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TESTIMONY

The Failure of Mississippi's Certificate-of-Need Laws

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Hearing on Certificate of Need (CON)

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Chairman Creekmore, Chairman Zuber, and members of the committee, thank you for giving me the opportunity to submit for the record my recent work on certificate-of-need (CON) laws as they apply to healthcare in Mississippi. My name is Thomas Stratmann, and I am a distinguished university professor of economics and law at George Mason University in Virginia and a senior research fellow at the Mercatus Center at George Mason University.

Certificate-of-need laws require healthcare providers to obtain permission to open or expand their practices or to purchase specific devices or new technologies by proving the "need" for their services in their community. CON laws exist in some form in 35 states.

The purpose of CON laws is to control healthcare costs by discouraging providers from investing in medical facilities or equipment deemed unnecessary. Unfortunately, in practice, these rules protect incumbent providers from competition more than they protect residents from unnecessary costs. And importantly, as a result, CON laws reduce the quality of medical services provided by hospitals and reduce access to healthcare for patients.

New York was the first state to pass a CON law in 1964. In 1974, the federal government also passed a CON law applicable to all states. Again, the justification for this law was to limit healthcare costs. However, because its CON law did not actually contain costs, the federal government repealed it in the early 1980s. Additionally and importantly, by the 1980s, the rationale for CON laws was gone.

Before the federal repeal, Medicare and other insurance providers used a retrospective reimbursement system, which meant that hospitals and other medical providers received reimbursement for whatever services they provided. This led to some concern about high costs because providers had an incentive to provide unnecessary services. After all, they were reimbursed for all the services provided. However, by the 1980s, Medicare and many insurance providers switched to the prospective, or DRG (diagnosis-related group), system, which reimbursed healthcare providers based on the patient's diagnosis. So,

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hospitals had an incentive to stop over-providing services. Prospective reimbursement is the system used today. Therefore, the original rationale for CON no longer exists.

CON laws were kept on state books, however, and resulted in negative consequences for patients. My coauthors and I documented these harmful effects in eight academic, data-driven studies. These studies compare economic and health measures in the 35 states that had CON laws to those that did not.[1] These peer-reviewed studies suggest that CON laws do the following:

1. Harm patients by reducing healthcare quality.
2. Harm patients by reducing access to healthcare. They reduce the availability of medical care by making it difficult for medical providers to offer their services.
3. Reduce the availability of medical equipment, such as MRI machines and CT scanners, that help diagnose illnesses and prevent premature death, thereby harming patients.
4. Harm patients in rural areas by reducing opportunities to obtain medical services through ambulatory surgery centers, for example.

These findings were consistent with the positions of the Federal Trade Commission (FTC) and the US Department of Justice (DOJ) under both Democratic and Republican administrations.[2] The FTC and DOJ argued that CON laws fail to meet their stated goals and are harmful to patients. The largest association of physicians, the American Medical Association, also favored repealing all CON laws.[3]

[1] Thomas Stratmann and Jake Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2014); Thomas Stratmann and Matthew C. Baker, "Are Certificate-of-Need Laws Barriers to Entry? How They Affect Access to MRI, CT, and PET Scans" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); Thomas Stratmann and Christopher Koopman, "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016); Matthew C Baker and Thomas Stratmann. "Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws," *Socio-Economic Planning Sciences* 77(2021); Matthew Mitchell and Thomas Stratmann. "The Economics of a Bed Shortage: Certificate-of-Need Regulation and Hospital Bed Utilization during the COVID-19 Pandemic," *Journal of Risk Financial Management* 15 (2022); Thomas Stratmann, "The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services," *Journal of Risk and Financial Management* 15, no. 6 (2022): 272; Thomas Stratmann, Markus Bjoerkheim, and Christopher Koopman, "The Causal Effect of Repealing Certificate-of-Need Laws for Ambulatory Surgical Centers: Does Access to Medical Services Increase?," *Southern Economic Journal* (August 13, 2024): 1–24.

[2] US Department of Justice and Federal Trade Commission, *Improving Health Care: A Dose of Competition*, July 2004, 22; *Certificate of Need: Evidence for Repeal* (Chicago, IL: American Medical Association 2015). See also Monica Noether, "Competition among Hospitals" (Washington, DC: Federal Trade Commission, 1987), 82; Daniel Sherman, *The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis* (Washington, DC: Federal Trade Commission, January 1988); US Department of Justice and Federal Trade Commission, *Competition in Health Care and Certificates of Need: Joint Statement of the Antitrust Division of the US Department of Justice and the Federal Trade Commission before the Illinois Task Force on Health Planning Reform*, September 15, 2008; Maureen K. Ohlhausen, "Certificate of Need Laws: A Prescription for Higher Costs," *Antitrust* 30, no. 1 (2015): 50–54; Letter from Federal Trade Commission Staff to Marilyn W. Avila, North Carolina State Representative, July 10, 2015; Federal Trade Commission and US Department of Justice, *Joint Statement of the Federal Trade Commission and the Antitrust Division of the US Department of Justice to the Virginia Certificate of Public Need Work Group*, October 26, 2015; Federal Trade Commission and US Department of Justice, *Joint Statement of the Federal Trade Commission and the Antitrust Division of the US Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250*, January 11, 2016.

[3] American Medical Association, "Certificate of need: Evidence for repeal," Advocacy Resource Center, 2015.

CON LAWS IN MISSISSIPPI

CON laws in Mississippi require already-licensed healthcare providers to obtain government permission to compete for 19 medical services (out of the 28 medical services regulated across the US states by CON laws). Among the states with the highest number of CON laws, Mississippi ranks 12th. Some examples of CON laws are the following:

- In Mississippi, a hospital needs permission to add a new bed.
- In Mississippi, permission is required for a new provider to open a new hospital.
- In Mississippi, permission is required to purchase an MRI machine, PET scanners, and, in some cases, CT scanners (in the Mobile Hi Technology CON category).
- In Mississippi, permission is required to open an ambulatory surgery center.

RATIONALE FOR AND CONCEPTUAL INEFFECTIVENESS OF CON LAWS

While there are many justifications for CON laws, the typical goals include

- ensuring an adequate supply of healthcare resources,
- protecting access in rural and underserved communities,
- promoting high-quality care,
- supporting charity care, and
- controlling cost.

Certificate-of-need laws were well-intentioned when states first introduced them in the mid-1960s. However, their effectiveness should be measured by their outcomes: Even the best-intentioned laws might not lead to the desired results and might yield unintended consequences.

The failure of CON laws to achieve their intended goals might have been expected because they grant incumbent providers a government-protected monopoly. Both basic economics and common sense tell us that government-protected monopolies have negative consequences, particularly for poor consumers. CON laws restrict competition by design. In healthcare, in a manner unheard of in any other industry, existing hospitals and other medical providers can oppose a would-be competitor's CON application simply by claiming that there is no need for that additional medical service. This is akin to McDonald's needing permission from Burger King to open a restaurant in Mississippi.

EMPIRICAL EVIDENCE OF THE FAILURE OF CON LAWS

My colleagues and I started analyzing data to rigorously test whether each CON-law goal was achieved. Specifically, we examined proponents' claims that CON laws provide better access to care, higher quality care, and improved indigent care.

We found that CON laws do not deliver on these promises, and, in fact, they have backfired. Patients in states with CON laws have less accessible and lower quality medical care, and hospitals in CON-law states do not provide more indigent care compared to hospitals in non-CON-law states. In this context, it is essential to note that CON laws, in fact, do not have a public health justification: CON requirements have absolutely nothing to do with public health or safety.

In our studies we compared states with CON laws to states without them. To ensure our studies are apples-to-apples comparisons, we adjusted our estimates according to the age distribution in each state.

Other adjustments include the population's health and the percentage of the population on Medicaid and Medicare.

CON LAWS REDUCE ACCESS TO MEDICAL FACILITIES ACROSS THE STATE

The data show that there are fewer hospitals and ambulatory surgery centers (ASCs) in states with CON laws than in states without them. Evidence shows that Mississippians in both urban and rural areas have fewer choices because of CON.

In 2017, Mississippi had about 116 hospitals. A comparable state without CON laws had 165 hospitals—over 30 percent more.[4] This finding suggests that CON laws reduce access to medical care.

Our research also shows that states without CON laws have more hospital beds per patient. Why is this important? Because when there are more hospital beds, patients have more hospitals to choose from, are less likely to be turned away, and might have the option to go to a more conveniently located hospital.

Mississippi also has a CON law for ambulatory surgery centers (ASCs). Comparing Mississippi to statistically similar states without CON laws shows that if Mississippi would not have had CON laws, instead of 67 ASCs in 2020, it likely would have had over 78.[5]

Another crucial issue is the effect of CON laws on medical services in rural areas. CON-law proponents say that the laws increase access to medical care in rural areas. However, the data show that CON laws have the opposite effect. Rural Mississippi has fewer ASCs and fewer hospitals, and thus offers fewer patient choices and less access to medical care. For example, as of 2020, comparable states without CON laws have 32 more rural hospitals than Mississippi's roughly 74 rural hospitals.[6]

PATIENTS IN STATES WITH CON LAWS HAVE LESS ACCESS TO MEDICAL IMAGING

The negative effect of CON laws on medical services is not restricted to the availability of medical facilities. Procedures such as MRI, CT, and PET scans are also negatively affected. This is because CON laws require healthcare providers to obtain government permission to purchase imaging equipment, thereby reducing patients' access to medical care.

For example, per year, about 90,000 MRI scans are performed in Mississippi. Our estimates show that residents in comparable non-CON-law states have more access to MRI scans.[7] They receive 120,000 MRI scans—almost one-third more than Mississippians. This provides a glimpse of how access to medical care in Mississippi would improve if the state were to abolish its CON laws.

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[4] "Mississippi and Certificate-of-Need Programs 2020," (website), March 23, 2021, https://www.mercatus.org/publication/mississippi-and-certificate-need-programs-2020.

[5] "Mississippi and Certificate-of-Need Programs 2020," (website).

[6] "Mississippi and Certificate-of-Need Programs 2020," (website).

[7] Stratmann and Baker, "Are Certificate-of-Need Laws Barriers to Entry?"

THE QUALITY OF HOSPITAL CARE IS LOWER IN STATES WITH CON LAWS

Hospitals cannot compete on prices like most other industries do because many patients are on Medicare and Medicaid and can only be charged fixed amounts. However, hospitals can compete on different margins, such as quality of service. In states without CON laws, hospitals are incentivized to compete to attract patients by providing better quality medical services. This incentive is weaker in states with CON laws because there, hospitals are legally shielded from competition.

The data show that CON laws reduce the quality of hospital medical services. This quality reduction is due to a lack of competition among medical providers. When my coauthors and I compared states with CON laws to those without them, we saw that states with CON laws have a lower quality of service as measured by their hospital mortality rates and hospital readmission rates. For example, states with CON laws have

- 0.5 percent more deaths for surgery patients with serious complications,
- 0.6 percentage point higher pneumonia mortality rate,
- 0.3 percentage point higher heart failure mortality rate, and
- 0.4 percentage point higher heart attack mortality rate.

This evidence shows that CON is harmful to patient health and survival.[8]

THE AMOUNT OF INDIGENT CARE IS NOT BETTER IN STATES WITH CON LAWS

CON-law proponents sometimes claim that CON laws increase indigent care because successful applicants might commit to improving their medical services to the indigent. However, the data fail to support such optimism. It turns out that hospitals in CON-law states have only as much indigent care as hospitals in non-CON-law states. Thus, CON laws do not lead to additional services for the poor.[9] In this study, we use uncompensated care to measure indigent care.

REPEALING CON LAWS

A compelling case study comparing Virginia, a current CON law state, and Pennsylvania, a former one, demonstrates the potential for significant savings on healthcare costs and improved provision of medical services.[10] This case study compares the growth of hospitals and ambulatory surgery centers in Pennsylvania with that in Virginia. The choice of Virginia for comparison is particularly apt, given its similarities to Pennsylvania's population distribution and urban centers. This study is crucial in understanding the benefits of a state legislature boldly abolishing its CON laws.

Just over 30 years ago, before it repealed its CON laws in 1992, Pennsylvania had 2.3 hospitals per 100,000 residents and Virginia had about 2.0: Pennsylvania had 15 percent more hospitals than Virginia. Twenty-five years after Pennsylvania repealed its CON laws, this percentage rose to 38. Moreover, Pennsylvania, which had fewer rural hospitals than Virginia in 1990, also experienced a growth in rural

[8] Thomas Stratmann, "The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services," 272; Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality."

[9] Stratmann and Russ, "Do Certificate-of-Need Laws Increase Indigent Care?"

[10] Matthew D. Mitchell, "Virginia's Certificate-of-Public-Need Law: A Comparison with Other States" (Testimony before the Virginia House of Delegates Health, Welfare, and Institutions Committee, Mercatus Center at George Mason University, Arlington, VA, April 19, 2018).

hospitals after the repeal and today has more rural hospitals than Virginia. In this context, it is important to note that over the past fifty years, the number of hospitals per capita in the United States has been falling; however, this decline has been less steep in Pennsylvania than Virginia.

The effect of Pennsylvania's CON-law repeal on access to ASCs was even more dramatic. In 1992 both Virginia and Pennsylvania had roughly 0.3 ASCs per 100,000 residents; in the second half of the 2010s, that ratio rose to 0.6 in Virginia while in Pennsylvania it increased to 1.8. Thus, while Virginia saw a doubling of its ASCs, Pennsylvania saw a six-fold increase. This is especially noteworthy given that many medical treatments that required high-cost inpatient services 20 years ago are now available in lower-cost outpatient facilities, or ASCs. This example shows how CON laws can restrict adoption of innovations in medical services and how repealing CON laws can generate innovations and cost savings.

In separate work, my coauthors and I showed that the rise of ASCs is not associated with closing hospitals nearby.[11] Hospitals may, in fact, benefit from the opening of ASCs nearby. A neighboring ASC makes it easier for a hospital to retain physicians, especially in rural areas, because the ASCs provide physicians with an opportunity to supplement their incomes.

States have been taking action to reverse the harmful effects of CON laws by repealing them. In some cases the detrimental impact of CON laws has become more apparent with population growth. In 2019 Florida repealed significant portions of its CON law. The largely rural state of Montana, also experiencing population growth, repealed its CON law in 2021. And in 2023 South Carolina followed.

CONCLUSION

The takeaway from these findings is that CON laws are detrimental to Mississippi residents: CON laws reduce the quality of medical care, access to healthcare, and opportunities to obtain medical services such as MRI, CT, and PET scans. Research shows that Mississippians would be better off if the state would join those that do not have CON laws.

[11] Thomas Stratmann, Markus Bjoerkheim, and Christopher Koopman, "The Causal Effect of Repealing Certificate-of-Need Laws for Ambulatory Surgical Centers: Does Access to Medical Services Increase?," *Southern Economic Journal* (August 13, 2024): 1–24.