

# Issue Brief: Certificates of Need

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## Certificate of Need Definition

A Certificate of Need (“CON”) regime generally prohibits new or existing healthcare providers and facilities from making large capital expenditures or expanding services and facilities unless a genuine public need exists in the relevant geographic market. Private parties must apply for a certificate of need from the state’s health department before proceeding with a development that meets the [statutory trigger](#), which varies from state to state. CON programs are [typically used](#) to restrict the growth of high cost healthcare services, long term care, acute care hospital beds and ambulatory surgical centers.

CON programs aim to correct market inefficiencies by restricting the *supply* of healthcare services as a means of slowing healthcare cost inflation. To be granted a certificate of need, proponents of the new facility must demonstrate that the proposed service or facility will improve access to and affordability of needed services in the area.

## Background

CON laws grew out of a federal attempt to control healthcare inflation in the states. In 1974, Congress passed [The National Health Planning and Resources Development Act \(“NHPDA”\)](#), which conditioned the receipt of federal funds by states on the creation and enforcement of CON regimes. In response to the legislation, by 1980, every state but Louisiana had enacted a CON program. The NHPDA was repealed in 1986 after failing to

achieve its desired result; however, a [substantial majority of states](#) continue to operate a CON program in some form.

The circumstances motivating Congress to coerce states into enacting CON regimes were in part unique to the period. At the time, third-party payers, including Medicare and Medicaid, reimbursed providers retrospectively on a [“cost-plus” basis](#), a type of contracting that increases the fee as the provider’s cost rises. Federal lawmakers believed the incentives inherent to this system only encouraged providers to try to sell more high cost services, rather than to consider appropriate levels of utilization. This problem was compounded by the fact that healthcare consumers were largely insensitive to price because third-party payers were paying their bills.

To address the shortcomings in provider incentives, Congress believed that a state-based centralized control system, seated in regulatory preapproval, would encourage state governments to rationally control the supply and geographic distribution of healthcare services. Ultimately, the goal was to create a more efficient system that would lower costs to the consumer.

Congress’ focus on supply was grounded in its contemporary understanding of the factors underlying rapid price growth in healthcare. Lawmakers assumed that the primary driver behind healthcare delivery costs was provider operating expenses (e.g., the cost of rent and supplies), and that those costs were passed on to consumers in the form of higher medical charges. Duplicative and/or poorly distributed services and facilities, it was thought, would only exacerbate this growth. In addition, Congress feared that that overcapacity and over-supply [“generated a self-fulfilling demand for use,”](#) based on the observation that when more hospital beds were available, more hospital beds were filled (called the [“Roemer Effect”](#)).

## Effects on Healthcare Delivery

Although the CON mandate under the NHPDA was predicated on controlling costs to consumers, the program failed to deliver the expected cost savings and was subsequently abandoned by Congress in 1986. From the time the NHPDA was passed in 1974, [hospital care expenditures](#) rose from \$52.4 billion to an estimated \$230.1 billion in 1989. [The empirical literature](#) tends to support the conclusion that CON programs failed to control costs and may actually have increased prices due to their anticompetitive nature.

CON laws have also been criticized for their negative effects on quality. In a [joint statement](#) issued by the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission (“the Agencies”) in 2008, the Agencies asserted that CON laws had been ineffective at controlling costs, and also could impair the quality of health services. They argued that because CON laws prevent new firms from entering healthcare markets, incumbent providers faced diminished competition on quality, which reduced the pressure to improve healthcare delivery.

The CON law process also created opportunities for misuse by incumbent providers. The Agencies’ statement noted that their investigation revealed evidence of “widespread recognition that existing competitors use the CON process to forestall competitors from entering an incumbent’s market.” Additionally, incumbent providers who sought to forestall or frustrate the entry of competitors by utilizing the state hearing and appeals process under the CON regime were likely shielded from federal antitrust scrutiny pursuant to the [state action doctrine](#). Under the doctrine, federal antitrust authorities may not restrain otherwise anticompetitive conduct that furthers a clearly articulated state policy that acknowledges the restraint on

competition.

## **Arguments for and against CON Regimes**

Proponents of existing CON regimes argue that protecting incumbent providers from new market entrants allows those providers to [cross-subsidize charity care](#) (i.e., charge higher prices to one group of customers in order to provide services to low-income populations at reduced prices). Opponents, including the Agencies, contend that subsidizing charity care was not the original purpose of the CON program.

Proponents also note that the CON regulatory planning process provides an open forum for public participation in the healthcare system as a species of deliberative democracy, which affords all stakeholders an opportunity to seek information and provide input in decisions affecting healthcare resources. Opponents would assert that competition in healthcare markets is preferable because it results in lower prices and broader access to healthcare and health insurance, noting also the demonstrated failure of CON regimes to control costs in the first instance.

## **Developments in CON Legislation**

The Agencies maintain that on balance, CON programs [contribute negatively to the healthcare system](#) and that states with these programs should reconsider the merits of continuing to operate them. The Centers for Medicare & Medicaid Services (“CMS”) is also encouraging states to develop alternatives to CON programs as part of the [State Innovation Model grant](#) process, which awards money to states to test and develop service delivery and payment reforms in an effort to reduce overall Medicare and Medicaid expenditures. The adoption of State Innovation Models could be expected to result in changes to the CON regime in the 20 plus states that have been awarded model test or design awards.

The current landscape of CON programs has seen [few changes](#) in the last decade. Seven states abandoned their CON programs from 1983-85, and an additional seven states enacted repeals of their CON programs by 1999 in the twelve-year period following the cessation of federal incentives. In 2012, New Hampshire became the [latest state to enact a repeal](#) of their program, approving a sunset date for the enabling legislation effective June 30, 2016. Approximately [36 states retain some type of CON program](#), law or agency as of 2014.

Several states have [initiated studies](#) to evaluate the effectiveness of their CON programs, including New York (2012), Connecticut (2012), New Jersey (2008), Illinois (2007), Georgia (2006), and Washington (1999). [South Carolina's CON program was suspended](#) by the state's Department of Health and Environmental Control after Governor Nikki Haley issued a line-item veto in 2013 eliminating funding for the program, although the S.C. Supreme Court ruled that the agency has a statutory duty to continue enforcement of the act. Legislators in [Michigan](#), [North Carolina](#), and [Maine](#) are also considering legislation to phase out their respective CON programs.

Despite recent legislative pushback against CON programs, [interviews](#) conducted in several states by the National Institute for Health Care Reform with healthcare providers, state officials and others involved with the CON process to supplement the quantitative literature on CON impacts tended to bear out the conclusion that although many think the CON process is imperfect, most believed that the programs should be maintained in their state. Their reasoning may be that adequate funding and rigorous and continued monitoring of the CON process could be expected to boost transparency and efficiency of the process while ensuring that CON programs meet their stated goal: maintaining access to quality care without allowing for excess capacity to unreasonably drive up health prices. It remains to

be seen whether there is still a glimmer of hope for the CON as a regulatory tool for controlling healthcare prices.

The Source will continue to monitor for developments in CON legislation. Please refer to the Source on Healthcare state pages under [Legislation/Regulation](#) and the Source Map for Certificate of Needs for state-by-state information.