the people of the state.”
- “That the development of health services and resources, including the construction, modernization, and conversion of health facilities, should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation.”
- “That the development and maintenance of adequate health care information, statistics and projections of need for health facilities and services is essential to effective health planning and resources development.”
- “That the development of nonregulatory approaches to health care cost containment should be considered, including the strengthening of price competition.”

<sup>13</sup> State of Washington, Joint Legislative Audit and Review Committee (JLARC), “Effects of Certificate of Need and Its Possible Repeal,” January 8, 1999, p. 1.

<sup>14</sup> Revised Code of Washington 70.38.015.

- “That health planning should be concerned with public health and health care financing, access, and quality, recognizing their close interrelationship and emphasizing cost control of health services, including cost-effectiveness and cost-benefit analysis.”

The Certificate of Need program is administered by the state Department of Health. Between 1971 and July 2005, the state made decisions on 1,786 applications for Certificate of Need. Of those decisions, 177 applicants were denied permission to provide new medical services. Two Certificates of Need were rescinded after the Department’s decision to grant was overturned on appeal.<sup>15</sup>

### Washington Compared to Other States

Washington has one of the most stringent Certificate of Need laws in the country. Fourteen states have no Certificate of Need restrictions on building new medical facilities, while 36 states and the District of Columbia have such programs in place.

The scope of Certificate of Need laws varies from state to state. Some are highly detailed. In Alabama, for example, hospital managers must obtain a Certificate of Need before purchasing a new ultrasound machine. Connecticut requires state approval before a health care office can buy certain computer equipment.<sup>16</sup> Other states, such as Louisiana and Nebraska, apply their Certificate of Need law to only one or two types of service, leaving health care managers free to make all other decisions without the health department’s prior approval.

Comparing state Certificate of Need programs is no easy task. Certain regulated medical services are more common or are more expensive than others. For example, one state might cover more medical services that are rare, like organ transplants, while another covers fewer services, such as CT scans, that are central to the health care infrastructure and affect more patients.

Figure 2 shows a comparison of Certificate of Need requirements in the fifty states and the District of Columbia. The comparison gives each state a weighted ranking, with higher numbers representing larger regulatory burdens. Under this method, Connecticut ranks the highest. Its law covers 24 services and expenditures, earning a rank of 28.8. Alaska is next highest – it covers 26 services and expenditures, but collectively these have less scope, earning a rank of 26. The last fourteen states in Figure 2 are ranked zero because they have no Certificate of Need laws.

Washington is the 18th most regulated in the country, with a weighted ranking of 12.8. Washington’s Certificate of Need law covers 16 different health care services and expenditures. Washington’s number 18

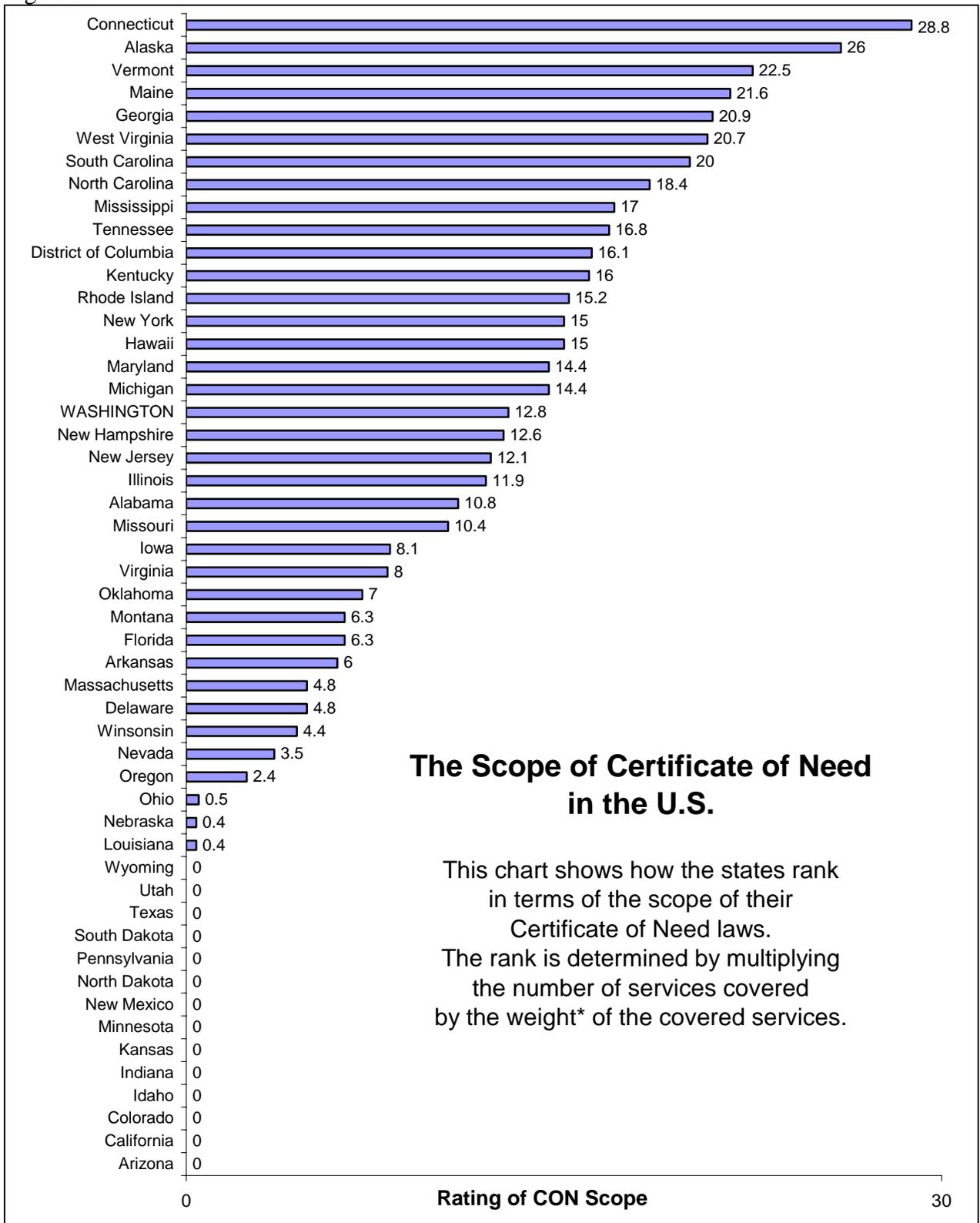
*Washington’s Certificate of Need law covers 16 important health care services, making the state one of the most heavily regulated in the nation.*

<sup>15</sup> Application figures cover the period August 27, 1971 through July 7, 2005, “Certificate of Need Action Log,” Office of Certificate of Need, Washington Department of Health, July 7, 2005.

<sup>16</sup> Mike Norbut, “Cutting through the CONfusion: Movement to Relax the Limits,” *American Medical News*, February 7, 2005.

ranking represents a higher level of regulation than may appear at first, for two reasons. First, almost two-thirds of the states have a lower level of regulation than Washington. Second, the rating method takes into account the scope of a state's regulatory burden, in addition to its place on the list. For example, Washington ranks only six places up the list from Iowa, but its weighted level of regulation is twice as high.

Figure 2.



\*The weight assigned to a given medical service is determined by the dollar amount above which a proposed project is subject to Certificate of Need regulation.

## IV. Description of the Process

### What Washington Law Covers

As reflected by its high national ranking, Washington's Certificate of Need law is very broad. It covers every major kind of health care facility and most major health services.<sup>17</sup> Without prior state approval, it is illegal in Washington for any person to:

- Construct, establish or develop a health care facility, including:
  - ◆ Hospitals
  - ◆ Kidney disease treatment centers (dialysis)
  - ◆ Psychiatric hospitals
  - ◆ Ambulatory surgical facilities (outpatient surgery)
  - ◆ Nursing homes
  - ◆ Hospices
  - ◆ Certain continuing care retirement communities
  - ◆ Home health agencies
  
- Sell, purchase or lease part or all of any existing licensed hospital, regardless of profit or non-profit status;
  
- Increase the number of kidney dialysis treatment stations;
  
- Increase the number of hospital beds available to patients, or redistribute the number of existing beds among acute care, nursing home care and boarding home care;
  
- Make any improvement to a nursing home that exceeds two million dollars;
  
- Replace an existing nursing home with a new one;
  
- “Bank” beds at a nursing home, that is, set aside some beds to reduce the home’s total number of regulated beds;
  
- Establish a new tertiary health service offered by a health care facility that was not offered by that health care facility within the 12-month period prior to the time the facility will offer the services. Tertiary health services include:
  - ◆ Specialty burn services
  - ◆ Intermediate care nursery
  - ◆ Neonatal intensive care
  - ◆ Transplantation of solid organs
  - ◆ Open heart surgery
  - ◆ Inpatient physical rehabilitation, Level I for persons with nonreversible multiple function impairments of a moderate-to-severe complexity.
  - ◆ Specialized inpatient rehabilitation services.

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<sup>17</sup> Washington Administrative Code 246-310-010.

Washington’s Certificate of Need law leaves few stones unturned. State lawmakers have placed all but a handful of medical services under the Certificate of Need umbrella. The exceptions include narrow services like air ambulance services, business computers and diagnostic imaging.

*Washington’s Certificate of Need law leaves few stones unturned, with all but a handful of medical services being subject to Certificate of Need requirements.*

**Timelines in the Process**

The Certificate of Need law is costly and time consuming. It includes a number of timelines intended to serve as a chronological framework for the process.<sup>18</sup> In practice, however, these deadlines mean little, since they are seldom met. Figures 3 through 6 show the required timelines.

Figure 3.

<b>Number of Days</b>	<b>Regulatory Action</b>
0	File a letter of intent with the Department of Health
30	File application for Certificate of Need
45	Department of Health screening period (15 working days)
90	Deadline for responding to screening questions (up to 45 days)
95	Notification of beginning of review (5 working days)
130	End of public comment period (35 days)
140	End of rebuttal period (10 days)
185	Department of Health decision date (final review period: 45 days)
<b>Total Time for Regular Review: Approximately 6 Months</b>	

There is also a timeline for an expedited review process.<sup>19</sup> If a business or organization is acquiring an existing health care facility, they fall into this category. Expedited reviews also include predevelopment expenditures and projects intended to correct deficiencies such as safety hazards or state licensing requirements. Figure 4 shows the expedited review timeline.

<sup>18</sup> Washington Administrative Code 246-310-160.

<sup>19</sup> Washington Administrative Code 246-310-150.

Figure 4.

<b>Number of Days</b>	<b>Regulatory Action</b>
0	File a letter of intent with the Department of Health
30	File application for Certificate of Need
45	Department of Health Screening period (15 working days)
90	Deadline for responding to screening questions (up to 45 days)
95	Notification of beginning of review (5 working days)
115	End of public comment period (20 days)
125	End of rebuttal period (10 days)
145	Department of Health decision date (final review period: 20 days)
<b>Total Time for Expedited Review: Approximately 5 Months</b>	

If the Department of Health denies a Certificate of Need, the applicant can ask for interim reconsideration.<sup>20</sup> If the Department of Health upholds its denial of a Certificate, the appeal process can begin. The first step is the Administrative Appeal, which takes the form of an adjudicative proceeding.<sup>21</sup> Figure 5 shows the timeline for the Administrative Appeal.

Figure 5.

<b>Time</b>	<b>Regulatory Action</b>
	1. File application for adjudicative proceeding (deadline: within 30 days after Department of Health decision)
20 days	2. Administrative Law Judge* issues scheduling order and notice of hearing
4 to 5 months	3. Hearing before Administrative Law Judge
1 to 2 months	4. Post-hearing briefs submitted
1 to 2 months	5. Administrative Law Judge issues decision
<b>Total Time for Adjudicative Proceeding: 7 to 10 Months</b>	

\*The Administrative Law Judge is an employee of the Department of Health whose role is to determine whether the Department's denial of a Certificate was made in accordance with the applicable statutes and regulations.

If the Administrative Appeal upholds the Department of Health's decision to deny a Certificate of Need, the applicant may then proceed to Judicial Review. The Judicial Review process is an appeal to Superior Court. Figure 6 shows the timeline.

<sup>20</sup> Washington Administrative Code 246-310-560.

<sup>21</sup> Washington Administrative Code 246-310-610. The appeal timelines are governed by the Administrative Appeals Act, Revised Code of Washington 34.05.

Figure 6.

<b>Time</b>	<b>Regulatory Action</b>
	1. File Petition for Judicial Review in Superior Court (deadline: within 30 days after Administrative Law Judge decision)
6-10 Months	2. Trial (oral argument based on administrative record; no new evidence)
1-2 Months	3. Superior Court issues decision
<b>Total Time for Judicial Appeal: 7 to 12 Months</b>	
<b>Total Potential Time for Certificate of Need Process: 2+ Years</b>	

The Judicial Review can reverse the Department of Health’s decision and issue a Certificate of Need. If that happens, then the project may begin. If the Judicial Review upholds the denial, then no Certificate of Need will be issued and the intended project cannot commence. The total potential time for the Certificate of Need Process is more than two years.

### **Other Factors in the CON Decision**

There is much more to the process than a mere timeline. The process for acquiring a Certificate of Need depends largely on the kind of project involved. The flow chart in Figure 7, at the center of this Policy Brief, shows the process required for opening a new surgery operating room.

Ambulatory surgical centers are outpatient surgery facilities that use a doctor’s office environment for minor surgeries that do not require overnight stays in a hospital. These centers began appearing in the early 1970s as a way to reduce the overhead cost of conducting simple, low-risk treatments. Today there are about 4,600 centers nationally, a 53% increase over the number operating just five years ago.<sup>22</sup> The state Department of Health has developed a complicated formula for analyzing the perceived need for such centers in Washington.

The Department of Health uses numerous criteria for making this determination. At their core is a numeric formula that uses current and projected changes in population and medical capacity to calculate “net need.”<sup>23</sup>

Other factors influence the decision as well. The Department of Health, not the marketplace, determines whether or not a proposed project is financially feasible and whether or not the project will, “foster containment of the costs of health care.”<sup>24</sup> The Administrative Code outlines 31 criteria and sub-criteria that state managers use to decide on the need for a proposed health care facility or service.<sup>25</sup> Those criteria include:

<sup>22</sup> Andree Brooks, “Walk inside, have surgery, but is it safe?”, *The New York Times*, June 14, 2005.

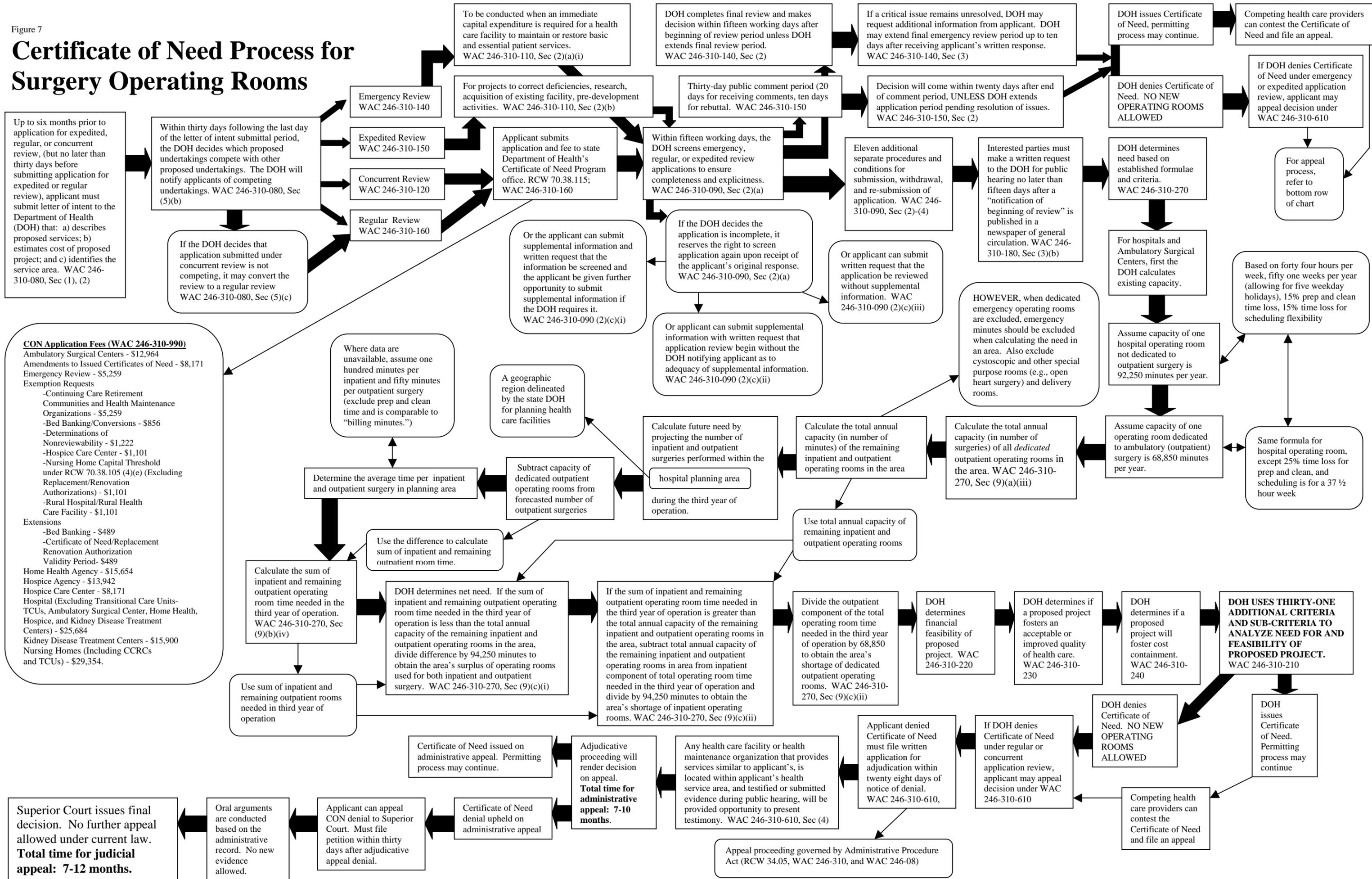
<sup>23</sup> Washington Administrative Code 246-310-270.

<sup>24</sup> Washington Administrative Code 246-310-200, Section (1).

<sup>25</sup> Washington Administrative Code 246-310-210.

Figure 7

# Certificate of Need Process for Surgery Operating Rooms



- The applicant’s past performance in meeting obligations under any applicable federal regulations requiring provision of charity care.
- The existence of any civil rights complaints against the applicant.
- The effect of the reduction, elimination, or relocation of a health service on the ability of low-income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly to obtain needed care.
- The likelihood that all residents of the area, including low-income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups and the elderly will have access to the proposed health service.
- That the proposed project will not have an adverse effect on health professional schools and training programs.

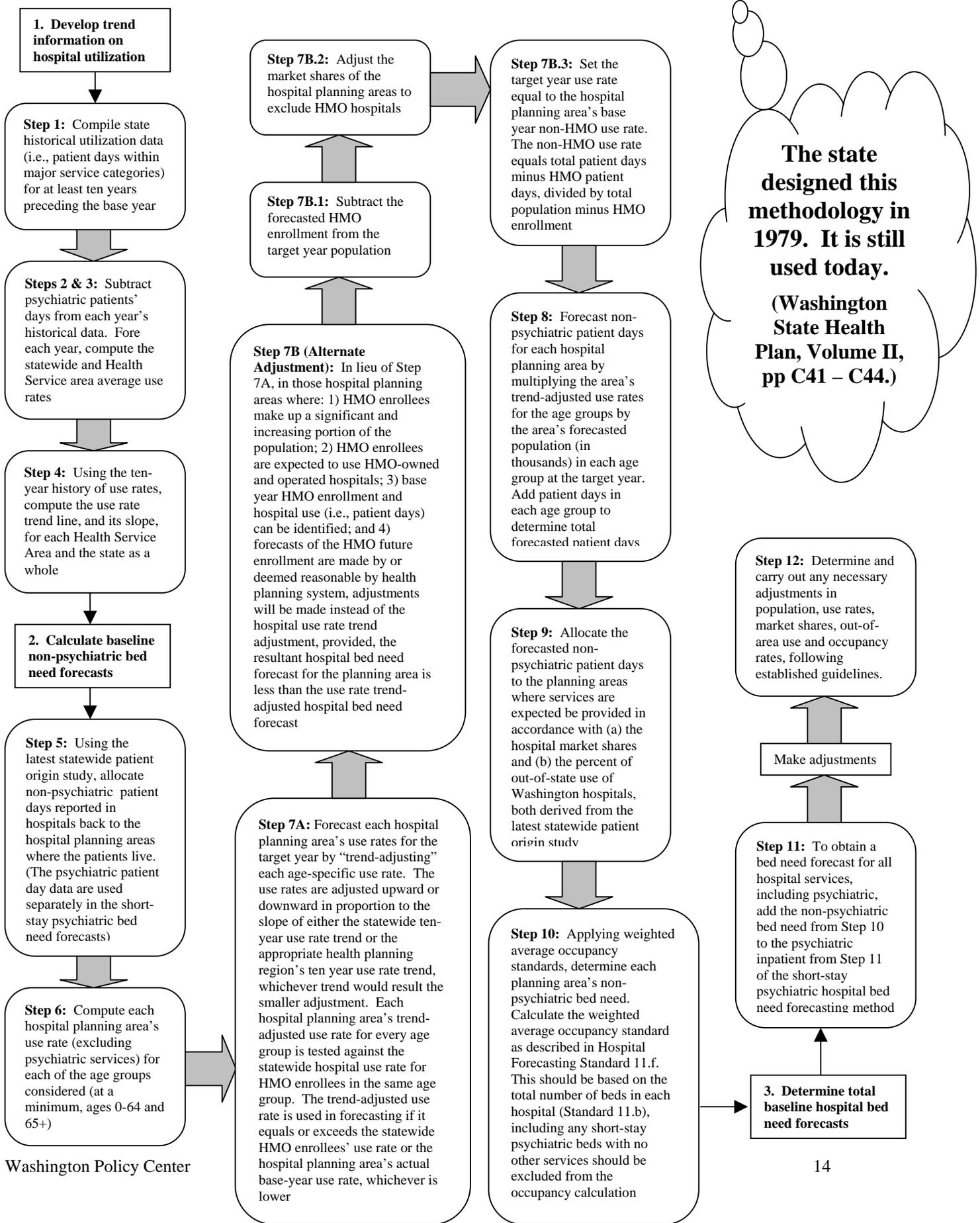
The criteria are much the same if an applicant proposes to build a hospital. The key difference is an additional formula to calculate the number of hospital beds. Figure 8 shows this process.<sup>26</sup> This complicated formula, drafted in 1979 and still in use today, is based on a methodology outlined in Section 4 of the State Health Plan. Section 4 alone is over 40 pages in length.

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<sup>26</sup> “Hospital Bed Need Forecasting Method,” Washington State Health Plan, Volume II, Washington Department of Health.

Figure 8.

## Summary of State Process for Determining Need for New Hospital Beds



## **V. Review of the Effectiveness of Certificate of Need**

The Certificate of Need law is intended to restrain costs and increase access to health care. The process actually has the opposite effect. By forcing anyone interested in building or expanding health care facilities to maneuver through an arcane maze of bureaucratic regulations, the state makes it harder to provide modern, flexible, community-responsive health care. This section reviews the Certificate of Need program and assesses its effectiveness based on its stated goals.

### **The Basic Reasoning behind the CON Law Is Faulty**

The chief argument proponents use to justify the Certificate of Need law is that surplus capacity in health care facilities leads to duplication of services and increased operating costs. These higher costs, they say, are then passed on to insurance companies and patients in the form of higher prices. By regulating the supply, surplus will be avoided. Health care is an “essential of life,” planning advocates say, and the market is incapable of producing the necessary supply of hospital beds on its own. The reasoning behind this justification is faulty for two reasons.

First, the realities of the economy make no distinction between things deemed “essentials of life” and any other product or service. The harmful impact of over-regulation on both is the same. Health care is no different than any other product or service in our economy and the same dynamic market forces determine the quality, availability and price of it. In fact, the more essential a product or service is to meeting basic human needs, the more important it is for policymakers not to place artificial restraints on it.

Second, the “essentials of life” argument for regulating health care overlooks the even more fundamental needs of life that are bountifully provided through vigorous competition in the free market. Food, clothing, housing and transportation are vital and immediate human needs. For the vast majority of Washington residents these needs are met through a vibrant system of private buying and selling. In these cases the government’s role is properly limited to protecting public safety, enforcing voluntary contracts and assisting the needy. Everyday experience shows that when the market is free to operate under minimal government oversight, the result is abundance, quality service and low price.

The more health care providers, consumers, and insurers are permitted to communicate freely in a normally-functioning marketplace, using advertising, price signals and other means, the more society will be able to provide sufficient affordable health services to meet essential human needs. The rapid growth of Health Savings Accounts and consumer-directed health plans is an indication of this trend. The Certificate of Need law works in the opposite direction, blocking fast and accurate communication between patients and health care providers, and preventing providers from responding to changing needs in the community.

## Certificate of Need Laws Do Not Save Money

The assertion that Certificate of Need laws save money is further refuted by a number of recent studies. In July 2004, the Federal Trade Commission and the Department of Justice found that, “the reason that CON has been ineffective in controlling costs is that the programs do not put a stop to ‘supposedly unnecessary expenditures’ but merely ‘redirect any such expenditures into other areas.’”<sup>27</sup>

In 1999, the Washington State Joint Legislative Audit and Review Committee (JLARC) reviewed the Certificate of Need law. JLARC found that the Certificate of Need law has not had any clear success in meeting its legislative goals. Its report, titled “Effects of Certificate of Need and Its Possible Repeal,” reached several conclusions:

“The study found that CON has not controlled overall health care spending or hospital costs. The study found conflicting or limited evidence about the effects of CON on the quality and availability of other health care services or about the effects of repealing CON.”<sup>28</sup>

The study went on to assess the effectiveness of the CON law in terms of cost, quality and access.

### Cost:

- The weight of the research evidence shows that CON has not restrained *overall* per capita health care spending.<sup>29</sup>
- Numerous studies have shown that CON has not controlled overall hospital spending. One study found that CON actually increased hospital expenditures.

### Quality:

- Certificate of Need concentrates volume, and the research evidence is strong that higher volumes of *certain* surgical procedures can lead to better outcomes.<sup>30</sup>

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<sup>27</sup> Federal Trade Commission and Department of Justice, “Improving Health Care: A Dose of Competition,” July 2004, chapter 8, p. 5. Text available at [www.usdoj.gov/atr/public/health\\_care/204694.htm](http://www.usdoj.gov/atr/public/health_care/204694.htm). Accessed December 20, 2005.

<sup>28</sup> Washington State Joint Legislative Audit and Review Committee (JLARC), “Effects of Certificate of Need and Its Possible Repeal,” January 8, 1999, p. i.

<sup>29</sup> *Ibid.*, p. 10, based on Conover, Christopher, and Frank A. Sloan, “Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?” *Journal of Health Politics, Policy, and Law*, Volume 23, No. 3, June 1998; Mendelson, Daniel M., and Judith Arnold, “Certificate of Need Revisited,” *Spectrum*, Winter 1993; Delaware Health Care Commission, “Evaluation of Certificate of Need and Other Health Planning Mechanisms,” Volume I, Final Report, May 1996; Arnold, Judith and Daniel Mendelson, (Lewin ICF) “Evaluation of the Pennsylvania Certificate of Need Program,” submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992; Custer, William S., Ph.D., “Certificate of Need Regulation and the Health Care Delivery System,” Center for Risk Management and Insurance Research, Georgia State University, February 1997.

<sup>30</sup> *Ibid.*, 15, based on Luft, Harold S., Deborah W. Garnick, David H. Mark, and Stephen J. McPhee, *Hospital Volume, Physician Volume, and Patient Outcomes: Assessing the Evidence*, Ann Arbor, MI, Health Administration Press, 1990; Conover, Christopher, and Frank A. Sloan, “Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?”, *Journal of Health Politics, Policy, and Law*, Volume 23, No. 3, June 1998.

- CON has a mixed record in concentrating volume. For example, studies show that CON was not effective in Ohio and Delaware in increasing volume, but did concentrate volume for some services in Pennsylvania.<sup>31</sup>

**Access:**

- Washington’s CON law has had no effect on improving access.<sup>32</sup>
- In some instances, CON rules are used to restrict access by preventing the development of new facilities.<sup>33</sup>

**CON Laws Do Not Increase Access**

In King County there are 120 retirement communities, but only twelve are tied to nursing homes. Almost all operating nursing homes are 30 to 40 years old.<sup>34</sup> Waiting lists are common at even mediocre facilities. Due to Certificate of Need restrictions and other state-imposed regulations, additional nursing homes are not being added as the population ages. Under normal market conditions, the supply of elder care would increase as the need increases. The burden of the CON law disrupts this natural development.

In addition to limited access, those seeking nursing home care face high costs, even though the Certificate of Need framework is intended to reduce costs. Continuing care retirement communities tied to nursing homes require monthly payments along with large up-front fees, which can range from \$270,000 to \$400,000, and are simply beyond the reach of most people.<sup>35</sup> The situation indicates that the Certificate of Need law has not been effective in easing the rising burden of medical expenses for the elderly.

Studies throughout the U.S. have arrived at similar conclusions: the data indicate that a program designed to reduce cost, improve quality and promote access has not achieved any of these goals.<sup>36</sup> In addition, the 14 states with no Certificate of Need laws, which are home to more than one in three Americans, show no significantly higher rate of health care spending due to the lack of such laws.

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<sup>31</sup> Ibid., p. 15, based on Delaware Health Care Commission, “Evaluation of Certificate of Need and Other Health Planning Mechanisms,” Volume I, Final Report, May 1996; Lewin/ICF and Alpha Center, “Evaluation of the Ohio Certificate of Need Program,” Executive Summary, June 28, 1991; Arnold, Judith and Daniel Mendelson, (Lewin ICF) “Evaluation of the Pennsylvania Certificate of Need Program,” submitted to the Pennsylvania Legislative Budget and Finance Committee, April 1992.

<sup>32</sup> Ibid., p. 6. “Key Informants: the Health Policy Analysis Program conducted interviews with ten experts chosen for their knowledge of the state’s CON program and the overall health policy environment in Washington state. Informants were chosen to represent consumer, business, labor, academic, and government perspectives.”

<sup>33</sup> Ibid.

<sup>34</sup> Liz Taylor, “How the state messed up your choices in nursing homes, retirement communities,” *The Seattle Times*, November 15, 2004.

<sup>35</sup> Ibid.

<sup>36</sup> See Christopher J. Conover and Frank A. Sloan, “Evaluation of Certificate of Need in Michigan,” Center for Health Policy, Law and Management, Terry Stanford Institute of Public Policy at Duke University, study commissioned by the Michigan Department of Community Health, May 2003. See also Rexford E. Santerre and Debra Pepper, “Survivorship in the U.S. Hospital Services Industry,” *Management Decision Economics*, Volume 21, 2000.

## **Assessing Promise and Performance: The Certificate of Need law has not met its stated goals**

(All quotes are from Revised Code of Washington 70.38.015)

The crafters of Washington's health planning and Certificate of Needs law had clear goals in mind. Thirty years later, it is possible to assess the law's success or failure in meeting its goals. A clear pattern emerges. Washington's Certificate of Need process has not achieved what the authorizing law promised.

What the law promised: Health planning "should be accomplished in a planned, orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation."

**The situation today:** A quick glance at the Certificate of Need procedure for surgery operating rooms (see figure 7) reveals a process that is anything but orderly. Moreover, health care providers seeking permission to build would hardly use the word "planned" to describe the process and its results. For those who must submit to it, the Certificate of Need process is expensive, inconsistent and unpredictable.

What the law promised: "The development of nonregulatory approaches to health care cost containment should be considered."

**The situation today:** There is far more regulation of health care today than when the CON law was enacted. State law now imposes 49 separate mandates on every health insurance policy sold in Washington. Hospitals, clinics and doctors must comply daily with stacks of complicated regulations that inhibit the practice of medicine. Under CON, the state alone decides what health care facilities are allowed and where they will be built.

What the law promised: "Price competition should be strengthened."

**The situation today:** There is far less price competition in health care today than there was when the CON law passed. Patients and providers are generally unaware of health care pricing and usually have no idea how much a particular treatment costs. The CON law directly stifles price competition by discouraging existing providers from offering new services, and by blocking new competitors from entering the marketplace.

What the law promised: "Health planning should be concerned with public health care financing, access, quality...emphasizing cost control of health services."

**The situation today:** The CON law has failed to control health care costs. In recent years the cost of health coverage has increased up to five times faster than inflation. The CON law has also failed to increase access to health care. In western Kittitas County, for example, one ambulance and one paramedic provide service for an area of some 800 square miles.<sup>37</sup>

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<sup>37</sup> Peter Neurath, "Help on the way?", *Puget Sound Business Journal*, October 28 – November 3, 2005, pp. 31-32.

## Certificate of Need Suppresses Competition and Creates Monopolies

Certificate of Need appeals are a legal mechanism that health care organizations and facilities use to fend off competition. A review of the Certificate of Need action log dating from 1971 to July 2005 reveals that the issuance of a Certificate of Need is often appealed by one or more medical businesses that perceive an economic threat if a new medical facility opens in their area.

When the Department of Health granted Swedish Health Services permission to build an ambulatory surgery center in Bellevue, Overlake and Evergreen medical centers asked the Department to reconsider on the grounds that Swedish's plans would intrude upon their health planning area. The Department upheld its original decision, so Overlake and Evergreen then filed an appeal. The adjudicative hearing resulted in Swedish losing the Certificate of Need.

The Bellevue situation is not an isolated incident; this happens on a regular basis. Easy appeal is built in to the Certificate of Need process. No reasoning or criteria is required for "affected parties" to request a hearing and appeal a decision.<sup>38</sup> Appeals center on the cryptic minutia of the way state employees interpreted the rules, contesting, for example, the method of regression analysis, the identification of service areas, and the definitions used to determine price competition and patient choice.<sup>39</sup>

*The Certificate of Need process functions as protection for monopolies, protecting businesses already in the market while keeping competitors from entering.*

The Certificate of Need process functions as protection for monopolies, insulating businesses that are already in the market and keeping competitors from entering. Anti-competitive activities that would be severely punished by federal anti-trust laws if attempted by other private companies are sanctioned and promoted by the state when they involve medical providers.

Even when established health care organizations are unable to prevent competitors from entering their area, they usually succeed in using the Certificate of Need appeals system to block market entry to new providers for significant amounts of time, often years.

A 2004 study by the Federal Trade Commission and the Justice Department reported that:

"...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."<sup>40</sup>

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<sup>38</sup> Washington Administrative Code 246-310-180.

<sup>39</sup> For a case description, see "High-stakes turf war erupts over kidney dialysis," by Peter Neurath, *Puget Sound Business Journal*, April 29 – May 5, 2005.

<sup>40</sup> "Improving Health Care: A Dose of Competition," Federal Trade Commission and the Department of Justice, Washington, D.C., July 2004, chapter 8, p. 2.

The same study found that the Certificate of Need process:

“has the effect of shielding incumbent health care providers from new entrants. As a result, CON programs may actually increase health care costs, as supply is simply depressed below competitive levels.”<sup>41</sup>

Increasingly, hospitals are facing competition from ambulatory surgery centers, which offer minor surgical procedures that do not require an overnight stay. Often times these facilities offer the same surgery as a hospital but at lower prices. It is one of the ways the market is adjusting to make health care delivery more efficient and cost effective. Established hospitals, however, use the Certificate of Need law to prevent ambulatory surgery centers from opening in their service areas, thus blocking access to health care choice and lower costs for consumers.

The 1974 national health planning law (NHPRDA) itself noted the need for incentives to develop more economical ways of treating minor surgery patients without formal admission into a hospital. Ironically, the very laws designed to foster alternatives to expensive hospital stays are today used against innovative providers who are trying to offer those very alternatives.

### **Discouraging Public Debate**

Fear of endangering their prospects for success prevents many applicants from publicly questioning or debating the process. When asked about the state refusing to issue his company a Certificate of Need, Bill Wolverton of Renal Care Group said “I’m not going to be able to speak for the record; we’re about to start an appeals process.”<sup>42</sup>

*“I’m not going to be able to speak for the record; we’re about to start an appeals process,” remarked Bill Wolverton of Renal Care Group.*

Representatives of other organizations have expressed similar sentiments about applications and appeals in the pipeline. During testimony before the Senate Health and Long-Term Care Committee on a bill calling for a study of the Certificate of Need program, one expert said, “Certificate of Need applications have become much more of a political struggle than they should be.”<sup>43</sup> Applicants are equally reluctant to appear critical of the process or departmental staff.

## **VI. Problems and Delays in Certificate of Need Review**

The foregoing section examined the basic weaknesses in the Certificate of Need law. Research shows the law is not fulfilling its goals because the concept on which it is based, top-down limits on health services through state central planning, is fundamentally

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<sup>41</sup> Ibid.

<sup>42</sup> Peter Neurath, “High-stakes turf war erupts over kidney dialysis,” *Puget Sound Business Journal*, April 29 – May 5, 2005.

<sup>43</sup> Testimony given in support of the bill before the Senate Health and Long-Term Care Committee, March 28, 2005, Bill Report for Engrossed Second Substitute House Bill 1688, Washington State Legislature, at [www.leg.wa.gov](http://www.leg.wa.gov).

unsound. A review of the law as implemented in practice indicates the process suffers from other shortcomings as well, primarily added delays and complications in the process of gaining state approval for a project. Even if the problems discussed below were addressed, however, the foundational defects in the Certificate of Need idea would remain.

### CON Process Exceeds Legal Timelines

In May 2005, the Department of Health denied permission to Swedish Medical Center and Overlake Hospital Medical Center to build new hospitals in Issaquah. This decision was the culmination of a regulatory tug-of-war that had been going on quietly since the two hospitals submitted their plans to the state more than a year before.<sup>44</sup> This does not include the six months Swedish and Overlake spent developing the proposal in the first place.

A review process that was supposed to provide expedited review and include public input did neither.<sup>45</sup> After more than a year of paperwork, lengthy meetings and countless staff hours, officials at Swedish and Overlake ended up right back where they started, and the people of Issaquah were deprived of new medical services that two respected and established hospitals were eager to provide.

Figure 9 shows the timeline for the Issaquah hospital decision process.<sup>46</sup> Compare this with the statutory timeline shown in Figure 3. What should have taken just over six months actually took more than thirteen months.

Figure 9.

<b>Timeline for Proposed Issaquah Hospital</b>	
<b>Date</b>	<b>Action</b>
April 6, 2004	Letters of intent submitted
July 21, 2004	Applications submitted
July 22, 2004 – Feb. 6, 2005	Certificate of Need office’s pre-review activities (application screening / public comments begin)
Feb. 7, 2005	Certificate of Need office begins review of applications
March 7, 2005	Public hearing conducted / end of public comment
March 25, 2005	Rebuttal documents submitted to Certificate of Need office
May 10, 2005	Certificate of Need office makes decision, does not issue Certificate of Need to Swedish or Overlake
<b>Total Time for Application Process: 13 months</b>	

<sup>44</sup> Sonia Krishman, “Issaquah hospital considered unnecessary,” *The Seattle Times*, May 11, 2005.

<sup>45</sup> See the requirements of Washington Administrative Code 246-310-160 and 246-310-180.

<sup>46</sup> Issaquah hospital timeline obtained from the Certificate of Need office, July 7, 2005.

The Issaquah case is not a lone example. A sampling of recent Certificate of Need application timelines, shown in figure 10, reveals that the process typically takes much longer than the law says it should. In these cases, the office handling Certificate of Need requests delayed giving answers by an average of 60% beyond the time required by law.

Figure 10

<b>Project</b>	<b>CON Process Should have Taken:</b>	<b>Actually Took:</b>
Sale of Providence Yakima Medical Center to Health Management Associates	5 months	8 months
Semper-Care establishing long-term acute care hospital in Spokane	6 months	9 months
Franciscan Health System establishing an ambulatory surgery center in Gig Harbor	6 months	9 months
Hospital Proposal in Gig Harbor	6 months	11 months
<b>Average Delay</b>		<b>3.5 months</b>

### CON Process Takes Longer than Planned Construction

The time for securing a Certificate of Need usually exceeds the time it takes to actually build the proposed medical facility. For example, in May 2003 the state granted Swedish Health Services permission to build an ambulatory surgery center in Bellevue. The process required six months for initial planning and eight months for Certificate of Need approval.

*So far, Swedish has spent three years processing Certificate of Need paperwork, for a facility that would take only 15 months to build.*

Swedish's competitors, Overlake and Evergreen medical centers, immediately appealed the Certificate of Need issuance. Today, more than two years after the state gave Swedish the go-ahead to begin construction, the project remains in limbo. The process dragged on so long that Swedish lost its lease option on the building it planned to convert to into the new surgery center. So far Swedish has spent three years processing Certificate of Need paperwork for a facility that, if approved, would take only fifteen months to complete. In the meantime, thousands of surgery patients who would have benefited from the new facility have been forced to go elsewhere or do without.

## Community Input Is Often Ignored

Defenders of the Certificate of Need programs call it a “flexible tool” that “helps protect the critical health care infrastructure” by means of “community based planning.”<sup>47</sup> There is no objective evidence, however, that Certificate of Need decisions include community feedback.

The recent battle over the proposed hospital in Issaquah serves as a case in point. On March 7, 2005, the Department of Health held a public hearing in Issaquah for the community to voice its concern about Swedish and Overlake’s desire to build a hospital in their area. More than five hundred people attended, many of them physicians. The real debate among participants was not whether or not there should be a hospital – only eleven people said the community did not need a new hospital – but rather who should build it, Swedish or Overlake.<sup>48</sup> As we know, the Department of Health denied both applications. The views of the vast majority of people who attended the public meeting had no effect on the final decision.

*The views of the vast majority of people who attended the public meeting had no effect on the final decision.*

In contrast to the Issaquah case, consider what happened in Gig Harbor. Franciscan Health System proposed building a 112-bed hospital there, and in May 2004 the Department of Health announced its approval of an eighty-bed hospital. In announcing its decision, the Department of Health said, “public input overwhelmingly supported a hospital in Gig Harbor, and that public sentiment was substantiated in the fact-based analysis.”<sup>49</sup>

Comparing what happened in Issaquah with Gig Harbor demonstrates that the public’s view only matters when it agrees with the state’s “fact-based analysis.” Public input only seems to be relevant when it supports the pre-set designs of the planning process, and is ignored when it contradicts the regulatory formulas.

## VII. Examining Arguments Made in Support of Certificate of Need

Advocates of Certificate of Need make a number of arguments to defend their views, and cite a number of states where they say it is working as intended. On closer examination, however, the evidence cited typically relies on a narrow set of data to back up these claims.

Planning proponents frequently point to studies by Ford, DaimlerChrysler and General Motors that compare health care costs in states where they have employees. For example, DaimlerChrysler says its costs ranged from \$1,331 in New York, birthplace of Certificate of Need, to \$3,519 per person in Wisconsin, which has a very limited

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<sup>47</sup> “The Federal Trade Commission and Certificate of Need Regulation: An AHPA Critique,” American Health Planning Association, January 2005, p. 14-15, at [www.ahpanet.org](http://www.ahpanet.org), accessed November 5, 2005.

<sup>48</sup> Sonia Krishman, “Hospital hearing draws split input,” *The Seattle Times*, March 8, 2005.

<sup>49</sup> Washington State Department of Health press release, “State Department of Health approves new hospital in Gig Harbor,” May 14, 2004. See [www.doh.wa.gov](http://www.doh.wa.gov).

Certificate of Need law.<sup>50</sup> The studies report that states with Certificate of Need laws had costs 11% to 39% lower than states without such regulations. These studies conclude that, cumulatively, all three automakers' health care costs were 30% lower in states with Certificate of Need laws.<sup>51</sup>

The research methods of the automakers' studies are fraught with difficulties. First, the studies only look at eight states, some with Certificate of Need laws and some without, and those states with such laws enforce them in varying degrees.<sup>52</sup> Moreover, these states are all in the same general region, making meaningful statistical conclusions difficult.

Second, the studies fail to establish a link between Certificate of Need laws and the cost of health care benefits. Built into the report is the assumption that because the cost of health care for a certain segment of the population (auto company employees) in a few states is less than in a few other states, Certificate of Need laws that are merely *intended* to reduce health care costs actually do work. One condition is not necessarily related to the other, and unless a cause-and-effect relationship can be established, the statistics are meaningless in the discussion of Certificate of Need's effectiveness.

Certificate of Need advocates use other, even less reliable, research conclusions. One oft-cited study claims that open-heart surgery mortality rates are 20% lower in states with Certificate of Need regulations than in other states.<sup>53</sup> A 1988 study, however, concluded the opposite of the above study; that Certificate of Need laws actually work to increase in-hospital mortality.<sup>54</sup>

Not long after the Federal Trade Commission and Department of Justice released their report critiquing Certificate of Need programs, the American Health Planning Association (AHPA) published a response. In it they attempt to highlight the benefits of Certificate of Need laws. Following is a point-by-point look at the AHPA's response.<sup>55</sup>

Claim: CON is a useful market balancing tool.

Proponents of central planning say that in an imperfect and increasingly inequitable health care system, CON regulation is a flexible tool that, when used intelligently, helps protect the critical health care infrastructure that is essential to meeting both expected and unanticipated needs.

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<sup>50</sup> Statistics from Thomas R. Piper, "Big-Three Automakers Health Care Costs: non-CON vs. CON States," as part of a planning panel on "Federal Trade Commission/Department of Justice Hearings on Health Care Competition, Quality, and Consumer Protection: Market Entry," June 10, 2003. Text available at [www.2.ftc.gov/ogc/healthcarehearings/](http://www.2.ftc.gov/ogc/healthcarehearings/). Accessed December 20, 2005.

<sup>51</sup> Ibid.

<sup>52</sup> The study looked at Michigan, Indiana, Kentucky, New York, Missouri, Wisconsin, Ohio, and Delaware.

<sup>53</sup> M.S. Vaughan-Sarrazin, E.L. Hannan, C.J. Gormley, and G.E. Rosenthal, "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States with and without Certificate of Need Regulation," *Journal of the American Medical Association*, Volume 288, No. 15, October 16, 2002, pp. 1859-66.

<sup>54</sup> Michael A. Morrissey, "Certificate of Need, Any Willing Provider and Health Care Markets," Lister Hill Center for Health Policy, University of Alabama at Birmingham, 1988-89.

<sup>55</sup> See "The Federal Trade Commission and Certificate of Need Regulation: An AHPA Critique," American Health Planning Association, January 2005.

If history has demonstrated anything, it is that the state has a poor track record when it comes to economic planning and forecasting. Yet that is exactly what the state attempts to do when it decides on the “need” for a local health care facility. Moreover, Washington’s Certificate of Need program is not really “community-based,” because it disregards community input that does not fit with pre-set planning formulas. The AHPA’s rationale is flawed because it proposes to solve problems created by government intervention with more government intervention.

Claim: empirical evidence shows substantial economic and service quality benefit from CON regulation and related planning.

The only source cited in this claim is a *Journal of the American Medical Association* article arguing that open-heart surgery mortality rates are 20% lower in states with Certificate of Need regulation. This is an isolated example that attempts to link the effects of regulation with a positive statistic. The empirical connection in this single instance is weak at best.

Furthermore, numerous studies show that Certificate of Need regulation has had zero or negative impact on the quality of health service. One specialist in Walla Walla estimates that up to three people in the area die each year because a cardiac surgery center is not close enough.<sup>56</sup> State regulators denied a Certificate of Need to a local hospital that sought to open such a center.

Claim: CON regulation is one of the few practical planning tools available to policymakers.

The underlying premise here is that public policymakers *need* to be involved in health care facility planning. But do they? Bureaucrats and central economic planning inhibit private provider’s ability to supply necessary services to the public at reasonable prices. Government management and the third-payer system have distorted the market, and the cost problems we see today are the results. The solution is to encourage greater consumer control and transparent pricing informed by unimpaired market inputs.

Central planners also use a volume and quality argument to justify Certificate of Need for tertiary services such as cardiac surgery, organ transplant, etc. The argument here is that by using Certificate of Need laws to concentrate volume at specialty hospitals, the quality of services provided there will increase.

This sounds attractive in theory, but in practice the evidence supporting the argument is weak. While Washington’s JLARC study concluded “the research evidence is strong that higher volumes of certain surgical procedures leads to better outcomes,” it admits that this is true only for some procedures and that not all evidence

*CON limits are of more than passing importance to kidney disease sufferers, to whom reduced access to reliable dialysis can prove fatal.*

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<sup>56</sup> Kathleen Obenland, “St. Mary wants to be able to offer heart surgeries,” *Walla Walla Union-Bulletin*, November 16, 1999, quoting Dr. Robert Arnold Johnson, cardiologist with the St. Mary Physician Group.

supports the conclusion.<sup>57</sup> The same report found that Certificate of Need might reduce the quality of kidney dialysis services by reducing access.<sup>58</sup> This point is of more than passing importance to kidney disease sufferers, to whom reduced access to reliable dialysis can prove fatal.

Some health care professionals have criticized the state's rationale for concentrating volume. Dr. Robert Johnson, a cardiologist in Walla Walla, once remarked that "our knowledge about how many operations have to be done by one surgeon to have good outcomes has changed since [the state placed CON regulations for volume]. It's not nearly as many as was thought to be the case."<sup>59</sup>

Attempting to control the geographic distribution of health care services is another way central planning reduces patient access. The government has offered special certification for regional centers of excellence in a given field so long as those institutions perform a certain number of procedures in a year. This produces two problems. First, the requirement concentrates certain health services in one geographic area, thereby creating a hardship for people who live out of the area. The added distance increases both patient cost and risk. Second, a facility that has to perform a certain number of procedures in a year to maintain government-sanctioned preferential status may be inclined to perform unnecessary procedures simply to boost its numbers.

## **VIII. Policy Recommendations**

Washington Policy Center's recommendations for addressing the Certificate of Need issue are presented below in priority order, beginning with the most effective and far-reaching proposal for reform. Next, two alternatives are given that would ease the regulatory burden the program places on the state's health care system.

### **1. Repeal the Certificate of Need Law.**

Washington should follow the example of the 14 other states that have repealed their Certificate of Need laws. Disaster did not follow repeal in those states, and it will not follow repeal in Washington. The 1999 JLARC study lists repeal a key policy option. Evidence cited by Certificate of Need proponents as justifying these complex regulations is inconclusive at best, and abundant evidence to the contrary shows that Washington's Certificate of Need law likely does more harm than good. The Certificate of Need law distorts important market signals that indicate when and where new health services will be needed. More than 30 years of experience shows that the Certificate of Need law acts as an impediment to achieving cost-effective, community-responsive health care.

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<sup>57</sup> Washington State Joint Legislative Audit and Review Committee (JLARC), "Effects of Certificate of Need and Its Possible Repeal," January 8, 1999, p. 15.

<sup>58</sup> *Ibid.*, p. 16.

<sup>59</sup> Kathleen Obenland, "St. Mary wants to be able to offer heart surgeries," *Walla Walla Union-Bulletin*, November 16, 1999, quoting Dr. Robert Arnold Johnson, cardiologist with the St. Mary Physician Group.

## 2. Significantly Scale Back the Certificate of Need Law.

Short of outright repeal, many states have scaled back their Certificate of Need laws so they cover only a few types of facilities or only kick in at a higher expenditure threshold. For example, CON requirements should be eliminated for nursing homes to help meet the needs of an aging population. Partial repeal could be adopted as the first step to completely phasing out Washington Certificate of Need law.

Alternatively, the legislature could enact partial repeal with the intention of leaving a limited number of health services permanently under the control of Certificate of Need regulation. In both cases, partially repeal would allow time for the legislature to review the results. Lawmakers may find the Certificate of Need law works best when it applies only to a few medical specialties, while leaving most providers free to open new clinics, hospitals and nursing homes as health needs change in the community.

## 3. Authorize the Certificate of Need Task Force to Investigate Thorough Reforms.

In early 2005 the legislature created a special task force to examine the Certificate of Need program. The task force began meeting later that year and is charged with making recommendations on ways to improve and update the program. Even those who support the Certificate of Need program tacitly admit it is not lowering health care costs: “We need to look at the Certificate of Need program as a health planning process in relation to escalating health care costs.”<sup>60</sup>

Unfortunately, the task force was hamstrung from the outset. In conducting its study the task force is required to presume “that the services and facilities subject to certificate of need should continue to be subject to it.”<sup>61</sup> Given this restriction, genuine reform is not possible. The legislature should expand the task force’s authority so its members can conduct a thorough investigation of the Certificate of Need program. The task force could then assess the program’s actual performance compared to stated goals, review the experiences of other states and propose practical reforms that will improve health care access for Washington residents.

## IX. Conclusion – Certificate of Need Represents the Failure of Government Central Planning

Three decades of experience has supplied ample evidence that Washington’s Certificate of Need program has not worked as its creators intended. The law has not controlled costs, improved quality or increased access to

*CON laws actively block citizens’ access to health care choices and to modernized health care facilities.*

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<sup>60</sup> Testimony given in support of the bill before the Senate Health and Long-Term Care Committee, Bill Report for Engrossed Second Substitute House Bill 1688, Washington State Legislature, March 28, 2005. See [www.leg.wa.gov](http://www.leg.wa.gov).

<sup>61</sup> Bill report on Engrossed Second Substitute House Bill 1688, “Creating a task force to review the certificate of need program and the health care facilities bonding program,” enacted May 4, 2005, Washington State Legislature at [www.leg.wa.gov](http://www.leg.wa.gov).

health care. In fact, the law has had the opposite effect, actively blocking citizens' access to health care choices and to modernized health care facilities.

There is, however, abundant evidence the process has become arcane and politicized, and that medical organizations holding Certificates of Need use the process to keep competitors out of their area. An indication of this effect is the program's use of non-medical criteria, like an applicant's record in providing charity care or the existence of any civil rights complaints, in deciding whether to approve a Certificate of Need.

In practice, Washington's Certificate of Need law is not about improving health outcomes for citizens, it is about controlling access to health care. The state's Certificate of Need process is more important in determining how and where patients will be treated than the decisions made by doctors and hospital administrators. This point is illustrated by an observation of economist F.A. Hayek, "The power that a millionaire, who may be my neighbor and perhaps my employer, has over me is much less than that the smallest functionary possesses who wields the coercive power of the state, and on whose discretion it depends whether and how I am able to live or work."<sup>62</sup>

When health care organizations are allowed to compete with each other in a system that functions more like a normal market, consumers of health care win because there are both short- and long-term incentives for providers to innovate and grow more efficient. Robust competition builds a more nimble, community-responsive and consumer-centered system that readily adapts to changing needs. Inflexible planning and regulatory structures that keep competitors out cannot achieve this.

The program's record indicates the Certificate of Need law no longer serves the public interest, if indeed it ever did. The stated purpose of the program is to foster a health care system that controls costs and meets changing conditions. Yet, to succeed such a system requires the very flexibility the Certificate of Need is designed to prevent. In a state experiencing rapid growth and demographic change, the Certificate of Need law prevents providers from adapting to the changing health needs of the community.

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<sup>62</sup> F.A. Hayek, "Law, Legislation and Liberty," University of Chicago Press, Chicago, 1947.

# Three Case Studies

## 1. A Flawed Process

When the Department of Health decided in June 2005 that Issaquah did not need a new hospital, it did so based on the proximity of three other hospitals. “If you put a point in the center of Issaquah, there are three hospitals within 12 miles,” said Laurie Jinkins, assistant secretary of health-systems quality assurance for the state Department of Health.<sup>63</sup> She was referring to Overlake Hospital in Bellevue, Group Health Cooperative in Redmond, and Snoqualmie Valley Hospital. A closer look, however, reveals flaws in the state’s decision.

First, Group Health Cooperative is not open to the general public. Only members of the Group Health insurance network can use Group Health services. Yet the state makes little adjustment for that fact in its calculation of hospital bed availability and need.

Second, Snoqualmie Valley Hospital has what one article called “a troubled past.” It is a hospital that has been plagued “by maintenance mishaps, two closures and eroded credibility.”<sup>64</sup> But it is a hospital with twenty-eight beds, and in spite of its demonstrated unreliability, its poor reputation and many people’s refusal to go there, the state included those beds when calculating bed availability and medical need.

This issue raises serious questions about the Certificate of Need determination process. Proponents of Certificate of Need planning tout the program as being “community based” or “community oriented,” but in this case the process ignored two important community factors that influence the availability of hospital services to the public. An inflexible bureaucratic structure was unable to take account of legitimate local concern.

## 2. Stifling Competition Does Not Lower Costs

In May 2005, the *Puget Sound Business Journal* reported that a “statewide turf war” had erupted amongst providers of kidney dialysis, one of the many services covered by Washington’s Certificate of Need law. Providers had filed more than a half dozen appeals regarding various dialysis station proposals. “I’ve never seen the number of appeals as high as now,” one industry consultant observed.<sup>65</sup>

Several dialysis providers sought state permission to open new facilities or expand existing capacity. Rival companies fought Certificate of Need approvals as a way of preventing another provider from encroaching into their region. The business journal reported, “Appeals are becoming more common, as competition in the industry has surged with new market entrants.”<sup>66</sup>

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<sup>63</sup> Sonia Krishman, “Issaquah hospital considered unnecessary,” *The Seattle Times*, May 11, 2005.

<sup>64</sup> Ibid.

<sup>65</sup> Peter Neurath, “High-stakes turf war erupts over kidney dialysis,” *Puget Sound Business Journal*, April 29 – May 5, 2005.

<sup>66</sup> Ibid.

So what is the effect of hindered competition? Higher prices. “Private carriers used to pay \$200 and \$300 per treatment,” remarked Palmer Pollock, a planning administrator with Northwest Kidney Centers, “now it’s more than \$1,000.” Instead of reducing cost, as Certificate of Need laws are intended to do, kidney dialysis prices have increased by 330% – 500%.<sup>67</sup> This case shows how the Certificate of Need law not only fails to constrain rising health care costs, it actually puts upward pressure on the price of certain health services.

### **3. Ignoring Community Input**

In the 1980s, the residents of Putnam County, Georgia, ran headlong into state Certificate of Need regulators. As their federal Representative reported to Congress:

“[T]he citizens of Putnam County are proud of their 20-year-old community hospital. They built it with local funding, without using any Federal Hill-Burton funds, and they still support it locally. They are proud enough to have recently approved a 1-cent sales tax to renovate the facility. They are not seeking an expansion. The hospital has always had 50 beds, and that’s what they propose to maintain.

“However, when Putnam County authorities went to the State health planning agency for the required approval under the certificate-of-need program this year, they ran into unexpected trouble. The agency looked over the request for the locally funded hospital improvements and decided to deny it – unless the hospital eliminated ten beds.”

The state refused to budge and local health officials were forced to comply. Growth projections indicated that eventually all 50 beds would be needed, but the state insisted that ten of the beds be dismantled. They did so in spite of the fact that eliminating ten beds would reduce the number of nursing students the hospital could enroll, at a time when the country faced a shortage of nurses. Regulators also ignored the tremendous cost the community would incur later when hospital authority had to add back those ten beds.<sup>68</sup>

This case shows how the centralized Certificate of Need process favors state-level regulators who insist on enforcing their decisions, regardless of the well-reasoned protests of local leaders.

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<sup>67</sup> Ibid.

<sup>68</sup> Patrick John McGinley, “Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System,” *Florida State University Law Review* (1995).

# Appendix

## Description of the Certificate of Need Process for Hospital Beds

Following, in shortened form, is a description of the steps an applicant must take in requesting a Certificate of Need to build a new hospital or to add beds to an existing facility. Together, these steps represent one phase of a much larger process.

### A. Develop Trend Information on Hospital Use

Steps 1 through 3: The hospital bed need determination begins with compiling historical use data—that is, how many days patients spent in hospitals based on types of treatment. (The state makes a distinction between time spent in a hospital for physical and psychiatric treatments. The need determination for psychiatric hospital beds is a separate process within the State Health Plan.)

Step 4: The state uses a ten-year history of hospital use rates to determine historical trends.

### B. Calculate Bed Need Forecasts

Steps 5 and 6: Each of Washington's hospital planning area's (how the state divides the population of large areas into geographic units for planning purposes) hospital use rates are computed. At a minimum, two age blocks need to be considered: people age zero to 64 and people over 65. Age groups may be divided further.

Step 7A: The state forecasts each hospital planning area's use rates. It does this based on historical trends and projections made by the Office of Financial Management. The forecast is done for a target year, which varies. It can be as little as five or six years.<sup>69</sup> Moreover, the trends are arranged according to age group. Once determined, these trends are adjusted up or down, in proportion to the trend of either the statewide ten-year trend or the specific planning area's ten-year trend.

Step 7B: This is an alternative to Step 7A. In planning areas where a Health Maintenance Organization is present, adjustments must be made to factor in HMO enrollees. These adjustments are necessary because HMOs can control where their enrollees go for hospital care.

Steps 7B.1 through 7B.3: These steps serve to illustrate and correct skews created by HMO enrollment in a hospital planning area.

Steps 8 through -10: Here the bed need forecasts begin to take shape. Trend-adjusted use rates (see Steps 7A and 7B) and projected population are used to determine total forecasted patient days. Forecasted patient days are then distributed to hospital planning areas based on market share and the use of out-of-state

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<sup>69</sup> In the recent unsuccessful Certificate of Need process undertaken by Swedish and Overlake hospitals to build a hospital in Issaquah, both companies were required to forecast need out to the year 2018.

hospitals. Average occupancy standards are then used to determine each planning area's bed need.

### C. Determine Total Hospital Bed Need Forecasts

Steps 11 and 12: The non-psychiatric bed need forecasts calculated from this process are added to the psychiatric bed need forecasts (calculated in a separate process) to determine overall bed need for all hospital services. Any necessary adjustments are then made—for example, population adjustments, use rates, market shares, and shifts in occupancy rates.

It is important to note that these processes outlined here are only part of a much larger process for building a health care facility. These regulations are above and beyond standard county and city building permits, land use requirements, Growth Management limits, environmental impact statements, zoning regulations, building codes, construction review applications and public health standards. Naturally, these additional regulations are strictest for hospitals. Other regulatory factors applied to hospitals, in addition to Certificate of Need, include the following.<sup>70</sup>

### **Additional Requirements**

#### Licensure and Physical Plant Requirements

- Finishes (carpet, tile, wall covering)
- Heating and ventilation system
- Hot water system
- Medication handling
- Nurse call system
- Room size, furniture & equipment
- Shower and toilet fixtures

#### Fire / Life Safety Requirements

- Automated sprinkler system
- Electrical generator system
- Fire alarm system
- Fire / life safety structural design
- Life support system
- Medical gas system
- Smoke control system

#### Standards Adopted by State Building Code Council

- 2003 International Building Code
- 2003 International Fire Code
- 2003 International Mechanical Code
- 2003 International Plumbing Code
- Barrier-free requirements

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<sup>70</sup> Washington State Department of Health, Facilities and Services Licensing, Construction Review Services, at [www.doh.wa.gov](http://www.doh.wa.gov).

- National electrical code
- Washington state energy code
- Washington state ventilation code

These regulations are important to protecting public health and safety, and there is no suggestion that this requirement should be loosened or repealed. The purpose here is to show that the lengthy and complicated Certificate of Need process is imposed *in addition* to a long list of existing requirements.

## About the Author



**John Barnes** is a policy analyst for Washington Policy Center and director of WPC's legislative information website, WashingtonVotes.org. He is the author of other WPC studies on education, transportation, health care, and government reform. Before joining WPC, John held the Robert M. Utley Editorial Fellowship with the *Western Historical Quarterly* in Logan, Utah. John is a graduate of Hillsdale College in Michigan and holds a Master's degree from Utah State University.

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