



Carmage Walls
Commentary Prize

2015-16 Entry Form

Name of Author(s): Anthony Barton Hinkle

Author's Title (editor, columnist, etc.): Deputy Editor of the Editorial Pages

Newspaper: Richmond Times-Dispatch

Address: 300 East Franklin Street

City: Richmond

State: VA

ZIP: 23219

Phone: 804-649-6627

Fax:

E-Mail:

bhinkle@timesdispatch.com

Submitted by:

Title of Person Submitting: A. Barton Hinkle

Phone Number: 804-649-6627

E-mail Address: bhinkle@timesdispatch.com

What is the subject/title of the entry? Regulation of medical providers through Virginia's Certificate of Public Need process

Date(s) of publication? July 26, 2015; October 18, 2015; October 28, 2015; December 15, 2015; February 2, 2016

Is your newspaper under 50,000 circulation or above 50,000 circulation? Over

Please give a brief explanation of issues discussed and the results achieved. (This space will expand as you type in your comments.)

Virginia requires providers of medical services to obtain permission before making significant new investments, in order to limit the supply of medical care to what state regulators deem necessary. This tends to limit competition and raise prices for consumers.

Debate over the Certificate of Public Need (COPN) system has percolated for years, without leading to much action. This year a state panel suggested minor changes to the regulations, and three state legislators introduced measures to repeal COPN oversight, either in whole or in part.

One of those measures passed the House of Delegates, but was carried over until 2017 in the State Senate on the grounds that it had revenue implications for state government and therefore should be considered by the Finance Committee.

Richmond Times-Dispatch

An Entry for the Carmage Walls Commentary Prize

A. Barton Hinkle, Deputy Editor of the Editorial Pages

Does charity care require COPN?

July 26, 2015

http://www.richmond.com/opinion/our-opinion/article_49713349-9f23-5ec9-890a-fcb2a81b1b8b.html

A Virginia panel is [considering](#) whether to do something many other states already have, and the commonwealth should: repeal the certificate of public need system. But as a recent *Times-Dispatch* front page story noted, the possibility of repeal raises a concern about the future of charity care.

Under COPN, health-care providers must get a permission slip from the state to open a new hospital, add beds to an existing one, purchase certain equipment, and so on. The system was established decades ago to offset perverse financial incentives under Medicare that have long since been corrected.

But COPN lives on, now justified on other grounds. One argument contends that health care is so heavily regulated now that repealing just one set of regulations — COPN — is not feasible. The whole system must be overhauled at once. Since that is a political impossibility, the result is that COPN must continue forever.

This isn't terribly persuasive. Many other states, from right-wing Texas to left-wing Wisconsin, have found a way to repeal their COPN systems without the sky falling. Virginia should be able to also.

If it does, however, then it will lose one crowbar it uses to pry charity care loose from medical providers. The state often conditions approval of a certificate for new facilities by demanding that the applicant agree to provide a certain level of charitable care in return. As *Times-Dispatch*

reporter Tammie Smith's excellent article [pointed out](#), considerable uncertainty exists as to whether providers live up to their obligations. Nobody in the state is checking up to ensure they do.

Still, if Virginia did repeal COPN, then it would lose some of the leverage it uses to obtain charitable care. And given that federal compensation for such care is shrinking as a result of Obamacare — expanded Medicaid was supposed to fill the gap — providers are not likely to do more charity work willingly.

But this is no argument against COPN repeal. As providers themselves note, health care already is heavily regulated, and COPN repeal would not lead to a Wild West world of unaccountable health-care companies. So there's an easy fix: Require a certain level of charitable care as a condition of some other operating permit. Problem solved.

True, complications might arise. But they do not justify maintaining a cumbersome, costly, and time-consuming system of regulation. The Federal Trade Commission and the Justice Department [repeatedly have concluded](#) that COPN systems “create barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs. Together, we support the repeal of such laws, as well as steps that reduce their scope.”

There's no clearer signal that a government program cannot be justified when even government agencies will not defend it.

It's time to kill useless health-care regs

October 18, 2015

http://www.richmond.com/opinion/our-opinion/article_847396f5-44e1-5443-aa4c-5395c6070400.html

It's no great surprise that conservative groups such as Americans for Prosperity are [chiming in](#) on the debate over health care regulation in Virginia. The only surprise is that it took them this long.

After all, the rules at issue — a system requiring that hospitals and other providers obtain a Certificate of Public Need from the state for new facilities or equipment — provide a costly and an outdated solution to a problem that was solved long ago. The COPN requirement has few defenders outside the hospital lobby and other interests that derive a direct benefit from it. It forces providers to waste months, and [hundreds of thousands of dollars](#), getting permission from the government just to spend their own money.

The Certificate of Need system was imposed by Washington to fix a problem caused by Medicare and Medicaid reimbursement formulas. The formulas eventually were changed, and Congress ultimately lifted the requirement that states operate COPN regimes. Some did, but more than 30 — including Virginia — still have COPN in some form or fashion. Market incumbents frequently use the system to block competition — as when VCU helped block a Bon Secours cancer center because VCU worried it could [take some of their business](#). Little wonder that some refer to the system as a “Certificate of Monopoly.”

For such reasons, even the federal government recognizes the wisdom of repeal. As the Justice Department’s antitrust division and the Federal Trade Commission [have said](#), certificate-of-need laws “are not successful in containing health care costs, and . . . pose serious anti-competitive risks. . . . Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anti-competitive barriers to entry.”

Defenders of the big-government status quo [dismiss](#) what they deem “ideologically shaped studies that suggest the mechanism doesn’t do a good job of controlling costs.” But they don’t point to any studies — ideologically shaped or otherwise — that suggest the COPN system actually works. They just like the general idea of state government telling providers what to do.

Some hospital representatives are willing to concede COPN regulation is far from ideal, and they profess to support health care competition in the abstract. But they argue COPN should not be eliminated on its own because that would be disruptive; any lifting of COPN requirements should occur as part of a much broader reform of health care regulation. This is a recipe for inaction, since wholesale changes are usually even harder to pass than piecemeal ones.

The inescapable fact about COPN is that it lacks any defensible justification. Not only does it fail to achieve its objective, it actually worsens the problem it was imposed to solve. In the process it also helps powerful industry players stifle competition and innovation, to the detriment of consumers and medical progress. Anyone who claims the system makes sense is either financially vested in it — or simply deluded.

Repeal COPN

October 28, 2015

http://www.richmond.com/opinion/our-opinion/article_9739632d-b5dd-55d7-97d0-fec10d416b57.html

An unusual number of highly questionable assumptions seems to pervade the debate over Virginia's system for regulating the supply of health care. A state panel is examining the commonwealth's Certificate of Public Need (COPN) law, which requires hospitals, outpatient clinics, and many other providers to get the state's permission before making new investments.

The COPN system is an outdated response to a bygone problem that had been created by old federal reimbursement formulas. But big hospital chains have found it very handy when they want to stifle competition from upstarts who might provide better services at lower prices. The requirement can tie up potential competitors with regulatory red tape for months on end, and force them to spend tens or even hundreds of thousands of dollars simply for the opportunity to open or expand their own businesses.

Two federal agencies — the Federal Trade Commission and the Antitrust Division of the Justice Department — repeatedly have pointed out that COPN laws in Virginia and elsewhere (a) do not lower costs, as they were meant to do, yet (b) permit market incumbents to keep competition at bay, thereby (c) reducing incentives to innovate and improve. The agencies reiterated those points recently in a 13-page [statement](#) to Virginia's COPN working group.

The statement cites considerable independent research showing, among other things, that COPN laws “may actually increase costs”; that repealing them has “contributed to an improvement in hospital cost efficiency” and has “had a salutary effect on the market for cardiac surgery by directing more volume to better doctors and increasing access to treatment”; that “safety net hospitals are no stronger financially in CON states than in non-CON states”; and so forth.

Against the weight of this powerful case, those defending the status quo contend, among other things, that COPN laws prevent over-investment and ensure the optimal distribution of health care facilities. They do not explain their apparent assumption that the state is more qualified than anyone else to know the right level of investment or the optimal distribution of health care facilities.

Defenders also worry that if COPN is repealed, ambulatory care centers and similar startups might cherry-pick profitable lines of business, leaving hospitals stuck with the sickest and least profitable patients. Behind that complaint lie two unsupported assumptions: (1) that hospitals enjoy an inalienable right to state protection from competition, and (2) that hospitals are incapable of doing anything to fend off competitors on their own.

The third assumption about COPN is perhaps the oddest of all: that market economics have no place in health care because providers are already so heavily regulated. In other words, the existence of regulation itself makes deregulation inappropriate.

That makes no sense. But it's the sort of desperate excuse that self-dealing interests are reduced to when the cause of reform has cornered the market on rational arguments.

Hinkle: To reduce inequality, cut red tape

By A. BARTON HINKLE

December 15, 2015

http://www.richmond.com/opinion/our-opinion/article_0b88f41d-ab72-5051-b9f2-b033b0b2d5fd.html

A “considerable portion of America’s exploding inequality,” [writes Steven Teles](#), “has been generated by government itself. . . . While the state is sometimes the friend of those working to produce a more egalitarian society, it is just as often the tool of those who would entrench inequality.”

Exhibit A: [Virginia’s Certificate of Need](#) program.

That program requires health-care providers to get the state’s permission before making new investments, such as building a hospital or buying an MRI machine. The result — the primary objective, in fact — is to restrict the supply of health care and limit competition. This raises prices and benefits market incumbents, especially large hospital corporations and the (often quite rich) doctors and executives who work for them.

Economists refer to that unearned benefit as “rent,” which Teles defines as “legal barriers to entry or other market distortions created by the state that create excess profits.” The interests that receive such rents [fiercely defend](#) them — which helps explain why efforts to repeal Virginia’s COPN rules have fizzled.

Earlier this month a state panel that [had been studying](#) the regulations recommended [several minor changes](#) — starting with drafting a statement of purpose, since even that is unclear — but not eliminating COPN wholesale. Elimination of COPN would lead to greater supply, and lower prices, as even the Justice Department and Federal Trade Commission [repeatedly](#) have [pointed out](#) — which would allow the market to transfer wealth from suppliers to consumers.

Teles doesn’t refer specifically to COPN laws in his article, “[The Scourge of Upward Redistribution](#),” which appears in the Fall issue of *National Affairs*. But he does point out that doctors, who make up a good part of America’s richest 1 percent, extract rents from the public through other government policies. One of those is licensure: “The law specifies tasks that only licensed doctors can perform, even though nurses are capable of performing them.”

Licensing limits the supply of physician services in other ways, too. Physicians in other countries often make considerably less than their American counterparts. But those who move to the U.S. usually [have to take years of retraining](#), no matter how advanced their degrees or their skills. This despite the fact that parts of the U.S. suffer from a severe [doctor shortage](#). Why not encourage immigration by foreign doctors — especially from advanced countries — and allow

them to start practicing quickly? Or, to take another example: Why not let eyeglass companies offer on-site optometry exams, which Virginia and many other states [prohibit](#)?

The answer is obvious: the doctors' lobby. Medical providers have a large financial incentive in the status quo. The rest of us have a very real but much smaller financial interest in changing it. Guess who's going to lobby Congress about the issue? Bingo. This is the same problem of concentrated benefits and dispersed costs that causes so many other regressive policies, from farm subsidies to import tariffs.

But Teles argues that lobbying is only part of the problem. There is also “cultural capture”: “Public officials tend to be disproportionately wealthy and have common social and educational experiences with those seeking high-end rents. Thus, when policymakers consider the claims of people like them — financiers, car dealers . . . dentists and doctors — they are likely to be sympathetic.” Moneyed interests also have a cadre of influence-peddlers who can appear before boards and commissions, submit public comments to rule-making agencies, and produce studies designed to make self-seeking look like public-spiritedness. That is why nearly every major proposed government program, project or regulation is supported by “research” purporting to show that it will “save money in the long run.” (If that were true, then at some point government spending would go down and stay down — which it never does.)

Health care is an extreme example, but upward redistribution of wealth through government action affects nearly every sector of the economy. In most states, [direct sales of new automobiles](#) to consumers are forbidden — you have to buy through a dealership. Roughly a third of all occupations now [require a government license](#) — up from only 5 percent of all occupations a few decades ago.

Technology has eroded the power of cartels and trade unions in some areas — newer market entrants such as LegalZoom can provide many standard legal services at a fraction of the traditional cost — but has left others untouched. Teles points out that the “unit cost of intermediation” in the financial sector has largely held steady — in part because the financial sector is so heavily regulated, and the regulators are so heavily influenced by those they regulate.

All of this is fixable: We can roll back occupational licensing, relax restrictive patents and copyrights, recognize foreign medical credentials, and more. Repealing Virginia's COPN requirements would be an excellent place to start.

With court ruling, COPN fix must come from lawmakers

February 2, 2016

http://www.richmond.com/opinion/our-opinion/article_5d92f9e5-d8e8-5660-ae44-252cfa69480b.html

J. Harvie Wilkinson, a widely esteemed member of the 4th Circuit Court of Appeals, was regrettably correct when he and two colleagues ruled last month that a Virginia law restricting the supply of health care is constitutional. His rationale, however, stands on shakier ground.

The COPN system requires hospitals, ambulatory-care centers, and other health-care providers to get permission from the state before making major new investments — i.e., before spending their own money. The lengthy and expensive process can take months and cost hundreds of thousands of dollars, and has been used to stop innovative new treatments that have proven successful elsewhere.

Hospitals not only use the system to throttle upstart competitors, they also wield it against one another — as when HCA tried to stop Bon Secours from building the St. Francis medical center in Chesterfield. The system is a gold mine for lawyers, who rack up huge fees trying to convince the state either to approve or reject projects — projects that often do little but follow customers by moving beds across town.

COPN has no benefit to consumers, though. By restricting supply, it forces patients to drive sometimes long distances to get services they should be able to get closer to home. Research has shown that COPN laws [reduce the number and availability of](#) services and hospital beds. With so many members of the baby boom generation reaching retirement age, Virginia should be trying to increase the supply of medical services, not restrict it.

The system has few defenders now except for large hospital chains that use the law to throttle competition (which they call “cherry-picking”) and their occasional allies. Those allies labor under the delusion that market incumbents run their businesses for purely virtuous motives while would-be competitors are driven strictly by greed and are unburdened by any scruple. The evidence for that assumption is, to put it kindly, elusive.

But the wisdom of a given policy has little bearing on its constitutionality. For many decades, the courts have given economic regulation carte blanche by setting the bar absurdly low. The relevant test is whether there might be a “rational basis” for a regulation. So long as someone can conceive of such a basis, no matter how fanciful or strained, the courts will uphold the government’s position. The result is a regulatory power of nearly infinite scope. Wilkinson was correct when he acknowledged that dubious reality.

Redress for that lamentable state of affairs will have to come from the Supreme Court. So redressing Virginia’s COPN regime now becomes the responsibility of the General Assembly.

Fortunately, several legislators have introduced measures that would either roll back parts of the COPN system or repeal it entirely. The bills are due to be taken up in committee today. They have been written precisely to meet the objections of the hospital lobby. For example: A measure

deregulating medical imaging, by Del. Chris Peace, would apply the same charity-care requirements that hospitals must meet. Del. John O'Bannon's measure would retain COPN regulation in those areas, largely rural, where hospitals face the highest fiscal stress.

In short, the sponsors of the bills have taken away the few cards that defenders of the status quo have left to play. The sooner their measures are signed into law, the better off Virginia consumers will be.