February 2, 2024

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House Committee on Behavioral Health and Health Care
Oregon State Capitol
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Re: Certificate of Need Laws Reduce Access to Health Care and Increase Costs

Dear Chair Nosse and Members of the Committee:

Hello, I am Thom Walsh, a health care regulator serving the people of Vermont. As a member of the Green Mountain Care Board, I oversee hospitals in the state, which includes issuing certificates of need, as well as approving annual hospital budgets and health insurance rates. The Care Board is unique in its capacity in that most states have multiple agencies to oversee these aspects of health care. Additionally, I teach Health Systems and Policy at the Geisel Medical School and Tuck Business School at Dartmouth College.

My career began 30 years ago as a physical therapist in private practice and hospital settings. I have studied health care system performance and health policy for 24 years. During the past 14 years, in addition to my teaching work, I have been a consultant for independent and integrated health care systems, as well as regulatory agencies such as Maine Medical Center, OneHealth Nebraska, Wyoming Spine and Neurosurgery Associates, Navy Medicine, the Veterans Health Administration, and The Joint Commission.

Even though I work to enforce Vermont's Certificate of Need (CON) laws, I believe CON laws should be reformed, and I am actively working to do so. I began working to reform CON policies after spending considerable time educating myself on CON laws and learning that they are primarily used to stifle new entrants into the health care market.[1] Current CON laws have not improved the safety, reliability, or quality of care nor helped restrain costs. To increase access to health care services and encourage competition that could slow price increases, states should repeal CON laws prohibiting new providers from opening.

One common argument I hear for keeping CON laws in place is that CON laws aren't harmful because most CON applications are granted. This is misleading. In my experience, only large health care systems have the time and money to go through the lengthy application process,

which typically involves litigation. Incumbent providers have the resources and incentive to use the current CON system, while newer market entrants lack experience with the process, as well as the needed resources for dealing with health care bureaucracy and its heavy administrative burden. This prevents competitors from opening. As a result, newer, innovative entrants give up. This means the current CON process facilitates consolidation and restricts access to care. This leads to higher costs for everyone, both privately insured patients and government payors.

The other argument I routinely hear for keeping CON laws in place is that they are necessary to protect existing providers. The argument goes that established providers will be forced to stop offering certain services or might close altogether if they lose patients to a competitor. This argument assumes that existing providers will lose privately insured patients and be left with patients insured by Medicare or Medicaid. There is an attempt to further justify this argument by noting how government payors reimburse less than private payers, and providers need higher private reimbursement to cover their costs. This is known as "the cost shift." However, the research shows that health care facilities do not rely on cost shifting to compensate for purported losses from Medicare or Medicaid payments.[2]

Although it is attractive to justify exorbitant health care charges using the cost shift argument, no serious literature finds this argument to be true. The data refuting the argument are based on multiple analyses of cost reports and prices gathered from thousands of hospitals. The data are clear, and the explanation for high and rising prices is very simple. Health care systems in consolidated markets raise prices substantially and repeatedly because they can, and current CON laws enable ever greater consolidation. This means there is frequently no other place for patients to receive care. The cost shift argument is an after-the-fact rationalization for practices that would be unthinkable in any other market.

If cost shifting was necessary for health care facilities to stay open, facilities with a greater percentage of patients with Medicare and Medicaid would be forced to charge higher prices. Yet, there is no correlation between what facilities recoup from Medicare and Medicaid patients and the rates they charge to other patients. Moreover, when Medicare and Medicaid reimbursement rates are increased, providers do not cut their rates for treating privately insured patients. Instead, most providers raise prices. Some do not. Conversely, there are no uniform price increases when Medicare and Medicaid rates are reduced. Uniform increases in response to cuts to Medicare and Medicaid rates would be an easily observable phenomenon, and researchers have not found evidence that it's happening.

To take another example, beginning about a decade ago, states began expanding Medicaid coverage in accordance with the Affordable Care Act, but private prices did not change based on whether a state expanded Medicaid. Instead, they continued to rise across most systems.

The data on cost shifting reveals something else. Providers with little competition have higher costs.[3] The Medicare Payment Advisory Commission found that providers with low-profit rates from private payers had cost 9% below the national median. In other words, providers are good

at being efficient when necessary. Providers with higher private-pay patients also had costs 2% higher than the national median. Thus, "it is hospitals' underlying costs, driven by competition, not cost shifting, that lead to differences in prices charged to insurers and shortfalls or profits from public programs."[4]

There are certainly financial struggles for rural facilities or those in underserved communities, but they are not addressed by CON laws. Moreover, the debate surrounding current CON laws and health care costs leaves communities underserved by hospitals. According to a 2020 study by the Congressional Budget Office (CBO), the cost per beneficiary for hospital and physician services under traditional "fee-for-service" Medicare rose just 0.2 percent more than the rate of general inflation from 2013 to 2018.[5] By contrast, the per-person costs in private plans rose by double the rate of general inflation. In fact, the cost for an average insurance plan per family is nearing $25,000, which could buy a new compact car every year. This is especially relevant in Oregon, a state where 30% of adults report struggling to pay medical bills.[6]

I am sharing this information with you because the connection between current CON laws and the affordability of health care is not widely understood. The data are clear, however, in showing that current CON laws decrease competition, which propels further consolidation of health care markets. **Providers within those consolidated markets have monopolistic power, resulting in ever-rising prices, reduced access, and lower quality health care for all patients, whether publicly or privately insured**.

I would be pleased to answer any questions you may have. I can be reached at either email address listed below.

Sincerely,

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[1] *See* https://washingtonmonthly.com/2023/06/19/dont-blame-medicare-for-rising-medical-bills-blame-monopolies/.

[2] *See* Austin Frakt. (2017). *Hospitals Don't Shift Costs From Medicare or Medicaid to Private Insurers*. JAMA. https://jamanetwork.com/channels/health-forum/fullarticle/2760166.

[3] *See supra* note 2.

[4] *See supra* note 2.

[5] *See* http://www.cbo.gov/publication/57422.

[6] *See* https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2021-Impact-of-Health-Care-Costs-on-Oregonians_FINAL.pdf.