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Illinois's Certificate-of-Need Laws: Effects on Quality, Spending, and Access to Care

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June 2017

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CERTIFICATE-OF-NEED (CON) LAWS REQUIRE healthcare providers wishing to open or expand a healthcare facility to first prove to a regulatory body that their community needs the planned services. The first healthcare CON program was enacted in New York in 1964, but it was a federal law, the National Health Planning and Resources Development Act of 1974,[1] that encouraged CON's adoption nationwide. The law withheld federal funds from states that did not implement CON programs. By the early 1980s every state except Louisiana had some version of a CON program. Among other goals, policymakers hoped CON laws would restrain healthcare costs, increase healthcare quality, and improve access to care for poor and underserved communities.[2]

Illinois's CON program came into force in 1974[3] and now limits 13 services (see table 1),[4] making it the 27th most restrictive CON program in the country.[5] According to the Illinois Health Facilities and Services Review Board, Illinois's CON program is intended to assure "the availability of quality facilities, related services, and equipment to the public, while simultaneously addressing the issues of community need, accessibility, and financing." Furthermore, it aims to encourage "health care providers to engage in cost containment, better management and improved planning."[6]

Twelve years after Illinois enacted its CON program, as evidence mounted that such programs were failing to achieve their stated goals, Congress repealed the act that encouraged states to adopt CON laws.[7] In the years since, 15 states have eliminated their CON programs.[8] In this brief, we examine the effects of Illinois's CON program in light of 40 years of academic research, looking in particular at how CON laws affect hospital quality, healthcare

Table 1. Services Regulated by CON in Illinois
Acute hospital beds
Ambulatory surgical centers (ASCs)
Cardiac catheterization
Intermediate care facilities for individuals with intellectual disability (ICF/IDs)
Long-term acute care (LTAC)
Neonatal intensive care
Nursing home beds/long-term care beds
Obstetrics services
Open-heart surgery
Organ transplants
Rehabilitation
Renal failure/dialysis
Subacute services

Source: Christopher Koopman and Anne Philpot, "The State of Certificate-of-Need Laws in 2016—Regulated Services by State, 2016," Mercatus Center at George Mason University, September 27, 2016.

spending, and access to care for communities in need. The evidence is overwhelming that CON laws have failed to achieve their intended goals and, in some cases, have backfired.

CON LAWS DO NOT INCREASE THE QUALITY OF MEDICAL SERVICES

By limiting the number of healthcare providers available to perform certain procedures, CON laws likely channel more patients through a smaller number of providers. Proponents of CON argue that this allows practitioners to specialize and improve service quality.[9] But this hypothesis must be weighed against well-established economic theory that predicts that competition yields better-quality products and service provision, while restrictions on entry protect incumbent firms, allowing them to neglect consumers' well-being.[10]

Using an empirical method that attempts to isolate the causal effect of CON on various hospital quality indicators, Thomas Stratmann and David Wille test whether hospitals in CON states are of higher quality than hospitals in states that do not protect providers with CON laws. Their analysis controls for both observed and unobserved factors that might confound the estimate. Their findings suggest that CON laws do not increase quality. Moreover, CON laws may actually have an adverse effect on hospital quality, measured by indicators including readmission rates, mortality rates, and patient experience surveys.[11]

Based on regression estimates comparing hospital quality indicators in CON and non-CON states, Stratmann and Wille estimate that Illinois would have lower mortality rates for pneumonia, heart attack, and heart failure, as well as fewer deaths among patients with serious complications following surgery, if the state repealed its CON program (see table 2).[12]

Importantly, the extent to which a state regulates healthcare with CON matters. Stratmann and Wille found that in states such as Illinois that have four or more CON laws, hospitals have lower quality across more indicators. Based on the results of this regression, they estimate that Illinois would have lower rates of heart failure readmission and heart attack readmission, as well as a higher share of patients giving their hospitals the highest overall quality rating, if the state did not have a CON program (see table 3).[13]

Table 2. Estimated Percentage Difference in Hospital Quality Indicators without CON in Illinois, Based on Regression Analysis of the Full Sample

HOSPITAL QUALITY INDICATOR	ESTIMATED PERCENTAGE DIFFERENCE WITHOUT CON
Deaths among patients with serious complications after surgery	−5.7
Pneumonia mortality rate	−5.3
Heart failure mortality rate	−2.9
Heart attack mortality rate	−2.5

Source: Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).

The evidence is overwhelming that CON laws have failed to achieve their intended goals and, in some cases, have backfired.

Table 3. Estimated Percentage Difference in Hospital Quality Indicators without CON in Illinois, Based on Regression Analysis of States with Four or More CON Laws

HOSPITAL QUALITY INDICATOR	ESTIMATED PERCENTAGE DIFFERENCE WITHOUT CON
Deaths among patients with serious complications after surgery	−6.3
Pneumonia mortality rate	−4.1
Heart failure mortality rate	−3.2
Heart attack mortality rate	−2.2
Percentage of patients giving their hospital a "high" overall rating	4.6
Heart failure readmission rate	−1.3
Heart attack readmission rate	−1.9

Source: Stratmann and Wille, "Certificate-of-Need Laws and Hospital Quality."

CON LAWS DO NOT REDUCE HEALTHCARE SPENDING

CON programs restrict the supply of the healthcare services they regulate. Economic theory predicts that such a supply restriction will increase per-unit costs while reducing the quantity of services provided. This reduction in the quantity of services provided could mean CON regulations might reduce *overall spending*, even while they raise the costs of particular procedures.

Yet 40 years of research demonstrates CON is associated with both higher per-unit cost *and* higher total healthcare spending. Matthew D. Mitchell recently conducted a survey of the academic literature on CON and spending, looking at both factors. As economic theory predicts, the empirical research consistently finds that CON laws fail to reduce per-unit costs and, if anything, seem to be associated with higher costs. The weight of evidence also suggests that CON laws are associated with higher overall spending: Seven studies find CON regulations are associated with higher spending, two find no statistically significant relationship, and only one finds CON to be associated with less spending.[14] Importantly, the connection between CON and lower spending in this last study is not direct. The author found that CON was associated with fewer hospital beds and that fewer beds were associated with slightly slower growth in spending. When he tested for a direct relationship between CON and spending, however, he found none.[15]

The evidence, therefore, is entirely consistent with economic theory. CON does not achieve its goal of cost containment and likely leads to higher per-unit costs as well as more overall spending.

CON LAWS DO NOT INCREASE ACCESS TO HEALTHCARE IN COMMUNITIES OF NEED

Somewhat paradoxically, CON proponents claim that by restricting the supply of healthcare services, they can increase the supply of services provided to certain communities. First, CON proponents claim entry restriction is necessary to ensure access to care for consumers in rural areas. Second, proponents claim that when competition is limited, incumbent providers can earn excess profits that may then be diverted to subsidize indigent care.

In order to ensure healthcare options in rural areas, some states control the entry and expansion of ambulatory surgical centers (ASC), which compete with hospitals by providing outpatient surgeries

and procedures. Absent CON, proponents claim, ASCs would only treat the most profitable conditions, leaving patients with more complicated and expensive conditions for hospitals. CON proponents call this "cream skimming." Theoretically, this could reduce access to services in rural areas if hospitals are forced to close because they are left to treat only the most complicated and expensive patients.[16] Contrary to this claim, however, CON laws are actually associated with fewer healthcare options, including hospitals and ambulatory surgical centers, in both rural and nonrural areas.[17]

Stratmann and Christopher Koopman examine the relationship between CON regulation and the number of healthcare facilities across 50 states spanning 27 years. They find that CON regulation is associated with about 30 percent fewer hospitals per capita. Moreover, they find that an ASC-specific CON requirement such as Illinois's is associated with about 14 percent fewer ASCs per capita. Figures 1 and 2 show what this could mean for Illinoisans. In 2011, Illinois had 208 hospitals and 120 ambulatory surgical centers.[18] These charts show that, without CON, Illinoisans would likely benefit from more hospitals (295 instead of 208) and more ASCs (140 instead of 120).

CON programs are also associated with fewer hospitals and fewer ASCs in rural communities, which are defined as those communities with fewer than 10,000 people in their urban centers.[19] Specifically, a CON program is associated with about 30 percent fewer rural hospitals per 100,000 rural residents, and an ASC-specific CON requirement is associated with about 13 percent fewer rural ASCs per 100,000 rural residents. In 2011, Illinois had 56 rural hospitals and 2 rural ASCs in communities with fewer than 10,000 people. Figures 3 and 4 suggest that, while intended to protect access to care in rural communities, CON seems to be associated with less rural access to care in Illinois. These charts show that Illinoisans in rural areas are estimated to benefit from more rural hospitals (80 instead of 56) and more rural ASCs (2.3 instead of 2) without CON.[20]

Additionally, Stratmann and Jacob Russ find that, contrary to the claims of CON proponents, CON laws are not associated with increased charity care. There is no evidence that incumbent providers use the extra profits afforded by CON protections to subsidize medical services for indigent patients. Controlling for other factors, they find that CON regulations have no effect on the level of uncompensated care across CON and non-CON states.[21]

CONCLUSION

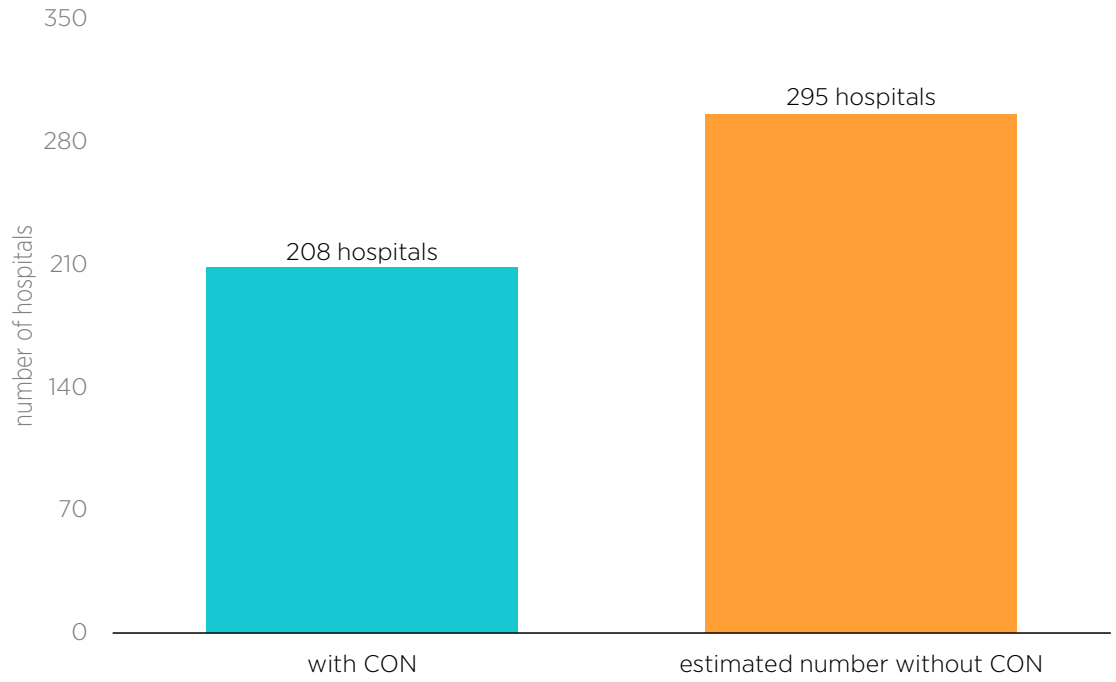
Contrary to the claims of CON proponents, CON programs are not associated with beneficial outcomes for healthcare consumers or payers. Instead, CON programs limit the supply of health care and insulate existing healthcare providers from new competition. These regulatory privileges protect incumbent providers at the expense of both patients and would-be providers, undermining consumer welfare and misallocating resources.[22] For Illinois and 34 other states, along with the District of Columbia, this means fewer providers offering lower-quality healthcare options at higher prices relative to states without CON programs. The better prescription for the Land of Lincoln is competition, not cartelization.

NOTES

1. Metcalf-McCloskey Act of 1964, ch. 730 [1964] N.Y. Laws 1183 (codified in scattered sections of N.Y. Pub. Health Law. McKinney 1971); National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k–300n-5), repealed by Pub. L. No. 99-660, § 701, 100 Stat. 3799 (1986).
2. Matthew D. Mitchell and Christopher Koopman, "40 Years of Certificate-of-Need Laws across America," Mercatus Center at George Mason University, September 27, 2016.
3. National Conference of State Legislators, "Certificate of Need State Laws," August 25, 2016.
4. Christopher Koopman and Anne Philpot, "The State of Certificate-of-Need Laws in 2016—Regulated Services by State, 2016," Mercatus Center at George Mason University, September 27, 2016.
5. Koopman and Philpot, "The State of Certificate-of-Need Laws in 2016—State Rankings by Number of CON Laws, 2016."
6. Illinois Health Facilities and Services Review Board, "Certificate of Need Program," accessed June 14, 2017.

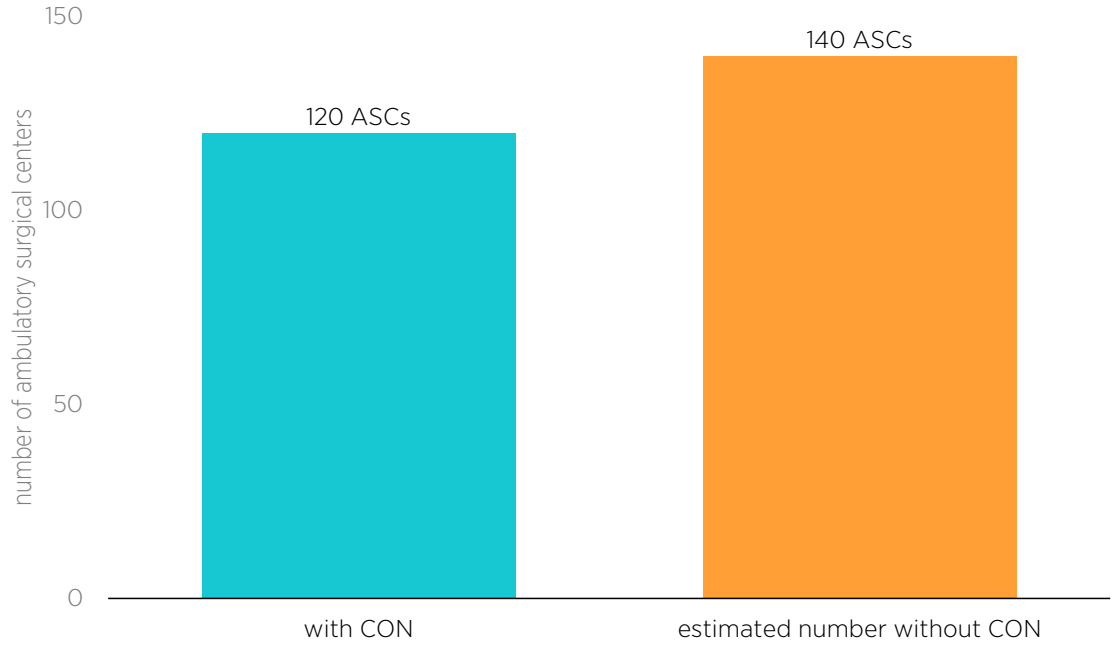
7. Patrick John McGinley, "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a 'Managed Competition' System," *Florida State University Law Review* 23, no. 1 (1995).
8. Mitchell and Koopman, "40 Years of Certificate-of-Need Laws."
9. John Steen, "Regionalization for Quality: Certificate of Need and Licensure Standards" (American Health Planning Association, March 2004).
10. Harvey Leibenstein, "Allocative Efficiency vs. 'X-Efficiency,'" *American Economic Review* 56, no. 3 (1966): 392–415.
11. Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).
12. These figures are derived from a multivariable regression that controls for other factors.
13. These figures are derived from a multivariable regression that controls for other factors.
14. Matthew D. Mitchell, "Do Certificate-of-Need Laws Limit Spending?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).
15. Fred J. Hellinger, "The Effect of Certificate-of-Need Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis," *American Journal of Managed Care* 15, no. 10 (2009).
16. 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).
17. Ibid.
18. 2011 was the latest year included in the study.
19. This study used the zip codes providers to determine rurality. Providers in communities falling outside of a core-based statistical area were defined as rural. The Office of Management and Budget defines "core-based statistical area" as having an urban center of at least 10,000 people. See Stratmann and Koopman, "Entry Regulation and Rural Health Care," 12.
20. These figures are derived from a multivariable regression that controls for other factors.
21. Thomas Stratmann and Jacob Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" (Mercatus Center Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2014).
22. Matthew D. Mitchell, *The Pathology of Privilege: The Economic Consequences of Government Favoritism* (Arlington, VA: Mercatus Center at George Mason University, 2014).

Figure 1. Estimated Effect of CON on Hospitals in Illinois



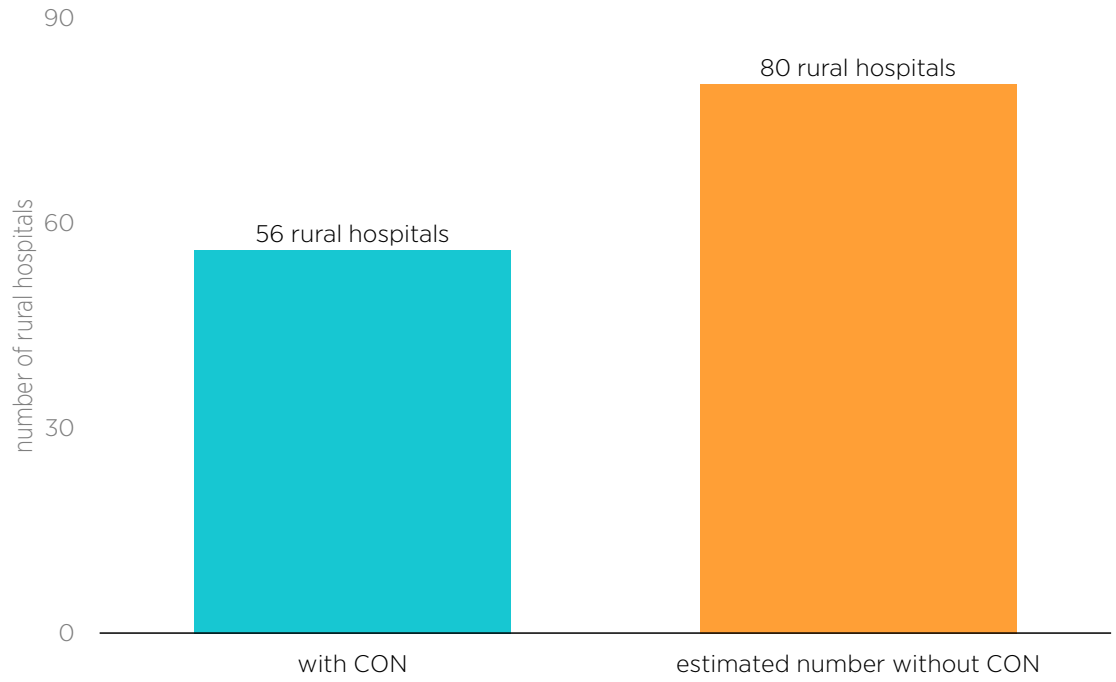
Source: Authors' calculations based on findings in Thomas Stratmann and Christopher Koopman, "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2016).

Figure 2. Estimated Effect of CON on Ambulatory Surgical Centers in Illinois



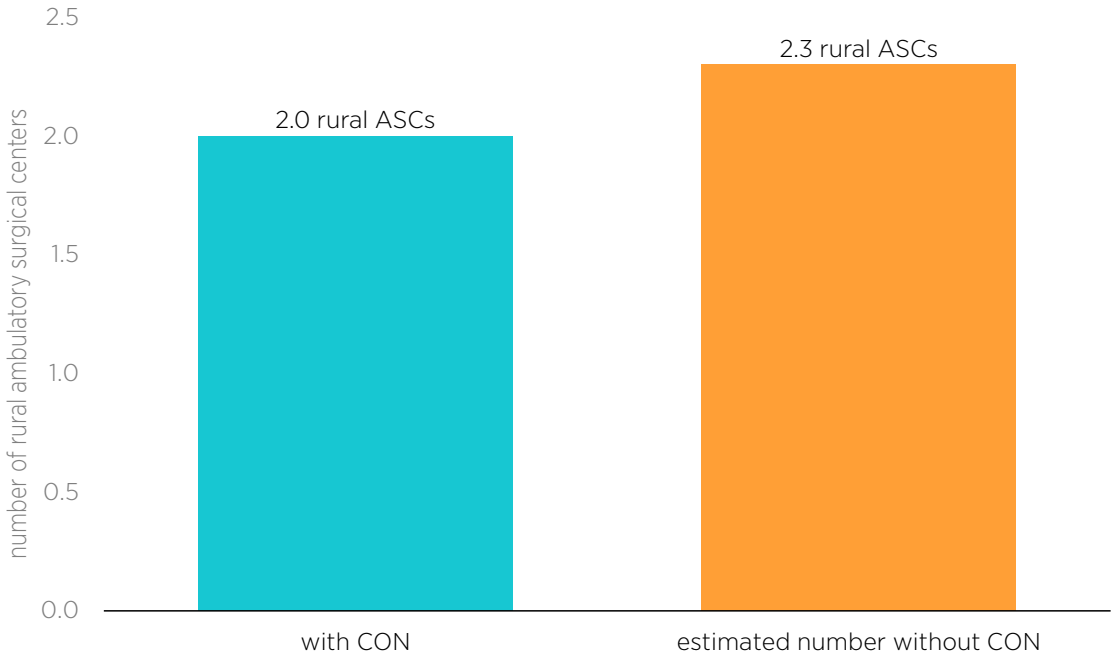
Source: Authors' calculations based on findings in Stratmann and Koopman, "Entry Regulation and Rural Health Care."

Figure 3. Estimated Effect of CON on Rural Hospitals in Illinois



Source: Authors' calculations based on findings in Stratmann and Koopman, "Entry Regulation and Rural Health Care."

Figure 4. Estimated Effect of CON on Rural Ambulatory Surgical Centers in Illinois



Source: Authors' calculations based on findings in Stratmann and Koopman, "Entry Regulation and Rural Health Care."

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