

Matthew Mitchell, PhD  
Senior Research Fellow



**MERCATUS CENTER**  
George Mason University

# FLORIDA'S CON LAW

LESSONS FROM THREE DECADES OF RESEARCH

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Florida House of Representative  
Health Market Reform Subcommittee

February 6, 2019

# WHAT IS A CON LAW ?



A permission slip to compete

Not a quality gate

Designed to assess “need”

Unusual in a market economy

A barrier to entry that restricts supply

Anticompetitive

## A SHORT HISTORY OF CON LAWS



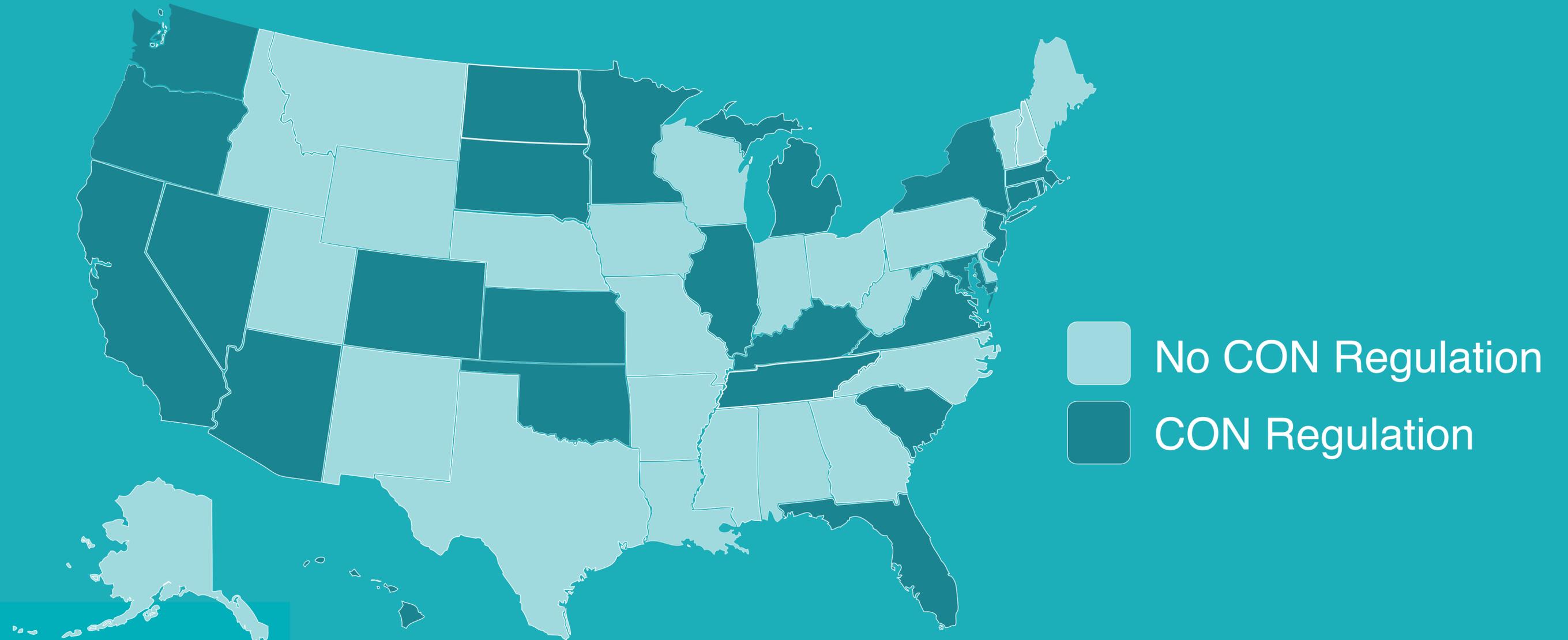
1974  
National Health  
Planning and  
Resources  
Development  
Act

Ensure an adequate supply of HC  
Ensure rural access to HC  
Promote high quality HC  
Promote charity care  
Encourage hospital substitutes  
Restrain the cost of care

# A SHORT HISTORY OF CON LAWS

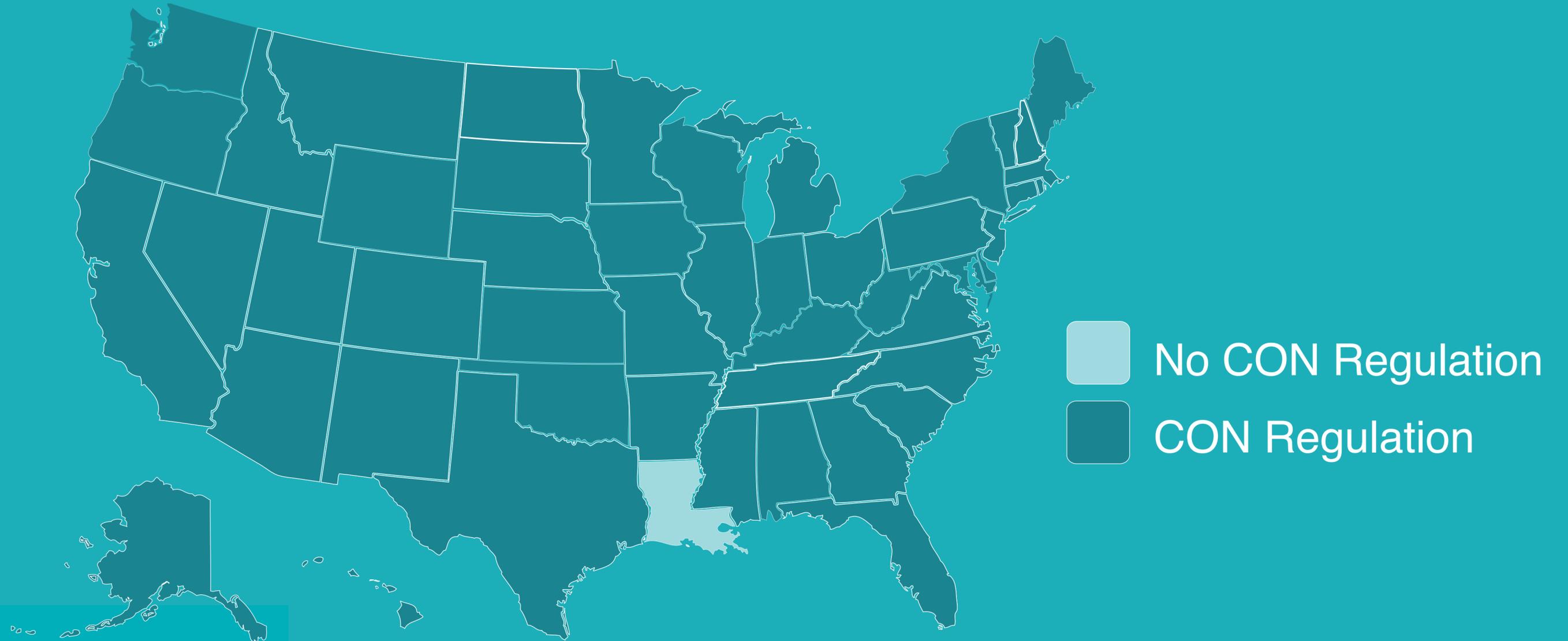
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1974



# A SHORT HISTORY OF CON LAWS

1980

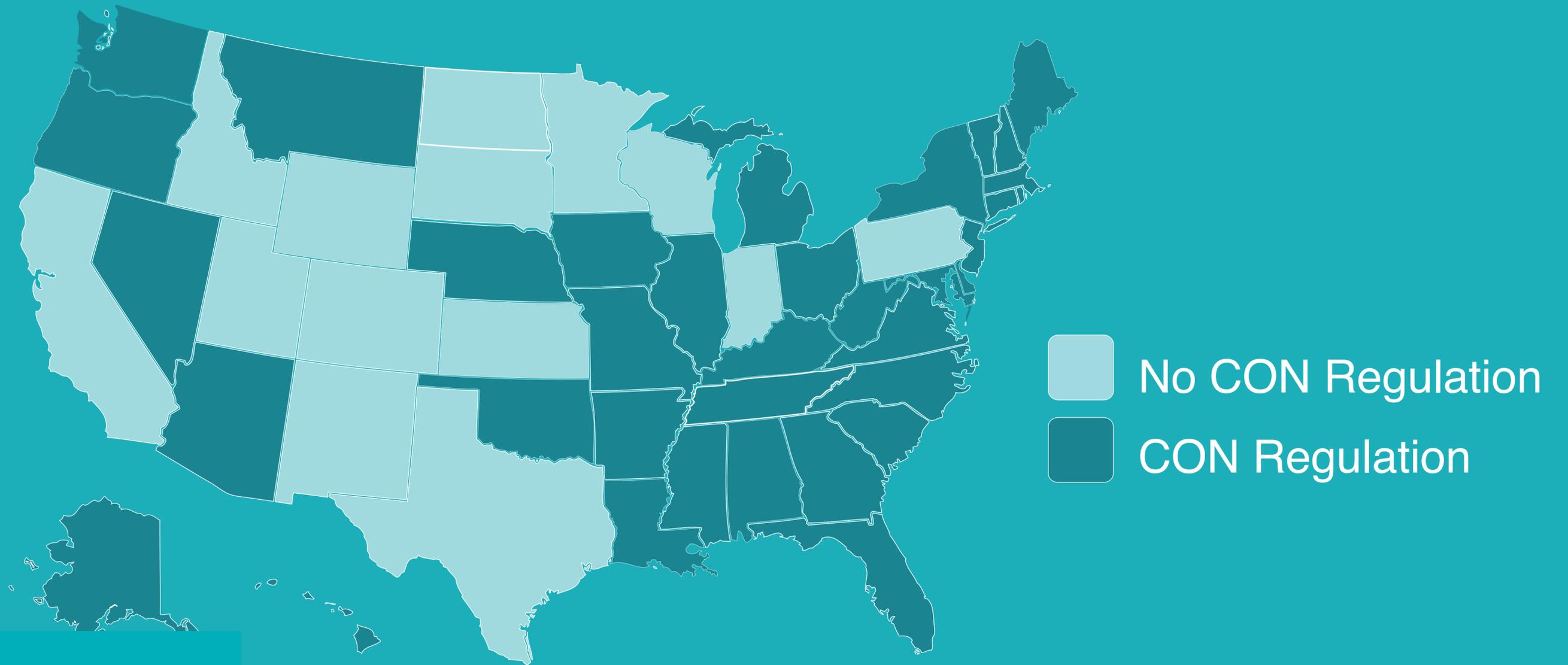






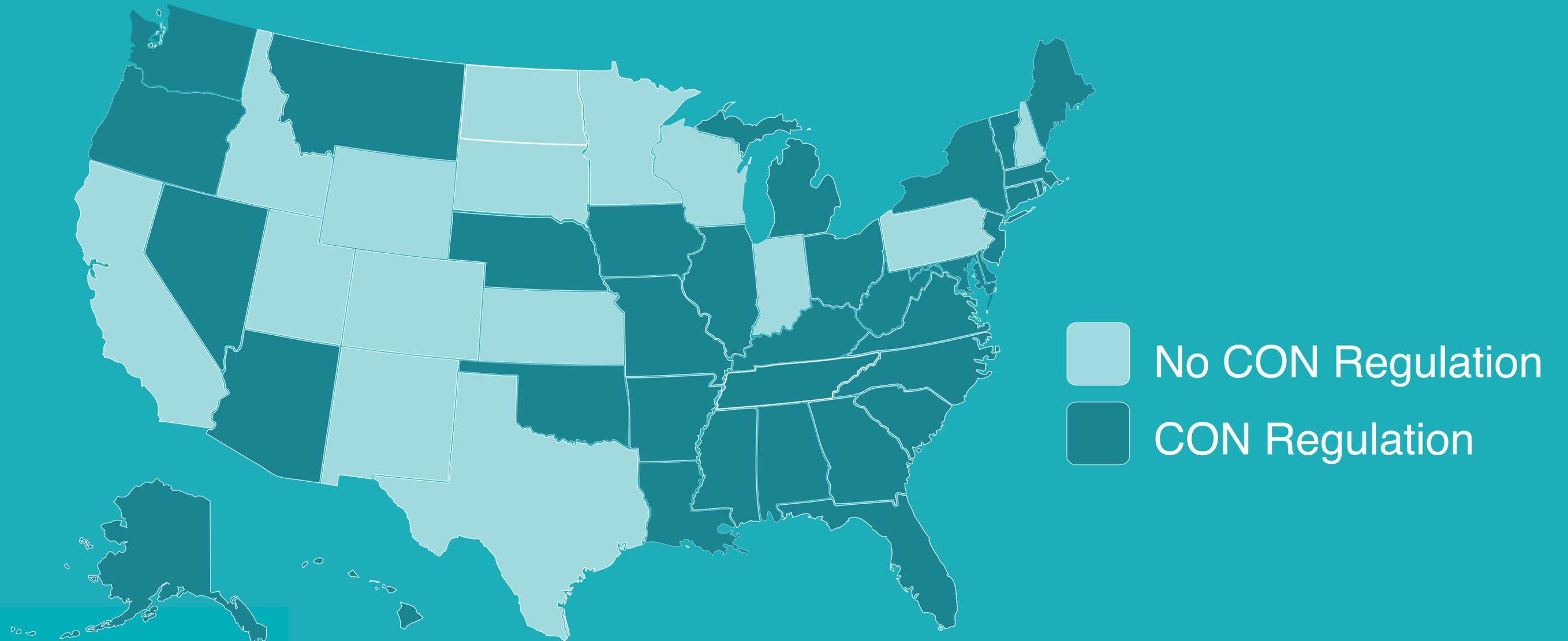
# A SHORT HISTORY OF CON LAWS

2015



# A SHORT HISTORY OF CON LAWS

2019



# FLORIDA'S CON LAW

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intermediate care facilities /  
mental disabilities

organ transplants

home health

burn care

Nursing home beds

psychiatric services

substance /  
drug abuse

open-heart surgery

NICU

rehabilitation

cardiac catheterization

hospice

swing beds

long-term acute care

acute hospital beds

subacute services

assisted living /

residential care facilities



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# THE STATED GOALS OF CON LAWS

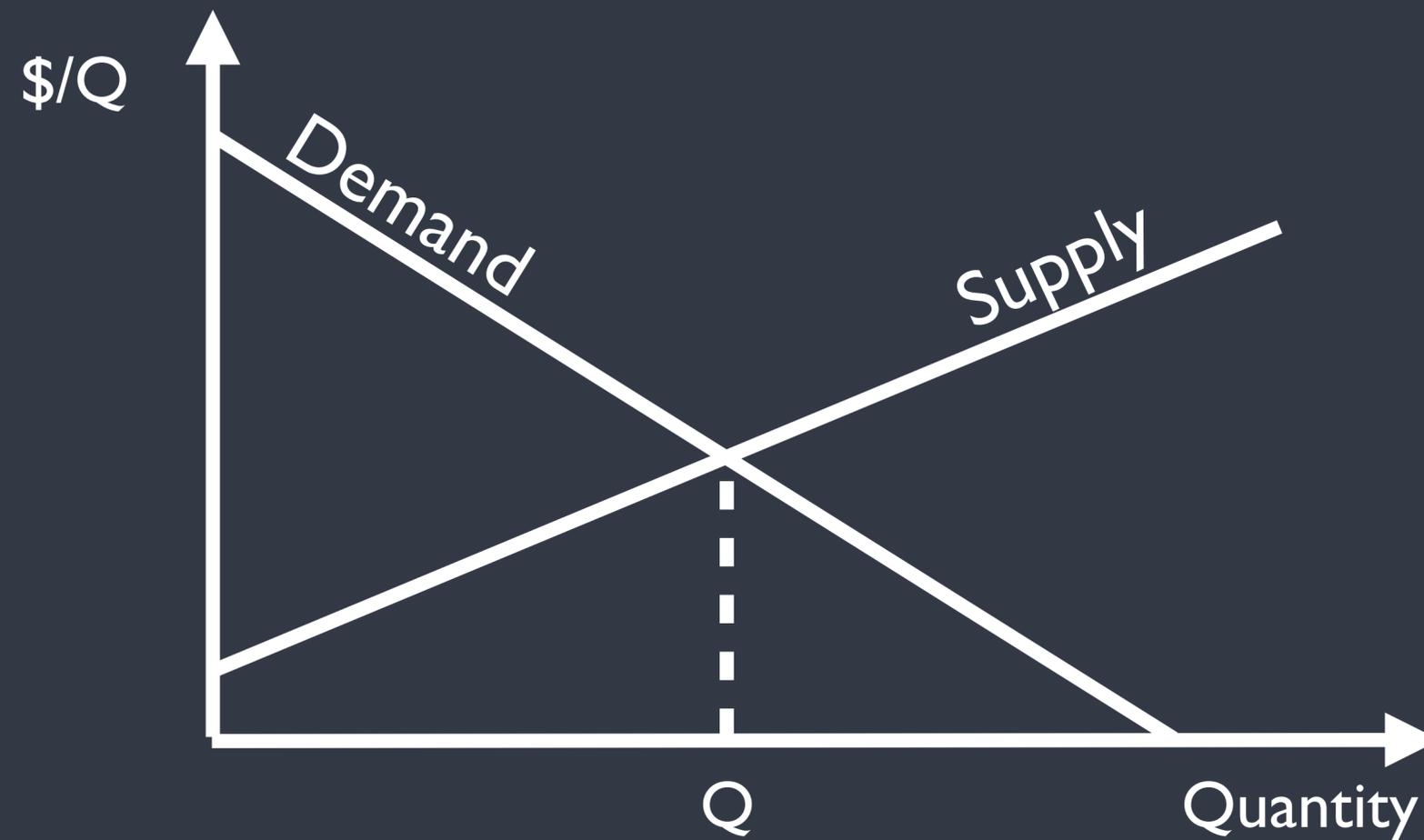


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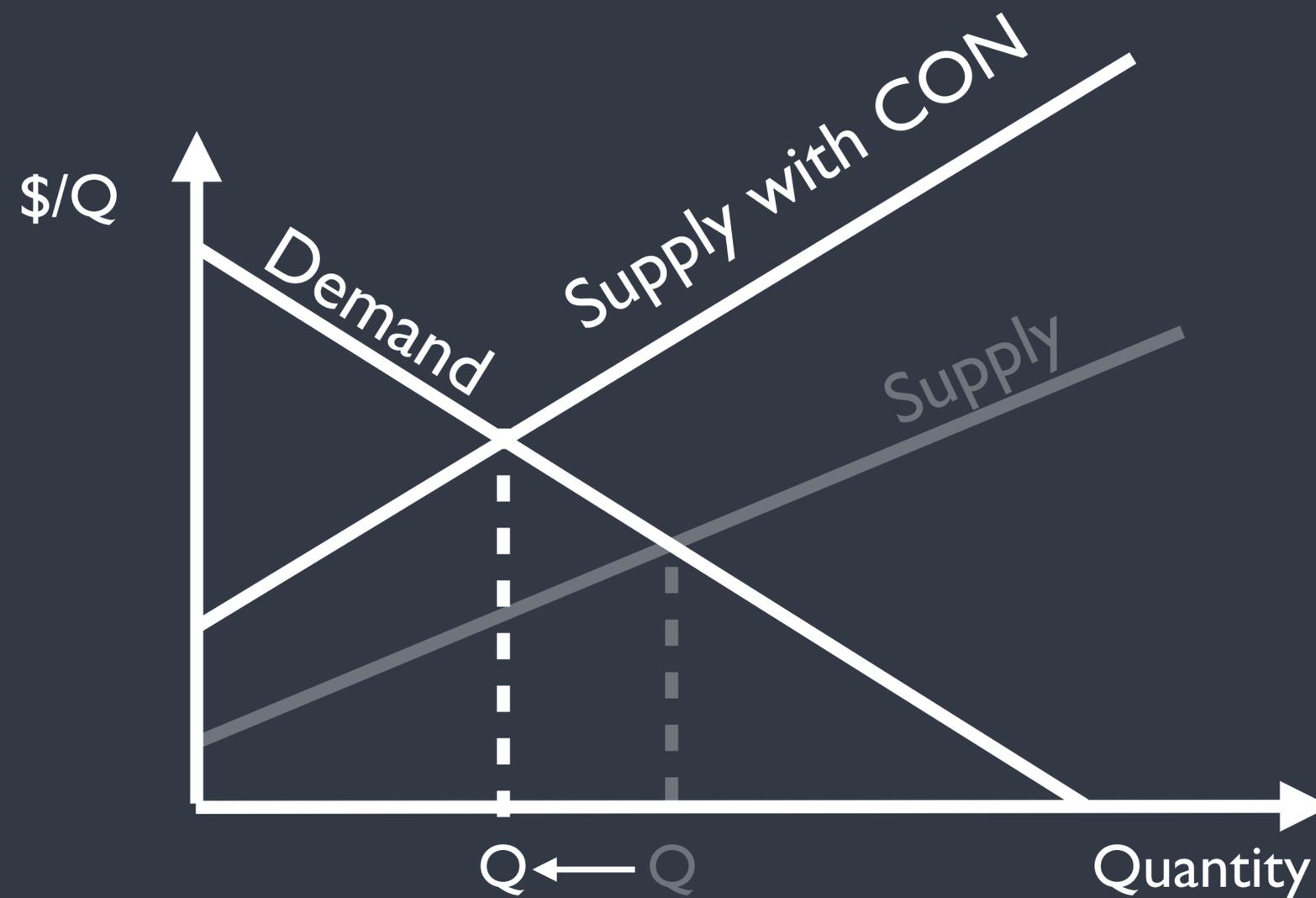
# THE REALITY OF CON LAWS

Ensure an adequate supply of HC?



# THE REALITY OF CON LAWS

Ensure an adequate supply of HC?



# THE REALITY OF CON LAWS

## Ensure an adequate supply of HC?

Limited supply of dialysis clinics (Ford and Kaserman, 1993)

Limited supply of hospice care (Carlson et al., 2010)

Fewer hospitals per capita (Stratmann and Russ, 2014)

Fewer hospital beds per capita (Stratmann and Russ, 2014)

Fewer hospitals with MRIs (Stratmann and Russ, 2014)

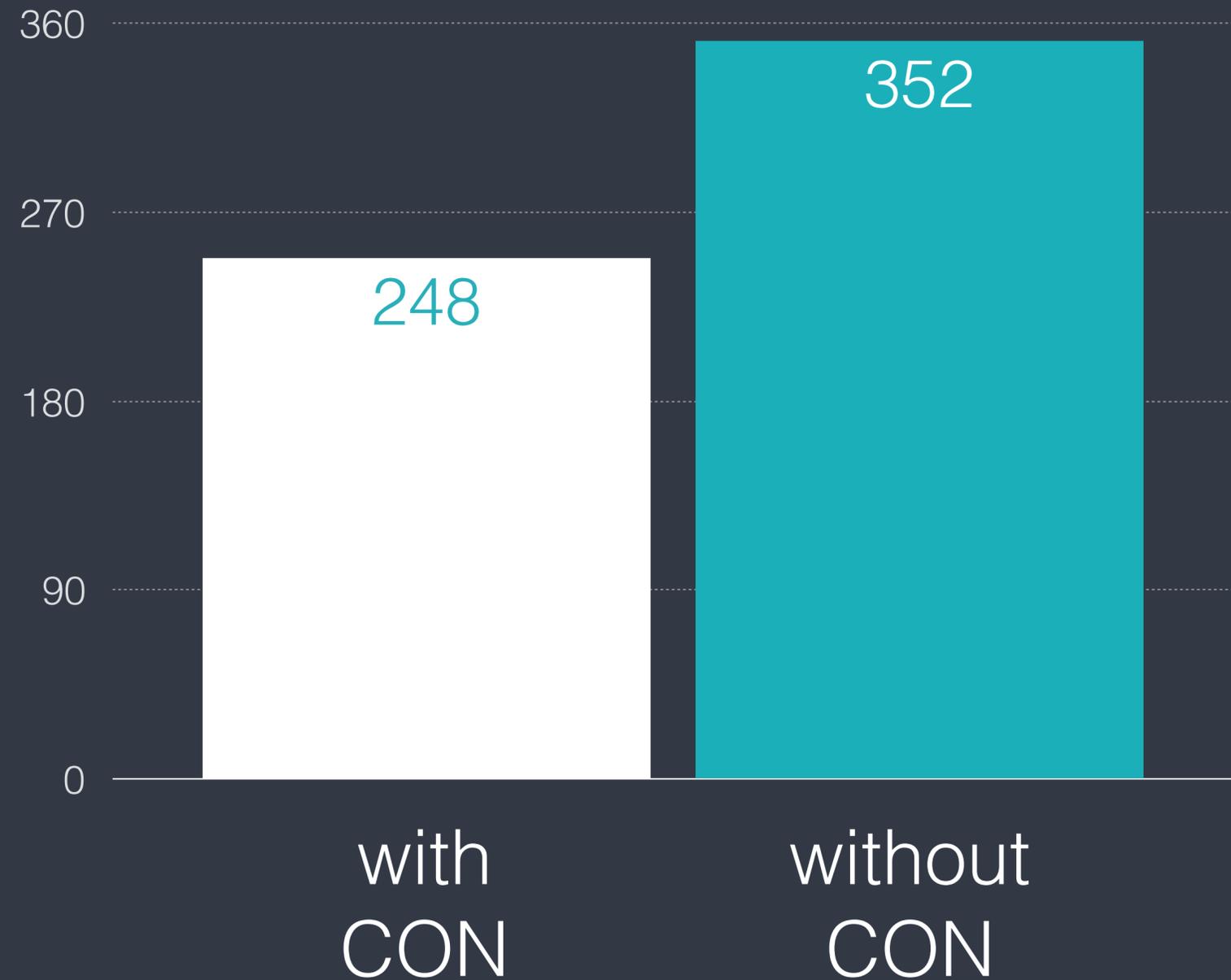
Fewer CT, MRI, PET scans (Stratmann and Baker, 2017)

More out-of-county CT, MRI, PET scans (Stratmann and Baker, 2017)

# THE REALITY OF CON LAWS

Ensure an adequate supply of HC?

Estimated number  
of Florida hospitals  
without CON



# THE STATED GOALS OF CON LAWS

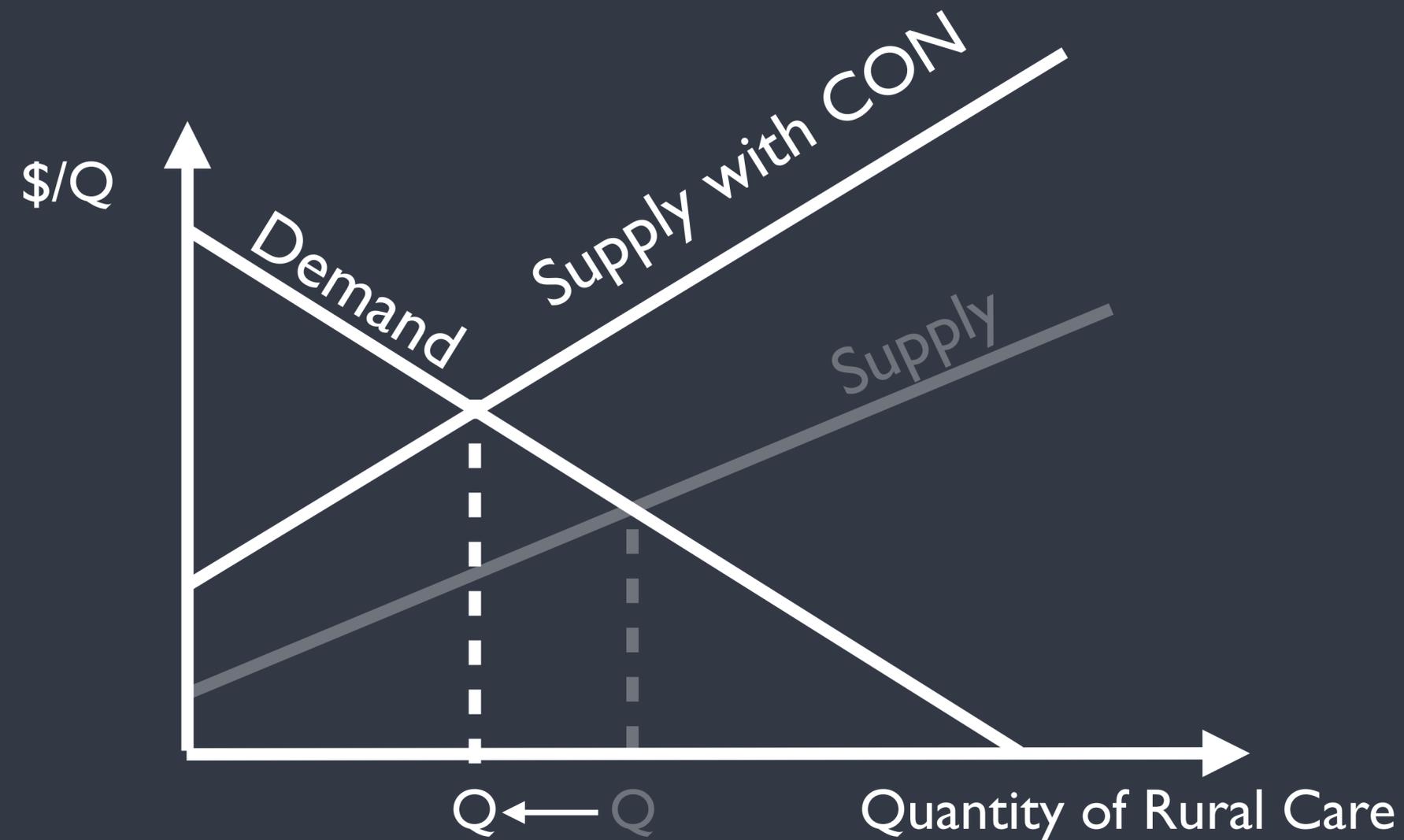


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Ensure an adequate supply of HC  
Ensure rural access to HC

# THE REALITY OF CON LAWS

Ensure rural access to HC?



# THE REALITY OF CON LAWS

Ensure rural access to HC?

30% fewer rural hospitals (Stratmann and Koopman, 2016)

Less access to rural hospice (Carlson et al., 2010)

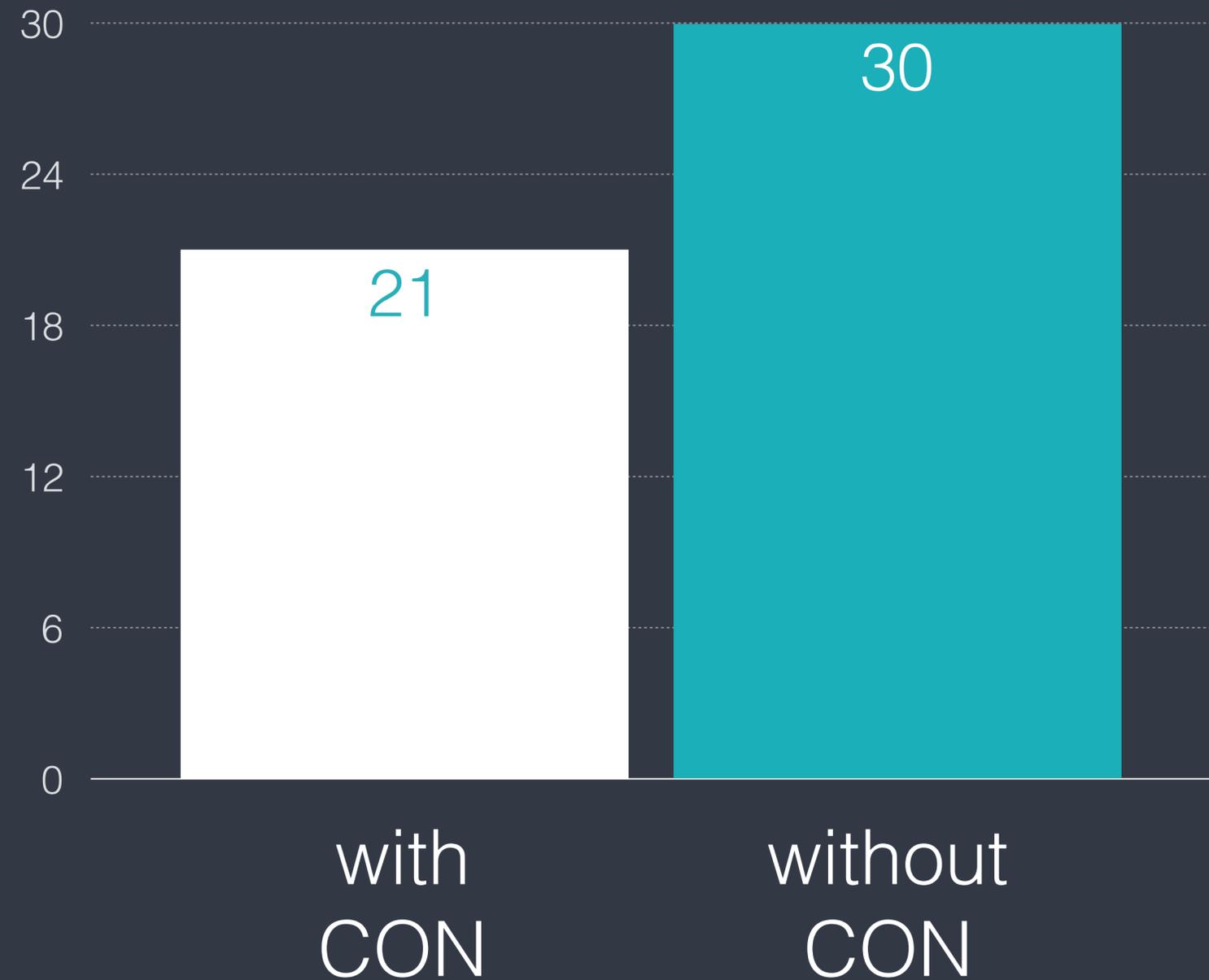
Longer travel distance to care (Cutler et al., 2010)

More out-of-county CT, MRI, PET scans (Stratmann and Baker, 2017)

# THE REALITY OF CON LAWS

Ensure an adequate supply of HC?

Estimated number  
of *rural* Florida  
hospitals  
without CON



# THE STATED GOALS OF CON LAWS



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Ensure an adequate supply of HC  
Ensure rural access to HC  
Promote high quality HC

# THE REALITY OF CON LAWS

Promote high quality HC?  
scale competence vs. less competition

Mixed early research on particular conditions

No effect on all-cause mortality (Bailey, 2016)

Higher mortality rates following heart failure,  
pneumonia, heart attacks (Stratmann and Wille, 2016)

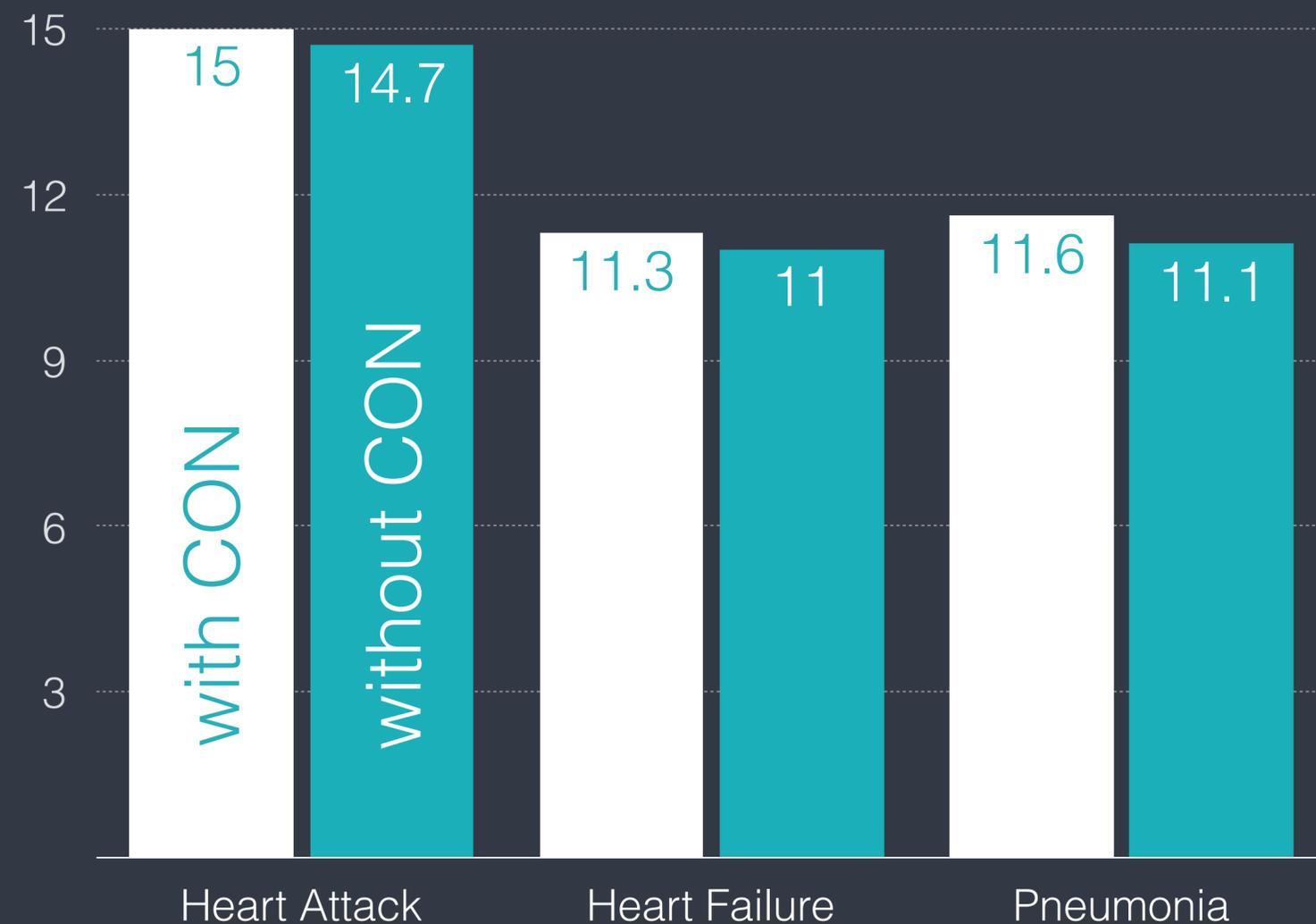
Higher rates of post-surgery complications  
(Stratmann and Wille, 2016)

Lower levels of patient satisfaction (Stratmann and  
Wille, 2016)

# THE REALITY OF CON LAWS

Promote high quality HC?

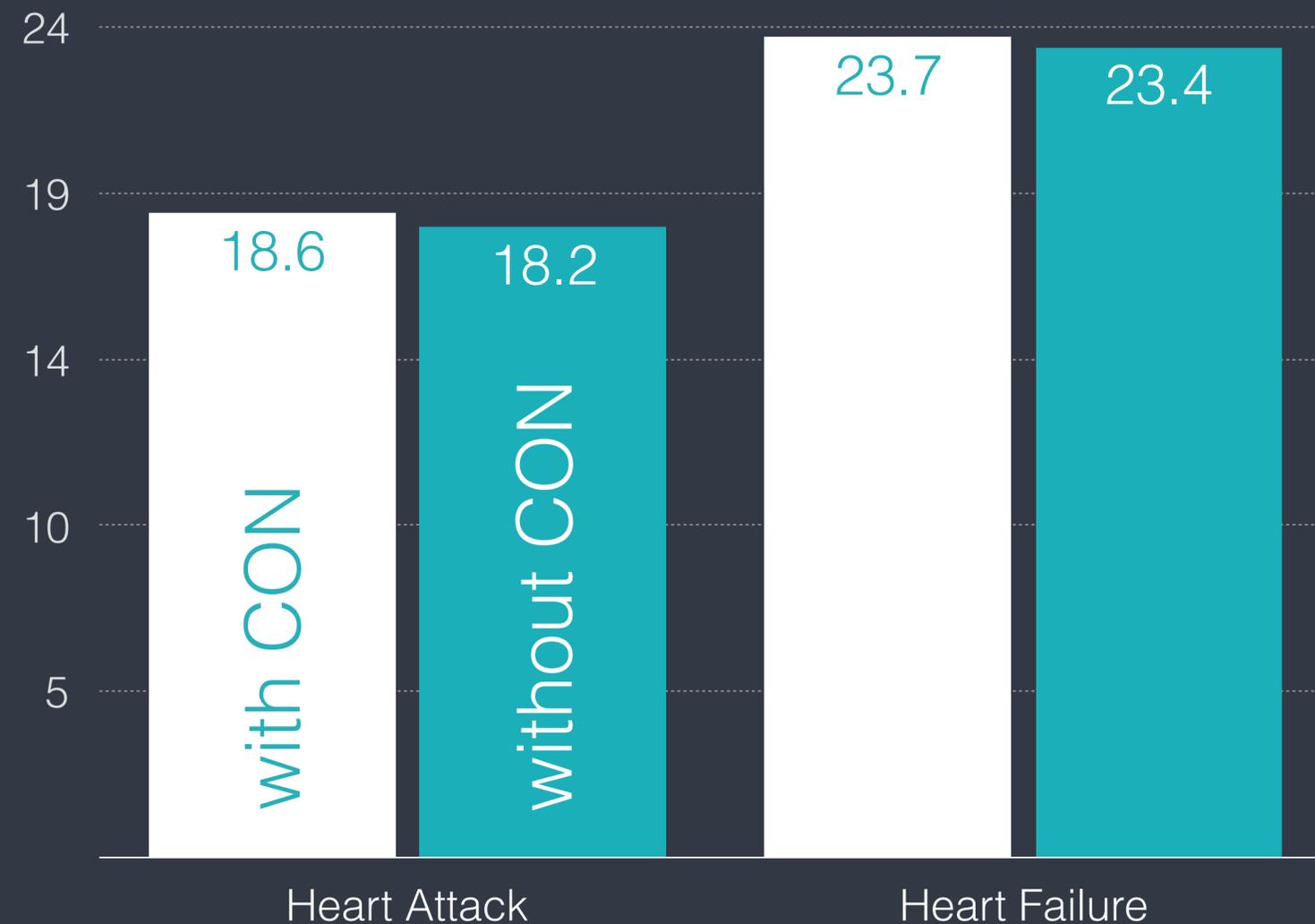
Estimated mortality rates  
in Florida



# THE REALITY OF CON LAWS

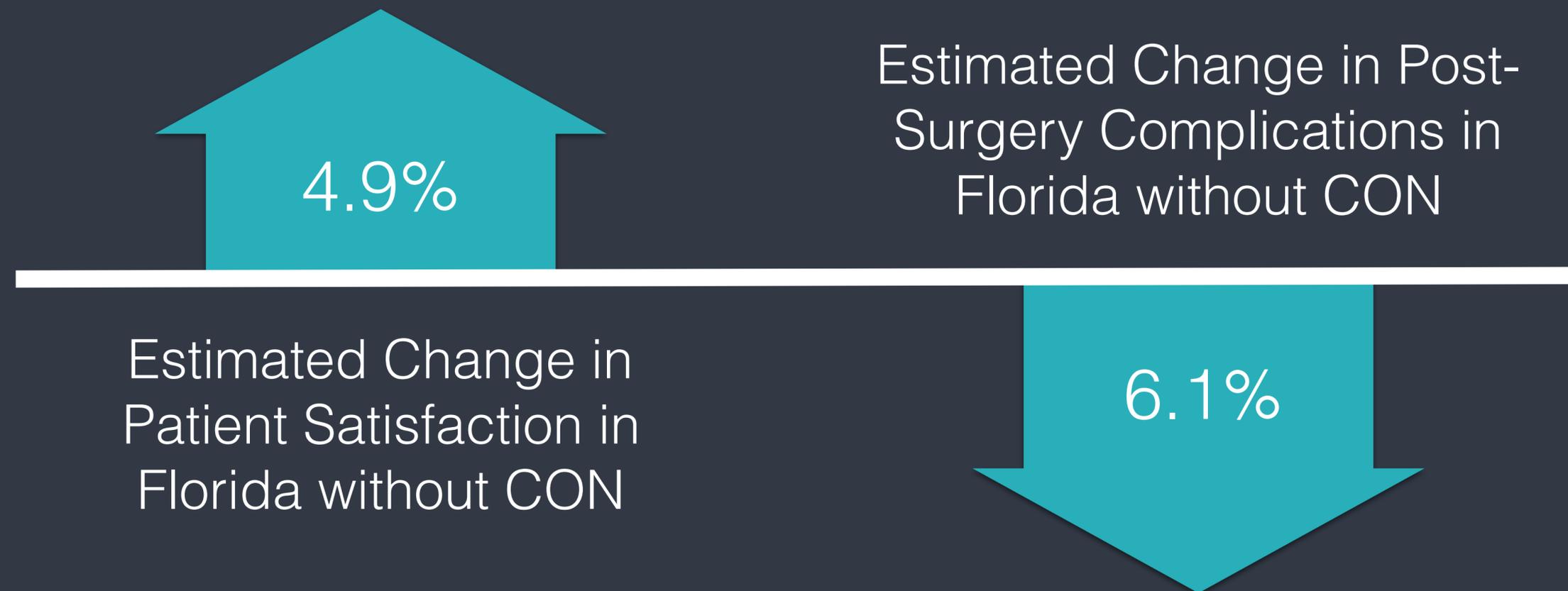
Promote high quality HC?

Estimated readmission rates in Florida



# THE REALITY OF CON LAWS

Promote high quality HC?



# THE STATED GOALS OF CON LAWS



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Promote charity care

# THE REALITY OF CON LAWS

## Promote charity care?

No evidence of higher rates of charity care  
(Stratmann and Russ, 2014)

Greater racial disparity in the provision of  
services (DeLia et al., 2009)

# THE STATED GOALS OF CON LAWS



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Ensure rural access to HC

Promote high quality HC

Promote charity care

Encourage hospital substitutes

# THE REALITY OF CON LAWS

## Encourage hospital substitutes?

ASC-specific CON states have 14% fewer ASCs per capita (Stratmann and Koopman, 2016)

ASC-specific CON states have 13% fewer rural ASCs per capita (Stratmann and Koopman, 2016)

CON limits use of *new* hospitals and *non-hospital* providers, but not existing hospitals (Stratmann and Baker, 2017)

# THE STATED GOALS OF CON LAWS

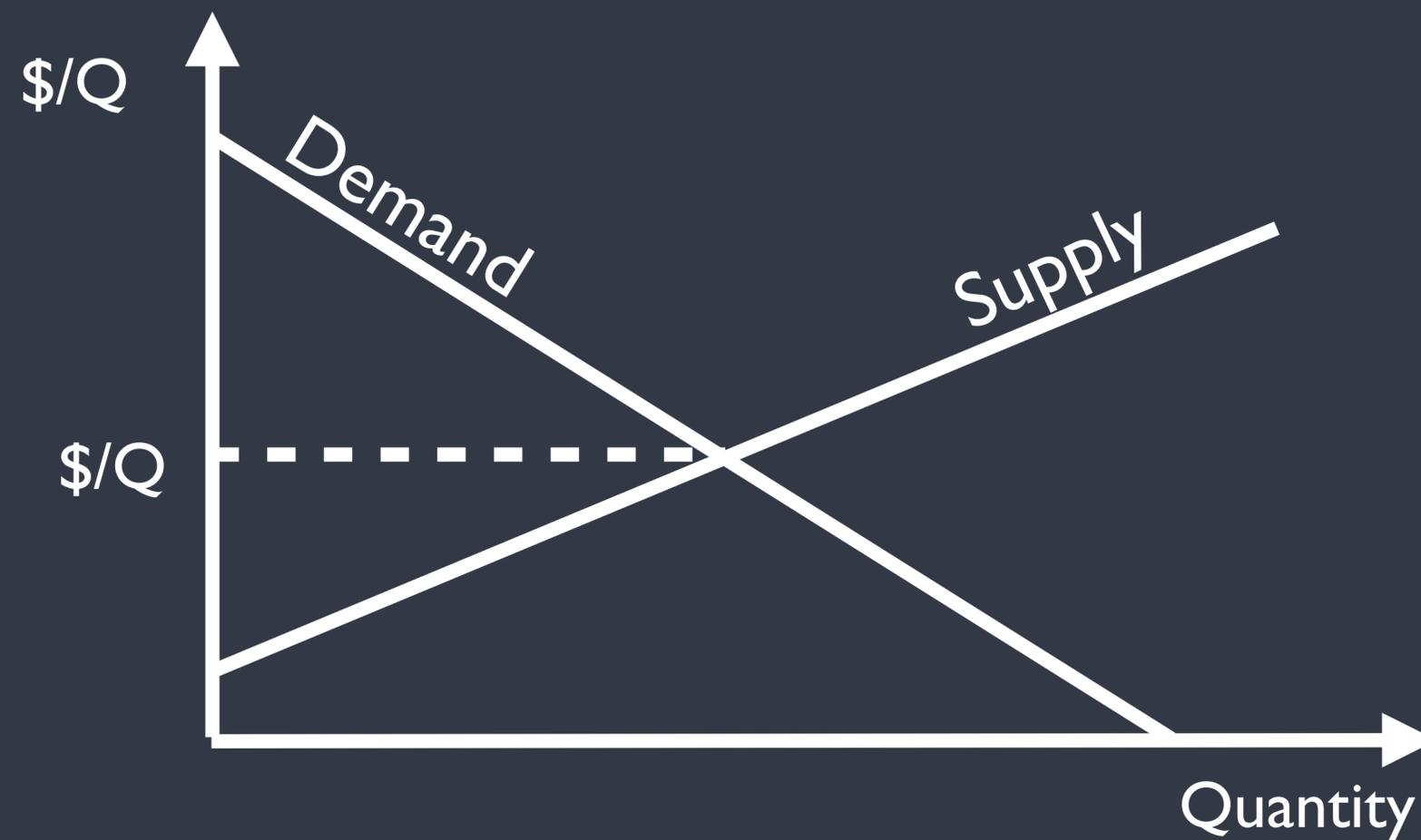


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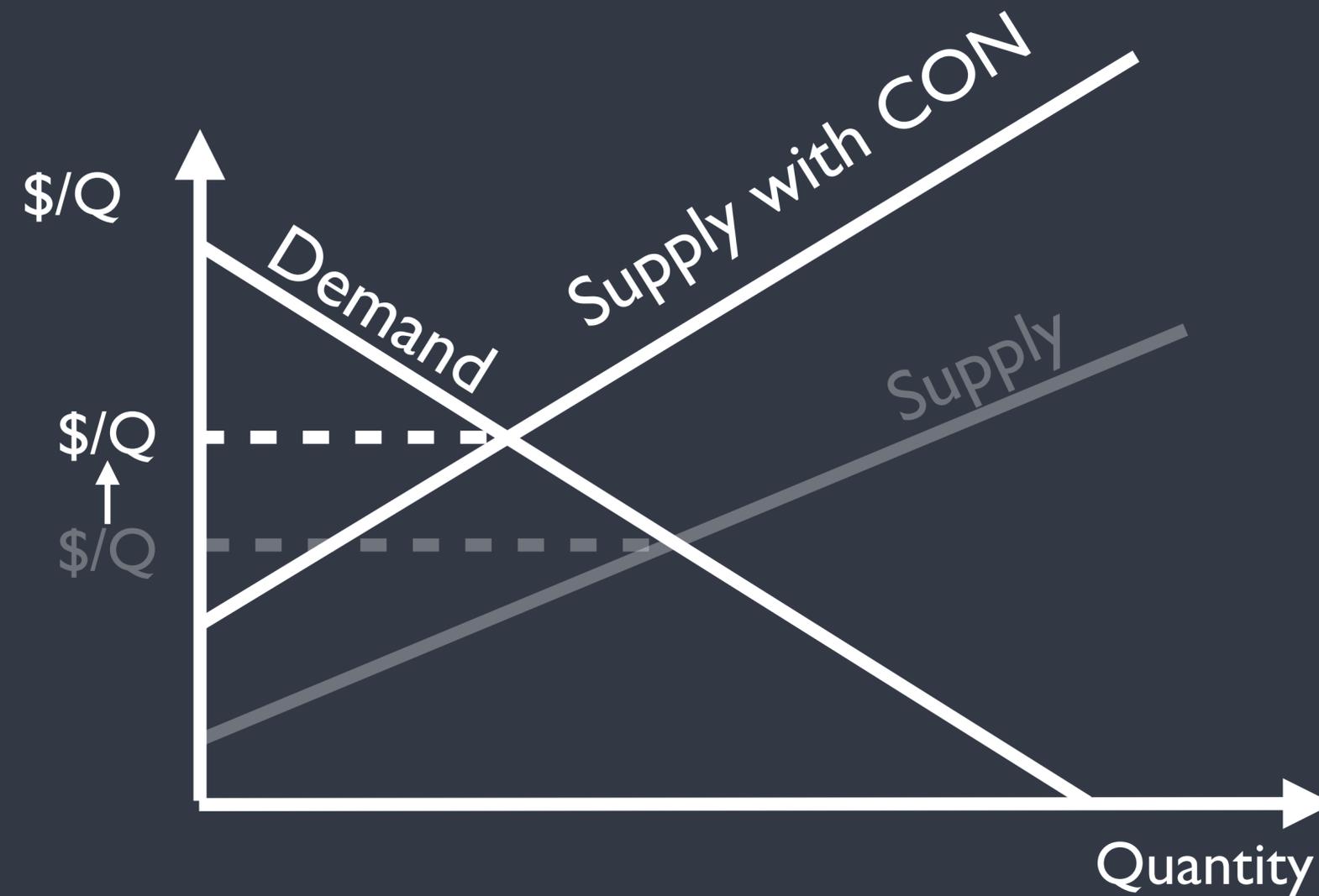
# THE REALITY OF CON LAWS

Restrain the cost of care?



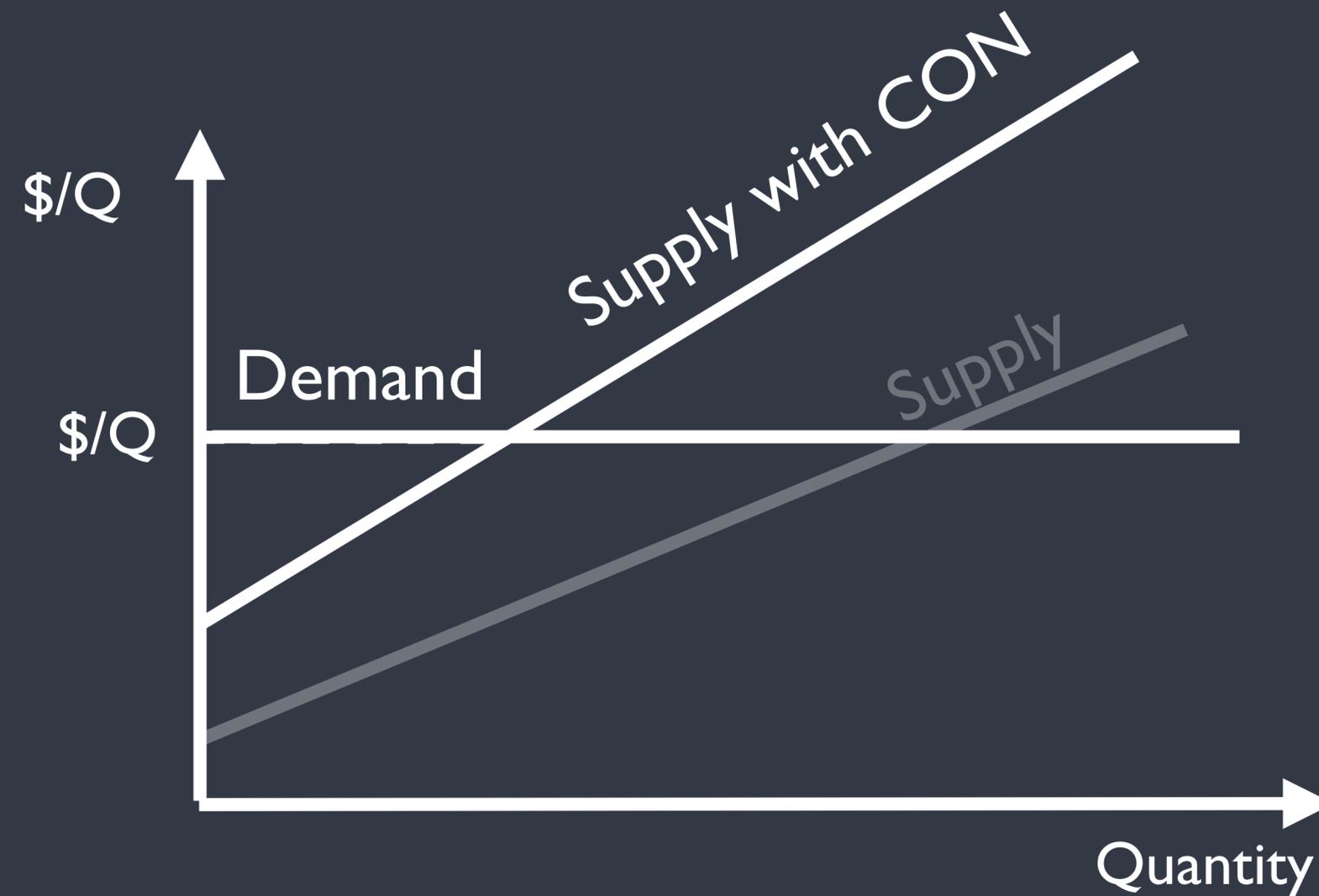
# THE REALITY OF CON LAWS

Restrain the cost of care?



# THE REALITY OF CON LAWS

Restrain the cost of care?



# Do Certificate-of-Need Laws Limit Spending?

Matthew D. Mitchell

*September 2016*

MERCATUS WORKING PAPER

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George Mason University  
3434 Washington Blvd., 4th Floor, Arlington, Virginia 22201  
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**Do Certificate-of-Need Laws  
Limit Spending?**

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*September 2016*

MERCATUS WORKING PAPER

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A review of 20 peer-reviewed academic studies finds that CON laws have worked largely as economic theory predicts and that they have failed to achieve their stated goal of cost reduction. The overwhelming weight of evidence suggests that CON laws are associated with both higher per unit costs and higher total expenditures.

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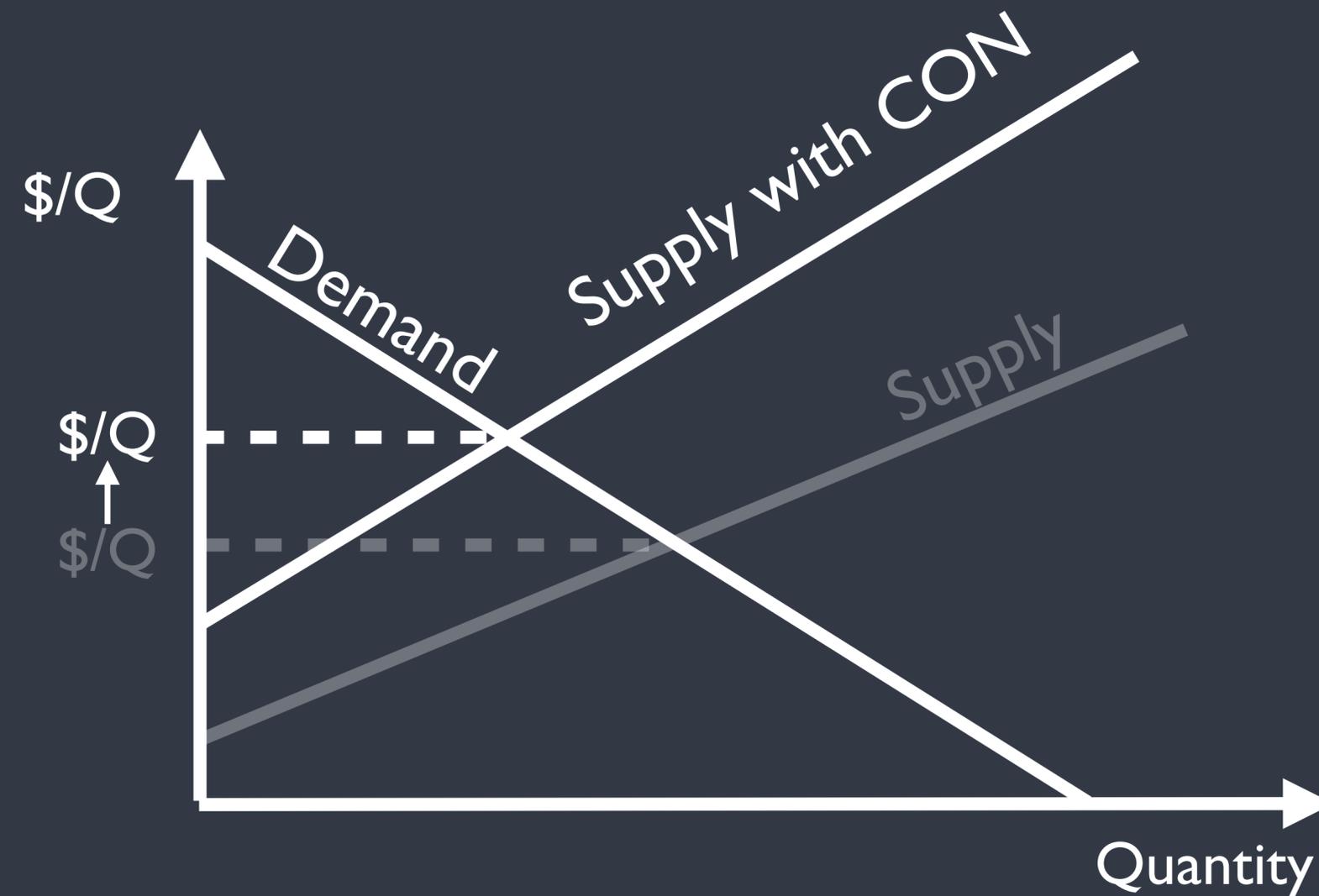
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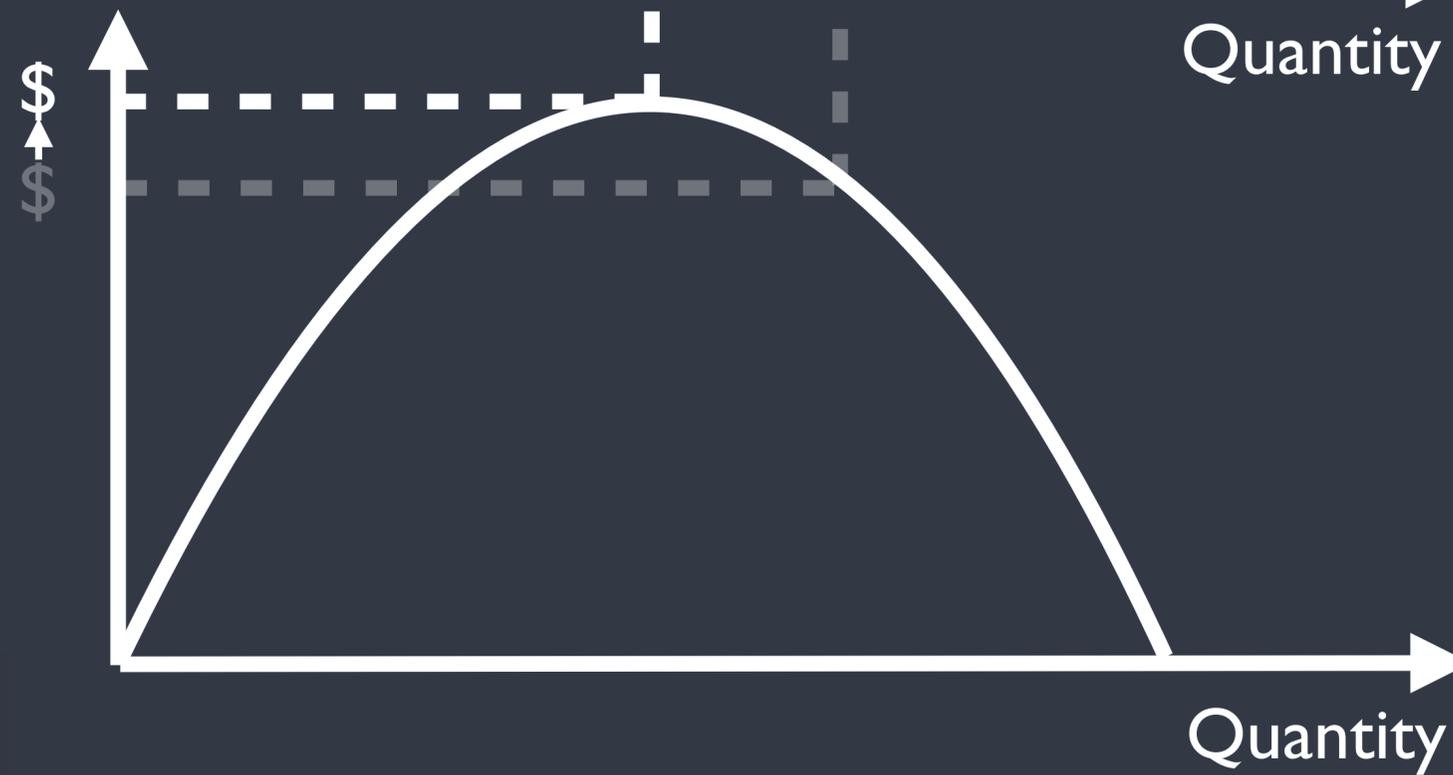
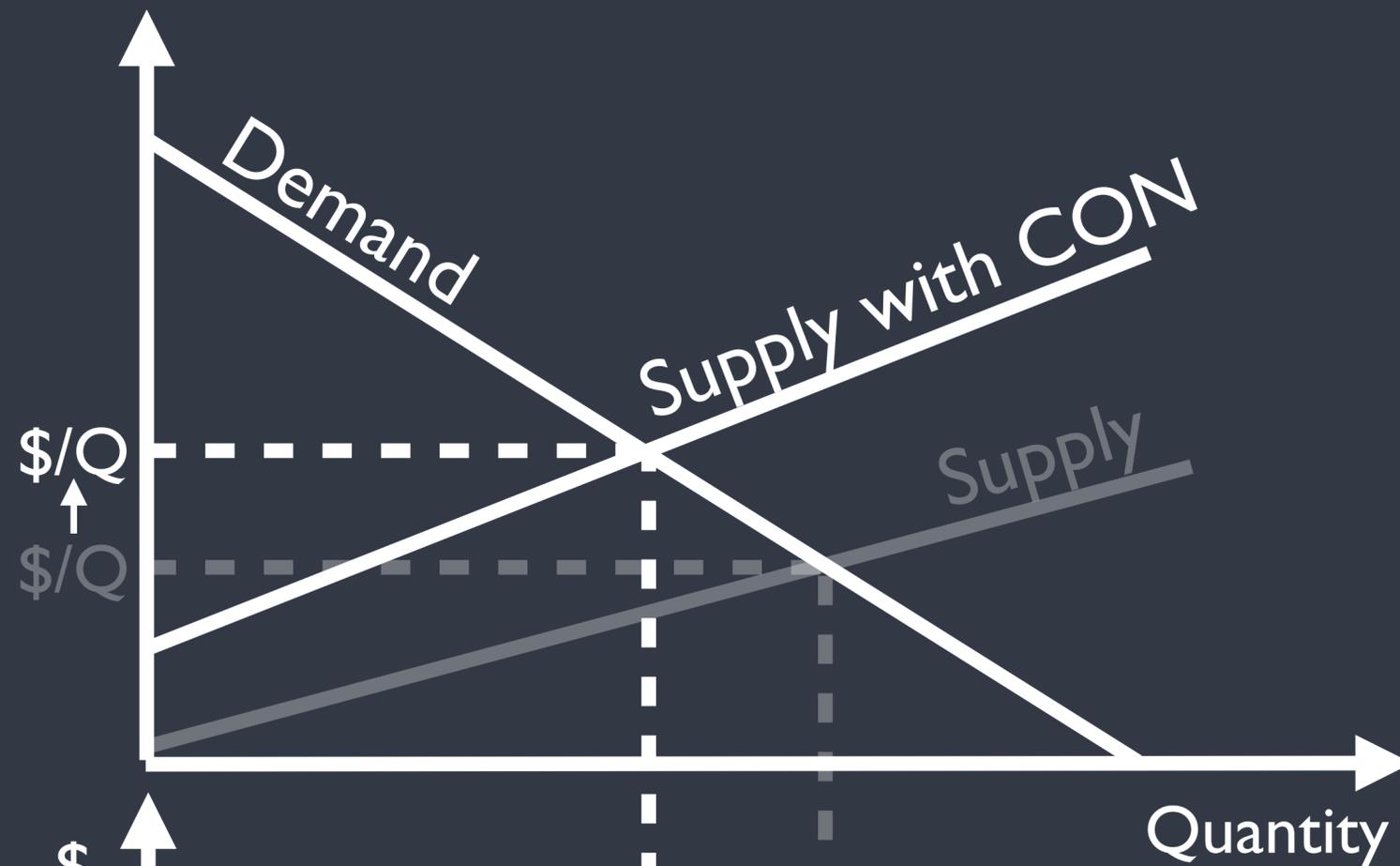
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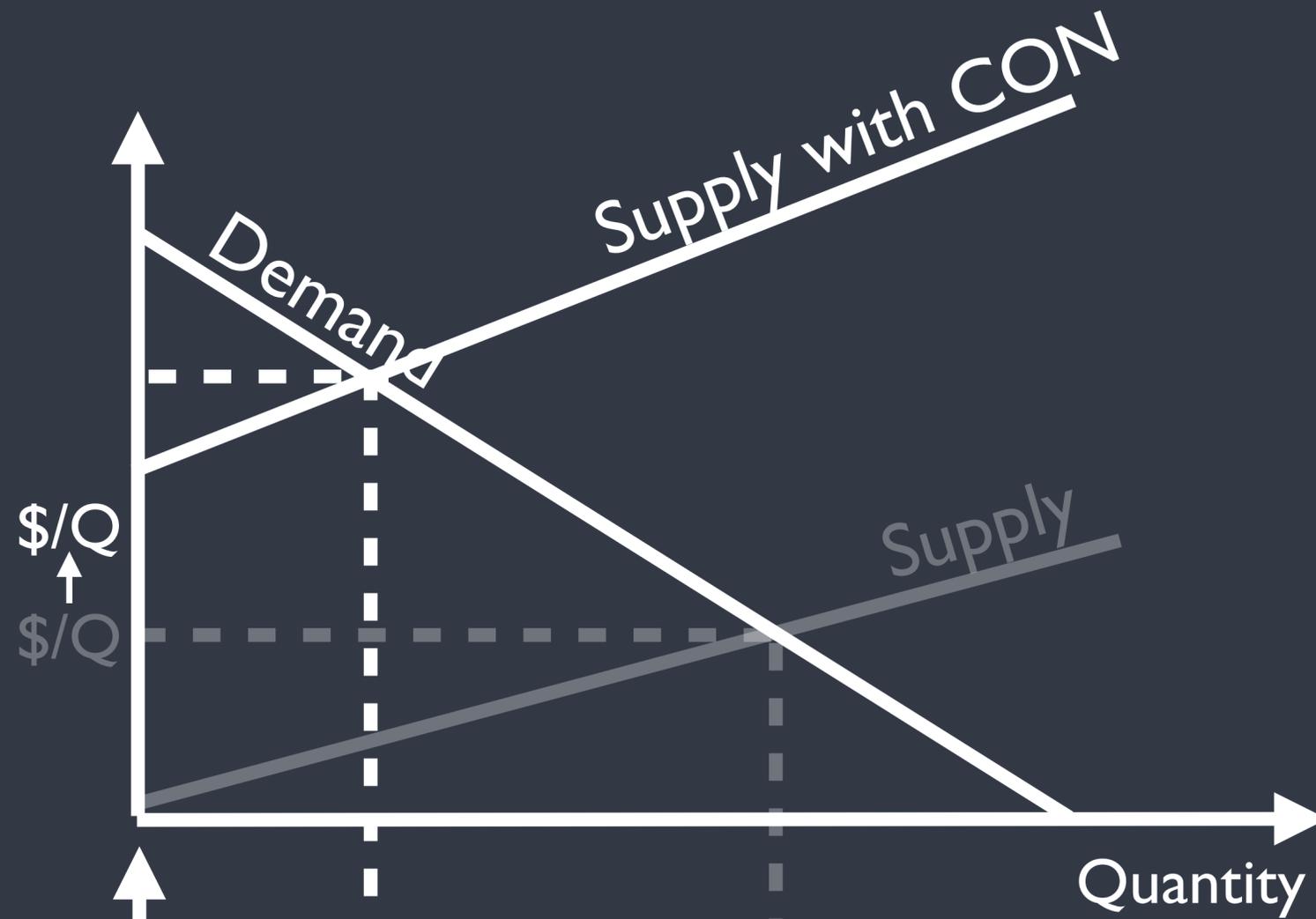
# Appendix

# WHY WOULD ANYONE THINK CON LAWS

Restrain the cost of care?







# THE REALITY OF CON LAWS

Restrain the cost of care?

4 decades of research

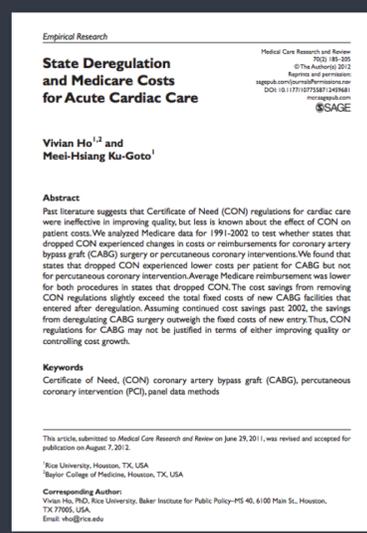
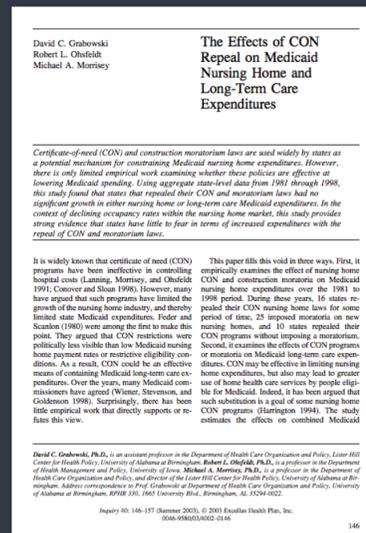
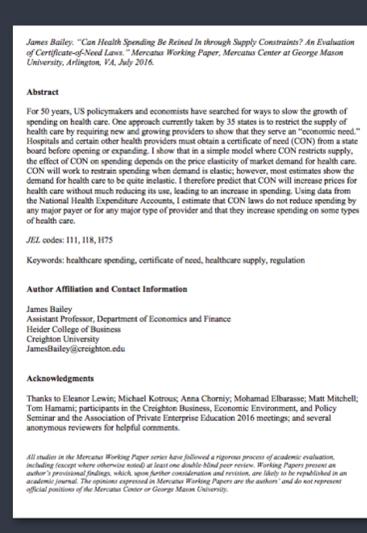
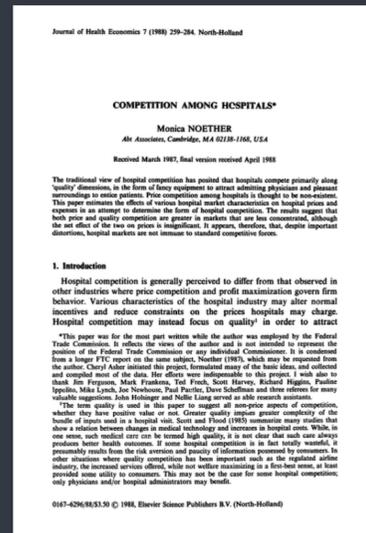
20 studies

only peer reviewed



# THE REALITY OF CON LAWS

## Per unit cost



3 studies: CON associated with higher cost

1 study: No detected effect on Medicaid costs

# THE REALITY OF CON LAWS

## Restrain the cost of care?

Journal of Health Economics 7 (1988) 239-264, North-Holland  
David C. Gmbowski  
Robert L. Ohsfeldt  
Michael A. Morley

**COMPETITION AMONG HOSPITALS\***  
Monica Noether  
Abn Associates, Cambridge, MA 02138-1166, USA

**Abstract**  
For 50 years, US policymakers and economists have searched for ways to slow the growth of spending on health care. One approach currently taken by 25 states is to restrict the supply of health care by requiring new and growing providers to show that they serve an "economic need." Hospitals and certain other health providers must obtain a certificate of need (CON) from a state board before opening or expanding. I show that in a simple model where CON restricts supply, the effect of CON on spending depends on the price elasticity of market demand for health care. CON will work to restrain spending when demand is elastic, however, most estimates show the demand for health care to be quite inelastic. I therefore predict that CON will increase prices for health care without much reducing its use, leading to an increase in spending. Using data from the National Health Expenditures Accounts, I estimate that CON laws do not reduce spending by any major payer or for any major type of provider and that they increase spending on some types of health care.

**1. Introduction**  
Hospital competition is other industries where price behavior. Various character incentives and reduce o Hospital competition ma This paper was for the annual Trade Commission. It reflects a larger FTC report on it. The results show that inelastic and compiled most of the data. I thank the Ferguson, Mark, Ty, Ippolito, Mike Lynch, Joe Neels, and various suggestions from the. The time quality is used in a weather they have positive sub-benefits of inputs used in a home, such medical care on conditions better health status presumably results from the risk. other situations where quality industry, the increased services o provided some ability to control only physicians and/or hospital

**The Impact of Certificate-of-Need on Hospital Investment**  
DAVID S. SALKEV  
THOMAS W. BICE

**Abstract**  
Certificate-of-Need (CON) controls over hospital investment have number of states in recent years and the National Health Planning Development Act of 1974 provides strong incentives for adoption of CON laws. In this study, we review the questions that have been asked, effectiveness of CON controls and then we develop quantitative estimates of CON on investment. These estimates show that CON did not dollar volume of investment but altered its composition, reducing supplies but increasing investment in new services and equipment. This finding may be due to (1) the emphasis in CON laws and programs on controlling bed supplies and (2) a substitution of new services and equipment for additional beds in response to financial factors and organizational pressures for expansion. Finally, we caution against the conclusion that CON controls should be broadened and tightened, though our results might be so interpreted, because of the practical difficulties involved in reviewing and certifying large numbers of small investment projects.

**Introduction**  
In the wake of rapid post-Medicare cost inflation, investment controls have emerged as important regulatory mechanisms for moderating the rise in health services expenditures. These controls take two forms: (1) legal prohibitions of unnecessary capital investment, and (2) financial controls, whereby a health care institution's eligibility to receive capital or operating funds relating to an investment project is dependent upon the approval of designated planning agencies. Presently, both types are widespread. Legal prohibitions are in effect through certificate-of-need (CON) laws in twenty-four states, and similar legislation has been proposed in seven other states (Lewin and Associates, Inc. 1974). Moreover, with the passage of P.L. 93-641, the National Health Planning and Resources Development Act of 1974, CON was slated for adoption by all participating states.

Several types of financial controls have been applied. Under MMFQ / Health and Society / Spring 1976 185

**The Effects of CON on Medicaid Nursing Home and Long-Term Care Expenditures**  
David C. Gmbowski  
Robert L. Ohsfeldt  
Michael A. Morley

**Abstract**  
Certificate-of-need (CON) and construction moratorium laws are used widely by states as a principal mechanism for constraining Medicaid nursing home expenditures. However, it is only limited empirical work examining whether these policies are effective in reducing Medicaid spending. Using aggregate state-level data from 1981 through 1998, this study finds that states that repealed their CON and moratorium laws had no lower growth in either nursing home or long-term care Medicaid expenditures. In the absence of declining occupancy rates within the nursing home market, this study provides evidence that states have little to fear in terms of increased expenditures with the repeal of CON and moratorium laws.

**Abstract**  
This paper fills this void in three ways. First, it empirically examines the effect of nursing home CON and construction moratoria on Medicaid nursing home expenditures over the 1981 to 1998 period. During these years, 16 states repealed their CON nursing home laws for some period of time, 25 imposed moratoria on new nursing homes, and 10 states repealed their CON programs without imposing a moratorium. Second, it examines the effect of CON programs or moratoria on Medicaid long-term care expenditures. As a result, CON could be an effective cost containment strategy for Medicaid long-term care expenditures, but also may lead to greater use of other health care services by people eligible for Medicaid. Indeed, it has been argued that such substitution is a goal of some nursing home CON programs (Harrington 1994). The study estimates the effects on combined Medicaid

**Abstract**  
This article uses data development analysis and multiple regression analysis to estimate the impact of various market structure characteristics of the hospital services industry in various metropolitan areas of the United States. Market structure elements include the degree of rivalry among hospitals, the degree of rivalry among hospital services, and the degree of rivalry among hospital services industries. The DEA results show that hospital services industry experienced 11 percent inefficiency in 1999. Multiple regression analysis indicates the level of technical efficiency in metropolitan hospital services industries in response to greater HMO activity rate health insurer concentration in the state. The analysis suggests that rivalry among hospitals had no marginal effect on technical efficiency at 1 level. Evidence also implies that the presence of a state Certificate of Need is associated with a greater degree of inefficiency in the typical metropolitan area industry.

**The Impact of CON Regulation on Hospital Investment**  
David S. Salkov  
Thomas W. Bice

**Abstract**  
Certificate-of-need (CON) regulations can promote hospital efficiency by reducing duplication of services; however, there are practical and theoretical reasons why they might be ineffective, and the empirical evidence in this study compares the cost-inefficiency of urban, suburban, and rural hospitals. The results suggest that CON regulation may be an era of a new medical arms race. However, broader regulation on efficiency, quality, access, prices, and policy recommendation can be made.

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**Access to Community-Based Long-Term Care: Medicaid's Role**  
Nancy A. Miller, PhD  
University of Maryland Baltimore County  
Charlene Harrington, PhD  
University of California, San Francisco  
Elizabeth Goldstein, PhD  
Health Care Financing Administration

**Abstract**  
The authors explore state variation in expenditures for Medicaid community-based care services for the period 1990 to 1997. Methods: A random effects panel model is used to explore the relationship between state demographic, supply, economic, programmatic, and political factors and state Medicaid community-based care expenditures. Results: Although states increased provision of services over the study period, significant state-level variation was evident. Expenditures were positively associated with state per capita income, regulation of nursing home bed supply, and the number of Medicaid home bed supply. Conclusion: Medicaid policy makers should consider the expansion of community-based care services to foster the expansion of long-term care services.

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**The Effect of Certificate-of-Need Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis**  
Fred J. Harrington, PhD

**Abstract**  
Certificate-of-need programs attempt to control the construction of unnecessary healthcare facilities and to limit the acquisition of costly equipment that provides little benefit to a community's health and welfare. However, these programs have not been shown to reduce the growth of hospital beds and healthcare expenditures. This study examines the effect of certificate-of-need laws on hospital beds and healthcare expenditures in 1990-1997. Results: The study finds that certificate-of-need laws have had little effect on the growth of hospital beds and healthcare expenditures. Conclusion: Certificate-of-need laws are not an effective way to control the growth of hospital beds and healthcare expenditures.

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# THE REALITY OF CON LAWS

## Per patient expenditure



7 studies: CON increases expenditures

2 studies: No statistically significant effect

2 studies: Increases some expenditures and reduces others

1 study: Reduces the number of beds



# THE REALITY OF CON LAWS

## Hospital Efficiency

**Market Structure and Technical Efficiency in the Hospital Services Industry: A DEA Approach**

Laurie J. Bates  
Bryant College  
Kankana Mukherjee  
Worcester Polytechnic Institute  
Rexford E. Santerre  
University of Connecticut

*This article uses data envelopment analysis and multiple regression analysis to examine empirically the impact of various market structure elements on the technical efficiency of the hospital services industry in various metropolitan areas of the United States. Market structure elements include the degree of rivalry among hospitals, extent of HMO activity, and health insurer concentration. The DEA results show the typical hospital services industry experienced 11 percent inefficiency in 1999. Moreover, multiple regression analysis indicates the level of technical efficiency varied directly across metropolitan hospital services industries in response to greater HMO activity and private health insurer concentration in the state. The analysis suggests the degree of rivalry among hospitals had no marginal effect on technical efficiency at the industry level. Evidence also implies that the presence of a state Certificate of Need law was not associated with a greater degree of inefficiency in the typical metropolitan hospital services industry.*

**Keywords:** technical efficiency; hospital services; data envelopment analysis

Health care spending as a percentage of GDP has begun to rise once again in the United States, spurring upward from 13.3 percent in 2000 to 15.3 percent in 2003 (Smith et al. 2005). A large part of the growth spurt can be

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*Empirical Research*

**The Association of Hospital Cost-Inefficiency With Certificate-of-Need Regulation**

Michael D. Rosko<sup>1</sup> and Ryan L. Mutter<sup>2</sup>

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**Abstract**  
Certificate-of-need (CON) regulations can promote hospital efficiency by reducing duplication of services; however, there are practical and theoretical reasons why they might be ineffective, and the empirical evidence generated has been mixed. This study compares the cost-inefficiency of urban, acute care hospitals in states with CON regulations against those in states without CON requirements. Stochastic frontier analysis was performed on pooled time-series, cross-sectional data from 1,552 hospitals in 37 states for the period 2005 to 2009 with controls for variations in hospital product mix, quality, and patient burden of illness. Average estimated cost-inefficiency was less in CON states (8.10%) than in non-CON states (12.46%). Results suggest that CON regulation may be an effective policy instrument in an era of a new medical arms race. However, broader analysis of the effects of CON regulation on efficiency, quality, access, prices, and innovation is needed before a policy recommendation can be made.

**Keywords:** certificate-of-need, efficiency, hospitals, stochastic frontier analysis

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**Allocative Inefficiency in the Production of Hospital Services\***

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**1. Introduction**

Researchers have offered numerous theoretical models of hospital behavior that suggest inefficiency in the provision of hospital services.<sup>1</sup> Explanations of inefficiency are tied to the organization and regulation of the industry, principal-agent problems, and the dominance of third-party reimbursement. Eakin and Knausner [3] use a non-minimum cost function to obtain estimates of allocative inefficiency for 331 U.S. short-term hospitals. In this paper, I fill a void in the hospital cost literature by investigating variations in allocative inefficiency in the short-term hospital industry. This is done by regressing the allocative inefficiency estimates from Eakin and Knausner against hospital characteristics predicted by theory as determinants of inefficiency.

I define allocative inefficiency at the firm level, but from a social point of view. Specifically, allocative inefficiency results from the technically efficient employment of inputs in a combination which is not cost-minimizing. A hospital may choose a non-cost-minimizing set of inputs if it evaluates the shadow prices of inputs as being different from the actual prices. A shadow price is the hospital's internal perception of the unit cost of an input. This perception may differ from the actual input price *if*, for example, the input enters directly into the hospital's objective function. The hospital is assumed to minimize shadow cost by equating the marginal rate of technical substitution and the ratio of input shadow prices. Thus, it is the shadow cost function that is dual to the underlying technology.

The hospital is modeled as a multiproduct firm. A modified translog cost function is used to develop a system of observed cost and share equations which is estimated via seemingly unrelated non-linear regressions. Empirical results indicate that overcapitalization and underemployment of physicians increase short-term hospital costs by about 5 percent. Hospital care expenditures are about 4.5 percent of the gross national product, which is almost three times the percentage in 1960. Thus, 5 percent represents a large amount in actual dollars. Further investigation identifies hospital size, market share, regulations and geographic region as the hospital characteristics related to the measure of allocative inefficiency.

This paper is organized as follows. In section II, I develop the empirical model based on a non-minimum cost function. The traditional minimum cost function is a special case and thus

\*Charles Glinits, Thomas Knausner, Karen Lovell and a referee have made helpful comments.  
1. For example, see Hems [7], Liu [10], Newhouse [15], and Pauly and Redish [17]. The issue of inefficiency and the non-profit medical firm is addressed in Pauly [16].

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**The impact of CON regulation on hospital efficiency**

Gary D. Ferrer · Hervé Léves · Yvonne G. Valdman

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**Abstract** In this paper we propose an empirically implementable measure of aggregate-level efficiency along the lines of Dobson's (1993) coefficient of resource utilization but restricted to the production side. The efficiency measure is based on directional distance functions, which allows the overall measure of efficiency to be decomposed into measures of technical and "structural" efficiency. The latter measure, which captures inefficiencies associated with the organization of production within an industry, is further decomposed into measures of scale and mix efficiency. The measures developed in this paper are illustrated using U.S. hospital data. The discussion sheds light on the efficacy of certificate of need (CON) regulations.

**Keywords** Hospital efficiency · Certificate of need · Directional distance function · Structural efficiency

**1 Introduction**

Health care reform has long been a political issue in the United States. The last federal push for comprehensive

reform was during the early years of the Clinton administration. More recent health care reforms, such as the implementation of Medicare Part D during the Bush administration, has been more cautious. Reforms have been initiated at the state level as well [1–6]. The main impetus for these state level health care reforms is increasing insurance coverage for individuals who are currently uninsured or underinsured. However, following one of the objectives of California's plan, affordability and cost containment [1], efficient production of health care services within the market (the state in this case) is also an important criteria insuring Pareto optimality in reform. Not only are costs relevant, but so is the state wide availability of services, implying that the proper allocation of resources is one that involves a "fair" distribution of resources throughout the state. While health insurance is the dominant issue in health care reform, it is a premise based on market based approaches. We take a slightly different and assess the efficiency of resource utilization within each state via regulation. The direct relationship between regulation, in this case certificate of need (CON) laws, and the state-level aggregation of hospital productivity, but the secondary implication is that for any state based reform to be successful, efficient operation is a necessary condition.

Rising health care costs and the increasing share of GDP accounted for by health care spending have been concerns for some time now; hospital costs are an important part of these issues. Prior to the implementation of the Medicare's prospective payment system (PPS) in 1983, hospitals were reimbursed on a fee-for-service (FFS) basis.<sup>1</sup> Under the FFS model, hospitals were reimbursed on a cost-plus basis

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<sup>1</sup>Over time other states followed Michigan's lead in shifting from FFS to PPS as an effort to contain costs. The Balanced Budget Act of 1997 furnished the transition from FFS to PPS.

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2 studies: CON increases some measures of efficiency  
1 study: CON has no effect on efficiency  
1 study: CON reduces efficiency



# THE REALITY OF CON LAWS

## Investment

### The Impact of Certificate-of Need Controls on Hospital Investment

DAVID S. SALKEVER  
THOMAS W. BICE

*Certificate-of-Need (CON) controls over hospital investment have been enacted by a number of states in recent years and the National Health Planning and Resources Development Act of 1974 provides strong incentives for adoption of CON in additional states. In this study, we review the questions that have been raised about the effectiveness of CON controls and then we develop quantitative estimates of the impact of CON on investment. These estimates show that CON did not reduce the total dollar volume of investment but altered its composition, retarding expansion in bed supplies but increasing investment in new services and equipment. We suggest that this finding may be due to (1) the emphasis in CON laws and programs on controlling bed supplies and (2) a substitution of new services and equipment for additional beds in response to financial factors and organizational pressures for expansion. Finally, we caution against the conclusion that CON controls should be broadened and tightened, though our results might be so interpreted, because of the practical difficulties involved in reviewing and certifying large numbers of small investment projects.*

#### Introduction

In the wake of rapid post-Medicare cost inflation, investment controls have emerged as important regulatory mechanisms for moderating the rise in health services expenditures. These controls take two forms: (1) legal prohibitions of unnecessary capital investment, and (2) financial controls, whereby a health care institution's eligibility to receive capital or operating funds relating to an investment project is dependent upon the approval of designated planning agencies. Presently, both types are widespread. Legal prohibitions are in effect through certificate-of-need (CON) laws in twenty-four states, and similar legislation has been proposed in seven other states (Lewin and Associates, Inc., 1974). Moreover, with the passage of P.L. 93-641, the National Health Planning and Resources Development Act of 1974, CON was slated for adoption by all participating states.

Several types of financial controls have been applied. Under  
MMFQ / Health and Society / Spring 1976 185

Fred J. Hellinger

### The Effect of Certificate-of-Need Legislation on Hospital Investment

There is presently an intense interest among third-party payers of health care, law-makers, and the public in the capital expenditures of health care facilities.<sup>1</sup> This interest has been engendered by the large increases in hospital and health care costs registered during the post-Medicare period, and by the prevailing conviction among health care researchers that excess capacity has contributed to this cost spiral. Investment in plant and equipment by health care facilities increases operating costs both through higher interest and depreciation expenses, and the associated operating expenses. The addition of a wing to a hospital will necessitate the employment of more nurses, maintenance personnel, and housekeepers, and the acquisition of new equipment. New equipment will increase operating costs by the amount of the depreciation expense plus the cost of training and employing personnel to operate and repair it.

The Hill-Burton program, passed in 1946, provided Federal funds for the construction of health care facilities that received the approval of a state planning agency. The 1966 Amendments to the Public Health Act created state and sub-state Comprehensive Health Planning (CHP) agencies (A and B agencies) which were required to develop a state plan for health care facilities. The CHP agencies, however, were given no statutory power to enforce their recommendations and were unable to require submission of capital budgets. Another indirect type control on capital expenditures was associated with these CHP agencies. Many Blue

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Cross Plans refused to reimburse health care facilities for interest and depreciation expense for a new facility unless the facility received CHP agency or their own review panel's approval.<sup>2</sup>

The Social Security Amendments of 1972 provided for the inclusion of controls on capital expansion by health care facilities through the withholding of Medicare and Medicaid funds for the interest and depreciation expenses associated with unapproved projects. Section 1122 of the 1972 Amendments allows the state to designate either their state CHP agency (A agency) or Hill-Burton agency to determine the need for new capital expenditures. A capital expenditure is defined as an expenditure that under generally accepted accounting principles is not properly chargeable as an operating expense and that 1) exceeds \$100,000, 2) changes the bed capacity, or 3) substantially changes the services of the facility.<sup>3</sup>

Under Section 1122, the recommendation of the designated state agency not to support a hospital construction project does not proscribe the use of interest funds or philanthropy by the hospital to finance the project. As Haightman has stated:<sup>4</sup>

Nevertheless, the Federal initiative by itself will probably fail to give state or local health planning decisions sufficient impact to obviate more substantial sanctions. The penalty of withholding an interest and depreciation component from payments under Medicare, Medicaid and maternal and child health programs is a relatively weak sanction, particularly since providers can control the number of Federal beneficiaries

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1 study: CON fails to reduce investment but changes its composition

1 study: CON backfires, increasing investment

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**MERCATUS CENTER**  
George Mason University

# FLORIDA'S CON LAW

LESSONS FROM THREE DECADES OF RESEARCH

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Florida House of Representative  
Health Market Reform Subcommittee

February 6, 2019