LAUREL LIBBY
State Representative

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Senator Bailey, Representative Gramlich, and distinguished members of the Committee on Health Coverage, Insurance and Financial Services,

My name is Laurel Libby, and I reside in Auburn. I represent House District 90, which is Minot and North Auburn. I come before you today to present two bills that would repeal portions of Maine's Certificate of Need laws:

- LD 189: An Act To Increase the Availability of Health Care Services by Eliminating the Certificate of Need for All Health Care Services
- LD ~~485~~ 743: An Act to Increase the Availability and Affordability of Health Care by Eliminating Certificate of Need Requirements

Before I can speak to my bills, I need to give some background on exactly what Certificate of Need (CON) is, how the CON application process works, and how CON affects healthcare in our state.

First of all, what is Certificate of Need? In Maine, Certificate of Need (CON) is a regulatory program requiring healthcare providers to obtain state approval prior to making changes in the healthcare landscape. The purpose is to verify that there is, indeed, a need for that particular service or facility in that community. The public, including competitors, are allowed to weigh in during the process. Maine has the highest CON application fees in the country, as high as $250,000, and that doesn't include attorney fees.

Changes include:

- Mergers / acquisitions
- New facilities / services
- Substantial capital investments in new equipment or facilities
- Changing access to services
- Increases in bed complement (1)

The theory behind the original CON laws was that by restricting the supply of healthcare facilities and services, you could control costs and increase access to care. Initially, CON laws were desired because the reimbursement method at the time (costplus reimbursement) incentivized over-investment in healthcare infrastructure. (2) In 1964, New York enacted the nation's first statewide CON law. The American Hospital Association then began nationwide lobbying efforts to pass CON laws at the state level, and even drafted model state law. These lobbying efforts were so successful that in 1974, under the Ford administration, Congress enacted the National Health Planning and Resources Development Act, which required states to enact CON laws to receive certain federal reimbursements. (3)

In 1986, however, Congress repealed NHPRDA because it "failed to control healthcare costs and was insensitive to community needs." (4) Since 1986, in a rare admission of policy failure, the federal government has continued to encourage repeal of CON laws, stating that "On balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits." (5) Over the intervening years, many states have amended or outright repealed their CON laws. There are many studies that have looked at the difference in spending in CON states and those without CON laws, and in 2018, The Journal of Public Health published a study that estimated CON laws lead to a statistically significant 3.1% increase in total spending. That study concluded that "rather than decreasing health care spending as intended, it appears that CON laws actually increase it." (6)

The evidence to date suggests that CON laws are frequently costly barriers to entry for healthcare providers rather than successful tools for controlling costs or improving healthcare quality. Based on that evidence and their enforcement experience, the two federal antitrust agencies–the Federal Trade Commission and the Antitrust Division of the Justice Department—have long suggested that states should repeal or retrench their CON laws. (7)

What does all of that mean in a practical context?

Let's say that you decide to open a coffee shop. In your community, you already have a Dunkin and Starbucks, but you think folks would appreciate a third option that's a little bit different, with specialized drinks and the latest coffee innovation at a lower price. But in your state, there is a Coffee Shop Certificate of Need law. That means you would have to submit an expensive application to the government for permission to open your coffee shop, in addition to all the other permitting and licensing applications and fees. The government would then determine if there was a community need for a new coffee shop, with part of the process being a public comment period. Dunkin and Starbucks would both weigh in to say that no, a new coffee shop is not needed, they are providing all the coffee anyone could want or need.

In 2015, testimony of the Maine Hospital Association against CON reform claimed, "The vast majority of CON applications are granted . . . 95% of applications were granted . . . At least with respect to hospitals, we are not aware of any proposal for major surgical center, imaging center, lab or hospital that was denied by the CON process." (17)

The problem with that statement, is that there is no way to capture how many CON applications were not filed, either because of reluctance to engage Maine's cumbersome process (including the fact that competitors weigh in, which is not universal in CON states), or because the filing and attorney fees were too steep to make application worth the potential payoff on the other side. Given the inability to capture the information regarding applications that were simply never made, the statement that 95% are granted has no value in this conversation.

You will also hear that Maine has recently made changes to the threshold amounts that require a CON application, and that no more changes are necessary. During Covid, that argument was proven to be incorrect. On April 10, 2020, the Division of Licensing and Certification issued guidance allowing hospitals and nursing homes to apply for emergency CONs to increase bed capacity in response to the Covid-19 pandemic. That change to the law is ongoing and will expire 60 days after the state of emergency ends. Thankfully we realized that Maine healthcare providers required greater flexibility to respond to the pandemic, but the response truly illustrates that Maine's CON law is out-of-date.

It's interesting that in a state chronically short on mental health services, alcohol and drug dependence treatment, and substance use disorder services, we would intentionally limit expansion of those services through the use of CON. We are

currently seeing a continued mental health crisis in Maine, and lack the facilities and staff to treat the never ending surge.

I could address the considerable evidence for repeal that the American Medical Association has provided, but instead let's talk about the primary arguments in support of CON.

1. The health care industry is not a competitive marketplace, and hospitals need CON in place in order to provide care to those with Medicaid, Medicare, and charity care patients. Hospitals are not like other businesses and must mix under-reimbursed services (such as emergency care) with those more lucrative, or go out of business.

While this is widely claimed by those intent on maintaining a monopolistic hold on their surrounding community, studies show this is not the case. In fact, there is no difference in the provision of charity care between states with CON programs and states without them, and CON regulation is actually associated with greater racial disparities in access to care. (8) (9)

CON laws may actually do more harm than good by allowing incumbent hospitals to subsidize care in this way.

- Consumers miss out on the opportunity to choose alternative, lower priced, higher quality, or more convenient care.

- That cost is imposed without any evidence that the charitable mission is fulfilled. The evidence shows that specialty hospitals do not undercut the financial viability of rival community hospitals. (10)

- New competition has a beneficial effect on community hospitals. A study published in the RAND Journal of Economics found that community hospitals responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business, as well as encouraging physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus. (2) (11) (12)

2. Experienced employers support CON laws: DaimlerCrysler found that its costs were highest in states without CON laws and lowest in states with CON laws.

Interesting that this is often the "study" referenced for this point. The information from DaimlerChrysler Corporation is actually a three-page testimony in favor of CON from 2002, and compares Kenosha, Wisconsin and the state of Indiana against Newark,

Delaware; Syracuse, New York; and the state of Michigan. I think we can all agree that a corporation's internal review comparing 3 cities and 2 states does not comprise a statistically significant study. (13)

What does the actual research show?

The Michigan Department of Community Health commissioned a review of their CON program in 2003, and that report found that "there is little evidence that CON results in a reduction in costs and some evidence to suggest the opposite." (14)

A study published in the Health Education Journal in 2007 examined the impact of CON regulation on hospital costs. This study looked at data from almost 2,000 hospitals in 301 standard metropolitan statistical areas, and found that CON laws had a positive, statistically significant relationship to hospital costs. Their conclusion was "that CON do not really contain hospital costs, but may actually increase them." (15)

A review of 90 articles published by BMC Health Services Research in 2020 estimated "that the average cost-benefit ratio of CON is 1.08, meaning costs exceed benefits by 8%, with the average costs exceeding benefits by an estimated $302 million per year." (16)

3. Lessons from other states: Ohio increase in imaging centers and surgical centers, Pennsylvania increase in surgical centers.

The report produced in 2003 by the Duke University Center for Health Policy, Law and Management at the commission of the Michigan Department of Community Health found that removal of CON does not consistently lead to a "surge" in either acquisition of new facilities or medical expenditures. (14)

There are lessons to be learned from other states, just not the ones CON lobbyists might want learned.

There is a substantial body of research documenting racial and ethnic disparities in access to medical care. These persistent disparities are well recognized by both policy makers and clinicians as a serious health system problem in need of correction.

In 1996, New Jersey passed legislation that reformed its CON process regarding diagnostic cardiac catheterization services. In a 2009 study published in the Journal of Health Politics, Policy and Law, it was found that the expanded capacity increased cardiac angiography utilization overall, and did so more rapidly for the black population. (8) It turns out, what we refer to as "limiting duplication of health care

services" is more correctly, rationing of health care services leading to racial disparities in who receives critical services.

Thank you to my co-sponsors, for their support of this bill. I ask this committee to look at the considerable research and represent the interests of the people of Maine by voting Ought to Pass, thus expanding access to healthcare at lower costs. I'm happy to answer any questions you may have.

(1) https://www.maine.gov/dhhs/dlc/healthcare-oversight

(2) https://www.justice.gov/sites/default/files/atr/legacy/2007/06/05/223754.pdf

(3) https://ir.law.fsu.edu/cgi/viewcontent.cgi?article=1460&context=lr

(4) https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-ThroughChoice-and-Competition.pdf

(5) https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dosecompetition-report-federal-trade-commission-and-department-justice/healthcarerptexecsum.pdf

(6) https://link.springer.com/article/10.1007/s10389-018-0998-1

(7) https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-ThroughChoice-and-Competition.pdf

(8) https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.825.9156&rep=rep1&type=pdf

(9) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3211637

(10) http://www.medpac.gov/docs/default-source/reports/Mar06_EntireReport.pdf

(11) https://pubmed.ncbi.nlm.nih.gov/12585304/

(12) https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.25.1.106

(13) http://www.ciclt.net/ul/sgh/CON%20Endorsement.pdf

(14) http://worldcat.org/arcviewer/1/EEX/2005/04/28/0000010745/viewer/file4.pdf

(15) https://journals.sagepub.com/doi/abs/10.1177/0017896907080127?journalCode=heja

(16) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7427974/

(17) http://www.mainelegislature.org/legis/bills/getTestimonyDoc.asp?id=24104