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Certificate-of-Need Laws: Implications for New Hampshire

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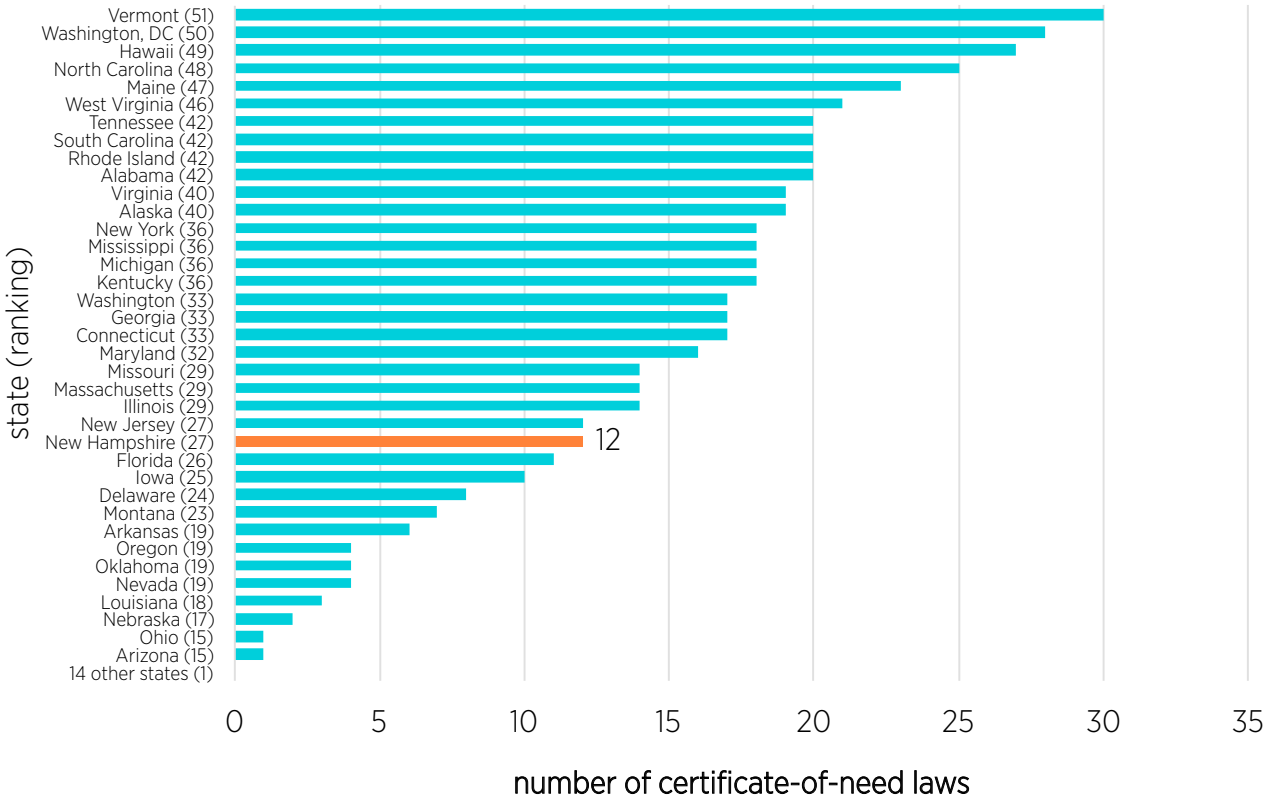
Thirty-six states and the District of Columbia currently limit entry or expansion of health care facilities through certificate-of-need (CON) programs.[1] These programs prohibit health care providers from entering new markets or making changes to their existing capacity without first gaining the approval of state regulators. Since 1979, New Hampshire has been among the states that restrict the supply of health care in this way, with 12 devices and services—ranging from magnetic resonance imaging (MRI) scanners to open heart surgery to psychiatric services—requiring a certificate of need from the state before the device may be purchased or the service may be offered.[2]

CON restrictions are in addition to the standard licensing and training requirements for medical professionals, but are neither designed nor intended to ensure public health or ensure that medical professionals have the necessary qualifications to do their jobs. Instead, CON laws are specifically designed to limit the supply of health care, and are traditionally justified with the claim that they reduce and control health care costs.[3] The theory is that by restricting market entry and expansion, states might reduce overinvestment in facilities and equipment. In addition, many states—including New Hampshire—justify CON programs as a way to cross-subsidize health care for the poor. Under these charity care requirements, providers that receive a certificate of need are typically required to increase the amount of care they provide to the poor. In effect, these programs intend to create *quid pro quo* arrangements: state governments restrict competition, increasing the cost of health care for some, and in return medical providers use these contrived profits to increase the care they provide to the poor.[4]

However, these claimed benefits have failed to materialize as intended. Recent research by Thomas Stratmann and Jacob Russ demonstrates that there is

FIGURE 1. RANKING OF STATES BY NUMBER OF CERTIFICATE-OF-NEED LAWS



no relationship between CON programs and increased access to health care for the poor.[5] There are, however, serious consequences for states continuing to enforce CON regulations. In particular, in New Hampshire these programs result in approximately 1,300 fewer hospital beds, seven fewer hospitals offering MRI services, and nine fewer hospitals offering computed tomography (CT) scans. For those seeking quality health care in New Hampshire, this means less competition and fewer choices, without increased access to care for the poor.

THE RISE OF CON PROGRAMS

CON programs were first adopted by New York in 1964 as a way to strengthen regional health planning programs. Over the following 10 years, 23 more states adopted CON programs.[6] Many of these programs were initiated as "Section 1122" programs, which were federally funded programs providing Medicare and Medicaid reimbursement for certain approved capital expenditures. The passage of the National Health Planning and Resources Development Act of 1974, which made certain federal funds contingent on the enactment of CON programs, provided a strong incentive to states to implement these programs.[7] New Hampshire enacted its first CON program in 1979. By 1982, just eight years later, every state except Louisiana had some form of a CON program.

In 1987, the federal government repealed its CON program mandate when the ineffectiveness of CON regulations as a cost-control measure became clear. Twelve states rapidly followed suit and repealed their certificate-of-need laws in the 1980s.[8] By 2000, Indiana, North Dakota, and Pennsylvania had also repealed their CON programs. Since 2000, Wisconsin has been the only state to repeal its program.

New Hampshire remains among the 36 states, along with the District of Columbia, that continue to limit entry and expansion within their respective health care markets through certificates of need. On average, states with CON programs regulate 14 different services, devices,

and procedures. New Hampshire's CON program currently regulates 12, less than the average. As figure 1 demonstrates, New Hampshire ranks as the 27th most restrictive state given its number of certificate-of-need regulations.

DO CON PROGRAMS CONTROL COSTS AND INCREASE ACCESS TO CARE FOR THE POOR?

Many early studies of CON programs found that these programs fail to reduce investment by hospitals.[9] These early studies also found that the programs fail to control costs.[10] Such findings contributed to the federal repeal of CON requirements. Since then, more recent research into the effectiveness of remaining CON programs as a cost-control measure has been mixed. While some studies find that CON regulations may have some limited cost-control effect,[11] others find that strict CON programs may in fact increase costs by 5 percent.[12] The latter finding is not surprising, given that CON programs restrict competition and reduce the available supply of regulated services.

While there is little evidence to support the claim that certificates of need are an effective cost-control measure, many states continue to justify these programs using the rationale that they increase the provision of health care for the poor. To achieve this, 14 states—including New Hampshire—include some requirement for charity care within their respective CON programs.[13] This is what economists have come to understand as a "cross-subsidy."[14]

The theory behind cross-subsidization through these programs is straightforward. By limiting the number of providers that can enter a particular practice and by limiting the expansion of incumbent providers, CON regulations effectively give a limited monopoly privilege to providers that receive approval in the form of a certificate of need. Approved providers are therefore able to charge higher prices than would be possible under truly competitive conditions. As a result, it is hoped that providers will use their enhanced profits to cover the losses from providing otherwise unprofitable, uncompensated care to the poor. In effect, those who can pay are charged higher prices to subsidize those who cannot.

In reality, however, this cross-subsidization is not occurring. While early studies found some evidence of cross-subsidization among hospitals and nursing homes,[15] the more recent academic literature does not show this cross-subsidy taking place. The most comprehensive empirical study to date, conducted by Thomas Stratmann and Jacob Russ, finds no relationship between certificates of need and the level of charity care.[16]

THE LASTING EFFECTS OF NEW HAMPSHIRE'S CON PROGRAM

While certificates of need are neither controlling costs nor increasing charity care, they continue to have lasting effects on the provision of health care services both in New Hampshire and in the other states that continue to require them. However, these effects have largely come in the form of decreased availability of services and lower hospital capacity.

In particular, Stratmann and Russ present several striking findings regarding the provision of health care in states implementing CON programs. First, CON programs are correlated with fewer hospital beds.[17] Throughout the United States there are approximately 362 beds per 100,000 persons. However, in states with a CON program, they find 99 fewer beds per 100,000 persons than the national average. In the context of New Hampshire, with its population of approximately 1.3 million, this means that there are about 1,300 fewer hospital beds as a result of the state's CON program.

Moreover, several basic health care services that are used for a variety of purposes are limited because of New Hampshire's CON program. Across the United States, an average of six hospitals per 500,000 persons offer MRI services. In states such as New Hampshire that regulate the number of hospitals with MRI machines, the number of hospitals that offer MRIs is reduced by 2.5 hospitals per 500,000 persons.[18] As a result, in New Hampshire there are approximately seven fewer hospitals offering MRI services. New Hampshire's CON program also affects the availability of CT services. While an average of nine hospitals per 500,000 persons offer CT scans, CON regulations are associated with a 37 percent decrease in these services. For New Hampshire, and its population of approximately 1.3 million, this could mean that about nine fewer hospitals offer CT scans.

CONCLUSION

While CON programs were intended to limit the supply of health care services within a state, proponents claim that the limits were necessary to either control costs

or increase the amount of charity care being provided. However, 40 years of evidence demonstrate that these programs do not achieve their intended outcomes, but rather decrease the supply and availability of health care services by limiting entry and competition. For policymakers in New Hampshire, this situation presents an opportunity to reverse course and open the market for greater entry, more competition, and ultimately more options for those seeking care.

NOTES

1. Thomas Stratmann and Jacob Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" (Working Paper No. 14-20, Mercatus Center at George Mason University, Arlington, VA, July 2014), http://mercatus.org/publication/do-certificate-need-laws-increase-indigent-care.
2. N.H. Rev. Stat. Ann. § 151-C (2015).
3. James Simpson, "State Certificate-of-Need Programs: The Current Status," *American Journal of Public Health* 75, no. 10 (1985): 1225–29.
4. Dwayne Banks, Stephen Foreman, and Theodore Keeler, "Cross-Subsidization in Hospital Care: Some Lessons from the Law and Economics of Regulation," *Health Matrix* 9, no. 1 (1999): 1–35; Guy David et al., "Do Hospitals Cross Subsidize?" (NBER Working Paper No. 17300, National Bureau of Economic Research, Cambridge, MA, August 2011), http://www.nber.org/papers/w17300.
5. Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?"
6. Simpson, "State Certificate-of-Need Programs," 1225.
7. Ibid.
8. These states were Arizona, California, Colorado, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah, Wisconsin, and Wyoming.
9. Fred Hellinger, "The Effect of Certificate-of-Need Legislation on Hospital Investment," *Inquiry* 13, no. 187 (1976): 187–93; David Salkever and Thomas Bice, "The Impact of Certificate-of-Need Controls on Hospital Investment," *Milbank Memorial Fund Quarterly: Health and Society* 52, no. 2 (1976): 185–214.
10. Frank Sloan and Bruce Steinwald, "Effects of Regulation on Hospital Costs and Input Use," *Journal of Law and Economics* 23, no. 1 (1980): 81–109; Frank Sloan, "Regulation and the Rising Cost of Hospital Care," *Review of Economics and Statistics* 63, no. 4 (1981): 479–87; Paul Joskow, "The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital," *Bell Journal of Economics* 11, no. 2 (1980): 421–24; Paul Joskow, *Controlling Hospital Costs: The Role of Government Regulation* (Cambridge, MA: MIT Press, 1981).
11. For further discussion of the scholarly literature, see Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?," 4. See also Christopher Conover and Frank Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," *Journal of Health Politics, Policy and Law* 23, no. 3 (1998): 455–81.
12. Patrick Rivers, Myron Fottler, and Jemima Frimpong, "The Effects of Certificate-of-Need Regulation on Hospital Costs," *Journal of Health Care Finances* 36, no. 4 (2010): 1–16.
13. See Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" New Hampshire's requirement can be found at N.H. Rev. Stat. Ann. § 151-C (2015).
14. Richard Posner, "Taxation by Regulation," *Bell Journal of Economics and Management Science* 2, no. 1 (1971): 22–50; Gerald Faulhaber, "Cross-Subsidization: Pricing in Public Enterprises," *American Economic Review* 65, no. 5 (1975): 966–77.
15. Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?," 5.
16. Ibid.
17. Ibid., 10–11.
18. Ibid.