Global Counsel

Can the covid-19 crisis reverse the decline of the American hospital?

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Summary

The US healthcare sector, and hospitals in particular, face a reckoning amidst the covid-19 crisis. The strains on the industry, encapsulated by indelible images of overwhelmed emergency rooms and frontline workers, has highlighted a years-long decline in hospital capacity in the US. The outbreak has also cast a new spotlight on a regulatory practice known as Certificate of Need – an approval process required in many US states for building or expanding hospitals or other healthcare facilities that can limit competition. In this Global Counsel Insight note, we examine the history and current state of play around Certificate of Need laws; the larger debate surrounding healthcare capacity in the US; and look ahead to how these dynamics may unfold going forward, particularly heading into a presidential election in which the nation's preparedness and response to covid-19 are sure to be critical issues.

Overwhelmed emergency rooms. Doctors and nurses putting their lives on the line to care for covid-19 patients. A field hospital built hurriedly in New York's Central Park. Rural hospitals closing as elective surgeries and non-covid-19-related visits plummet.

It might seem improbable that the US healthcare system, which has demonstrated these strains and others as a result of the covid-19 outbreak, could emerge bigger and stronger from the crisis. But just as cities build higher seawalls after a 100-year flood, and industries have been re-examined and renewed after periods of intense disruption, we think the covid-19 outbreak will lead to a major policy debate about questions of capacity and resource allocation in US healthcare. And in the long run, we think the policy results of this discussion could benefit the same hospital sector that today is experiencing such stress.

Background

One obscure but significant policy area where this debate is likely to play out as the covid-19 crisis recedes is what is known as Certificate of Need (CoN) laws. CoN regulations exist in 35 US states and the District of Columbia (an additional three states have modified versions of these laws). CoN laws require hospitals and some other healthcare providers to receive approval from a government-appointed board before building, expanding or acquiring a facility, or even adding certain services at an existing one. The process can be lengthy, costly, and gives incumbents ample opportunity to oppose a petition from the potential new player (what provider would welcome new competition?).

While there are certainly many other factors that have led to a reduced number of hospitals over the years, CoN regulations have played a role in limiting capacity and competition in US healthcare. And while the debate can certainly be drawn along traditional political lines, in practice CoN procedures are often driven not by ideology but by preventing or delaying new entrants from challenging incumbents, both for-profits and not-for profits.

The covid-19 crisis has led some to question whether the reduction in hospital capacity has gone too far. This will place CoN regulations back in the spotlight when state legislatures return to work, a trend well worth following for corporates and investors with interests in the US healthcare system.

Despite spending more on healthcare than any other country in the world, US hospital beds per capita are well below those of many other developed nations (Fig 1). The number of US hospital beds has actually been on a decades-long decline, from 1.5 million in 1975 to about 931,000 in 2017, according to the American Hospital Association and the Centers for Disease Control. The healthcare industry has focused more on outpatient

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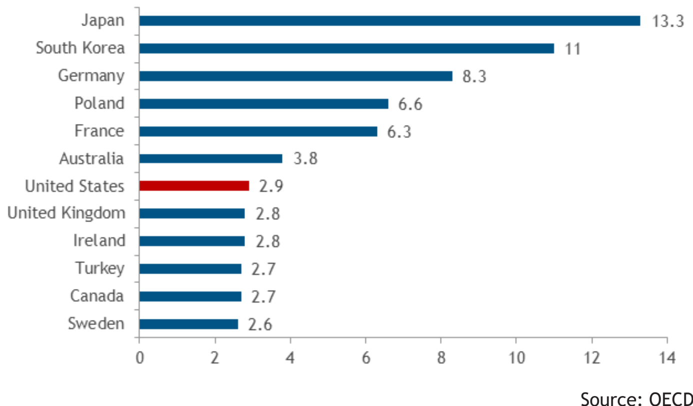
services and attempted to shorten hospital stays for patients given the high expense of treatment in that setting. Hospitals have been subjected to greater cost pressures over the years from the rise of managed-care insurance organisations and other factors.

Fig 1. Hospital Beds Per 1,000 People



Source: OECD

CoN regulations in the US date back to the 1960s. The idea is that as a public good, provision of healthcare services should not be left to the free market, because the market may not provide adequate care for less-wealthy people on its own, and consumers are not able to shop freely for healthcare as they are for most other products and services.

Think of an expensive new piece of medical equipment that a wealthy hospital wishes to buy. The hospital's affluent clients may well value and be willing to pay for use of the equipment, so the purchase makes economic sense for that hospital. But less-wealthy hospitals in the same region may be disadvantaged because affluent patients are more likely to go to the centre with the fancy new machine, leaving competitors caring for poorer clients who present a greater burden on their resources.

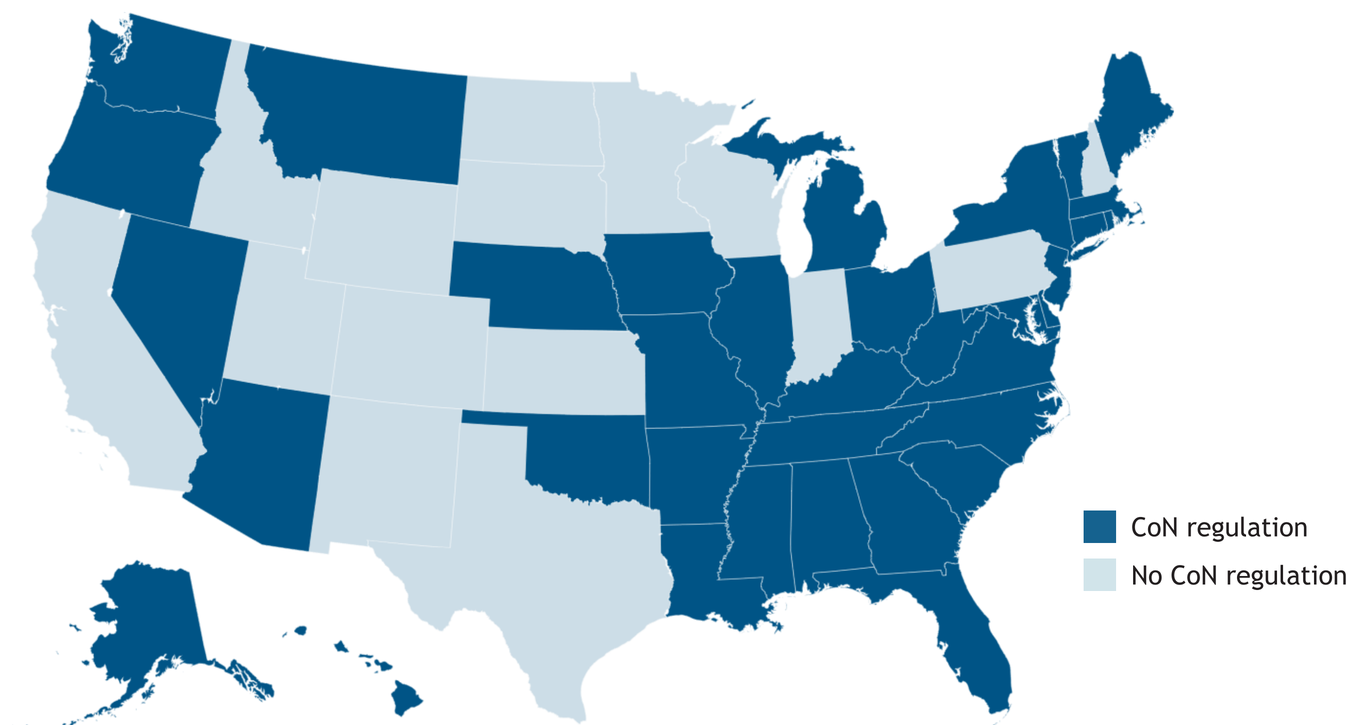
And perhaps the piece of equipment provides little long-term benefit to the community at large, but only for a few consumers. Supporters of CoN regulation would argue that this purchase should be blocked (for this example we credit a *2015 American Bar Association article by Maureen Ohlhausen, a former Commissioner of the US Federal Trade Commission under presidents Obama and Trump*).

With its overtones of government regulation meddling with private enterprise, CoN laws have been a target of conservative think tanks and scholars since well before covid-19. "Certificate of need laws give incumbent businesses the ability to veto their competition," reads one 2014 commentary from the libertarian Cato Institute, one of several similar arguments by the think tank over the years. The Trump administration recommended that states repeal or scale back CoN laws in a *December 2018 white paper*.

However, opinions on CoN regulations do not always break neatly on ideological lines, particularly as the practice is now administered by the states (a federal mandate requiring CoN approval was repealed in 1986). Some liberal observers have argued CoN laws can restrict new competition from entering an underserved healthcare market. A number of Western and Southwestern states traditionally thought of as free-market conservative bastions (Texas, Utah and Idaho, for example) do not have CoN laws. But neither does California, often thought of as one of the liberal states in the nation, or Pennsylvania, a "purple" state with strength in both political parties. And states in the traditionally politically conservative Southeast all maintain some degree of CoN regulation.

On balance, our reading of the research suggests that states without CoN regulation have lower costs and better outcomes than those that do. The Mercatus Center, a think tank, has conducted the most exhaustive research on CoN regulation. The group found in 2017 that "states with CoN programs have about 99 fewer hospital beds per

Fig 2. US States with Certificate of Need (CoN) Hospital Regulation



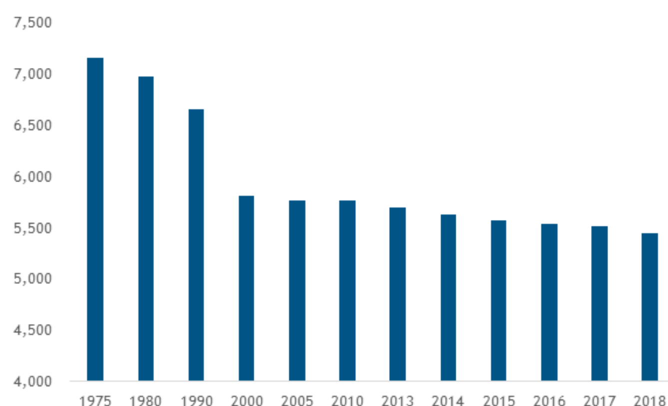
Source: Mercatus Center

100,000 people than states without these regulations." Mercatus also found that CoN programs "that specifically regulate acute hospital beds are associated with an average of about 131 fewer hospital beds per 100,000 people relative to non-CON states." Mercatus is a conservative-leaning think tank. But data from the Kaiser Family Foundation, a non-partisan group, supports Mercatus' conclusion that healthcare costs are higher in states with CoN regulations than those without such laws (see Fig 4).

Hampered by regulation as well as the industry dynamics described above, US hospitals have been in retreat. While much of the US economy had grown solidly in the years leading up to the covid-19 crisis, hospital construction grew at a rate of just 1% from 2015 to 2019, and fell 2% in 2019, according to IBISWorld. The number of US hospitals has fallen in each of the last five years, totaling a net loss of 240 during that period, according to the American Hospital Association. The number of US hospitals is well below levels of decades past (see chart below), as more care has moved to outpatient facilities, and hospitals have faced greater cost pressures.

As one measure of the limitations on US hospitals, the two largest for-profit US hospital operators, HCA Healthcare (ticker: HCA) and Tenet Healthcare (THC), only operate in 21 and nine states, respectively. Reflecting modest growth expectations -- as well as the very real current challenges of navigating the health risks to employees and a drop in non-covid-19 related patient demand -- HCA and Tenet shares were trading at 9.0x and 6.2x 2021 consensus EPS estimates as of April 23th, well below the broader market.

Fig 3. Number of US hospitals



Source: Centers for Disease Control, American Hospital Association.

Note: For comparison purposes the 2017 and 2018 figures are adjusted for a reclassification of the data, which resulted in a reported increase of 700 facilities in those years.

Momentum toward CoN reform fades

15 states have repealed their CoN laws, New Hampshire the last in 2016. However, CoN repeal and reform efforts seem to have weakened in recent years. In 2019, efforts to repeal CoN laws failed in state legislatures in North Carolina, West Virginia, Georgia, South Carolina, Virginia and Alaska, though some of these states passed modified CoN laws for some healthcare services, and Florida repealed substantial portions of its CoN requirements.

A lawyer we spoke with who has represented healthcare firms in opposing CoN requests from potential competitors says many providers are managing toward shorter hospital

The saga of Fort Mill, SC

A look at one example highlights the bureaucratic delays the CoN process can generate – and the complicated policy and political dynamics that often surround decisions of healthcare capacity. In 2004, the state of South Carolina sought applicants to build multiple hospitals in Fort Mill, in the northern part of the state about 30 minutes south of Charlotte. Fort Mill is a small town with about 15,000 residents, but the county of which it is a part was (and is) a fast-growing destination for retirees and commuters from Charlotte, increasing its population by 25% in the prior census. Three providers bid for the facilities, two from North Carolina and the third a unit of Tenet, which already operated a hospital in nearby Rock Hill, SC. The state initially granted a CoN to Tenet, but the certification was overturned on appeal and given to one of the other bidders, which built a 64-bed rheumatology center in Fort Mill in 2006.

Tenet appealed the case and continued to seek approval to build a 100-bed acute-care hospital. Tenet finally won last year in a case that went up to the South Carolina Supreme Court, 15 years after the process began. The company has estimated the hospital will bring 400 jobs and $4.3m in annual tax revenue to Fort Mill, which had an annual budget of $48m in 2018. Tenet reported in a securities filing in February 2020 that it is planning to submit its plans for the hospital to a separate state regulatory body, and that after that approval is granted construction is expected to take an additional two years.

We have watched many political battles over the years, and we are highly aware that an incumbent's strategy against a challenger can often be to just run out the clock, rather than win a resounding victory on the merits. And we are not familiar enough with the details of the Fort Mill case to weigh each objection to the project by outside parties or the regulators. But the case appears indicative of a process where the trees have been lost amidst the forest, and the goal of providing better healthcare services for a growing, vibrant rural area has been lost in bureaucratic morass. Just a few weeks ago, the two largest hospitals in the Charlotte region petitioned the North Carolina state government to convert dormitories at the University of North Carolina-Charlotte into temporary hospital beds to handle a potential need for up to 3,000 beds more than the hospitals had available due to covid-19. To date, it does not appear the space has been needed given the path of the virus. But would another hospital 30 minutes south of Charlotte relieve some of the pressures on the health system in the region, either with this wave of covid-19, or if, as health officials are starting to project, the next?

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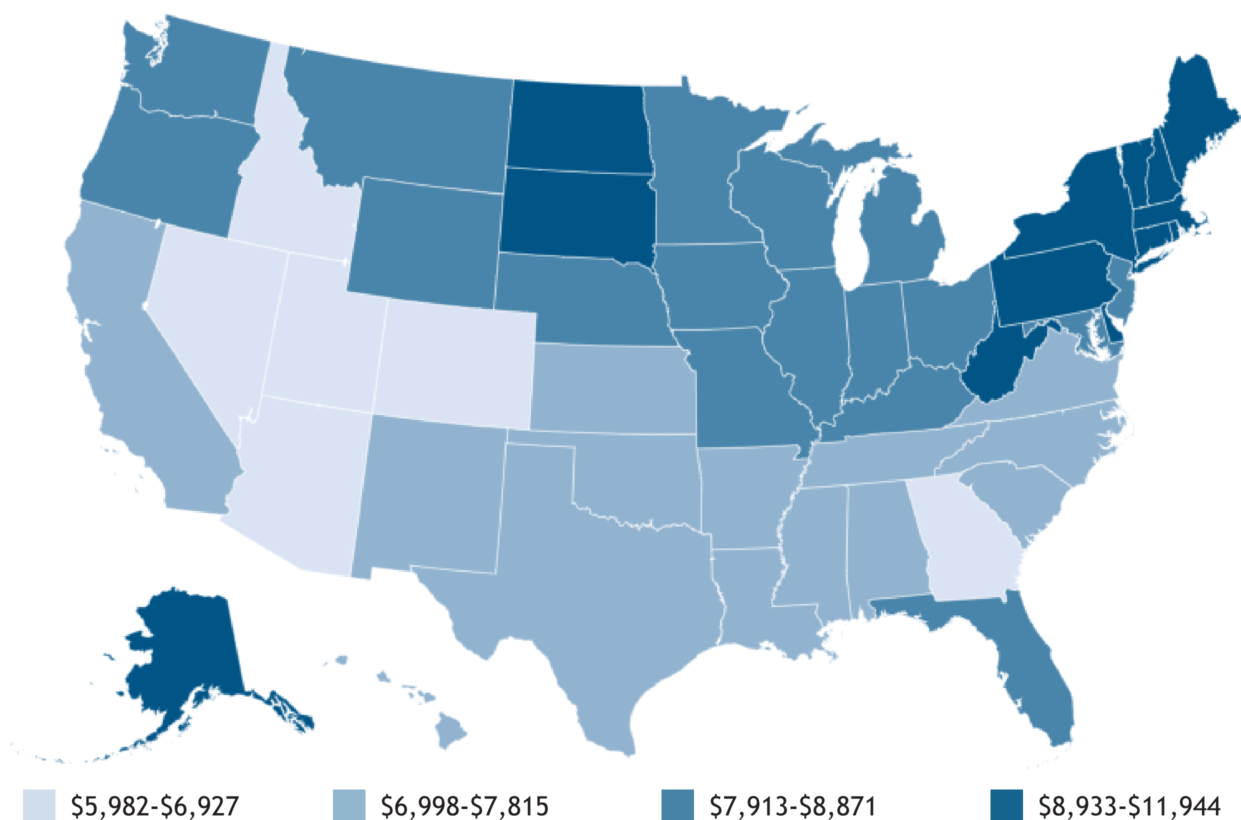
Fig 4. Health care expenditures per capita by state of residence, 2014



Sources: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: Health Expenditures by State of Residence, June 2017.

Notes
The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary produces Health Expenditures by State of Residence and Health Expenditures by State of Provider every five years. The State Health Expenditure Accounts are a subcomponent of the National Health Expenditure Accounts (NHEA), the official government estimates of health spending in the United States. Additional information on data and methods is available here. For additional analysis of these data, please see Health Affairs article

Definitions
Health Spending Per Capita includes spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of residence (aggregate spending divided by population). Hospital spending is included and reflects the total net revenue (gross charges less contractual adjustments, bad debts, and charity care). Costs such as insurance program administration, research, and construction expenses are not included in this total.

stays for patients in response to industry cost pressures. The ACA has increased the size of the market by expanding coverage, but brought in new populations who cost more to care for. With more sensitivity around the bottom line, incumbent providers are worried about new capacity coming into their area and are more willing to oppose CoN requests. This attorney says both wealthy for-profit hospitals and less affluent not-for-profits will fight CoN application requests from potential competitors. Defending one's turf, it seems, is an activity all ideologies can support.

CoN Laws and covid-19

The covid-19 crisis has led to some movement in the CoN debate. Some 15 states have temporarily repealed or modified their CoN rules in response to the outrbreak, according to a recent podcast by Angela Erickson, strategic research director of the Pacific Legal Foundation, a libertarian legal advocacy group. The field hospital built in New York's Central Park, for instance, was the result of a CoN exemption by the state to help support hospitals in that city overwhelmed by covid-19 patients, according to Erickson. In South Carolina, the home of the years-long legal battle over hospital expansion in Fort Mill, Republican Governor Henry McMaster has temporarily suspended CoN enforcement to combat the virus. The question now is whether covid-19's impact will shift the debate when most state legislatures return to session in early 2021, and lawmakers will surely restart efforts to repeal or weaken CoN laws.

As CoN laws are decided on by each state, the 2020 elections will not have a direct bearing on repeal or modification efforts in state legislatures. However, healthcare resources and access will surely be a major focus for the next president given the focus on the industry amidst the covid-19 crisis, whether Trump wins a second term or former vice president Joe Biden unseats him in November. Biden and other Democrats have staked much of their party's proposition to voters on supporting the Affordable Care Act (ACA) signed into law when Biden was vice president under Barack Obama, which widened government-sponsored health insurance to a larger population. A number of analyses of the 2018 midterm elections suggested that Democrats' defense of the ACA against efforts by President Trump and the Republican-controlled Congress to repeal or weaken the health law was a key reason that Democrats won back the House of Representatives in 2018.

Biden has made continued support and expansion of the ACA a key element in his run for president. And he has pivoted to incorporate covid-19 response into his campaign platform. In a lengthy post to his campaign website clearly intended to highlight his long experience in "big government" to oppose Trump and Republicans' long-held criticism of that notion, Biden proposes *numerous federal programs to increase spending on healthcare facilities, staffing and medical research to combat covid-19*. Included in his plan is a new "State and Local Emergency Fund" that would be directed to state and local governments for, among other functions, "expanding critical health infrastructure, including building new or renovating existing facilities, if necessary." With the covid-19 crisis at best a searing memory for the nation, and at worst a still-present danger, Biden would take office in January 2021 with an imperative to focus his administration's efforts and the nation's fiscal resources to shoring up the healthcare system, supporting frontline workers and trying to get ahead of the next pandemic through research and crisis-response planning.

For Trump's part, if he is re-elected in November, it will almost certainly be because his administration, in conjunction with state governors, are able to navigate the tricky balance this year between re-opening economies too late to prevent economic collapse, versus re-opening too early and inciting a renewed spike in covid-19 cases and deaths. While Trump had arguably not made health policy a key element of his first term since the Senate failed to repeal portions of the ACA in summer 2017, Trump is effectively now spending a substantial portion of his every day in office on healthcare, and likely will continue to do so for months to come, an experience that indelibly will color his approach to a second term.

Just as Congress created special commissions to investigate the terrorist attacks of September 11, 2001 as well as the Global Financial Crisis of 2007-09, surely a similar panel will be appointed to assess the federal government's preparedness for and handling of the covid-19 outbreak. The commission is likely to focus in part on issues of healthcare capacity and flexibility and the many ways these functions are restricted, not just by CoN laws, but by restrictions on telehealth, international supply chains for medical equipment, and the lack of backup capacity for frontline healthcare workers.

Conclusion

The focus on the performance of the healthcare system during the pandemic - and the funding the federal government has committed during the crisis – means a wholesale re-examination of CoN laws and other healthcare regulations at the federal and state levels is inevitable. That in turn will yield numerous opportunities for corporates and investors willing to embrace the challenges currently facing the system, regardless of who sits in the White House in 2021.

This Global Counsel Insight note was written by Erin Caddell, Director at Global Counsel.

To contact the author, email:
e.caddell@global-counsel.com

The views expressed in this note can be attributed to the named authors only.

A: 1050 Connecticut Ave NW, Suite 500, Washington, DC 20036
T: +1 [202] 742 6764
E: info@global-counsel.com
www.global-counsel.com
@global_counsel

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