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Certificate-of-Need Laws: Implications for Georgia

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Thirty-six states and the District of Columbia currently limit entry or expansion of health care facilities through certificate-of-need (CON) programs.[1] These programs prohibit health care providers from entering new markets or making changes to their existing capacity without first gaining the approval of state regulators. Since 1979, Georgia has been among the states that restrict the supply of health care in this way, with 17 devices and services—including acute hospital beds, positron emission tomography (PET) scanners, and open heart surgery—requiring a certificate of need from the state before the device may be purchased or the service 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 will reduce overinvestment in facilities and equipment. In addition, many states—including Georgia—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. 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 Georgia these programs could mean approximately 13,227 fewer hospital beds, between 20 and 40 fewer hospitals offering magnetic resonance imaging (MRI) services, and between 50 and 71 fewer hospitals offering computed tomography (CT) scans. For those seeking quality health care throughout Georgia, 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 took steps to adopt certificate-of-need statutes. Georgia enacted its first CON program in 1979. 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.

Georgia 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. Georgia's CON program currently regulates 17 different services, devices, and procedures, which is more than the national average. As figure 1 shows, Georgia's certificate-of-need program ranks the 18th most restrictive in the United States.

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

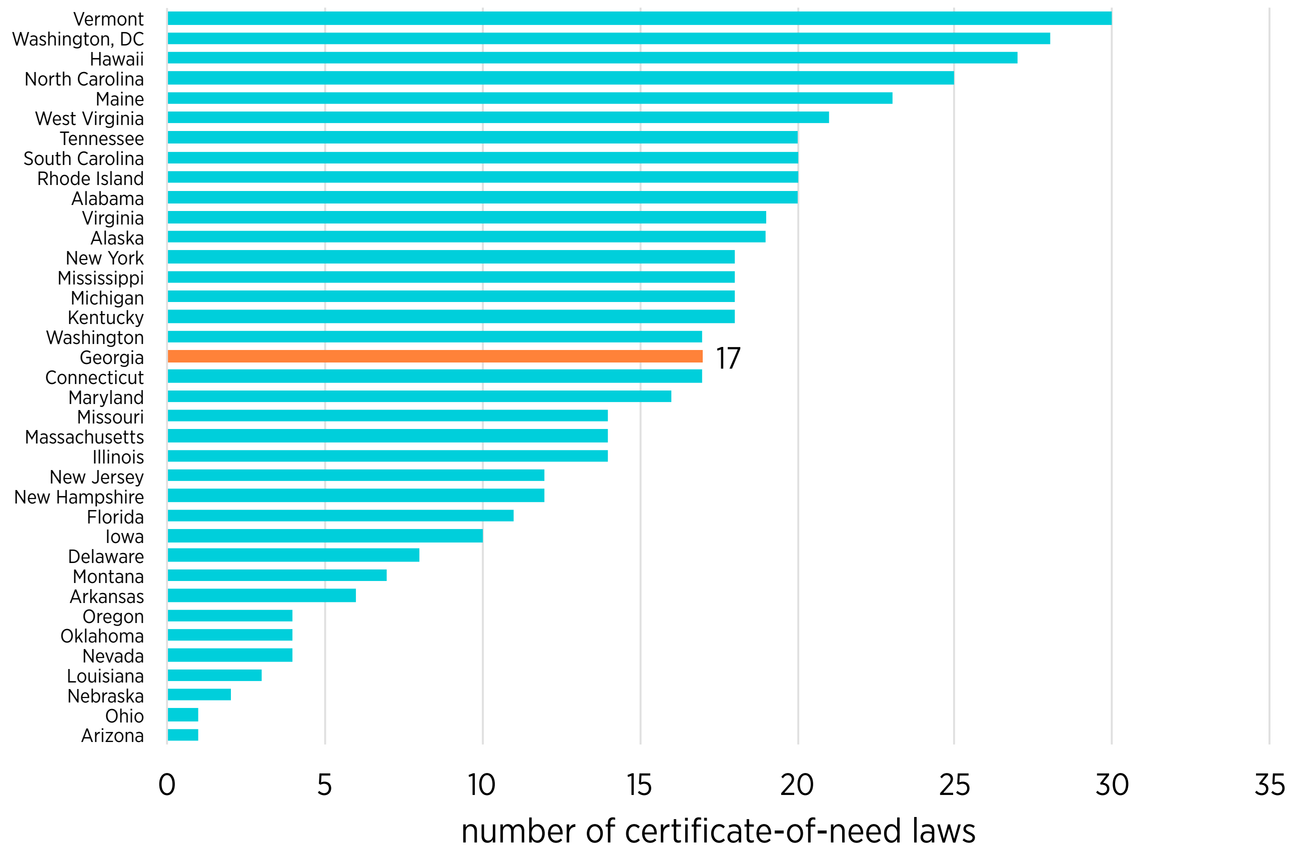
Many early studies of CON programs found that these programs fail to reduce investment by hospitals.[9] These early studies also found that the programs fail to control costs.[10] Such findings contributed to the federal repeal of CON requirements. More recently, research into the effectiveness of remaining 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 Georgia—make some requirement for charity care within their respective CON programs.[13] This is what economists 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 to the poor. Those who can pay are supposed to be 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

FIGURE 1. NUMBER OF CERTIFICATE-OF-NEED LAWS BY STATE



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.

show evidence of this cross-subsidy taking place. The most comprehensive empirical study to date, conducted by Thomas Stratmann and Jacob Russ, finds no relationship between certificates of need and the level of charity care.[16]

THE LASTING EFFECTS OF GEORGIA'S CON PROGRAM

While certificates of need neither control costs nor increase charity care, they continue to have lasting effects on the provision of health care services both in Georgia 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 Georgia that regulate acute hospital beds through their CON programs, Stratmann and Russ find 131 fewer beds per 100,000 persons. In the case of Georgia, with its population of approximately 10.01 million, this could mean about 13,228 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 Georgia's CON program. Across the United States, an average of six hospitals per 500,000 persons offer MRI services. In states such as Georgia that restrict hospitals' capital expenditures (above a certain threshold) on MRI machines and other equipment, the number of hospitals that offer MRIs is reduced by between one and two per 500,000 persons.[18] This could mean between 20 and 40 fewer hospitals offering MRI services throughout Georgia. 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 Georgia, this could mean between 50 and 71 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 Georgia, this situation presents an opportunity to reverse course and open the market for greater entry, more competition, and ultimately more options for those seeking care.

NOTES

1. Thomas Stratmann and Jacob Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" (Working Paper No. 14-20, Mercatus Center at George Mason University, Arlington, VA, July 2014), http://mercatus.org/publication/do-certificate-need-laws-increase-indigent-care.
2. O.C.G.A. § 31-6 (2014).
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?" Georgia's requirement can be found at O.C.G.A. § 31-6-40.1(c) (2014).
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.