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Certificate of Need (CON) Law Series: Part I - A Controversial History

The four-part *HC Topics Series: CON Laws* will provide an in-depth examination of Certificate of Need (CON) programs and their impact on the healthcare industry. The first installment provides an overview of states' CON programs and the history of their development, and Part II will discuss the current state of CON regulations. Part III will evaluate CON programs against the changing landscape of the healthcare industry, and Part IV will examine the impact of the *Patient Protection and Affordable Care Act (ACA)* on CON programs.

Certificate of Need (CON) laws are state-level regulatory initiatives that require individuals in the healthcare industry to obtain permission to make significant capital expenditures or to construct or expand facilities and services, based on the theory that controlling the supply of facilities, equipment, and services is the best method to restrain rising healthcare costs.[1] Most states' CON laws were introduced in the 1970s as part of the federal *National Health Planning and Resources Development Act.* Though the Act and its federal funding opportunities were later repealed in 1987, approximately 36 states have some form of a CON requirement today.[2] The usefulness of CON laws has been highly contested by many in the healthcare industry. Proponents argue these laws reduce waste and duplicative services, while opponents argue they do not effectively restrain rising healthcare costs and may actually result in higher prices because they limit consumer choice and serve as a competitive barrier to entry.[3] This article examines the historical development of CON laws and the process by which states arrived at their present-day CON policies.

Rising healthcare costs have been an increasing concern since the 1970s, however, the first part of the 20th century was characterized by perceived shortages of healthcare facilities and a push to build community hospitals following World War II.[4] In 1946, Congress passed the *Hospital Survey and Construction Act*, also known as the *Hill-Burton Act*, which was designed to promote the development of community hospitals by providing states with funds for facility construction.[5] In exchange for federal funds, the Act required states to implement health policy planning initiatives.[6] As early as the 1950s, increasing attention was paid to the overutilization of hospital beds and what became known as the "*Roemer Effect*," i.e., the theory that there is a high correlation between the number of available hospital beds and the use of those beds.[7] By the late 1960s and early 1970s, the state health policy planning initiatives required under the *Hill-Burton Act* had proven ineffective at controlling inflating healthcare costs and two additional federal laws were passed in an attempt to restrain this growth.[8] *Section 1122* of the Social Security Act allowed the federal government to withhold Medicare and Medicaid capital payments for healthcare facilities and service expansions that had not received approval from their respective state health planning agencies.[9] The *National Health Planning and Resources Development Act (NHPRDA)* of 1974 went even further, attempting to establish a health planning policy at the national level and withholding federal funds from states that did not pass CON laws as defined under the NHPRDA.[10] By the following year, 20 states had enacted CON laws and by 1978, a total of 36 states had CON laws in place.[11]

In the decade that followed the NHPRDA's enactment, national healthcare expenditures continued to rise dramatically and CON laws' effectiveness on controlling rising healthcare costs were called into question.[12] In a 1976 study, Salkever and Bice found that "*no significant savings in hospital costs were achieved through certificate-of-need programs*," and their results showed that in the first five states to adopt CON laws, the restrictions may have actually caused healthcare costs to increase.[13] Schwartz and Joskow's 1980 study showed that duplicative services were only responsible for a small amount of the medical cost inflation that had occurred in the previous few decades, and later studies showed that CON regulations had a negative secondary effect on health outcomes.[14] Congress responded to these results by repealing the NHPRDA in 1987, which left states free to discontinue their CON programs in the absence of a federal mandate or federal funding, however, many states elected to continue their policies.[15] Since the repeal of NHPRDA, 14 states have dropped their CON programs while several others narrowed their laws' application. Today, 36 states, the District of Columbia, and the Commonwealth of Puerto Rico all have some form of a CON program.[16]

Despite widespread evidence that CON laws are ineffective at controlling healthcare costs, most states continue to restrict healthcare facility construction and other major capital expenditures. The debate as to the usefulness of these regulations continues as alternative

(Continued on next page)

cost containment initiatives are implemented and the healthcare market is transformed as a result of national healthcare reform. The next installment of the *CON Law Series* will examine the states' present-day CON programs and their impact on the industry.

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2 Certificate of Need: State Health Laws and Programs" National Conference of State Legislatures, March 2012, http://www.ncsl.org/issues-research/health/con-certificate-of-need-state-laws.aspx#Program (Accessed 9/10/12).
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13 "Hospital Certificate-of-Need Controls: Impact on Investment, Costs, and Use" By David S. Salkever & Thomas W. Bice, American Enterprise Institute for Public Policy Research, Washington, D.C., 1976, p. 73, 75.
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(Continued on next page)

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