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Certificate-of-Need Laws: Implications for North Carolina

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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 1978, North Carolina has been among the states that restrict the supply of health care in this way, with 25 devices and services—ranging from acute hospital beds to magnetic resonance imaging (MRI) scanners 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 North Carolina—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 no relationship between CON programs and increased access to health care for the poor.[5] There are, however, serious consequences for continuing to enforce CON regulations. In particular, for North Carolina these programs could mean approximately 12,900 fewer hospital beds, 49 fewer hospitals offering MRI services, and 67 fewer hospitals offering computed tomography (CT) scans. For those seeking quality health care throughout North Carolina, 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 other 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 for the remaining states to implement CON programs.[7] In the seven years following this mandate, nearly every state without a CON program, including North Carolina, took steps to adopt certificate-of-need statutes. By 1982 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.

North Carolina 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. North Carolina's CON program currently regulates 25 different services, devices, and procedures, which is much more than the national average. As figure 1 shows, North Carolina's certificate-of-need program ranks fourth most restrictive in the United States.

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

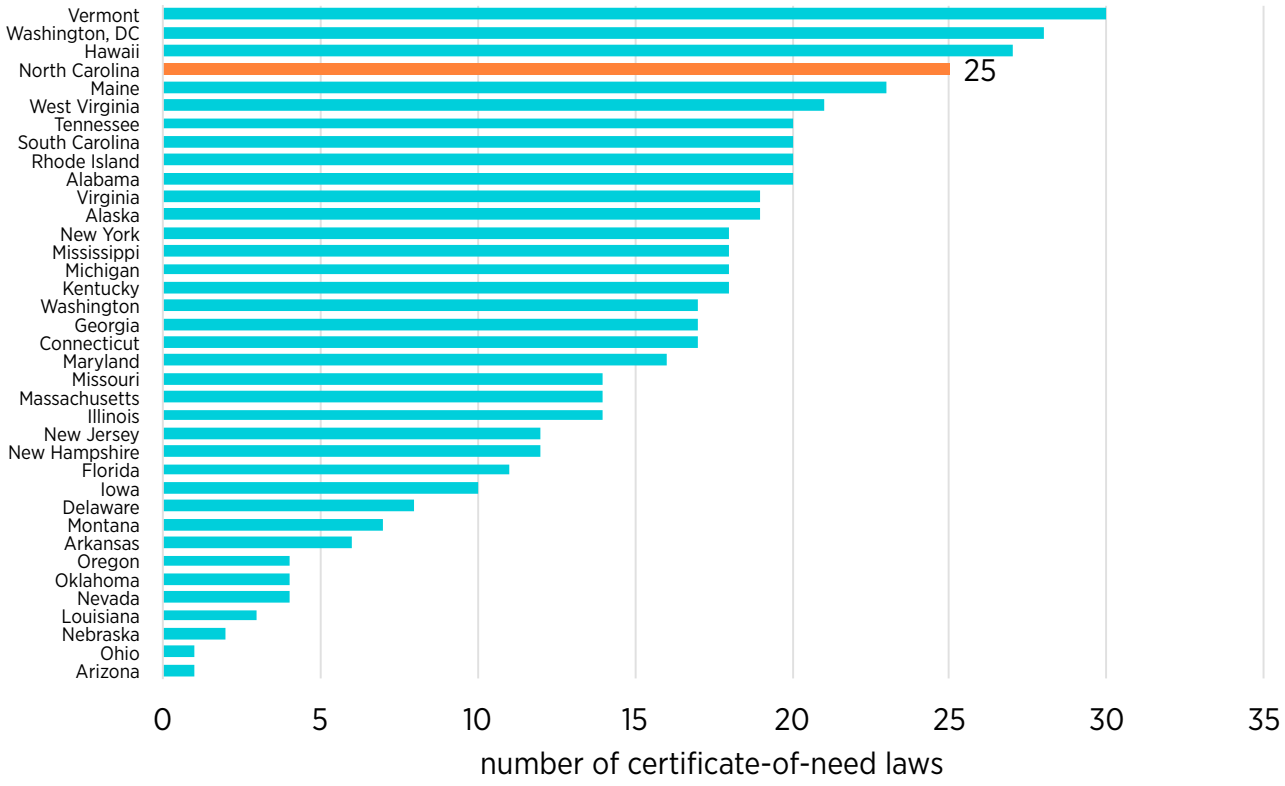
Many early studies of CON programs found that these programs fail to reduce investment by hospitals.[9] These early studies also found that the programs fail to control costs.[10] Such findings contributed to the federal repeal of CON requirements. More recently, research into the effectiveness of remaining 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 North Carolina—include some requirement for charity care within their respective CON programs.[13] This is what economists have come to refer to 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 for 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

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



Note: Fourteen states either have no certificate-of-need laws or they are not in effect. In addition, Arizona is typically not counted as a certificate-of-need state, though it is included in this chart because it is the only state to regulate ground ambulance services.

Stratmann and Jacob Russ, finds no relationship between certificates of need and the level of charity care.[16]

THE LASTING EFFECTS OF NORTH CAROLINA'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 North Carolina and in the other states that continue to enforce 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 such as North Carolina that regulate acute hospital beds through their CON programs, Stratmann and Russ find 131 fewer beds per 100,000 persons. In the case of North Carolina, with its population of approximately 9.85 million, we can assume that there are about 12,900 fewer hospital beds throughout the state as a result of its CON program.

Moreover, several basic health care services that are used for a variety of purposes are limited because of North Carolina's CON program. Across the United States, an average of six hospitals per 500,000 persons offer MRI services. In states such as North Carolina that regulate the number of hospitals with MRI machines, the number of hospitals that offer MRIs is reduced by 2.5 per 500,000 persons.[18] This could mean 49 fewer hospitals offering MRI services throughout North Carolina. The state'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 North Carolina, this could mean about 67 fewer hospitals offering 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 North Carolina, this situation presents a particularly rich 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.C. Gen. Stat. Ann. § 131E-178.

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?" North Carolina's requirement can be found at N.C. Gen. Stat. Ann. § 131E-178.

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.