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POLICY BRIEF

Phasing Out Certificate-of-Need Laws: A Menu of Options

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RESEARCH SHOWS THAT CON LAWS DO NOT ACHIEVE THEIR OBJECTIVES

Certificate-of-need (CON) laws in healthcare are currently found in 36 states and the District of Columbia. These laws require those aspiring to offer certain medical services, acquire certain devices, or open or expand particular medical facilities to first obtain authorization from a regulatory authority. Four decades of research show that CON laws are associated with limited access, diminished quality, and higher costs of care. The most promising CON reform, therefore, is complete repeal, a strategy that has been successfully pursued by 15 states comprising nearly 40 percent of the US population. Complete reform, however, is politically difficult, given the outsized influence of incumbent providers, who have an interest in maintaining the current system. In this policy brief we therefore offer a menu of alternative reforms that can limit the anticompetitive effects of CON laws and illuminate a path toward more comprehensive reform in the future.

Unlike other forms of regulation, the immediate goal of CON is not to assess the provider's qualifications. Instead, regulators attempt to determine whether or not the service is needed by the community, an assessment that in most other markets is made by entrepreneurs with an eye toward expected profitability.

The federal government once encouraged states to adopt these procedures with the 1974 passage of the National Health Planning and Resources Development Act. It withheld federal funding from states that failed to adopt CON laws.[1] The goals of the legislation, often echoed by CON advocates today, were (1) to ensure an adequate supply of healthcare services, (2) to enhance access to care for rural populations, (3) to encourage higher-quality care, (4) to encourage more charity care for impoverished and underserved communities, (5) to encourage the use of lower-cost

healthcare alternatives such as ambulatory care, and (6) to lower the cost of care. Early research suggested that CON laws were failing to achieve these ends, and by the mid-1980s, Congress eliminated the mandate.

Several states immediately repealed their CON laws, and over the years, others have followed. Today, nearly 40 percent of the US population lives in states without a CON law in healthcare. Over the past several decades economists and other researchers have compared outcomes in these states with those in CON states to assess the effects of CON on access, quality, and cost. Their examinations use regression analyses with controls that account for potentially confounding factors such as demographics and local economic conditions. This research shows that CON laws have failed to achieve their goals.[2]

Access

Consider access to care. A CON law explicitly restricts the supply of services, so economic theory suggests that it is unlikely to expand access. Indeed, this is what the data show. Controlling for other factors, relative to patients in non-CON states, patients in CON states have access to fewer hospitals per capita,[3] fewer hospital beds per capita,[4] fewer dialysis clinics,[5] fewer ambulatory surgical centers,[6] fewer medical imaging services,[7] and fewer hospice care facilities.[8]

Nor do CON laws seem to expand access to care for certain vulnerable populations. There is no greater provision of charity care in CON states than non-CON states.[9] There are not just fewer hospitals and fewer ambulatory surgical centers in CON states, there are also fewer *rural* hospitals and fewer *rural* ambulatory surgical centers in these states.[10] This helps explain why patients in CON states must drive further to obtain care and are more likely to seek care in a different state.[11] There is also greater racial disparity in the provision of certain services in CON states than in non-CON states.[12] Finally, hospitals in CON states are less adaptable to change.[13]

Quality

These restrictions on access do not seem to have resulted in higher-quality care. In fact, research suggests that patients in CON states have higher mortality rates following heart attacks, heart failure, and pneumonia.[14] And patients in states with four or more CON laws have higher readmission rates following heart attacks and heart failure, more postsurgery complications, and lower patient satisfaction levels.[15]

Cost

Finally, both costs per procedure as well as spending per patient (or resident) are higher in CON states than in non-CON states.[16]

FULL REPEAL

The experience of the past half century suggests that full CON repeal would increase access to lower-cost, higher-quality healthcare. In spite of the social benefits of full CON repeal, however, it is not a politically easy thing to do. This is because the anticompetitive benefits of CON laws redound to a small and highly organized group of incumbent providers, while the costs of CON laws fall on a large, diffuse, and politically unorganized group of patients, taxpayers, and would-be providers. This problem was first laid out by economist Mancur Olson.[17] He noted that if public policy imposes costs on a large group of citizens, individual members of that group have little incentive to organize against the policy. For one thing, for any one member of the group, the costs of political engagement in such a fight are typically greater than the benefits that he or she stands to gain from policy change. And for another, members of large and diffuse groups have a strong incentive to free ride on the political engagement of others in their group, and this incentive tends to make all members of large and diffuse interest groups less likely to become engaged at all. To compound the problem, those who bear the costs of CON laws are often unaware that these rules even exist.[18] In contrast, those who benefit from CON laws—generally large, existing hospitals—are few in number, well acquainted with these rules, and typically able to organize to defeat any reforms.

In light of this political reality, the most successful reforms are likely to be those that allow policymakers to cast conspicuous votes for the general interest while giving them some cover as they remove special interest privileges.[19] In the rest of this policy brief, we outline suggestions to enable policymakers to ease their state's CON requirements.

PARTIAL REPEAL

CON laws cover a wide assortment of technologies and procedures: everything from new hospitals and hospital beds to air ambulances and radiation therapy. With 30 separate CON requirements, Vermont requires a CON for more services and technologies than any other state.[20] At the other end of the spectrum is Ohio, which requires a CON only for nursing home beds. Research suggests that the negative effects of CON requirements on hospital quality may be cumulative. In states with four or more CONs, postsurgery complications and readmission rates following heart attacks and heart failure are higher while patient satisfaction levels are lower.[21]

One potential path to reform, recently pursued by West Virginia and Florida, is to eliminate CON requirements for certain services or technologies. In 2017, West Virginia legislators eliminated the need for a CON for telehealth, remedial care, ambulatory health facilities, and imaging services.[22] And in 2019, Florida legislators eliminated the need for a CON for new hospitals; specialty hospitals converting to general hospitals; children's, women's, specialty medical, rehabilitation, psychiatric, and substance abuse hospitals; and intensive residential treatment facilities services for children.[23]

If policymakers wish to eliminate certain varieties of CONs, there are a number of promising options.

Eliminate CONs That Harm Vulnerable Populations

Good candidates for repeal are CONs that restrict access to services utilized by particularly vulnerable populations, such as CONs for drug and alcohol abuse treatment centers (found in 24 states), CONs for psychiatric care facilities (found in 28 states), or CONs for intermediate-care facilities for those with intellectual disabilities (found in 28 states).[24]

Eliminate CONs for Procedures That Are Unlikely to Be Overprescribed

Another option would be to eliminate CONs for procedures that are unlikely to be overprescribed. In these cases, the rationale for a CON is especially weak. Options here include the elimination of CONs for neonatal intensive care units (found in 22 states), CONs for burn care units (found in 14 states), and CONs for hospice care facilities (found in 18 states).

Eliminate CONs for Low-Cost Modes of Care

Another option is to eliminate CONs that restrict access to lower-cost modes of care. These reforms make sense, given that one of the initial goals of CON regulations was to encourage the use of lower-cost, ambulatory care.[25] Options here include the elimination of CONs for ambulatory surgical centers (found in 28 states) or CONs for home healthcare facilities (found in 19 states).

Eliminate CONs for Small Investments

Many states have a capital investment threshold that triggers the requirement of a CON. The lower the threshold, the more minor investments necessitate a CON. A low threshold discourages new providers from entering a market and makes it difficult for existing providers to modify their services in response to changes in demand or technology. One simple reform that can significantly ease the CON burden is to raise these thresholds.

PHASED REPEAL

There are several options to gradually eliminate CON laws.

A Time-Bound Phase Out

In the 1980s, 19 states repealed or scaled back their CON laws. Two states, Arkansas and Colorado, had adopted legislation committing to repeal their regulations in the event that the federal mandate was eliminated.[26] Eight other states (California, Idaho, Indiana, Kansas, Mississippi, Montana, Wisconsin, and Wyoming) had adopted sunset clauses that ensured that the regulations would

be eliminated after a certain period of time; given the elimination of the federal mandate, these sunsets were allowed to take place.[27]

In 1992, Pennsylvania's statutes were modified to contain a sunset clause under which the CON system would automatically terminate after four years.[28] As the sunset date drew near, special interests and the governor supported an extension of the CON law. The legislature, however, resisted, and the state's CON regulations were allowed to sunset in 1996.[29] In their place, however, the state began enforcing licensing provisions that focused on whether a proposed project met certain quality requirements.[30] More recently, New Hampshire passed a law in 2012 that repealed its CON law, effective 2015.[31] There, too, special interests mounted an unsuccessful defense of the program (though they did manage to delay the repeal by one year).

Other states could replicate these examples with legislation sunsetting individual CON mandates or entire CON programs.

A Temporary Elimination

As an alternative to a time-bound phase out, states could pursue the reverse strategy. They might eliminate one or more CON laws for a set period of time as a way of testing what a full repeal would be like. Such a sunset provision might give lawmakers the opportunity to look back over the effects of repeal on healthcare access, quality, and costs. However, it is not clear that providers would be willing to undertake investments under such an uncertain regulatory environment, skewing the results of the experiment. Moreover, this method risks allowing CON to return before the legislature has had a chance to act.

Gradual Increases in the Approval Rate

Another option would be to require CON boards to approve an increasing share of applications over successive years. For example, in Florida, the approval rate from 2014 to 2016 was 45 percent.[32] A state like Florida might decide to establish a four-year schedule where it would accept 55 percent of applications in year one, 65 percent in year two, 85 percent in year three, and 100 percent in year four. This would allow for a slow transition away from CON restrictions.

REPEAL CONTINGENT ON THE ACTIONS OF OTHERS

In another variation, states might attempt to replicate the Arkansas and Colorado path to reform by making CON repeal contingent on the actions of policymakers elsewhere. For example, a state might pass legislation that would automatically eliminate its CON program in the event that certain neighboring states did away with their own programs. This would allow policymakers to institute a reform that benefits the general interest while limiting the ability of special interests to counter it.

This approach may be viable given the fact that both patients and providers are influenced by the policies of neighboring states. As we have already noted, compared with patients in non-CON states, patients in CON states are more likely to seek out-of-state care. And as advancements in telemedicine continue, it will get easier for them to do so. Providers, too, may be tempted to explore alternative investments in neighboring states if doing so allows them to avoid a long and costly regulatory hurdle.

In short, state policymakers may be compelled to liberalize their CON laws as those around them liberalize, and a reform that is contingent on the actions of neighboring states may be easier to accomplish than an outright repeal.

ADMINISTRATIVE RELIEF

CON application processes are expensive and time consuming. Here, we suggest ways to alleviate those burdens.

Fee Reduction

Application fees vary widely between states. Connecticut prices applications at just $300.[33] But in many states, an application can cost thousands of dollars. In Virginia, the application fee can reach $20,000.[34] In North Carolina, the base application fee is $5,000 plus 0.3 percent of the capital costs of the project if those costs are greater than $1,000,000, for a total fee of up to $50,000.[35]

There seems to be no economic rationale for those discrepancies. However, if boards have discretion over the fee schedule and are funded by applications fees, they have a perverse incentive to maximize these fees. Lower application fees would ease one hurdle in the way of healthcare access.

Simplified Application and Reporting Requirements

High fees are not the only obstacle. Applications are costly in other ways. Many are long and require complex calculations and forecasts. Providers can spend years and hundreds of thousands of dollars in attorney and consultant fees. By way of example, Illinois's application template is 78 pages long. One Virginia radiology center spent five years and $175,000 applying for a CON.[36] CON boards should consider simplifying the reporting requirements to make the process more manageable for applicants.

MODIFICATION OF CRITERIA

States use different criteria to evaluate whether or not a service is "needed" in a certain community.

Eliminate the Nonduplication Criterion

In several states, applicants are required to demonstrate that the service, facility, or technology they wish to offer will not duplicate an already-existing service. If regulators determine that the applicant is likely to duplicate an existing service, the CON will be denied and the current provider will be ensured a monopoly.

Not all services and facilities can be compared in an apples-to-apples fashion. For example, physician Mark Baumel wanted to open a virtual colonoscopy clinic in northern Virginia. It would have used CT scanners to conduct noninvasive alternatives to traditional colonoscopies. His request was denied on the grounds that CT scanners were already being used by another provider in northern Virginia, despite the fact that that provider was not performing virtual colonoscopies.[37]

Beyond this practical consideration, there is no reason to prevent the duplication of a service. When more providers offer similar care, each has an incentive to compete over price and quality so as to attract and retain customers. As in other markets, healthcare quality tends to be higher and prices tend to be lower with more competition.[38] This explains why the Federal Trade Commission and the Department of Justice under both Democratic and Republican leadership have long maintained that CON laws are anticompetitive.[39] As a result, states should consider eliminating the nonduplication criterion.

Eliminate the Utilization Criterion

In certain states, CON boards assess the need for a new hospital by measuring the utilization of existing ones. For example, they will count the number of occupied beds or how often pieces of equipment are used. If existing facilities have low utilization rates, the board concludes that providers have overbuilt facilities and that any additional services of the same type would be wasteful.

This approach is flawed in a few regards. First, practically speaking, current utilization may not reflect needed utilization. For example, states that are prone to natural disasters may need to have the capacity to accommodate many more patients than average utilization levels suggest. Second, incumbent hospitals are aware of the utilization criteria, which gives them an incentive to overinvest in equipment and to underutilize what equipment they have so as to ensure rivals will be denied CONs. Ironically, this encourages the very problem this regulation was intended to prevent. Third, patients often know what services providers do and do not offer, especially in the case of specialty services. For example, patients are likely to know whether or not a certain hospital has a neonatal intensive care unit. As a result, patients are not likely to show up and ask for neonatal

intensive care if the hospital doesn't have a unit. In this case, the utilization rate fails to capture the fact that some patients do indeed need the service.

In sum, the utilization criterion creates perverse incentives and risks understating the true need for new services. State policymakers should consider eliminating it.

Narrow the Geographic Scope of Analysis

As we have noted, CON regulators assess need based on the current level of care offered by existing providers. A provider on the far side of a state is not able to offer convenient care, however, so one simple reform would be to narrow the geographic scope of the analysis to ensure that need is being assessed on a local basis.

INCREASED TRANSPARENCY

The pathway to reform can be illuminated by transparency measures, especially those that shed light on the fact that CON laws afford special interests anticompetitive benefits while costing patients and would-be competitors. We suggest six practical steps that states can take to discourage anticompetitive practices and make more ambitious reforms more likely.

Disclose Approval Rates

As we have noted, Florida approved about 45 percent of CON requests from 2014 to 2016.[40] We know this only because, prior to testifying in the Florida House of Representatives, we requested this information from the deputy secretary of the Florida Agency for Health Care Administration Division of Health Quality Assurance. This figure is not available on the CON board's website, however, and publishing it would be an easy way to make the process more transparent.

Disclose Applications Opposed by Incumbents

The CON process is anticompetitive because it gives incumbent providers a direct opportunity to oppose the entrance of would-be competitors. To mitigate the risk of special interests unduly influencing the decision of the board, states could require CON boards to disclose the percentage of applications that are opposed by incumbent hospitals and providers. Ideally, boards would release all data from past applications and pair it with approval rates, as that would enable analysts to see if incumbent opposition makes approval less likely.

Disclose Applicants' and Incumbents' Donations to Political Action Committees

In order to inform the public of the interests at play and to ensure objectivity throughout the review process, states could require both applicants and those opposing applications to disclose their donations to political action committees (PACs). It is common for CON board members to be affiliated with political parties, which may lead to subjective assessments and politically motivated decisions.[41] Moreover, recent research suggests that PAC contributions can affect the likelihood of CON approval.[42] Mandating the disclosure of donations would serve to mitigate this problem.

Disclose CON Board Members' Financial Ties

Along similar lines, states could require that the identities and financial interests of all members of the CON board be disclosed to the public. (Most states do already require this.) Boards are often composed of public officials and healthcare insiders, both of whom have certain interests in the handling of applications. In its decision in *North Carolina State Board of Dental Examiners v. FTC*, the US Supreme Court ruled that when boards are dominated by members of the professions they oversee and when elected officials fail to exercise adequate control over these boards, states may be liable for antitrust violations.[43] More broadly, the presence of industry insiders on CON boards may allow the CON system to function as a cartel. By making the composition of the board transparent, states would shed light onto members' potential motivations.

Ensure That Boards Are Not Dominated by Industry Insiders

Boards should not be dominated by the members of the professions or businesses they oversee. States should ensure that a clear and controlling majority of CON board members do not have financial ties to the existing healthcare industry. Ideally, boards would be comprised of disinterested professionals who are acquainted with the economics of CON regulation and are interested in improving the health and safety of the public, not in protecting incumbent providers from competition.

Disclose Applicants' Compliance Costs

We noted above that application costs can reach tens of thousands of dollars. In many cases, the total cost of applying for a CON is much higher, as illustrated by the case of a Virginia doctor who wished to purchase a second MRI scanner for his practice group and spent $175,000 preparing the lengthy application.[44] A large share of the costs went to attorney and consultant fees. Even in states where application fees are low, applicants can be deterred by these sorts of steep compliance costs. And if they are not deterred, they will end up expending valuable resources on the application when those resources could instead have been invested in patient services. To make this burden apparent to potential applicants and the public, states could require that applicants report their own compliance costs, such as the number of full-time employee hours used in preparing the application, the labor cost, and the opportunity cost of the time spent preparing it.

Duty to Follow Up after Application Denial

States would be well advised to follow up with providers whose applications have been denied and ask them how their inability to offer the requested service has affected their overall performance in order to make apparent the consequences of denials. A recent incident in southwestern Virginia illustrates the point. In 2010, a local hospital applied for a certificate to create a neonatal intensive care unit (NICU). Despite overwhelming support from the local community, the board was swayed by an incumbent provider's claim that the new service was superfluous. Two years after the denial, a pregnant woman came to the hospital in premature labor. Lacking a NICU unit, the hospital requested transport to the nearest facility with such a unit. But, unfortunately, the baby died before the transportation could arrive.[45]

CONCLUSION

A large body of academic research suggests that CON laws limit access, degrade quality, and increase cost. Given this evidence, state policymakers who wish to increase patient access to high-quality, lower-cost care would be well advised to eliminate their entire CON programs.

A full repeal, however, may be politically difficult given the outsized influence of special interests. In this brief, we have suggested a number of alternatives to full repeal that would improve the CON process and ease the path for future reforms.

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