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Pandemic economics: The U.S. is learning why limiting hospital beds carries a steep cost

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The coronavirus outbreak should be teaching an important lesson. Capping the number of hospital beds is a bad idea.

Around half of all Americans live in states governed by iron-fisted regulations that effectively block the construction of new hospitals, the expansion of existing facilities, or even the addition of beds in recovery rooms to treat an overflow of patients in a bad flu season. Those certificate-of-need laws, or CONs, artificially hold the number of hospital beds at far lower volumes than providers would supply in a free market. When a deadly outbreak strikes, hospitals in the regulated states are handcuffed. The flood of infected patients need unoccupied beds, but those beds aren't available because the hospitals are tightly packed. The CONs hobble their flexibility to handle a surge.

Given those constraints, you'd think that the coronavirus pandemic would have swamped America's hospitals, forcing providers to turn sick patients away, and accelerating COVID-19's spread. Indeed, many experts were predicting that doomsday scenario just a few weeks ago. It hasn't happened—and not just because the remarkable adherence to social distancing flattened the curve of new infections much sooner than forecast. In reality, the U.S. escaped disaster in large part because restrictive states suspended their caps, allowing hospitals to expand far beyond their official "capacity" and so that tightly controlled New York became just as free as such non-CON peers as Texas.

The remarkable results from letting freedom ring should prompt the states to weigh permanently scuttling their CONs. If that happens, states constrained for decades would add all the new beds providers could profitably fill in normal times, as well as a cushion for future outbreaks that's now a thin, fragile buffer. If the CONs are reinstated, American hospitals could well get overwhelmed when the next pandemic strikes. "I would hope the governors would say, 'Let's not risk this again,'" says Jeffrey Singer, a surgeon in Phoenix and fellow at the Cato Institute. "The free-market states have a lot more capacity than the CON states. They should be the model for ensuring America has the right hospital capacity in the future."

What are certificate-of-need laws?

In 1987, Congress repealed the federal mandate, and over the next three decades, 15 states have scuttled their CONs. In the 35 that kept them, state agencies hold the power to approve, deny, or alter applications from hospitals, ambulatory centers, and other providers for new or expanded facilities. The list of regulated services varies widely by state. In New Jersey, the Healthcare Facility Licensing/Certification Agency grants or withholds CONs for all types of hospitals, as well as diagnostic treatment centers, nursing homes, and a dozen other services.

Among the most commonly and heavily restricted categories are hospitals. Of the 35 CON states, 28 require their agency's approval for construction of a new hospital or additions to an existing one. States regularly ban hospitals in the same chain from transferring beds from a site that has too many, to facility that needs them. The restricted 28 encompass most of the states hit hardest by the coronavirus, including New York, Massachusetts, Connecticut, Washington, and Illinois. Notable non-CON states are Pennsylvania, California, and Texas.

CONs don't deliver the promised benefits

The idea that artificially constraining the supply of any product or service would expand availability and lower costs is suspect. And in the case of CONs, many studies show that the practice cripples competition with predictable results: higher prices, bigger total costs, and less access. The rub is that incumbent hospitals, nursing homes, and diagnostic centers have a strong incentive to block lower-cost rivals from invading their markets and forcing down rates. "It's protectionism on the state level," says Matt Mitchell, senior research fellow at the Mercatus Center at George Mason University. Mitchell found that CON jurisdictions offer far fewer ambulatory surgery centers, dialysis facilities, and MRIs than non-CON states. In a letter to the President in 2018, the secretaries of Labor, Treasury, and HHS warned that "state policies that restrict entry into provider markets can limit choice, competition, and innovation." The three departments, along with the FTC and antitrust arm of the Justice Department, advise states to consider repealing or scaling back their CONs. "It's as though a state agency told all retailers that each store could devote only four shelves to toilet paper, when customers would be buying out six shelves,“ says Singer. "You'd have a shortage of toilet paper, and consumers would pay much higher prices for it."

The supply of beds is a lot lower in the CON states

Contrary to the claims that restrictions greatly improve access and choice, Mercatus found that the free-market states have, on average, 30% more hospitals per capita than do the CONs, and that edge holds for both urban and rural facilities. Across the U.S., the average number of hospital beds per 1,000 people is 2.77. By contrast, Italy has 3.18, China 4.3, South Korea 12.3, and Japan 13.1. The divide is stark between the two categories of states. According to Mercatus' research, the CON states have 1.31 fewer beds per 1,000 people than the non-CONs.

Many of the CON states with large metro areas offer extremely low levels of empty beds, and hence lack a crucial buffer if a new virus attacks. The Urban Institute's Fredric Blavin conducted a study of unoccupied beds per 1,000 residents in all 50 states in 2018; those figures are likely little changed since just before the outbreak. While the national average stands at 0.80 free beds

per 1000 population, Connecticut registers 0.45, Massachusetts 0.51, Washington 0.57, and New York 0.58.

Miraculously, tight supply didn't cause crippling shortages

A warning to the reader: I was unable to fully reconcile the hospitalization numbers coming from such sources as New York State, the CDC, and the University of Washington's Institute for Health Metrics and Evaluation (IHME). It's unclear precisely which categories of beds different sources are counting. Still, here's my best take on the predicted "shortages" that didn't materialize for both the U.S. overall and for certain states.

On its website, IHME shows "beds needed" for the U.S. at roughly 66,000, and a "shortage" of 13,400, split between a shortfall of 8,900 ICU and 4,500 regular beds. Those figures suggest that the areas hit, or expected to be hit, by the virus, dominated by urban hotspots such as the New York metro area, offered around 52,600 available beds before the outbreak (66,000 beds needed minus the shortage of 13,400). Those figures square with the Urban Institute numbers showing total unoccupied beds in New York, New Jersey, Massachusetts, Connecticut, and Rhode Island of less than 24,000, since those five account for around half of all coronavirus cases.

Those 24,000 free beds are an incredibly lower number compared with national norms. For example, Long Island's Nassau County had just 0.34 empty beds per 1,000 people, while Kings County, home to Brooklyn, had 0.32, and Connecticut's Fairfield County 0.42—all far below the U.S. average of 0.8.

But wait! The U.S. found beds for all the coronavirus patients who required hospitalization. All of the 66,000 "beds needed" were supplied. According to the IHME site, New York State alone is lodging 20,300 coronavirus sufferers, 7,200 more than the state's capacity, apparently meaning the level of unoccupied beds prior to the pandemic. All told, hospitals in the five states are supplying 38,500 beds for COVID-19 patients, 60% more than their pre-crisis capacity.

So how did America defy the CONs and create such an on-the-spot gusher in beds?

States loosened the regs to help America's hospitals handle the surge

A big factor was the ban on elective procedures, opening up beds that would have gone to patients recovering from or hip replacement surgery to folks gravely ill with COVID-19. But the states also helped big-time with what amounted to a sweeping wave of deregulation. No fewer than 18 states waived or scaled back the CONs restricting more hospital beds, including New York, North Carolina, and Kentucky. "In non-CON states, hospitals couldn't bring in more beds fill part of the ERs and recovery rooms," says Singer. "That's what the Arizona hospitals always do when hit by a bad flu season. But when states lifted their CON restrictions, the hospitals were able to add lots of beds."

Granting hospitals the flexibility that the CON laws normally deny them worked beautifully. But what if total hospitalizations hadn't peaked below 70,000, and had hit the roughly 200,000 that the IHME and other organizations believed possible just a few weeks ago? In that case, making

up for the shortfall, even if the states once again lifted their CONs, would be a lot harder. The CONs are designed to keep capacity tight, and that policy runs directly counter to fighting an epidemic. The better option is for the states to scrap their CONs and allow rising entrepreneurs and new rivals to provide all the beds America's health care customers want, and ample extra capacity to tackle the next attack.