

February 21, 2023

Senator David Wilson, Chair

Senate Health and Social Services Committee

Alaska State Capitol

Juneau, Alaska 99801-4711

Dear Senator Wilson and members of the Senate Health and Social Services Committee:

My name is Jeffrey A. Singer. I am a Senior Fellow in Health Policy Studies at the Cato Institute. I am also a medical doctor specializing in general surgery and have been practicing that specialty in Phoenix, Arizona, for over 40 years. Thank you for allowing me to testify before the Senate Health and Social Services Committee regarding SB 8, which seeks to repeal health care Certificate of Need requirements. I appreciate this opportunity to provide my perspective as a health care practitioner and policy analyst to assist this committee in assessing existing policies.

Roughly four decades since the repeal of the 1974 federal law that incentivized states to establish “Certificate of Need” (CON) requirements before new health care facilities can develop—or existing ones can add beds or equipment—CON requirements still exist to varying degrees in 35 states. A classic example of central planning, CON commissions are heavily influenced by incumbent health care providers. Attempts to reform or repeal them are often met by fierce resistance from the incumbents who try to make the case that they only have the interests of the general public in mind. CON laws render state health care systems sclerotic and unable to rapidly adjust their infrastructure to meet the changing demands of public health emergencies. Many governors suspended CON laws during the public health emergency. State legislators should formally repeal the CON laws in those states and those where they were not suspended.[[1]](#endnote-1)

Lawmakers enacted Certificate of Need Laws based on the theory that restricting the supply of health care services would somehow reduce demand for those services and thus restrain health care spending. However, policymakers should have noticed that third-party payers, private or government-run, pay for most health care services. This insulates most patients from the actual prices of health care services, while the third-party payers absorb the costs. Consumer-patients with little skin in the game have no incentive to be cost-effective. When price signals are inoperative, demand continues despite restrictions in supply. Shortages inevitably develop while prices paid by third-party payers increase at a greater rate than would have otherwise occurred. This is basic economics.

The only way to reduce health care expenditures when health care consumers are largely insulated from price effects is to decrease availability and access to health care. In a George Mason University Mercatus Center working paper, a review of 20 academic studies found that CON laws largely failed to achieve their goal of reducing health care costs and concluded that the overwhelming evidence is that CON laws are associated with higher per-unit costs and higher expenditures.[[2]](#endnote-2) The numbers speak for themselves. National per capita health expenditures increased from $2354 in 1974 to $12,914 in 2021 (in constant 2021 U.S. dollars).[[3]](#endnote-3)

Despite the ineffective nature of these laws, states still have a variety of CON laws on the books today. The various states differ in the type and number of restricted facilities and expenditures. For example, Ohio restricts only long-term care services, while Kentucky restricts more than 24 different types of health care facilities.[[4]](#endnote-4) The state where I reside and practice medicine, Arizona, repealed all of the CON laws except for ambulance services in 1990. The Arizona Hospital Association supported this action. By 1990, California, Colorado, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah, Wisconsin, and Wyoming repealed all of the CON laws.[[5]](#endnote-5)

The certificate-granting process effectively gives monopoly privileges to existing hospitals and facilities. When a new provider petitions for a certificate, established providers are usually invited to testify against their would-be competitors.[[6]](#endnote-6) This means that some health care practices can openly challenge the right to exist of any practice that might hurt their bottom line. Indeed, hospital administrators openly admit that protection against competition, thanks to CON laws, has become an integral part of their business model.

Hospital administrators argue against the repeal of CON laws claiming these laws allow them to generate enough revenue to provide 24-hour emergency services and uncompensated care. Physicians and other health care practitioners also provide uncompensated care and other services. Yet state professional organizations don’t argue for creating a certificate of need requirement before allowing additional doctors, nurses, psychologists, physical therapists, etc., to set up practices in a state. And they would be publicly derided if they did so.

New health care practitioners entering the state may provide competition to incumbents. This has not stunted the growth of the health care professions. Instead, it has benefitted health care consumers by increasing choice and access.

According to one health care journal, “hospitals tend to view CON restrictions favorably when they serve to exclude [competing] facilities from entering a market, but may take steps to circumvent the CON application process where their own expansion is concerned.”[[7]](#endnote-7)

One of the original purposes of CON laws was to encourage hospital substitutes. Yet ironically, 28 states now restrict ambulatory care services, a common hospital substitute that competes with traditional hospitals.[[8]](#endnote-8)

Long-term care and hospice care can be offered either in nursing homes or through home health care services. Many states that have repealed some CON laws retain them for nursing homes. Comparisons between states with some CON laws and those with no CON laws show hospice expenditures in states with CON laws are dominated by nursing homes rather than alternatives like home health care.[[9]](#endnote-9)

We have seen and continue to see that countries embracing central planning fall victim to what economists call “the knowledge problem.” It is impossible to predict how many ICU beds, general beds, or other health care facilities and services will be needed to serve a growing and dynamic population. Markets are the most accurate and efficient way of allocating goods and services.

With the advent of the COVID-19 pandemic, many states realized their CON laws left them unprepared for a sudden surge in demand for critical care and other health care services and straight-jacketed by bureaucratic red tape. Therefore, 20 states, including Alaska, suspended their CON laws, and four other states issued emergency certificates of need (thus bypassing the usually months-long certificate application process).[[10]](#endnote-10) This was a tacit admission that Certificate of Need laws impede the rapid response of the health care system to changes in society.

Lawmakers should heed the lessons the public health crisis provided and act now to repeal CON laws and rid their health care systems of discredited central planning reminiscent of a bygone era.

Respectfully,

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1. <https://www.cato.org/blog/certificate-need-laws-will-impede-preparedness-expected-surge-covid-19-cases> [↑](#endnote-ref-1)
2. https://www.mercatus.org/system/files/mercatus-mitchell-con-healthcare-spending-v1a.pdf [↑](#endnote-ref-2)
3. <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20per%20capita,%201970-2021> [↑](#endnote-ref-3)
4. Jack Pistor, ‘States Modernizing Certificate of Need Laws,*’* National Conference of State Legislatures Vol. 27, No. 41 (Dec. 2019), <https://www.ncsl.org/research/health/states-modernizing-certificate-of-need-laws.aspx>; National Conference of State Legislatures, (2019), ‘CON State List 2019’, <https://www.ncsl.org/documents/health/CON_State_List_2019.pdf#page=41> [↑](#endnote-ref-4)
5. https://medium.com/concentrated-benefits/how-state-certificate-of-need-con-laws-impact-access-to-health-care-b8d3ec84242f [↑](#endnote-ref-5)
6. https://www.bizjournals.com/charlotte/blog/health-care/2015/01/carolinas-healthcare-asks-court-to-block-fort-mill.html [↑](#endnote-ref-6)
7. http://www.healthcapital.com/hcc/newsletter/11\_12/CON2.pdf [↑](#endnote-ref-7)
8. https://www.mercatus.org/publications/corporate-welfare/certificate-need-laws [↑](#endnote-ref-8)
9. Momotazur Rahman, Omar Galarraga, Jacqueline S. Zinn, David C. Grabowski & Vincent Mor, ‘The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures,’ *Journal of Medical Care Research and Review* (July 2015), <https://journals.sagepub.com/doi/abs/10.1177/1077558715597161> [↑](#endnote-ref-9)
10. https://pacificlegal.org/certificate-of-need-laws-covid-19/ [↑](#endnote-ref-10)