Weighing Certificates of Need in Times of Need

Martin Kiernan

I. INTRODUCTION TO CERTIFICATES OF NEED

At varying degrees, 38 states and the District of Columbia have—or have some variation of—Certificate of Need ("CON") laws that regulate the establishment or expansion of healthcare facilities by approval from state governmental authorities.[1] CON laws aim to curb "health care costs by restricting duplicative services."[2] However, limiting facilities directly stunts the number of available health care providers and has adverse effects on communities at large.[3] Moreover, CONs serve as barriers to entry into the healthcare market that effectively limit both the availability of healthcare options and the competition faced by established healthcare providers.[4] Further exacerbating this issue, COVID-19 caused some CON states to fail to meet healthcare demand.[5] CON served as a causal factor for limited bed availability and healthcare services during COVID-19, forcing some hospitals to ration their services.[6]

---

1. *Certificate of Need State Laws*, NAT'L CONF. STATE LEGISLATURES (Jan. 1, 2023), https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx [https://perma.cc/2WCH-3NMR].

2. *Id.*

3. *See generally* Matthew C. Baker & Thomas Stratmann, *Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws*, 77 SOCIO-ECON. PLAN. SCIS., no. 101007, 2021, at 1 (discussing the adverse effects of CON implementation).

4. *Id.*

5. Gavin Wax, *"Certificate of Need" Health Care Laws Made COVID-19 Much Worse*, FOUND. ECON. EDUC. (May 11, 2020), https://fee.org/articles/certificate-of-need-health-care-laws-made-covid-19-much-worse/ [https://perma.cc/KXB8-Y3RQ].

6. *Id.*

This Note will elucidate CON's practical effects, as it exists in a fragmented healthcare market, especially in light of COVID-19. Part I begins with a description of the events that lead CON laws to become widespread before giving an overview of the healthcare system, given CON law's unique role in the emergence of COVID-19. Part II contributes to the CON literature by considering how COVID-19 seriously frustrated many CON law states. It suggests that the motivations and practice of CON laws are not feasible if the regime is too burdensome on supply.[7] Healthcare market inefficiencies—the primary issue CON laws were intended to address—caused states to undertake a central planning model that cannot possibly assess needs fairly or accurately.[8]

Finally, Part III suggests that to address healthcare market failures, CON states should consider curtailing or completely repealing their CON laws and instead shift to a more free market-oriented approach that accepts active competition. The downstream effects, consistent with the combined efforts of healthcare providers and insurers' abilities to set pricing, lie at the heart of what CON laws were enacted to protect against.[9] A focus elsewhere (for example, on controlling supply), leads to undesirable results, as COVID-19 revealed.[10]

II. BACKGROUND

A. CON Laws Explained

Under the U.S. Constitution, it is a state's purview to protect the public health of its citizens.[11] The extensive exercise of state public health authority is referred to as "police powers."[12] However, the Constitution provides limitations as safeguards to prevent excessive state exercise of authority.[13]

Article 1, Section 8 of the U.S. Constitution grants Congress the authority to provide for the "general welfare of the United States" and to regulate interstate commerce.[14] The former includes actions related to the Center for Disease Control and Prevention (CDC) and U.S. Public Health Service members;[15] the latter includes health-related activities, food transportation, biological products, and medical devices, among other activities.[16] If the federal government is acts on health-related matters, then it must do so only within its

7. *Id.*
8. *Id.*
9. *See infra* Part IV.
10. *Id.*
11. *See* James D. Holt, Sudevi Navalkar Ghosh & Jennifer R. Black, *Legal Considerations*, CTR. DISEASE CONTROL, https://www.cdc.gov/eis/field-epi-manual/chapters/Legal.html [https://perma.cc/SP5Z-JS4C] (last visited Apr. 23, 2023) (discussing legal considerations concerning governmental authority).
12. A state's "police power . . . may be lawfully resorted to for the purpose of preserving the public health, safety, or morals, or the abatement of public nuisances, and a large discretion 'is necessarily vested in the legislature, to determine, not only what the interests of the public require, but what measures are necessary for the protection of such interests.'" Holden v. Hardy, 169 U.S. 366, 392 (1898) (quoting Lawton v. Steele, 152 U.S. 133, 136 (1894)).
13. Holt, Ghosh & Black, *supra* note 11.
14. U.S. CONST. art. I, § 8.
15. Holt, Ghosh & Black, *supra* note 11.
16. *Id.*

enumerated powers.[17] For citizens, the Constitution does not afford a right to health care, nor has the U.S. Supreme Court ever interpreted the Constitution as guaranteeing a right to health care services from the government.[18]

CON laws are a regulatory procedure states enact to control the supply of health care resources.[19] A CON is a permit to perform, provide, or modify specific health care-related activity.[20] As CON laws differ between states, they generally address types of health care facilities, capital expenditure activity related different facility types, the agency that reviews a CON application, and factors the agency considers.[21] The baseline procedure is that before a healthcare facility breaks ground for construction or expansion, offers new services, or increases its equipment inventory up to a certain amount, the facility must first receive approval.[22]

A project must be submitted by formal application to a local state health agency, which determines the surrounding population's need through a multifactored review, which is not limited to market analysis, healthcare utilization patterns, health status, or demographics.[23] In Illinois, for example, the Health Facilities Planning Board, when making a need projection for beds and services, uses a Demand Based Formula and an Incidence Based Formula.[24] The Demand Based Formula creates an equation utilizing past inpatient days of care, population projections, an adjustable use rate, and an occupancy factor to arrive at the amount of beds a population needs.[25] The Incidence Based Formula estimates the population who will require hospitalization using that area's incidence level of disease or condition.[26] Absent a showing of need amidst the community to be serviced, the CON application will be denied.[27] Notwithstanding CON states providing statutory and

17. *See* Bond v. United States, 572 U.S. 844, 854 (2014) (quoting McCulloch v. Maryland, 17 U.S. 316, 405 (1819) (stating that the federal government "possesses only limited powers" and "'can exercise only the powers granted to it'").

18. *See* KATHLEEN S. SWENDIMAN, CONG. RSCH. SERV., R40846, HEALTH CARE: CONSTITUTIONAL RIGHTS AND LEGISLATIVE POWERS 1 (2012) ("The United States Constitution does not explicitly address a right to health care.").

19. Christopher J. Conover & James Baily, *Certificate of Need Laws: A Systematic Review and Cost-Effectiveness Analysis*, 20, 748 BIOMED CENT. HEALTH SERV. RSCH. 1, 1 (2020).

20. Jordan A. Zoeller, Matthew J. Muller & Nicholas J. Janiga, *Understanding the Value of a Certificate of Need*, HEALTHCARE APPRAISERS 1, 1 (Jan. 29, 2020), https://healthcareappraisers.com/wp-content/uploads/2020/01/FMVantagePoint_UNDERSTANDING-THE-VALUE-OF-A-CERTIFICATE-OF-NEED.pdf [https://perma.cc/MVT9-NG94].

21. Adney Rakotoniaina & Johanna Butler, *50-State Scan of State Certificate-of-Need Programs*, NAT'L ACAD. STATE HEALTH POL'Y (May 22, 2020), https://nashp.org/50-state-scan-of-state-certificate-of-need-programs/ [https://perma.cc/2CZ9-DZGR]; s*ee, e.g.*, IOWA CODE § 135.63 (Administered 2020).

22. Patrick John McGinley, Comment, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System*, 23 FLA. ST. U. L. REV. 141, 144 (1995); *see, e.g.*, IOWA CODE § 135.63(2)(e)(1) (2020) (applying to a health maintenance organization that "[c]onstructs, develops, renovates, relocates, or otherwise establishes an institutional health facility"); *see infra* Part II.C.

23. *See, e.g.*, IOWA CODE § 135.63 (2020). An application fee is often required. In Iowa, "[t]he application shall be accompanied by a fee equivalent to three-tenths of one percent of the anticipated cost of the project with a minimum fee of six hundred dollars and a maximum fee of twenty-one thousand dollars." *Id.*

24. ILL. ADMIN. CODE tit. 77, § 1100.510.

25. *Id*.

26. *Id.*

27. *See, e.g.*, IOWA CODE § 135.66 (2020) (outlining that "[t]he department shall examine the application" for its form and substance, including its need).

rule criteria, the subjective determination of need has posed problems for those who seek to satisfy its requirements.[28]

CON laws found support in their primary purpose of controlling health care costs by directing the supply of health care services, thereby providing equal access to quality health care.[29] CON laws first originated in New York in 1964, and with great support from the American Hospital Association, by 1978, 36 states had adopted CON regimes. [30]

The enactment of the National Health Planning and Resources Development Act of 1974 (NHPRD) served as a nudge by Congress to spur states to pass CON programs.[31] The NHPRD provided funds to state and local health planning efforts but conditioned receipt of certain health care funds on having CON laws.[32] Congress found, as a motivation to NHPRD's enactment, that the "infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources."[33]

When Ronald Reagan was elected president in 1980, he was determined to bring health care policy into a new era.[34] Reagan's Secretary of Health and Human Services affirmed the administration's intentions, saying:

> The future of health care under the Reagan Administration can be described in two words: competition and prevention. We intend to loosen the forces of the market to make the healthcare system more competitive. We believe competition will prove to be the single greatest force for controlling prices.[35]

Unfortunately, the healthcare market would not realize Reagan's vision. The NHPRD induced every state except Louisiana to adopt CON programs by 1982.[36]

However, the federal NHPRD legislative scheme would meet its end after some unfortunate developments just 12 years later; aggregate healthcare costs did not decrease[37] and the laws had harmful effects on communities.[38] These developments revealed that CON laws could not decrease costs and prevent community harm as Congress had hoped.

First, the primary purpose of CON laws, which was to realize a reduction in healthcare costs, never came to fruition. Congress believed the cause of the healthcare market

---

28. McGinley, *supra* note 22, at 145.

29. James B. Simpson, *State Certificate-of-Need Programs: The Current Status*, 75 AM. J. PUB. HEALTH 1225, 1225 (1985). Other related ends have been described as maintaining a comprehensive health care delivery system and the promotion of economic development within health care. *See, e.g.*, ILL. ADMIN. CODE tit. 77, § 1100.30 (2018) (describing comprehensive health care delivery as a related goal of its Certificate-of-Need program).

30. N.Y. PUB. HEALTH LAW § 730 (McKinney 1971) (requiring hospital or nursing home developers to receive a CON); *see also* McGinley, *supra* note 22, at 147 (describing early mandatory health planning agencies in New York).

31. *See* McGinley, *supra* note 22, at 147 n.45 (collecting and citing relevant federal statutes).

32. Simpson, *supra* note 29.

33. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

34. David L. Ginsberg, *Health Care Policy in the Reagan Administration: Rhetoric and Reality*, 11 PUB. ADMIN. Q. 59, 60 (1987).

35. *Id.*

36. Simpson, *supra* note 29.

37. *See infra* Part II.E (discussing how CON laws never reduced healthcare costs).

38. McGinley, *supra* note 22 at 157.

fragmentation was largely due to the marketplace itself lacking adequate cost containment incentives.[39] The average cost of a one-day hospital stay between 1950 and 1974 rose by 700%,[40] and medical costs experienced a 16.6% annual increase around NHPRDs inception.[41] Congress was also aware of the $52.4 billion in annual healthcare costs.[42] Despite nearly all states enacting CON laws by 1989, healthcare costs ballooned to $230.1 billion,[43] displaying CON laws to be ineffectual and possibly spurring greater costs.

The increased costs additionally shot down CON laws' motivations to foster a more fairly distributed healthcare system. A system where the average healthcare consumer bears increased costs cannot suggest that CON successfully decreased costs. Moreover, some suggested that communities were made worse off not by NHPRD, but really by CON programs, because they lacked sensitivity to the needs of communities.[44] Health planning agencies, in some instances, would require healthcare developers to act in ways that work against cost-cutting efforts.[45] Questions were appropriately raised when a 50-bed, locally-run Georgia hospital challenged its CON determination that the hospital would need to remove ten beds before making its improvements.[46]

Second, the NHPRD targeted hospital resources, acting as though increased healthcare costs resulted from unnecessary, duplicative services by underutilization and overinvestment.[47] The NHPRD drafters found that the nation's hospital bed usage exceeded supply, noting a 20,000-bed surplus in 1974.[48] It was estimated that that number would increase by 235% by 1975.[49]

B. States with CON Laws

The 49 states that sought to satisfy NHPRD's CON requirement had programs that resembled the federal model.[50] States' health planning agencies took broad regulatory control of "hospitals, skilled nursing and intermediate care facilities, kidney dialysis centers, and ambulatory surgery centers."[51] Additionally, these agencies reviewed expenditures on a dollar amount basis, including "general purpose capital expenditures exceeding $600,000, additions of new services with annual operating costs exceeding $250,000, and acquisitions of medical equipment for inpatient use exceeding $400,000."[52]

---

39. S. REP. NO. 93-1285, at *7878–82 (1974).

40. *See* BUREAU OF THE CENSUS, U.S. DEP'T COM., STATISTICAL ABSTRACT OF THE U.S: 1977, at 104 (1977) (displaying expenses for non-federal, short-term, general and special hospitals).

41. S. REP. NO. 93-1285, at *7893.

42. Mark E. Kaplan, *An Economic Analysis of Florida's Hospital Certificate of Need Program and Recommendations for Change*, 19 FLA. ST. U. L. REV. 475, 487 n.102 (1991).

43. *Id.*

44. S. REP. NO. 93-1285 (1973), *reprinted in* 1974 U.S.C.C.A.N. 9260.

45. *Id.*

46. *Id.*

47. Randall Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83, 83 (1978).

48. S. REP. NO. 93-1285, at *7864.

49. *Id.*

50. Simpson, *supra* note 29, at 1225.

51. *Id.*

52. *Id.*

The majority of these CON states hoped to effectuate the competing goals of "cost, quality, and accessibility" as advertised.[53]

However, following NHPRD's repeal, 11 states followed suit with their CON laws. "Mitchell and Koopman note that "[b]y 1990, [the repealed states consisted of] California, Colorado, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah, Wisconsin, and Wyoming."[54] To date, 12 states do not have CON laws: California, Colorado, Idaho, Kansas, Pennsylvania, New Hampshire, New Mexico, North Dakota, South Dakota, Texas, Utah, and Wyoming.[55]

Of the states that continued their CON laws, most did so on largely modified terms. Most states increased the threshold measurements for capital expenditures and limited the types of projects considered, thereby reducing the total number of CON law triggers.[56] Additionally, most states created exemptions or streamlined processes for expenditures unrelated to clinical services and less significant projects, such as heating or mechanical work.[57]

CON laws were necessarily exercised through alternate means as states balanced their respective interests and shifted requirements over time. For example, in Nevada, only hospitals in rural areas making expansions in excess of $2 million require a CON.[58] The opposite is true in Alabama, Florida, Kentucky, Oregon, and Washington, where rural areas are exempted either completely or to a lesser degree depending on the service type.[59] Most states require CONs for hospice services or facilities, but Connecticut and Maine do not.[60] A review of the varying CON regimes highlights that the most regulated CON triggers are long-term care facilities, psychiatric services, and the construction or expansion of hospitals.[61] States that lead with the most CON triggers are Hawaii, North Carolina, and

53. *Id.*

54. Matthew D. Mitchell & Christopher Koopman, *40 Years of Certificate-of-Need Laws Across America*, MERCATUS CTR. (Sept. 27, 2016), https://www.mercatus.org/publications/corporate-welfare/40-years-certificate-need-laws-across-america [https://perma.cc/X53S-2B9A].

55. NAT'L CONF. STATE LEGISLATURES, *supra* note 1; *see* Victor Skinner, *North Carolina Appeals Court Rejects Challenge of State's Certificate of Need Law*, CTR. SQUARE (June 21, 2022), https://www.thecentersquare.com/north_carolina/north-carolina-appeals-court-rejects-challenge-of-states-certificate-of-need-law/article_847cf73c-f186-11ec-9da2-b78bc308a839.html [https://perma.cc/X53S-2B9A] (reporting on a North Carolina court of appeals that upheld the state's CON laws); *see also* Matthew D. Mitchell, Anne Philpot & Jessica McBirney, *CON Laws in 2020: About the Update*, MERCATUS CTR. (Feb. 19, 2021), https://www.mercatus.org/publications/healthcare/con-laws-2020-about-update [https://perma.cc/7UHV-5YAC] (reporting on CON law status).

56. *See* NAT'L CONF. STATE LEGISLATURES, *supra* note 1 (discussing the status and nature of CON laws across the country); Mitchell, Philpot & McBirney, *supra* note 55 (same).

57. Simpson, *supra* note 29, at 1226; *see generally* sources cited *supra* notes 55–56, *infra* notes 58–59 (cataloging different state statutory CON law schemes); *see, e.g.*, WASH ADMIN. CODE § 246-310-040.

58. NEV. REV. STAT. § 439A.100 (2022) (defining a rural project as "a county whose population is less than 100,000, or in an incorporated city or unincorporated town whose population is less than 25,000 that is located in a county whose population is 100,000 or more").

59. ALA. ADMIN. CODE r. 410-1-2.17; (1991); FLA. STAT. § 408.036; (2021); KY. REV. STAT. ANN. § 216B.020 (West 2022); OR. REV. STAT. § 442.315(8) (2022); WASH ADMIN. CODE § 246-310-042. (1996).

60. *Id.*

61. *See* NAT'L CONF. STATE LEGISLATURES, *supra* note 1 (cataloging the nation's various CON laws).

the District of Columbia.[62] CON laws have the intended effect of limiting beds, and doing so has left those states with roughly 13 fewer hospital beds per 100,000 persons.[63]

C. Enter COVID-19

The COVID-19 pandemic is an important and useful event to analyze CON laws with, because the spread of the virus onto American shores resulted in some states being unable to meet the healthcare demands of their citizens.[64]

COVID-19 is a conduit for revealing unintended consequences of CON laws. COVID-19 diverted hospital resources in order to meet the specific demands of the virus. State-specific healthcare facility reallocation responses were oriented toward the needs of hospitals to meet COVID-19-fueled demands.

At the onset of the COVID-19 pandemic, hospitals understood most of the resources they would need to face the outbreak. The Center for Disease Control (CDC) made this much clear when, in March 2020, hospitals received instructions on COVID-19 preparedness measures.[65] The CDC cautioned health care facilities to have representative planning and decision-making processes in place, sufficient quantities of essential patient care materials and equipment (such as intravenous pumps, ventilators, and pharmaceuticals), a sufficient inventory of personal protective equipment (such as facemasks, respirators, and hygiene products), and specifically trained healthcare personnel.[66]

Another preparedness measure recognized was the continued administration of non-COVID-19-related healthcare services in furtherance of a hospital's missions and continued care for patients with chronic diseases, childbirth, and emergency services.[67] This was intended to include strategies that would increase hospital bed capacity.[68]

D. No More Room in the Inn

The COVID-19 virus started as an overseas whimper around the end of 2019, eventually growing louder in 2020 until large portions of the U.S. healthcare system faced a crisis: some states could not meet demand. Critically, CON laws allocating medical goods and services were not formulated to prepare for demand surges.[69] By the end of March

62. *Id.*

63. Thomas Stratmann & Jacob W. Russ, *Do Certificate-Of-Need Laws Increase Indigent Care?* 3 (Mercatus Ctr., Working Paper No. 14-20, 2014).

64. *See infra* Part II.D.

65. *See generally* CTR. DISEASE CONTROL, COMPREHENSIVE HOSPITAL PREPAREDNESS CHECKLIST FOR CORONAVIRUS DISEASE 2019 (COVID-19) (2020), https://www.medbox.org/pdf/5ebc47ee7ee73671a0136792 [https://perma.cc/C6PY-AJP9].

66. *Id.* at 1, 7.

67. *Id.*

68. *Id.*

69. *See* Agnitra Roy Choudhury, Sriparna Ghosh & Alicia Plemmons, *Certificate-of-Need and Healthcare Utilization During COVID-19 Pandemic*, 15 J. RISK & FIN. MGMT, no. 76, 2022 (describing the unprecedented demand for medical equipment during the surge of COVID-19).

2020, there were 192,301 infections and 5334 related deaths within the United States.[70] Only a few weeks into April 2020, twenty states suspended or issued moratoria on their CON laws,[71] and four issued special emergency CONs.[72] States were limited by their resource restraints in equipment, such as intensive care unit (ICU) beds and ventilators, as well as with personnel.[73]

An early summer 2020 study focused on (1) mortalities caused and not caused by COVID-19 and (2) how CON laws affected healthcare access for illnesses that might require similar medical equipment.[74] Its findings suggested that states with CON laws had greater mortality rates than states without.[75] The research also showed that states that reformed their CON laws due to heightened COVID-19-related healthcare utilization saw a significant reduction in mortality resulting from natural death, septicemia, diabetes, chronic lower respiratory disease, influenza or pneumonia, and Alzheimer's Disease, in addition to a reduction in COVID-19 deaths.[76] These findings lend credence to an aggregate number of hospital admissions falling precipitously throughout 2020, well below baseline pre-COVID-19 levels. These findings were bolstered by research published in 2022 that concluded that CON law reform states saved more lives relative to non-reforming CON law states.[77]

The pandemic nonetheless caused many hospitals to postpone nonessential or elective surgeries.[78] Some governors or state officials issued directives to delay elective procedures.[79] Near the middle of 2021, as the postponement periods passed, hospitals were at odds about using resources for elective procedures.[80]

---

70. Ivan Pereira & Arielle Mitropoulos, *A Year of COVID-19: What Was Going on in the US in March 2020*, ABC NEWS (Mar. 6, 2021), https://abcnews.go.com/Health/year-covid-19-us-march-2020/story?id=76204691 [https://perma.cc/V3QR-RL3D].

71. Angela C. Erickson, *States Are Suspending Certificate of Need Laws in the Wake of COVID-19 but the Damage Might Already be Done*, PAC. LEGAL FOUND. (Jan. 11, 2021), https://pacificlegal.org/certificate-of-need-laws-covid-19/ [https://perma.cc/E4GV-WECK].

72. *Id.* These states are Maryland, Michigan, Kentucky, and Illinois. *Id.*

73. Ezekiel J. Emanuel et al., *Fair Allocation of Scarce Medical Resources in the Time of Covid-19*, 382 NEW ENG. J. MED. 2049, 2050 (2020).

74. Choudhury, Ghosh & Plemmons, *supra* note 69; Jaimie Cavanaugh & Daryl James, *Why Would States Limit Hospital-Bed Supply?*, WALL ST. J. (Aug. 19, 2020), https://www.wsj.com/articles/why-would-states-limit-hospital-bed-supply-11597877841 [https://perma.cc/2USP-J74W].

75. Choudhury, Ghosh & Plemmons, *supra* note 69, at 1–2, 7–9.

76. *Id.* at 7–10.

77. *Id.*; *see also* Matthew D. Mitchell & Thomas Stratmann, *The Evidence is Clear: States Exacerbated Pandemic's Effect*, HILL (July 7, 2022), https://thehill.com/opinion/healthcare/3549438-the-evidence-is-clear-states-exacerbated-pandemics-effect/ [https://perma.cc/RCG8-UN4V] (discussing the effect state action, or inaction, had on COVID-19's impact).

78. John D. Birkmeyer et al., *The Impact of the COVID-19 Pandemic on Hospital Admissions in the United States*, 39 HEALTH AFFS. 2010, 2010 (2020).

79. *See generally States With Elective Procedures Guidance in Effect*, AM. COLL. RADIOLOGY (May 18, 2020), https://www.acr.org/-/media/ACR/Files/COVID19/May-18_States-With-Elective-Medical-Procedures-Guidance-in-Effect.pdf [https://perma.cc/S2UB-2L2T].

80. Alia Paavola, *106 Hospitals Postponing Elective Procedures Amid the COVID-19 Resurgence*, BECKER'S HOSP. REV. (June 1, 2021), https://bit.ly/3m6tJLT [https://perma.cc/9SND-K6M6].

In September 2021, five states—Alabama, Georgia, Texas, Florida, and Arkansas—had less than 10% of ICU beds available.[81] In the following month, Alabama reached its ICU bed capacity, and Georgia came close, reaching 89% ICU capacity, 80% emergency department capacity, and 86% inpatient capacity.[82] Other states that reached high COVID-19 hospitalization levels include California, Idaho, Louisiana, Mississippi, New Mexico, and North Carolina. North Carolina's Chief Deputy Secretary of Health lamented that the "high levels of COVID-related admissions jeopardize the ability of our hospitals to provide needed care in our communities."[83] These problems necessarily beg the question: just how did the U.S. healthcare market become so fragmented?

E. Healthcare Market Concerns

There are problems inherent to the healthcare market that make its readily discernable qualities dissimilar from a normal, more free-flowing market. It is important to note not only the present defects, but also how these defects entered the healthcare market.

A movement toward centralization of healthcare facilities began and, when combined with demand uncertainty, increased healthcare providers' overhead costs.[84] To cover these costs, health insurance plans were developed which, over time, restricted the supply of providers.[85] Health insurance allowed hospital administrators to cover overhead costs despite uncertain demand by prorating the costs over the population of hospital users[86]—a means of pooling risk to limit costs.[87] The supply crunch increased demand for services and added transaction costs.[88] The World War II wage and price controls, as well as tax policy, married the average American's health insurance to their employment.[89] The competitive market forces gave way, and overall healthcare costs rose.[90]

Additional healthcare market problems arose—albeit not an exhaustive list[91]—with the mediating influences of service selectors and purchasing intermediaries in insurance,

81. Madeline Holcombe, *These 5 States Have Less than 10% of ICU Beds Left as Covid-19 Overwhelms Hospitals*, CNN (Sept. 1, 2021), https://www.cnn.com/2021/08/31/health/us-coronavirus-tuesday/index.html [https://perma.cc/4PG6-8NKR].

82. Dave Muoio, *10 States Nearing—or Exceeding—Hospital Capacity During COVID's Summer Resurgence*, FIERCE HEALTHCARE (Aug. 19, 2021), https://www.fiercehealthcare.com/hospitals/10-states-nearing-or-exceeding-hospital-capacity-during-covid-s-summer-resurgence [https://perma.cc/SZ3A-EE3P].

83. *Id.*

84. Andrew Ferris & Griffin Seiler, *Health Care Reform – A Free-Market Proposal*, 7 LOY. CONSUMER L. REV. 45, 47 (1995).

85. *Id.* at 47–48.

86. *Id.*

87. *Id.* at 48.

88. *Id.* at 47.

89. Ferris & Seiler, *supra* note 84, at 48.

90. *Id.*

91. *See also* Martin Hensher, John Tisdell & Craig Zimitat, "*Too Much Medicine": Insights and Explanations from Economic Theory and Research*, 176 SOC. SCI. & MED. 77, 77 (2017) (analyzing the economics of overconsumption of healthcare services).

such as Medicare and Medicaid,[92] the lack of price and quality information,[93] legislatively imposed service mandates,[94] cross-subsidization within the system,[95] and hospitals providing services to all persons in urgent and emergent need regardless of ability to pay.[96] In a system where insurers reimburse providers directly, patients are ultimately divorced from costs and thus have diminished incentives to guard against waste or reduce consumption.[97]

Since the NHPRD repeal, CON laws have drawn their fair share of criticism from different branches of government and federal agencies. The Federal Trade Commission and the Department of Justice jointly took aim at CON laws in 2016 when they reviewed South Carolina's program and provided a recommendation.[98] The agencies pointed to several features of the CON laws that they considered harmful to the state's healthcare market.[99] The recommendation suggested that CON laws created barriers to entry and expansion, possibly suppressing effective, innovative, and high-quality healthcare options.[100]

The agencies explained that "[b]y interfering with the market forces that normally determine the supply of facilities and services, CON laws can suppress supply, misallocate resources, and shield incumbent health care providers from competition from new entrants."[101] CON laws leave open the possibility that states can arbitrarily raise entry costs, thereby hardening barriers to entry.[102] Additionally, the agencies expressed concern about potential exploitation by established entities because the CON process allows established healthcare providers to challenge the entrance of competitors.[103] Unfortunately, far too little attention has been paid to what should be the greatest of

92. Edward Berkowitz, *Medicare and Medicaid: The Past As Prologue*, 27 HEALTH CARE FIN. REV. 11, 11 (2005).

93. *See* Hans B. Christensen, Eric Floyd & Mark Maffett, *The Only Prescription Is Transparency: The Effects of Price Transparency Regulation on Prices in the Healthcare Industry*, 66 MGMT. SCI. 2861, 2861–62 (2020) (discussing the politics and policy arguments surrounding price and information disclosure).

94. Michael Bihari, *Mandated Health Insurance Benefits Explained*, VERYWELL HEALTH (Oct. 30, 2022), https://www.verywellhealth.com/mandated-health-insurance-benefits-1738931 [https://perma.cc/K2QV-DUMG].

95. Dwayne A. Banks, Stephen E. Foreman & Theodore E. Keeler, *Cross-Subsidization in Hospital Care: Some Lessons from The Law and Economics of Regulation*, 9 HEALTH MATRIX 1, 1–2 (1999).

96. *See* James Yoo, *What Will Happen If I Go to the Hospital Without Insurance?*, HEALTHCAREINSIDER (Sept. 23, 2021), https://healthcareinsider.com/hospital-no-insurance-59540 [https://perma.cc/YBB7-6JSC] ("If you end up in the hospital in an emergency without health insurance, doctors and medical professionals are required to treat you . . . because the Emergency Medical Treatment and Labor Act [requires them to.]").

97. Ferris & Seiler, *supra* note 84, at 48.

98. FED. TRADE COMM'N & THE ANTITRUST DIV., U.S. DEP'T OF JUST., JOINT STATEMENT ON CERTIFICATE-OF-NEED LAWS AND SOUTH CAROLINA HOUSE BILL 3250 (2016) [Hereinafter JOINT STATEMENT].

99. *See id.* at 4–13 (pointing to time-consuming cost detriments, administrative difficulty, barriers to entry and expansion, and more).

100. *Id.* at 6–7.

101. *Id.* at 6.

102. *Id.* at 6–7.

103. JOINT STATEMENT, *supra* note 98, at 8. In 2006, a West Virginian hospital used the threat of an objection during the CON process to deter one of its competitors from requesting CON permission to build a new facility in the hospital's area. *Id.*

concerns in the healthcare market found in pricing and its somewhat indirect connection to CON laws.[104]

III. ANALYSIS

Continuing into the second half of 2021, communities remained plagued by healthcare facility limitations. In light of these problems, this Part will discuss the states and communities most affected by healthcare facility limitations and their connections to CON. This Part will also mention states that face similar medical hurdles but that do not have operating CON laws. Ultimately, this Analysis contends that CON laws serve as a causal factor for the limited availability of medical care but are not a necessary condition.

A. CON Laws with COVID-19

States facing bed capacity limitations were more likely to be CON states.[105] These states limited bed and facility expansions, and their communities suffered—and continue to suffer—the consequences. The link between CON laws and hospital bed insufficiencies alone cannot be ignored. An examination of states undergoing bed capacity shortages serves as a prime example of the harms caused by CON laws. This is because "a bed is merely an item of furniture on which a patient can lie. For a bed to make any meaningful contribution to a health care facility's ability to treat someone, it must be accompanied by an appropriate hospital infrastructure, including trained professional and managerial staff, equipment[,] and pharmaceuticals."[106]

Essentially, the accompaniments follow the beds; Alabama, Georgia, Florida, and Arkansas exemplify this truth.[107]

Alabama has restricted the supply of its healthcare facilities and operations since 1979, and its CON triggers, as of 2020, are amongst the most in the United States.[108] The restrictions include the standard practiced control over hospital beds (acute, general licensed, medical-surgical, and others), new hospital or hospital-sized investments, psychiatric service, and hospice.[109] Yet, COVID-19 caused the Alabama Hospital

104. *See infra* Part IV.

105. *See* Matthew Mitchell & Thomas Stratmann, *The Economics of Bed Shortage: Certificate of Need Regulation and Hospital Utilization During the COVID-19 Pandemic*, 15 J. RISK FIN. MGMT. 10, 10 (2022) ("Controlling for other possibly confounding factors, we find that states with bed CONs had 12 percent higher bed utilization rates and 58 percent more days in which more than 70 percent of their beds were used. Individual hospitals in bed CON states were 27 percent more likely to utilize all of their beds. States that relaxed CON requirements to make it easier for hospitals to meet the surge in demand did not experience any statistically significant decreases in bed utilization or number of days above 70 percent of capacity. Nor were hospitals in states that relaxed their CON requirements any less likely to use all their beds.").

106. Martin McKee, *Reducing Hospital Beds: What Are the Lessons to Be Learned?*, 6 EUR. OBSERVATORY ON HEALTH SYS. & POL'Y 1, 1 (2004)., https://apps.who.int/iris/bitstream/handle/10665/107615/WHO-EURO-2004-654-40389-54118-eng.pdf?sequence=8&isAllowed=y [https://perma.cc/5SK9-6LZ4].

107. *See* Part II.B (discussing different states and their CON laws).

108. *Alabama and Certificate-of-Need Programs 2020*, MERCATUS CTR. (Mar. 18, 2021), https://www.mercatus.org/publications/certificate-need-laws/alabama-and-certificate-need-programs-2020 [https://perma.cc/AA75-VNEH].

109. *Id.* Additional health care services covered by Alabama's CON are ambulatory surgical centers, cardiac catheterization, home health, intermediate care facilities for individuals with intellectual disabilities, long-term

Association President to bemoan that "[w]e've never been here before. We are truly now in uncharted territory in terms of our ICU bed capacity,"[110] as ICU beds reached a deficit, placing emergency patients on waitlists.[111] An Alabama state health officer added:

> In most parts of the state, [for] the average person who has a heart attack today or is involved in a serious automobile accident, it's going to be difficult [to find an open ICU bed]. The hospitals are going to have to be quite creative in finding a place to be able to care for that patient.[112]

Similarly, Georgia's CON laws have been operable since 1979.[113] Despite undergoing a less regressive CON legislative makeover in 2019,[114] Georgia hospitals reached near capacity topping 96% of ICU beds.[115] Their CON program covers beds and facilities and is more expansive than Alabama's CON laws.[116]

Florida's CON programs, adopted in 1973, maintain significantly fewer triggers than Georgia and Alabama.[117] State legislators have made efforts as recently as June 2021 to curtail CON restrictions,[118] but the laws nonetheless cover the supply of beds and facilities,

---

acute care, nursing home beds/long-term care beds, open-heart surgery, organ transplants, psychiatric services, radiation therapy, rehabilitation, renal failure/dialysis, substance/drug abuse, swing beds. *Id.*

110. Joe Hernandez, *Alabama Hospitals Have Run out of ICU Beds As COVID-19 Cases Surge*, NAT'L PUB. RADIO (Aug. 19, 2021), https://www.npr.org/2021/08/19/1029260134/alabama-hospitals-icu-beds [https://perma.cc/U7VP-M9GJ].

111. *Alabama's Hospital Crisis Intensifies; 29 Now Waiting for ICU Beds*, WSFA 12 NEWS (Aug. 18, 2021), https://www.wsfa.com/2021/08/18/alabamas-hospital-crisis-intensifies-29-now-waiting-icu-beds/ [https://perma.cc/D3K6-VB4U].

112. *Id.*

113. *Georgia and Certificate-of-Need Programs 2020*, MERCATUS CTR. (Mar. 22, 2021), https://www.mercatus.org/publications/certificate-need-laws/georgia-and-certificate-need-programs-2020 [https://perma.cc/NPW3-JDFY].

114. Neil Hoffman, *Georgia Certificate of Need Bill Passed By General Assembly*, JDSUPRA (Apr. 3, 2019), https://www.jdsupra.com/legalnews/georgia-certificate-of-need-bill-passed-26279/ [https://perma.cc/DJG7-UQ7R].

115. *See* Part II.D; Beth Gavin, *Just Over 96% of Georgia's ICU Beds Are Now Full*, FOX 5 ATLANTA (Sept. 8, 2021), https://www.fox5atlanta.com/news/just-over-96-of-georgias-icu-beds-are-now-full [https://perma.cc/FC3L-Y4RM] (stating ICU beds in Georgia are 96% full).

116. *Compare Alabama and Certificate-of-Need Programs 2020*, *supra* note 108, *with Georgia and Certificate-of-Need Programs 2020*, *supra* note 113 (reporting the different CON laws of Alabama and Georgia, respectively). Health care services covered by Georgia's CON are ambulatory surgical centers (ASCs), cardiac catheterization, computed tomography (CT) scanners, gamma knives, home health hospital beds (acute, general licensed, medical-surgical, and others), intermediate care facilities (ICFs) for individuals with intellectual disabilities, linear accelerator radiology, lithotripsy, long-term acute care (LTAC), magnetic resonance imaging (MRI) scanners, mobile hi technology (CT, MRI, PET, etc.), neonatal intensive care, new hospitals or hospital-sized investments, nursing home beds/ long-term care beds. *Georgia and Certificate-of-Need Programs 2020*, *supra* note 113.

117. *Florida and Certificate-of-Need Programs 2020*, MERCATUS CTR. (Mar. 22, 2021), https://www.mercatus.org/publications/certificate-need-laws/florida-and-certificate-need-programs-2020 [https://perma.cc/2QRX-4837].

118. Charmaine Mech & Hedy S. Rubinger, *No Need for Certificate of Need: Florida Eliminates Certificate of Need Review for Specialty Hospitals*, JDSUPRA (June 23, 2021), https://www.jdsupra.com/legalnews/no-need-for-certificate-of-need-florida-8919123/ [https://perma.cc/ZD6B-9VEZ].

and have done so for decades.[119] Florida's ICU bed capacity reached 95%, and the high levels persisted even with diminished COVID-19 hospitalizations.[120]

Finally, Arkansas has been a CON law state since 1975.[121] However, Arkansas' CON laws do not control the same array of bed and facility investments. Instead, Arkansas focuses on the supply of nursing home beds and long-term care beds.[122] Still, ICU beds there that were equipped to treat COVID-19 reached full capacity, and patients in need of emergency care waited or were transferred to another facility, some even having to travel across the state.[123]

B. Goals and Consequences

With the situation faced by the aforementioned states, CON advocation may still be ostensibly supported by efforts to contain healthcare costs, prevent duplicitous services, and foster a more equitable healthcare system.[124] If these goals were being realized in theory, states should (1) produce a sufficient supply of institutional healthcare services; (2) increase access to healthcare, especially in rural areas; (3) increase the quality of healthcare; (4) expand access to healthcare to indigent consumers; (5) diversify the available institutional healthcare facilities by introducing and encouraging the construction of hospital alternatives; and (6) generally restrain healthcare costs.[125] However, there seems to be a disconnect between CON laws' intentions and reality.

Georgia's CON laws, for example, require that the applicant must prove that there is a "need for such services," that "existing alternatives" are unavailable in the "service area," and that the applicant "has a positive relationship to the existing health care delivery system."[126] Terminology such as this, which is often broadly stated by its drafters, allows state planning agency bureaucrats, hardly subject to the political process let alone to the applicants themselves, the opportunity to act without regard for appropriate objective standards or the quality of the applicants.

---

119. MERCATUS CTR., *supra* note 117. Health care services covered by Florida's CON include air ambulance, ground ambulance, hospice, intermediate care facilities (ICFs) for individuals with intellectual disabilities, new hospitals or hospital-sized investments, nursing home beds, long-term beds, care beds, psychiatric services, substance/drug abuse, swing beds. *Id.*

120. Christopher Heath, *95% of Florida's ICU Beds in Use, Even As COVID-19 Cases Start to Decline*, WFTV (Aug. 30, 2021), https://www.wftv.com/news/local/orange-county/95-floridas-icu-beds-use-even-covid-19-cases-start-decline/7ZPCYSEEJJBXVLRNBESXSPCCH4/ [https://perma.cc/7S4R-KQ43].

121. Christopher Koopman, Thomas Stratmann & Mohamad Elbarasse, *Certificate-of-Need Laws: Implications for Arkansas*, MERCATUS CTR. (June 9, 2015), https://www.mercatus.org/publications/corporate-welfare/certificate-need-laws-implications-arkansas [https://perma.cc/TT94-CDUC].

122. *Arkansas and Certificate-of-Need Programs 2020*, MERCATUS CTR. (Mar. 19, 2021), https://www.mercatus.org/publications/certificate-need-laws/arkansas-and-certificate-need-programs-2020 [https://perma.cc/Y3BX-FPJV].

123. Parris Kane, *'At Some Point, We Will Be out of Options:' COVID ICU Beds Full in Arkansas*, ABC 7 (Aug. 24, 2021), https://katv.com/news/local/covid-icu-beds-full-in-arkansas-how-state-health-officials-are-responding [https://perma.cc/UAX8-LK7H].

124. *See* Part II.A (outlining the background and rationale behind CON laws).

125. Matthew D. Mitchell, *Certificate-of-Need Laws: Are They Achieving Their Goals?*, MERCATUS CTR., 1, 1–2 (Apr. 2017) https://www.mercatus.org/system/files/mercatus-mitchell-con-qa-mop-v1.pdf [https://perma.cc/469C-C9N9].

126. GA. CODE ANN. § 31-6-42; (2010); *see also* GA. COMP. R. & REGS. 111-2-2-.09 (2023) (defining and explaining relevant terms and topics within the Georgia code).

It is questionable whether a state health planning agency can adequately assess the needs of all communities within its borders. It is even more questionable whether a state health planning agency can do so more accurately than the community members themselves who seek the services. The healthcare industry is likely far too complex to be accurately predicted by anyone, including industry experts or government officials. Such complexity makes central planning difficult, as Nobel laureate Friedrich A. Hayek wrote in one of his famous essays:

> This is, perhaps, also the point where I should briefly mention the fact that the sort of knowledge with which I have been concerned is knowledge of the kind which by its nature cannot enter into statistics and therefore cannot be conveyed to any central authority in statistical form. The statistics that such a central authority would have to use would have to be arrived at precisely by abstracting from minor differences between the things, by lumping together, as resources of one kind, items which differ as regards location, quality, and other particulars, in a way which may be very significant for the specific decision. It follows from this that central planning based on statistical information by its nature cannot take direct account of these circumstances of time and place, and it follows that the central planner will have to find some way or other in which the decisions depending on them can be left to the "man on the spot."[127]

To know every communal need—whether in the present or as they extend into the future—is not realistic, and acting on those intuitions will likely lead to myopic results. Central planners must think in terms of aggregates, which necessarily limits the significance of local knowledge. The state planning health agencies cannot have the information necessary to plan for a healthcare market because the most valuable information is simultaneously in the hands of millions of potential patients and in the unknowable future. The CON law aggregation did not have the effect of increasing the quality of available healthcare services; instead, it lowered quality and indirectly raised the associated costs.

Additionally, a state actively promoting less competitive healthcare markets opens the door for already existing healthcare providers to charge higher up-front rates.[128] The theory is that by restricting market entry and expansion, states will reduce over-investment in facilities and equipment, and it has not stood up to reason.[129] The practical effect of states limiting the scope and amount of their CON triggers is unquestionably increased competition in the healthcare market. This is a fear that, if realized, would strike at the heart of existing providers and their profit-driven beneficiaries. A staggering feature of some states' CON regimes, like Georgia's, is the allowance of competing and currently operating healthcare facilities to object to applications without a showing of evidence.[130] These challenged applicants are not even given an opportunity to rebut the objection at a subsequent hearing.[131]

Another argument that is often advanced in favor of CON laws is one of administrability—the burden that would be placed on healthcare-related agencies in the

127. Friedrich A. Hayek, *The Use of Knowledge in Society*, 35 AMER. ECON. REV. 519, 524 (1945).
128. Banks, Foreman & Keeler, *supra* note 95, at 10–117–12.
129. *Id.*
130. GA. CODE ANN. § 31-6-43(h) (West 2019); GA. COMP. R. & REGS. 111-2-2.07(1)(h) (2005).
131. *See* sources cited *supra* notes 55–56, 58–59 (cataloging different state CON law schemes).

pursuit of ensuring compliance among providers under its scope and supervision. For example, state health planning regulators in the Louisiana Department of Health rejected a proposal from a social worker making a CON application to service special needs children in her New Orleans community.[132] The Department found that her planned services proposal—which primarily focused on tackling rising youth crime and parental needs for backup resources—did not address a need, and thus, the Department rejected her proposal.[133] The Department justified its decision, finding "[r]egulating [to be] a resource-intensive process" and also noting that rejecting applicants helps "limit the burden on regulators."[134] This retort should raise eyebrows for several reasons. It suggests that healthcare services with negative effects on criminal activity might not be services that would constitute a need in New Orleans or Louisiana, or it possibly suggests that the special needs market in Louisiana is overserved, a rather unlikely scenario.

The vast array of criteria that can inform a state health planning agency in making a CON determination poses many complications to applicants.[135] Maybe the need intended to be serviced must more directly relate to the actual health of the community as opposed to well-being. But then, what is "need" if not a reduction in crime among troubled youths? How much of a burden is placed on regulators by marginal increases in service providers?

There are fundamental healthcare market issues that lead to inefficient results,[136] and CON laws add another layer of complexity. The often-recapitulated normative end of health care is that it is equitable, high-quality, and accessible. There has certainly been no shortage of calls to further that end at the community, state, and federal levels.[137] But the means have been undertaken with varied forms, resulting in the current state of affairs.

Friedrich A. Hayek declared, "Where it is impossible to create the conditions necessary to make competition effective, we should resort to other methods of guiding economic activity."[138] To many, the healthcare market is of this sort and requires an alternative approach. Whether it is necessarily the case that state-level healthcare markets cannot be made competitive is questionable. There is clear obstinance to shifting towards a more free-market-oriented approach among healthcare market stakeholders, contextually within and outside of CON laws.[139] There also seems to be an emotional and philosophical

132. Newell-Davis v. Phillips, 551 F.Supp.3d 648, 651–52 (E.D. La. 2021); *see also* Nathaniel Hamilton, *State Regulators Are Preventing a New Orleans Social Worker From Helping Families With Special Needs Children*, PAC. LEGAL FOUND. (Nov. 18, 2021), https://pacificlegal.org/state-regulators-preventing-new-orleans-social-worker-from-helping-special-needs-children/ [https://perma.cc/SUS3-WZHJ] (describing a time when Louisiana Department of Health rejected a proposal form a social worker making a CON application).

133. *See* sources cited *supra* note 132.

134. John Stossel, *Louisiana Requires Respite Care Providers to Prove They're Needed*, BUDGET TAX NEWS (Nov. 16, 2021), https://heartlanddailynews.com/2021/11/stossel-louisiana-requires-respite-care-providers-to-prove-theyre-needed/ [https://perma.cc/PYC9-HBAE].

135. *See supra* Part III.A (analyzing complications under CON law schemes).

136. *See supra* Part II (discussing fundamental healthcare issues, especially as they relate to CON laws).

137. Matthew Fiedler & Christen Linke Young, *Current Debates in Health Care Policy*: *A Brief Overview*, BROOKINGS INST. (Oct. 15, 2019), https://www.brookings.edu/policy2020/votervital/current-debates-in-health-care-policy-a-brief-overview/ [https://perma.cc/8ZHP-KA62].

138. FRIEDRICH A. HAYEK, THE ROAD TO SERFDOM 37 (Univ. of Chi. Press 1944).

139. *See Certificate of Need: Evidence for Repeal*, AM. MED. ASS'N (2015). https://www.ama-assn.org/media/14736/download [https://perma.cc/8S2L-Z43T] (advocating for the repealing of various CON laws); Marcelo Hochman & Daryl James, Opinion, *Hospitals Shouldn't Get to Choose Their Competition*, WALL

repulsion in healthcare to the role of pricing, profits, and markets in urgent or desperate health-related situations.

C. States Without CON Laws

As of 2023, 13 states did not have CON laws to any degree.[140] These states will not be viewed in the same way as the states that have placed moratoria or exemptions on their CON programs. These momentary allowances spurred by COVID-19 do not suggest that all CON law repercussions within the respective states are thereby alleviated.

The states that are experiencing serious bed capacity limitation, despite having no CON laws, are Idaho and Texas.[141] Considering that no two states face the same problems,[142] further investigation reveals that some of their respective characteristics are unique—so much so that their healthcare systems were ripe for disruption.

Texas is the oft-cited case study of CON proponents because it is accused of causing "empty beds and poor levels of care" as the state entirely deregulated CON in 1985, and mass hospital closures ensued in the decade that followed.[143] Hospitals typically close when experiencing decreased revenues due to low patient volumes, canceled elective procedures, and increased expense costs.[144] However, hospital closures should not *always* be viewed in such a negative light. Closures allow for the repurposing of resources no longer needed, the removal of unnecessary costs, and, perhaps most importantly, do not necessarily lead to adverse health outcomes for the communities that the closing hospital serviced.[145]

As one of the largest states in the Union, Texas receives its most accurate population count through the census, occurring once every ten years.[146] Census data has numerous implications for states that are not limited to legislative redistricting, congressional

---

ST. J. (Jan. 23, 2023), https://www.wsj.com/articles/hospitals-should-not-get-to-choose-their-competition-healthcare-patient-wholesale-poaching-certificate-of-need-medical-cost-11642970952 [https://perma.cc/F6ZY-59R8] (same); Fiedler & Young, *supra* note 137 (same).

140. Part II.D; Hochman & James, *supra* note 139; *Certificate of* Need, MOST POL'Y INITIATIVE, INC. (2022), https://mostpolicyinitiative.org/wp-content/uploads/2022/01/Certificates-of-Need-1.pdf [https://perma.cc/NKJ3-V29B].

141. *Supra* notes 78–83, *infra* note 142.

142. *See* Part II.C–E (discussing different states, their CON law challenges during COVID-19, and more).

143. Charles Peck, Brian Fisher & Ally Grant, *The Removal of Florida Certificate of Need: Anticipating Impact to Hospitals Across the State*, GUIDEHOUSE 1, 3 (Oct. 2019), https://guidehouse.com/-/media/www/site/insights/healthcare/2019/the-removal-of-florida-certificate-of-need-anticip.pdf [https://perma.cc/BJN8-9GY7].

144. *See* Ayla Ellison, *47 Hospitals Closed, Filed for Bankruptcy This Year*, BECKER HOSP. REV. (Oct. 16, 2020), https://www.beckershospitalreview.com/finance/47-hospitals-closed-filed-for-bankruptcy-this-year.html?utm_campaign=bhr&utm_source=website&utm_content=related [https://perma.cc/43BZ-N9EC] (discussing hospital closures).

145. *See* Jordan Rau, *When Hospitals Close, Frequent Fears About Care Aren't Realized*, NAT'L PUB. RADIO (May 4, 2015), https://www.npr.org/sections/health-shots/2015/05/04/404226975/patients-not-hurt-when-their-hospitals-close-study-finds [https://perma.cc/985J-RSQX] (discussing a recent study that "offers some comfort, finding that when hospitals shut down, death rates and other markers of quality generally don't worsen").

146. *See About the 2020 Census*, U.S. CENSUS BUREAU, https://www.census.gov/programs-surveys/decennial-census/decade/2020/about.html [https://perma.cc/7JSK-UM99] (explaining what the U.S. Census is and details about how it works).

apportionment, and infrastructure appropriations, but are also useful for effectively allocating health services.[147]

For collectors and their states, retrieving accurate census data in Texas is fraught with complications,[148] and COVID-19 only frustrated the matter by forcing the delay of releasing 2020 data by nearly a full year.[149] Texas must have had to account for its large undocumented immigrant population when considering the next decade of its healthcare market.[150] The number of immigrants residing in Texas was estimated at 1.6 million in 2016,[151] but illegal border crossings soared between 2020 and 2021, with an estimated 1.7 million people entering the United States.[152] It is unclear what the final destination was for many migrants, but Texas leads as the most heavily utilized doorway into the United States.[153]

Ultimately, Texas faced a roughly 16% population increase between 2010 and the 2020 census.[154] Such a prodigious shift would lead any state to be woefully unprepared for a drastic surge in healthcare demand.

IV. RECOMMENDATION

As the foregoing analysis suggests, if the stated goals of health care are still to improve access and costs, the path forward for many states should be to address the limitations of CON laws and their consequences. States with CON laws are faced with serious choices ahead, but the feasible options are confined to four: (1) let CON laws remain as they currently operate; (2) limit the number of CON triggers; (3) alter CON law practices to account for the possibility of resource depletion and stockpiling; or (4) total repeal of their CON laws. This Note recommends at least the third option, while not totally foreclosing the fourth, because CON laws fail to address the pervasive pricing root cause problems:

---

147. *Id.*

148. *See* Madeline Brown & Robert Santos, *The 2020 Census Deadline Was Just Extended, but so Far, Texas Has Failed to Ensure Its Latinx Residents Are Accurately Counted*, URBAN INST. (Oct. 2, 2020), https://www.urban.org/urban-wire/2020-census-deadline-was-just-extended-so-far-texas-has-failed-ensure-its-latinx-residents-are-accurately-counted [https://perma.cc/2464-Q2C6] (noting factors such as lack of funding, COVID-19, seasonal catastrophes, and other factors all as affecting the accuracy of census data).

149. *2020 Census Delays and the Impact on Redistricting*, NAT'L CONF. STATE LEGISLATURES (Aug. 23, 2021), https://www.ncsl.org/research/redistricting/2020-census-delays-and-the-impact-on-redistricting-637261879.aspx [https://perma.cc/H582-C8QB].

150. *See generally* Rohit Kuruvilla & Rajeev Raghavan, *Health Care for Undocumented Immigrants in Texas*, 110 TEX. MED. J. 63 (2014) (discussing the health care and immigration situation in Texas during 2014).

151. *U.S. Unauthorized Immigrant Population Estimates by State, 2016*, PEW RSCH. CTR. (Feb. 5, 2019), https://www.pewresearch.org/hispanic/interactives/u-s-unauthorized-immigrants-by-state/ [https://perma.cc/9JBJ-KVTW].

152. Eileen Sullivan & Miriam Jordan, *Illegal Border Crossings, Driven By Pandemic and Natural Disasters, Soar to Record High*, N.Y. TIMES (Oct. 22, 2021), https://www.nytimes.com/2021/10/22/us/politics/border-crossings-immigration-record-high.html [https://perma.cc/5XAZ-4TX4].

153. *See* John Gramlich & Alissa Scheller, *What's Happening at the U.S.-Mexico Border in 7 Charts*, PEW RSCH. CTR. (Nov. 9, 2021), https://www.pewresearch.org/fact-tank/2021/11/09/whats-happening-at-the-u-s-mexico-border-in-7-charts/ [https://perma.cc/U53W-MT7K] (highlighting that the Rio Grande, Del Rio, and El Paso, all in Texas, had the three highest migrant encounters at the border).

154. Alex Ura et al., *People of Color Make up 95% of Texas' Population Growth, and Cities and Suburbs Are Booming, 2020 Census Shows*, TEXAS TRIB. (Aug. 12, 2021), https://www.texastribune.org/2021/08/12/texas-2020-census/ [https://perma.cc/7J2V-SB8J].

CON laws are generally not cost-effective, and they do not provide sufficient benefits to justify the cost to consumers.

A. The Free Market Promotes Choice and Competition

It is undeniably the case that the United States possesses one of the leading healthcare industries in the world with unparalleled medical innovation, but it is simultaneously one of the most expensive for consumers.[155] Healthcare's existence in a fragmented system, forcing its participants through hoops and hurdles to enter the market and to reap the benefits of the efforts made within, poses great consequences that cannot always be accurately quantified. It could be possible to ascertain, for instance, the number of rejections a state health planning agency has made,[156] and by extension, the equipment and services that said rejected CON proposals would be comprised of. Unfortunately, it is exceedingly difficult, and maybe even impossible, to accurately assess the going needs of communities.

The rising cost of healthcare has propelled a largely undiscussed market phenomenon of medical tourism, wherein many U.S. citizens opt to undergo procedures in foreign countries because they are much more affordable than in the United States.[157] Foreign citizens coming to the United States still remains a commonality, so much so that the government will issue special travel visas.[158] Still, U.S. medical tourists with destinations outside the United States will travel despite primary concerns about the quality of care abroad.[159] This is just another consequence of limited access to the healthcare that patients demand and lacking healthcare competition.

To improve a struggling healthcare market, CON laws were principally enacted because of the aforementioned concerns raised by provider costs being shifted to consumers in unfair and exorbitant ways.[160] To combat this harm, states reacted by forcing limitations on facilities and services. It is arguable that market forces acting on institutional health facilities could alleviate some of the concerns of CON laws, because inflated pricing necessarily leads to inflated costs.

The initial investment required to develop or alter institutional health facilities—not limited to high construction costs, high costs of state-of-the-art equipment, recruitment of credentialed professionals and talented staff, and licensing fees—all serve as barriers to

---

155. *See* James E. Dalen & Joseph S. Alpert, *Medical Tourists: Incoming and Outgoing*, 132 AM. J. MED. 9, 9 (2019) (discussing the high costs of healthcare in the United States).

156. State health planning agencies do not publish a public record of their CON applications or rejections.

157. *See* Dalen & Alpert, *supra* note 155, at 9 ("In 2017, more than 1.4 million Americans sought health care in a variety of countries around the world.").

158. Kristina Gasson, *B-2 Visas for U.S. Medical Treatment: Who Qualifies*, NOLO, https://www.nolo.com/legal-encyclopedia/b-2-visa-us-medical-treatment-who-qualifies.html [https://perma.cc/E3QV-NAS2]; *Getting Health Care During Travel*, CTR. DISEASE CONTROL (Oct. 31, 2022), https://wwwnc.cdc.gov/travel/page/health-care-during-travel [https://perma.cc/J5RN-HNXN]; *see also* Randi Druzin, *Crossing the Border for Care*, U.S. NEWS (Aug. 3, 2016), https://www.usnews.com/news/best-countries/articles/2016-08-03/canadians-increasingly-come-to-us-for-health-care [https://perma.cc/S3TY-ZVLK] (discussing Canadian citizens coming to the U.S. for medical care).

159. *See* Dalen & Alpert, *supra* note 155, at 9 ("The reason more Americans have become medical tourists is simply that they are seeking less expensive health care.").

160. *See supra* Parts II.A, II.D (outlining the response that healthcare providers took when they enacted CON laws).

entry into the healthcare marketplace. With the potential to profit and serve the needs of communities, able, willing, and capable investors can assess the market need for their facilities and services without the help of the CON process.

An increased utilization of market forces that spur competition addresses problems faced by states. Primarily, it addresses the ability of hospitals to set their own pricing. The problem is not solely that hospitals set their prices, as any ordinary market provider can and should be able to do so, but it is instead the relationship with insurance providers and broker-dealers that is further facilitated by protectionist CON laws. If CON laws were repealed, the relationship between hospitals and broker-dealers would of course still exist, but a present and pervasive problem in the healthcare market—a lack of competition among suppliers and providers—would be ameliorated.

Ultimately, it is pricing that lies at the heart of the past, present, and future of healthcare concerns and is the greatest roadblock to a system that remotely resembles the desired equitable, quality, and accessible system. Prices, whether complex or arbitrarily set, serve two purposes very well. Prices effectively delineate between the disinterested and interested buyers, and prices redistribute between buyer and seller.[161] Resulting shortages can therefore be created by arbitrary pricing.

If an uninsured individual was to pay out of pocket for their health care expense, they would likely shop around and consider affordability, quality, and other subjective criteria important to inform their decision. Depending on the service desired, the healthcare-seeking individual may not be able to find their reservation price, despite their best efforts. This remains so even with new federal hospital transparency laws in effect since the beginning of 2021 that require hospitals to establish, update, and publicly list standard charges for the items and services they provide.[162] Notwithstanding that some of the largest providers refuse to comply,[163] disclosures have revealed that prices for the same procedure can vary greatly even between nearby hospitals.[164]

---

161. Russell Roberts, *Where Do Prices Come From?*, LIBR. ECON. & LIBERTY (June 4, 2007), https://www.econlib.org/library/Columns/y2007/Robertsprices.html [https://perma.cc/F2AX-93K9].

162. Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65524, 65524 (Nov. 27, 2019).

163. Melanie Evans, Anna Wilde Mathews & Tom McGinty, *Hospitals Still Not Fully Complying with Federal Price-Disclosure Rules*, WALL ST. J. (Dec. 30, 2021), https://www.wsj.com/articles/hospital-price-public-biden-11640882507 [https://perma.cc/MD3G-JEJC]. Some research indicates that less than six percent of hospitals have acted accordingly under the transparency rules. PATIENT RTS. ADVOC., SEMI-ANNUAL HOSPITAL PRICE TRANSPARENCY COMPLIANCE REPORT 1 (2021), https://context-cdn.washingtonpost.com/notes/prod/default/documents/ccb84a11-75f7-450c-a44f-b752e35940f2b752e35940f2/note/83ba8b81-fa73-483b-8d4d-3f3563ee6388 [https://perma.cc/M8NY-FUQQ]. Hospital noncompliance suggests that the two-million-dollar annual fine is too low and that the associated costs of compliance to a hospital—such as a loss in competitive advantage and reduced revenues from consumers shopping elsewhere—exceed the benefits. *See* Anne Wilde Mathews & Melanie Evans, *Hospitals Face Steeper Fines for Shunning Federal Price-Disclosure Rules*, WALL ST. J. (Nov. 2, 2021), https://www.wsj.com/articles/u-s-raising-penalty-for-hospitals-that-dont-publish-prices-11635900197?mod=article_inline [https://perma.cc/6YW9-V52R] (noting that "large hospitals could pay as much as $2 million annually if they don't make prices public").

164. Cynthia A. Fisher, *Hospitals Price Disclosures Reveal Price Can Vary By Ten Times*, ORANGE CNTY. REG. (Feb. 1, 2022), https://www.ocregister.com/2022/02/01/hospital-price-disclosures-reveal-prices-can-vary-by-ten-times/ [https://perma.cc/YGY7-TKAW].

The unsuspecting consumer—which can take the form of a manager tasked with seeking a plan for their business or any single individual—is further divorced from ascertaining any pricing knowledge when contracts are agreed upon between health service providers and the insurers or pharmaceutical companies. If the consumer enlists the assistance of a health insurance broker, the consumer is once more removed from pricing knowledge. The consumer faces the payment of deductibles and premiums to receive care, and "the real victim is the patient's wallet over which the providers and insurers fight their proxy wars."[165] Even where high deductibles are paid in an individual health insurance plan, the deductible is normally paired with a low premium or low deductibles with high premiums. The inverse relationship is aerated with annual rising health care costs where premiums, deductibles, and out-of-pocket expenses will move together. The time between 2011 and 2016 saw a 63% increase in single coverage annual deductibles for insured works and correspondingly a 19% increase in single coverage premiums, much greater than increases in wages and adjusted inflation figures.[166]

The role of the health insurer is necessarily implicated where the industry realizes greater earning potential with increased insurance payments. Keith Smith, M.D. founded the Surgery Center of Oklahoma (SCO) in 1997, offering transparent, direct, and packaged pricing directly to patient hopefuls.[167] Astonishingly, one can go to the SCO website, pick any listed desired procedure, and receive a price estimate that is very near to the final payment amount.[168] Finding bureaucracy at the insurance and hospital levels to be one of the primary defying forces to providing quality surgical care, Dr. Smith has acknowledged the pressing concerns insurers raise:

> There's a real misunderstanding that insurance companies care about prices . . . They really don't. All they care about are charges, because . . . they are in the business of selling discounts. One insurance company will compete with another insurance company because their discounts off of billed charges are better. And . . . what is not regularly discussed is the way in which these companies make money selling these discounts.[169]

This fact puts to question the role of insurers and their ability to act as loyal stewards under contract to assist with cost-reductive efforts. When the prices are high at the outset, the insurer is able to earn more by discounting those high prices.

This pricing dilemma may be best illustrated in two examples. The first comes from research compiled through the efforts of surgeons at the University of Iowa. One surgeon called a random sample of 101 hospitals to obtain price estimates for a coronary artery

---

165. Roman Zamishka, *A Libertarian's Case Against Free Markets in Health Care*, HEALTH CARE BLOG (Aug. 2, 2018), https://thehealthcareblog.com/blog/2018/08/02/a-libertarians-case-against-free-markets-in-healthcare/#comments [https://perma.cc/94ZQ-25VE].

166. Jeanne Pinder, *Cash Prices Stay Level, While Overall Costs Continue to Rise*, CLEAR HEALTH COSTS (Mar. 23, 2017), https://clearhealthcosts.com/blog/2017/03/cash-prices-stay-level-overall-costs-continue-rise/ [https://perma.cc/P2K6-NPY6].

167. *About SCO*, SURGERY CTR. OKLA., https://surgerycenterok.com/about [https://perma.cc/SQ32-WSNF].

168. *Pricing Disclaimer*, SURGERY CTR. OKLA., https://surgerycenterok.com/pricing-disclaimer/ [https://perma.cc/S9R3-4ENU].

169. Pinder, *supra* note 166.

bypass graft (open heart surgery) for a hypothetical uninsured patient.[170] The surgeon was able to receive prices from only 53 of the hospitals, with some difficulty, and the provided estimates ranged from $44,824 to $448,038.[171] There was surprisingly no correlation whatsoever between price and quality, and some of the best hospitals were some of the cheapest.[172] In effect, these outrageous out-of-pocket charges are passed onto and shared by consumers directly and indirectly through insurance programs.

The second pricing conundrum comes from the efforts of Adam Russo, CEO of The Phia Group in Massachusetts.[173] Employer-sponsored health plans have the relationship of the employer taking on the role of proxy agent for their employees.[174] In so doing, the employer would benefit greatly from knowing what hospitals are charging for any one service. Russo's company was faced with a dilemma where two Harvard hospitals were charging drastically different prices to deliver a baby, one charging $7,000 and the other $41,000.[175] This is by no means a phenomenon unique to the Boston area, the east coast, or childbirth, for that matter.[176]

Attempts to reign in healthcare pricing by requiring hospitals to disclose their service prices should not be seen as successful, but it is a positive step.[177] The clear motivation is that if hospitals comply, the transparency rule should lower patient costs. However, no success should be maintained where most hospitals have been non-compliant. Some research indicates that less than six percent of hospitals have acted accordingly under the transparency rules.[178]

A reduction of CON law triggers would allow for greater consideration of shifting costs to investors, necessarily limiting CON laws' grip on healthcare allocations. This would foster a freer market-oriented approach with greater competition at lower costs to consumers.

V. CONCLUSION

States repealing their CON laws would likely be a beneficial step towards improving a frustrated healthcare system. Its removal would allow for more attention to be focused on the pricing mechanisms at play as they are set by the market makers—healthcare providers and insurers. The dark, protectionist underbelly of health care has once again reared its ugly head. COVID-19 has revealed CON states inadequacies in meeting their public health authority to serve their respective citizens. States should review CON's feasibility and consider taking a less limiting control on their healthcare development efforts.

---

170. Bria D. Giacomino et al., *Association of Hospital Prices for Coronary Artery Bypass Grafting with Hospital Quality and Reimbursement*, 117 AM. J. CARDIOLOGY 1101, 1104–05 (2016).

171. *Id.* at 1105.

172. *Id.*; *see also* MARTY MAKARY, THE PRICE WE PAY 17 (2019).

173. *Marty Makary on The Price We Pay*, LIBR. ECON. & LIBERTY (Feb. 10, 2020), https://www.econtalk.org/marty-makary-on-the-price-we-pay/#audio-highlights [https://perma.cc/QSA3-3TM2].

174. *Id.*

175. *Id.*

176. *See generally* MAKARY, *supra* note 172 (discussing the phenomenon generally).

177. *See* CY 2020 Hospital Outpatient PPS Policy Changes, 84 Fed. Reg. 65524.

178. PATIENT RTS. ADVOC., *supra* note 163, at 1.