Certificate of Need, Any Willing Provider and Health Care Markets

Michael A. Morrisey, Ph.D.
Lister Hill Center for Health Policy
University of Alabama at Birmingham

Certificate of Need

- CON programs were established in the 1970s to control health care costs.
  - Hospitals, nursing homes and often other providers were required to obtain state approval to open or expand a facility.
  - At its peak all states except Louisiana had a CON program.
  - In 2002, 36 states and the District of Columbia had some form of CON (APHA 2002)

CON: Rationale

- Health care providers typically paid on a cost-based basis. Any new facility or service essentially has its costs covered.
- Non-price competition led providers to expand services leading to duplication of services.
- CON would control costs by preventing the duplication of services.

CON: Economic Model

- In a standard demand and supply model, CON would be viewed as a barrier to entry.
- Artificially restricting the supply of a particular health care service would allow current providers to charge higher prices.
- Providers would be expected to devote resources to obtaining a CON “franchise.”

CON: Role of Market Forces

- CON proponents argue that health care markets are not price competitive
  - Regulation of supply is necessary to control costs.
- CON opponents argue that health care markets are price competitive
  - CON franchise allows providers to charge higher prices
  - Increase in price competition would also lead to greater demand for CON entry barriers

Did CON Result in Lower Hospital Costs?

- No
  - Series of rigorous multi-state econometric studies in the 1970s, 1980s and 1990s
  - See Morrisey (2000) for a review
  - In the most recent work, Conover & Sloan (1998) conclude that CON repeal had no effect on hospital costs

Did CON Raise Hospital Costs?

- Some evidence that it did
- Hospitals in states with CON had costs that were 20.6% higher
  - Lanning et al (1991)

Did CON Advantage Existing Hospitals?

- Noether (1988) showed that hospital costs and prices were higher the longer CON had been in effect
- McCarthy and Kass (1983) argued that greater CON "toughness" resulted in smaller investor-owned market shares
- Alexander and Morrisey (1988, 1989) concluded that hospitals were less likely to join a hospital system and less likely to be contract managed the longer CON had been in effect.

Did CON Affect Quality?

- Mixed (old) evidence on technology diffusion
  - Most studies found no effect
  - See Morrisey (2000) for a review

Did CON Affect Quality?

- Mixed evidence on mortality
  - Shortell & Hughes (1988) found that CON increased Medicare in-hospital mortality
  - Robinson et al (2001) found substantial growth in CABG programs in Pennsylvania after the repeal of CON but no effect on CABG fatalities
  - Vaughan-Sarrazin et al (2002) found Medicare CABG mortality rates higher is states without CON

CON in the Nursing Home Market

- Standard model:
  - Nursing home facing both private relatively inelastic demand and perfectly elastic Medicaid demand.
  - Providers are alleged to price discriminate.
  - CON serves to limit Medicaid expenditures while allowing the private residents to be cared for at market prices.
  - Thus, CON constrains Medicaid expenditures and may result in higher private prices.

CON and Nursing Home Costs and Supply

- Harrington et al (1997)
  - 1979-93: presence of CON or moratorium reduced nursing home bed growth
- Miller et al (2001,2002)
  - CON redirects spending to home & community based services
  - States with CON have higher total per capita long term care expenditures
- Conover & Sloan (n.d.)
  - CON repeal had no statistically significant on Medicaid plus private nursing home expenditures per capita

CON and Medicaid Nursing Home Expenditures

- Effect of CON repeal on Medicaid nursing home expenditures
  - 1981 thru 1998 analysis of Medicaid nursing home and long term care expenditures by state
  - No statistically significant effects on Medicaid expenditures
- CON not binding or many substitutes available for older adults

Grabowski, Ohsfeldt & Morrisey (2003)

Summary of CON

- CON is ineffective in controlling hospital costs
  - May have raised costs and restricted entry
  - No studies have examined effect of CON on prices paid by managed care
  - CON has probably delayed entry and reduced competition in hospital markets
- CON is ineffective in controlling Medicaid nursing home costs
  - May have restricted supply of beds
  - Many new substitutes for nursing homes

Any Willing Provider Laws

- Require an HMO &/or PPO to accept in its panel any provider willing to accept the terms and conditions of the contract
- By mid 1990s:
  - 11 states had AWP laws covering physicians
  - 9 states had AWP laws applicable to hospitals
  - 25 states had AWP laws applicable to pharmacies

  (Ohsfeldt et al 1998)

Freedom of Choice Laws

- Require an HMO &/or PPO to allow a subscriber to use a non-panel provider and to obtain partial payment from the managed care plan
- By the mid 1990s:
  - 6 states had FOC laws covering physicians
  - 5 states had FOC laws covering hospitals
  - 18 states had FOC laws covering pharmacies

  (Ohsfeldt et al 1998)

Conceptual Effects of AWP & FOC

- Managed care was successful in reducing its rate of increase in premiums during the 1990s by selectively contracting
  - Trading volume for lower provider prices
- AWP and FOC laws arguably reduce or eliminate the ability of managed care plans to selectively contract

Theory of AWP

- Any Willing Provider
  - HMO/PPO exchanges the promise of volume for a lower price from a provider
  - AWP eliminates the exclusivity of the contract
  - Providers are unwilling to offer as low a price because they cannot be assured of volume

Theory of FOC

- Freedom of Choice
  - Under an FOC law, subscribers face lower out-of-pocket prices if they use a non-panel provider
  - This gives some subscribers sufficient incentive to use non-panel providers
  - This reduces the volume a managed care plan can assure and results in higher prices

Empirical Evidence on AWP & FOC

- AWP & FOC laws are not randomly distributed across states, but are more likely to appear in states with limited managed care penetration.
  - Marsteller et al (1997)
  - Ohsfeldt et al (1998)
- AWP & FOC laws as preemptive efforts

AWP/FOC & Health Care Spending

- States with a “high intensity” of AWP/FOC regulation had a:
  - 2.7% increase in spending on physicians
  - 2.1% increase in spending on hospitals, and
  - 1.8% increase in health spending overall

  (Vita 2001)
- Suggests that managed care plans were inhibited in negotiating lower prices with providers

AWP/FOC Laws and HMO Market Share

- Metropolitan areas with a “high intensity’ of AWP/FOC regulation had HMO market shares 6 to 7 percentage points lower.
- FOC laws reduced market share more than did AWP laws.
- Laws affecting physicians reduced market share; hospital and pharmacy laws did not.

(Morrisey and Ohsfeldt 2003)

AWP/FOC Summary

- Laws tend to be preemptive
- Laws appear to have increased health care costs and reduced HMO market share
- Findings consistent with limiting the ability of HMOs and PPOs to selectively contract
- Effects in current market may be attenuated by the managed care backlash