CERTIFICATE OF NEED LAWS: WHY THE PROS DO NOT OUTWEIGH THE CONS

BY: MORGAN TANDY*

INTRODUCTION

Jared, a male in his early twenties with an IQ score of fifty-four, lived with his mother because he suffered from severe mental illness, autism, and an intellectual disability. One day, out of the blue, Jared physically assaulted

* Juris Doctor candidate, Belmont University College of Law, 2023; B.B.A., Baylor University, 2019. I want to thank all of my Professors, especially Professor Jeffery Usman, for their guidance in developing this note. Additionally, I am very grateful to the entire editorial team for their invaluable feedback. Lastly, thank you to my husband, family, and friends for your love and support throughout my law school career.

his mother. The police arrested Jared, and the nightmare began. The sole magistrate judge in Tama County, Iowa immediately determined that Jared needed medical treatment, not criminal punishment. He was mentally ill—not a criminal. County officials desperately tried to find a mental health facility in the state of Iowa to accept Jared for inpatient treatment. Not a single bed was available.[1]

The judge knew he could not release Jared to go back home without treatment because there was a high risk he would harm himself or his mother again. In the meantime, Jared was held in the county jail while the search for mental health beds continued. The county's mental health advocate told the judge that he should release Jared if he did not have a treatment facility to send him to. They devised a plan to send Jared to an in-patient psychiatric unit at the University of Iowa, but hospital officials refused to admit Jared due to the lack of beds in their mental health unit.[2]

For over a week, Jared's volatility and dangerousness increased as he remained untreated, hand-cuffed to a hospital bed.[3] After intense pressure from the judge and others, the state's mental hospital finally admitted Jared to an open bed in its psychiatric ward to receive much needed medical care. Jared's story highlights the impact that certificate of need ("CON") laws, which condition the establishment or modification of health care facilities upon state approval, have on the availability of beds in mental healthcare facilities and healthcare generally.[4]

This is just one example of how the shortage of beds in mental health facilities is failing to offer much needed care to mentally impaired people.[5] Iowa is one state that has retained its CON laws. Mental health facilities are required to obtain CON approval, but political agendas control the landscape for establishing these facilities, which perpetuates the on-going shortage of beds in these facilities.[6] The lack of access to appropriate mental healthcare leaves people in a mental health crisis without the resources they need, which endangers doctors, nurses, social workers, other patients, and the community in general. Jared's story is just one of many that has instigated a call to action to rethink the negative impact that CON laws have in the mental healthcare space.[7]

---

1. *See* Mark Flatten, *Con Job: Certificate of Need Laws Used to Delay, Deny Expansion of Mental Health Options*, GOLDWATER INST. 2 (Sept. 25, 2018), https://www.goldwaterinstitute.org/wp-content/uploads/2018/09/Mark-CON-paper-web.pdf (condensed and adapted from an Goldwater Institute anecdote) [https://perma.cc/3KTR-ZRJD].

2. *Id.*

3. *Id.* at 3.

4. *See id.*; *see also Certificate of Need (CON) State Laws*, NAT'L CONF. OF STATE LEGISLATURES (last updated Dec. 20, 2021), https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx [https://perma.cc/2JME-DPPE] [hereinafter Certificate of Need (CON) State Laws].

5. *See* Flatten, *supra* note 1, at 3.

6. *See id.* at 3–4.

7. *See id.* at 6.

State governments passed CON laws in the late 1970s to control how healthcare entities enter different markets.[8] CON laws were originally supposed to be a mechanism for controlling healthcare costs and increasing access to care.[9] In practice, CON laws require healthcare facilities to seek state approval before establishing new facilities in a certain area or prior to spending a large sum of money on new capital investments.[10] Despite policymakers' original goals, CON laws routinely fail to control healthcare costs and improve quality and access.[11] The COVID-19 pandemic further illuminated these shortcomings as hospitals in CON states faced barriers to increasing the number of hospital beds to meet demand.[12] To resolve the lack of quality healthcare in rural areas, CON laws should be repealed in every state where they remain in effect, and states should instead implement transparent funding and programs to improve indigent and mental healthcare services in rural areas.

Part I of this Note gives a general overview of the history and development of CON laws. Next, Part II explains the arguments for and against the existence of these CON laws and the impact (or lack thereof) of CON laws on indigent and mental healthcare services. Finally, Part III proposes that states eliminate CON laws in favor of directly providing funds to support increased access to indigent and mental healthcare in rural areas.

I. A STORIED HISTORY OF CON LAWS

The United States continuously struggles to balance healthcare costs with access and quality. Over the past several decades, many attempts have been made to combat rising costs and improve the quality of care.[13] State CON laws are one example of a long-standing, outdated effort to purportedly control costs, improve access, and ensure quality healthcare.[14] CON laws control entry and expansion of health care providers by requiring new

8. Certificate of Need (CON) State Laws, *supra* note 4.

9. *Id.*

10. Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30 ANTITRUST 50 (2015), https://www.ftc.gov/system/files/documents/public_statements/896453/1512fall15-ohlhausenc.pdf [https://perma.cc/YKY7-6R7U].

11. Flatten, *supra* note 1, at 5; *see also* Certificate of Need (CON) State Laws, *supra* note 4.

12. *See* Matthew Mitchell, *It's Time for States to Ditch Certificate of Need Laws*, U.S. NEWS (July 9, 2021, 12:08 PM), https://www.usnews.com/news/best-states/articles/2021-07-09/on-the-heels-of-the-pandemic-states-should-get-rid-of-certificate-of-need-laws; *see also* Jeffery A. Singer, *Certificate of Need Laws Will Impede Preparedness for the Expected Surge in COVID-19 Cases*, CATO INST. (March 11, 2020, 10:51 AM), https://www.cato.org/blog/certificate-need-laws-will-impede-preparedness-expected-surge-covid-19-cases [https://perma.cc/UX9P-DVU5].

13. Ohlhausen, *supra* note 10.

14. *Id.*

healthcare entities receive state approval before entering the market or making capital investments.[15]

A. The Rise of CON Laws

In the 1960s, many people became concerned with rising healthcare costs that were thought to be the product of duplicative healthcare facilities in concentrated areas.[16] However, the system of cost-based reimbursement may have been the source of the problem.[17] At the time, government and private insurance retroactively reimbursed healthcare expenses, and there was a concern that patients selectively demanded the highest quality services. Together, these concerns led to the theory that healthcare providers were offering duplicative services.[18] As a result, CON laws became a popular solution to control healthcare costs.[19] The major goal of CON programs was to control costs by restricting capital expenditures by healthcare providers, such as MRI machines or additional patient beds.[20]

In 1964, New York State took the first step to create change by implementing its own CON law to contain healthcare costs by limiting excessive spending on facilities and equipment.[21] Over the next decade, twenty-six more states enacted CON laws.[22] Early CON laws regulated healthcare facilities when making any capital expenditures over $100,000, increasing their bed capacity, and expanding their healthcare services.[23] After significant lobbying efforts by the American Hospital Association (AHA) to expand CON laws to other states, Congress passed the National Health Planning and Resources Development Act of 1974.[24]

Through this legislation, the federal government heavily incentivized states to adopt CON laws to regulate the entry of different healthcare entities into the market.[25] As a result, by 1980, CON laws were established in every state except Louisiana.[26] States gained broad regulatory control because

---

15. *Id.*
16. *Id.*
17. DEP'T OF JUST. & FED. TRADE COMM'N, *Chapter 8: Miscellaneous Subjects*, *in* IMPROVING HEALTHCARE: A DOSE OF COMPETITION 2 (July 2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [https://perma.cc/AB43-M8V7] [hereinafter A Dose of Competition].
18. *Id.*
19. *Id.*
20. *Id.*
21. *See* Ohlhausen, *supra* note 10; *see also* Thomas Strattmann, *Do Certificate-of-Need Laws Increase Indigent Care?*, MERCATUS CTR. AT GEO. MASON UNIV. (July 15, 2014), [https://perma.cc/2VXL-3SAQ].
22. Certificate of Need (CON) State Laws, *supra* note 4.
23. *Id.*
24. A Dose of Competition, *supra* note 17.
25. *Id.*
26. Ohlhausen, *supra* note 10.

applicants seeking a CON certificate must prove to state regulators that there is an unmet need for their services.[27] This process involves a significant investment of time and money.[28] By 1986, significant evidence demonstrated that CON laws failed to meet its intended objectives of controlling healthcare costs, improving quality, or expanding access to care.[29] Therefore, in 1987, Congress repealed the CON mandate and the associated state funding.[30]

At the time, some policymakers speculated that a substantial number of states would retain their CON programs since they aligned with a wide range of state policies.[31] However, other commentators believed that some states would abandon the program to promote a competitive environment in their healthcare markets.[32] Even in 1985, policymakers, who anticipated the repeal of the federal CON mandate, stated, "Like any regulatory program that intervenes in the market to accomplish some social good, the need for CON programs ought to be continuously evaluated, and the scope of the program tailored to meet specific, concrete, and current purposes."[33] Policymakers further suggested that the repeal of the program would create a "natural experiment" to determine whether the presence or absence of CON laws impacted the direction and scope of healthcare facility spending.[34]

After the 1987 repeal of the federal CON mandate, several states repealed their CON laws.[35] Presently, thirty-five states, and the District of Columbia, maintain some form of CON laws and varying degrees of regulatory control.[36] Over the past several years, these states have enacted legislation to modify their CON programs in many different ways; ranging from full repeals to creating a new CON program altogether.[37] States primarily use CON laws to regulate outpatient and long-term care facilities, which is largely due to the significant increase in free-standing, physician-owned facilities over the years.[38]

More recently, state legislatures have modified CON laws by significantly reducing regulatory controls.[39] For example, in May 2021,

---

27. A Dose of Competition, *supra* note 17.
28. *Id.*
29. Matthew Mitchell, *Certificate-of-Need Laws: How They Affect Healthcare Access, Quality, and Cost*, MERCATUS CTR. AT GEO. MASON UNIV. (May 21, 2021), https://www.mercatus.org/Certificate-of-Need-Laws-How-They-Affect-Healthcare-Access-Quality-and-Cost#conlawhistory [https://perma.cc/2EGN-6J76].
30. Certificate of Need (CON) State Laws, *supra* note 4.
31. James B. Simpson, *State Certificate of Need Programs: The Current Status*, 75 AM. J. PUB. HEALTH 1225 (Oct. 1985), https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.75.10.1225 [https://perma.cc/7MZD-DMHL].
32. *Id.* at 1228.
33. *Id.*
34. *Id.*
35. Certificate of Need (CON) State Laws, *supra* note 4.
36. *Id.*
37. *Id.*
38. *See id.*
39. *See id.*

Tennessee reformed its CON program, responding to the need to improve healthcare access to rural communities, increase mental health services, and to adjust its approval process after COVID-19 exposed significant flaws.[40] Under the new Tennessee law, mental health hospitals are no longer subject to CON requirements, and psychiatric services can be initiated without CON approval.[41] Taking a different approach, Indiana enacted legislation in 2018 that established a new CON program despite formerly repealing its previous CON program in 1999.[42] By contrast, in 2018 Indiana revived the CON program its legislature repealed in 1999. Other states, including Arizona, Minnesota, and Wisconsin, maintain regulatory processes that function similar to CON laws, but do not officially have CON laws on the books.[43]

As part of CON laws in some states, moratoriums may be placed on certain healthcare facilities and beds within those facilities.[44] Typically, moratorium regulations impact nursing facilities and long-term care facilities.[45] If a state places a moratorium on a certain type of healthcare facility, no CONs will be issued for capital expenditures in facilities of that type.[46] For example, Arkansas placed moratoria on psychiatric residential facilities, intermediate care facilities for the intellectually disabled, and residential care facilities.[47]

B. The General Process of Obtaining a CON

While regulatory authority varies, the process for obtaining a CON is generally similar from state to state. Tennessee's law is a good example of the general process.

In Tennessee, a "healthcare institution" must obtain a CON prior to its construction, development, or establishment.[48] "Healthcare institution" is defined as "an agency, institution, facility, or place, whether publicly or privately owned or operated that provides health services and that is one of the following: hospital; nursing home; ambulatory surgical treatment center (ASTC); intellectual disability institutional habilitation facility; home care organization (home health and hospice); outpatient diagnostic center (ODC); rehabilitation facility; residential hospice; and nonresidential substitution-

40. *Tennessee General Assembly Passes Highly-Anticipated CON Reform Bill*, BASS, BERRY & SIMS PLC (June 7, 2021), https://www.bassberry.com/news/tennessee-con-reform-bill/ [https://perma.cc/4ZKY-7EFZ] [hereinafter Tennessee General Assembly Passes CON Reform Bill].

41. *Id.*

42. Certificate of Need (CON) State Laws, *supra* note 4.

43. *Id.*

44. *See id.*

45. *See id.*

46. *Id.*

47. *Id.*

48. *Certificate of Need Basics*, TENN. HEALTH SERV. AND DEV. AGENCY (last visited Jan. 8, 2022, 3:29 PM), https://www.tn.gov/hsda/certificate-of-need-information/certificate-of-need-basics.html [https://perma.cc/U58S-WY5G].

based treatment center for opiate addiction."[49] In addition, some services, such as hospice and organ transplantation, require a CON before any person initiates the specified services.[50] Certain types of expensive imaging equipment, like magnetic resonance imaging (MRI) machines, also require a CON.[51]

To apply for a CON, a Letter of Intent must be filed with the Tennessee Health Facilities Commission (the "Agency"), and the information in the Letter must be published in a general circulation newspaper in that area at the time of filing.[52] The CON application and associated fees are due within five days of newspaper publication.[53] The Agency will review the application, which typically takes sixty days.[54] During that time, the Department of Health, the Department of Mental Health and Substance Abuse Services, and/or the Department of Intellectual and Developmental Disabilities also review the application.[55]

CON applications require a high burden of proof to successfully obtain a CON.[56] A CON will "only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards and will contribute to the orderly development of adequate and effective health care facilities and/or services."[57] Each reviewing department issues a report to be considered at a board meeting with the Health Facilities Commission.[58] After gathering all necessary information, the Agency will then vote to accept or deny the application.[59] If approved, the applicant receives the actual certificate roughly four weeks after the decision.[60]

Applying for and maintaining a CON can be quite costly. In terms of application costs, the fees vary widely from state to state. Tennessee recently moved away from their old, per-application fee structure and toward an annual fee process.[61] For example, effective October 1, 2021, a hospital with

---

49. *Id.*
50. *Id.*
51. *Id.*
52. *CON Process and How to Apply*, TENN. HEALTH SERV. AND DEV. AGENCY (last visited Jan. 8, 2022, 3:32 PM), https://www.tn.gov/hsda/certificate-of-need-information/how-to-apply-for-con.html [https://perma.cc/BG5K-HRM2] [hereinafter CON Process and How to Apply].
53. STATE OF TENN. HEALTH SERV. AND DEV. AGENCY, INSTRUCTIONS FOR FILING AN APPLICATION FOR A CERTIFICATE OF NEED 4 (2016), https://www.tn.gov/content/dam/tn/hsda/documents/CON_Application_Instructions.pdf [https://perma.cc/H2MJ-9D28].
54. *Id.* at 5.
55. *Id.*
56. *Id.* at 11.
57. *Id.* at 1.
58. *Id.* at 10.
59. CON Process and How to Apply, *supra* note 52.
60. *Id.*
61. Michael D. Brent et al., *Tennessee Makes Major Changes to Con Law*, 12 THE NAT'L LAW REV. 1, 6 (2022).

more than 200 beds is charged with an annual fee of $5,000.[62] In comparison, Alabama requires CON applicants to submit a nonrefundable fee equal to 1% of the estimated project cost, with the maximum filing fee, as of 2021, of $23,448.[63] Information for application fees or annual fees can typically be found on a state's department of health or development website.

C. Federal and State Guidance

On November 13, 2020, the Federal Trade Commission ("FTC") and Department of Justice ("DOJ") released a joint statement urging for repeal of CON laws still in effect across the country.[64] The entities expressed concern over the barriers that CON laws present to healthy hospital competition.[65] To prove its point, the FTC filed a complaint and instituted a federal suit to block the proposed $350 million dollar acquisition of two Memphis-area hospitals, known collectively as Saint Francis, by another Memphis-based hospital, Methodist Le Bonheur Healthcare.[66] The FTC argued that the proposed acquisition "would substantially lessen competition in the Memphis area for a broad range of inpatient medical and surgical diagnostic and treatment services that require an overnight hospital stay, known as inpatient general acute care services, sold to commercial insurers and their insured members."[67]

In addition, the complaint alleged that acquisition would cause healthcare costs to rise and diminish the incentive to invest in access, quality, and services.[68] The complaint alleged that Methodist and Saint Francis are direct competitors for inclusion in insurers' networks and in attracting patients through physician recruiting, improved quality, and increased access.[69] The Deputy Director of the FTC's Bureau of Competition, Daniel

---

62. *Id.*

63. *Alabama Certificate of Need Overview*, RSCH. AND PLAN. CONSULTANTS LP (last updated Jan. 2019), https://www.rpcconsulting.com/certificate-of-need/alabama/#:~:text=Certificate%20of%20Need%20Application%20Filing,CON%20filing%20fee%20is%20%2422%2C828 **[**https://perma.cc/TK89-M4K9]; EMILY MARSAL, STATE HEALTH PLAN. AND DEV. AGENCY, MEMORANDUM (2020), http://shpda.alabama.gov/documents/conforms/confee/FY%202021%20Thresholds.pdf [https://perma.cc/MD5V-J25C].

64. *See* CHRISTINE S. WILSON & NOAH JOSHUA PHILLIPS, FED. TRADE COMM'N, FILE NO. 191-0189, IN THE MATTER OF METHODIST HOSPITAL/TENET ST. FRANCIS HOSPITAL (2020), https://www.ftc.gov/system/files/documents/public_statements/1583210/d-9396_methodist_and_tenet_-_cw_and_np_statement.pdf [https://perma.cc/2DFE-WJ72].

65. *Id.*

66. *In the Matter of Methodist Le Bonheur Healthcare*, FED. TRADE COMM'N (Dec. 29, 2020), https://www.ftc.gov/enforcement/cases-proceedings/191-0189/methodist-le-bonheur-healthcare-matter [https://perma.cc/KQ83-WC6U] [hereinafter Methodist Le Bonheur Healthcare].

67. *Id.*

68. *Id.*

69. *FTC Sues to Block Proposed Acquisition of Two Memphis-Area Hospitals*, FED. TRADE COMM'N (Nov. 13, 2020), https://www.ftc.gov/news-events/press-releases/2020/11/ftc

Francis, stated in a press release that the Memphis area has benefitted from the competitive pressure that Saint Francis brings because it offers lower rates and more options for patients than Methodist.[70] After the FTC filed its administrative complaint, the parties announced that the proposed acquisition would be abandoned.[71]

The FTC released a subsequent statement, again joined by the DOJ. In the statement, the FTC expressed great concern over the barriers that CON laws create for free market competition.[72] For the past few decades, the FTC strongly opposed CON laws because they stifle healthcare providers from responding quickly to meet increased market demand.[73] Furthermore, the FTC grounds its position on research showing that states with CON laws have fewer hospitals, charge higher prices, offer lower quality service, and have higher mortality rates.[74]

In addition, the FTC points to "fresh illustrations" of the shortcomings of CON laws from the COVID-19 pandemic.[75] Particularly, the FTC mentions the threat CON laws posed to the shortage of hospital beds.[76] The FTC encourages policymakers and scholars to pay attention to the ways individual states responded to this issue.[77] Tennessee, for example, temporarily waived the need for healthcare entities to obtain a CON to expand the number of hospital beds during the pandemic.[78] By urging policymakers to study the positive effects that reducing regulatory barriers have on access to care, the FTC hopes that states will prevent the use of CONs as an anticompetitive tool.[79]

This is not the first time that the FTC voiced its opinion on CON laws. In 2017, the FTC and the Antitrust Division of the DOJ (the "Agencies") released a joint statement in support of Alaska's Senate proposal to repeal Alaska's CON laws.[80] The Agencies cite four primary reasons why CON laws have proven time and time again that they actually cause

-sues-block-proposed-acquisition-two-memphis-area-hospitals [https://perma.cc/U6QS-A54E].

70. *Id.*
71. Methodist Le Bonheur Healthcare, *supra* note 66.
72. *See* Wilson & Phillips, *supra* note 64.
73. *Id.*
74. *Id.*
75. *Id.*
76. *Id.*
77. *Id.*
78. *Id.*
79. *Id.*
80. DEPT. OF JUST. & FED. TRADE COMM'N, JOINT STATEMENT OF THE ANTITRUST DIVISION OF THE U.S. DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION ON CERTIFICATE-OF-NEED LAWS AND ALASKA SENATE BILL 62 (April 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006_ftc-doj_comment_on_alaska_senate_bill_re_state_con_law.pdf [https://perma.cc/3RFV-WG7M] [hereinafter Joint Statement on Alaska Senate Bill 62].

inefficiency in the healthcare market and undermine their original goals.[81] First, the barriers created by CON laws lead to limited entry and expansion, stifle consumer choice, and prevent innovation.[82] Second, existing healthcare facilities can use CON laws to prevent or delay entry of competitors into the market.[83] Third, consumers are denied an effective remedy after an anticompetitive merger.[84] Fourth, substantial evidence shows that CON laws fail to fulfill their purported goals of controlling costs and improving quality.[85]

The Agencies place competition at the heart of America's economy.[86] Competition in the marketplace generally provides consumers with lower prices, higher quality, and better access to services and innovation.[87] The FTC and DOJ promote competition through antitrust laws, which are designed to prevent conduct that interferes or harms competition and consumers in the marketplace.[88] Enforcing antitrust laws to ensure healthcare competition is a top priority for these Agencies, who devote a significant amount of resources to educating the healthcare industry about these laws.[89] In the past several decades, the Agencies have examined the competitive impact of CON laws through hearings, independent research, and workshops.[90] Through extensive review of CON laws, the Agencies concluded that proposals such as Alaska's decision to repeal CON laws altogether are the best course of action to maintain competition in the healthcare space.[91]

In addition, CON laws can stifle antitrust remedies.[92] After recent litigation in *FTC v. Phoebe Putney*, it was evident that CON laws can limit the government's ability to offer structural remedies when anticompetitive mergers are established.[93] Specifically, *Phoebe Putney* involved a two-hospital merger in Albany, Georgia.[94] The FTC sought a preliminary injunction claiming that the merger would create a monopoly over inpatient hospital services sold to commercial health plans in Albany.[95] The United States Supreme Court held that "state action immunity" did not apply and that Georgia's CON laws failed to offer relief for the anticompetitive

81. *Id.* at 2.
82. *Id.* at 1.
83. *Id.*
84. *Id.*
85. *Id.* at 2.
86. *Id.*
87. *Id.*
88. *Id.*
89. *Id.*
90. *Id.* at 3.
91. *Id.* at 15.
92. *Id.* at 7.
93. F.T.C. v. Phoebe Putney Health System Inc., 568 U.S. 216 (2013).
94. *Id.*
95. *Id.*

merger.[96] This case is yet another example of how state CON laws act as a barrier to entry to healthcare facilities, which quashes competition and hurts healthcare consumers.[97]

The FTC's assertions have been met with resistance.[98] After the FTC and DOJ published its widely read 2004 analysis on the state of healthcare, the American Health Planning Association ("AHPA") argued against the call to repeal CON laws.[99] Specifically, the AHPA attacked the report's sourcing and analytical processes.[100] Further, the AHPA claims that the FTC treats healthcare as a privilege instead of a right to the consumer.[101] Yet, because the AHPA's objection fails to point to specific issues in the report, it is largely unhelpful in understanding their position.[102]

Overall, the Agencies recognize and advocate for states to consider a variety of policy objectives when dealing with health care legislation.[103] However, the bottom line is that CON laws do not benefit healthcare consumers as intended and create serious antitrust concerns. Thus, these Agencies continue to advocate for states like Alaska to repeal their CON laws.[104]

D. The COVID-19 Pandemic Exposed the Shortcomings of CON Laws

The COVID-19 pandemic exposed the arcane, bureaucratic system that surrounds CON laws in the United States.[105] The threat of a global pandemic should not have to be the catalyst for lawmakers to realize that CON laws only "serve to prop up hospitals' bottom lines artificially at the expense of public well-being and preparedness."[106] China's ability to construct a one-thousand bed hospital in ten days to isolate their COVID-19 patients stands in stark contrast to the United States' ability to respond urgently as a result of a complicated, unnecessary "web of federal, state, and local regulations."[107]

---

96. *Id.*

97. *Id.*

98. *See Improving Health Care: A Dose of Competition—AHPA Response*, AM. HEALTH PLAN. ASS'N (last visited Jan. 16, 2022, 2:56 PM), http://www.ahpanet.org/AHPAargagainst FTC.pdf [https://perma.cc/JE6Y-GEBA].

99. *See id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. Joint Statement on Alaska Senate Bill 62, *supra* note 80. .

104. *Id.*

105. Lindsay Killen & Naomi Lopez, *How lawmakers can proactively protect communities from pandemic threats*, WASH. EXAM'R (March 11, 2020, 12:00 AM), https://www.washingtonexaminer.com/opinion/op-eds/how-lawmakers-can-proactively-protect-communities-from-pandemic-threats [https://perma.cc/3AD5-BF9Q].

106. *Id.*

107. *Id.*; Singer, *supra* note 12.

On the average day in the United States, there are approximately 600,000 hospital beds are filled out of the roughly 900,000 total beds, which leaves only the remaining one-third of beds available for extraordinary seasons of illness.[108] According to a COVID-19 analysis, if a mere 1% of the 330 million people in the United States contracted COVID-19 simultaneously, there would not be enough hospital beds to accommodate the volume of patients.[109] This should alarm citizens, healthcare workers, and policymakers alike.

In response to the shortage of hospital beds, the United States seemingly took two approaches to curb the impact on the nation's healthcare resources.[110] First, the most popular approach was to "flatten the curve."[111] This approach sought to reduce COVID-19's overwhelming impact on the nation's healthcare resources by reducing the number of people infected at one time.[112] The second, less popular approach focused on increasing the nation's ability to handle the rising number of cases.[113] Since CON laws contribute to the limitation on hospital beds, one solution was to suspend or eliminate them completely.[114]

The focus here is on the second approach. This Note focuses attention on the second approach. As the pandemic spread, policymakers recognized the underlying issues created by CON laws.[115] States with CON laws had a higher projected bed shortage than states without CON laws.[116] Specifically, CON states were estimated to have a shortage of 8,000 ICU beds (equating to 9 beds per 10,000 residents).[117] Whereas, states without CON laws saw a shortage of 114 ICU beds (equating to 1 bed per 10,000 residents).[118] With this data surfacing, policymakers eagerly stripped away regulatory barriers to create more hospital beds for sick patients.[119]

108. Killen & Lopez, *supra* note 105.

109. *Id.*; Robert Cyran, *Breakingviews – Breakdown: Coronavirus goes global*, REUTERS (Feb. 27, 2020, 6:03 PM), https://www.reuters.com/article/us-china-health-breakingviews/breakingviews-breakdown-coronavirus-goes-global-idUSKCN20L3DR [https://perma.cc/PD2R-UXRM].

110. *See* Matthew Mitchell et al., *Raising the Bar: ICU Beds and Certificates of Need*, MERCATUS CTR. AT GEO. MASON UNIV. (Apr. 29, 2020), https://www.mercatus.org/system/files/mitchell_stratmann_and_bailey_-_policy_brief_-_covid_series_-_raising_the_bar_icu_beds_and_certificates_of_need_-_v1.pdf [https://perma.cc/U9AC-AFP7].

111. *See id.*

112. *Id.*

113. *Id.*

114. *Id.*

115. Mitchell, *supra* note 12.

116. *Id.*; Mitchell et al., *supra* note 110.

117. Mitchell et al., *supra* note 110.

118. *Id.*

119. Mitchell, *supra* note 12.

The COVID-19 pandemic forced twenty-four CON states to temporarily suspend their CON laws or take other emergency action.[120] For example, states like New York, Tennessee, and South Carolina all suspended CON laws for projects considered necessary to respond to COVID-19.[121] Other states such as New Jersey, Oklahoma, and Iowa suspended restrictions on the number of hospital beds in their respective states.[122] On the other hand, states like Maryland, Michigan, and Kentucky took a different approach by issuing emergency CONs to stimulate the amount of hospital beds.[123] The purpose of these emergency authorizations was to increase the number of hospital beds and to alleviate the intense strain on the medical system.[124] However, the existence of CON laws in the first place had already caused extensive damage because hospital capacity cannot be increased overnight to meet the significant demand.[125]

One study from George Mason University's Mercatus Center investigated the temporary policy changes that states with CON laws made to see if suspending the regulations affected ICU bed shortages.[126] Unfortunately, these temporary policy changes had no statistically significant effect on the ICU bed shortage crisis, suggesting that it could take months or years even for CON states to build sufficient hospital capacity.[127]

Legislators have the authority and the duty to prioritize patient safety and health by ensuring healthcare facilities can meet the demand of a large influx of patients.[128] Therefore, state lawmakers should not wait until there is an imminent threat of a public health emergency to develop an action plan.[129] As the United States emerges from COVID-19, many states are considering whether CON laws should be repealed or eliminated because they obstruct preparedness in situations like a public health crisis.[130]

E. The Current State of CON Laws

Based on significant evidence that CON laws fail to control cost, improve quality, or increase access, the Federal Trade Commission and the Antitrust Division of the Justice Department have repeatedly urged states to

120. 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/AS3F-N6cv].

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

126. Mitchell et al., *supra* note 110.

127. *Id.*

128. *See* Killen & Lopez, *supra* note 105.

129. *Id.*

130. *See* Singer, *supra* note 12; Mitchell, supra note 12.

repeal or, at a minimum, heavily pull-back on their CON programs.[131] Since Congress's repeal of the National Health Planning and Resources Development Act in 1986, fifteen states have eliminated their CON laws completely.[132] The remaining states maintain CON programs to regulate specific types of healthcare facilities (e.g. regulating the number of nursing homes), to exempt certain facilities (e.g. Tennessee exempted mental healthcare facilities), or to maintain control over facilities that exceed a certain size.[133]

The shortcomings of CON laws received heightened scrutiny during the COVID-19 pandemic.[134] With hospitals reaching capacity, state policymakers began reevaluating whether CON laws that were meant to restrict growth of healthcare services and facilities are actually putting an excess strain on medical systems.[135] As the pandemic raged on, policymakers noticed that states with CON laws were suddenly eager to remove their barriers to entry for healthcare providers.[136] States with CON laws also saw greater projected shortages of hospital beds than states without CON laws. In an unprecedented movement, twenty-four states relaxed CON requirements or issued emergency exceptions to the CON approval process.[137]

These factors led policymakers in many states—at least eighteen states in the past year—to consider reforming or repealing their CON laws.[138] For example, Tennessee received notoriety for its recent overhaul of its CON laws, which made significant improvements in the mental healthcare space.[139] The growing momentum in conversations surrounding CON laws does not appear to be stopping anytime soon and will likely dominate many health law conversations for years to come.[140]

F. Notable Reformation: Big Changes to Tennessee's CON Program

By way of example, this Note will examine Tennessee's recent changes to CON laws spurred by the COVID-19 pandemic. Several years of contentious debate regarding Tennessee's CON laws led to an impasse at the end of the 2020 legislative session.[141] However, on May 5, 2021, the 112th

131. U.S. DEP'T OF HEALTH AND HUM. SERVS., U.S. DEP'T OF THE TREASURY, & U.S. DEP'T OF LAB., REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 50, 59 (Dec. 3, 2018), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf#page=64 [https://perma.cc/XL8G-UEDJ] [hereinafter Reforming America's Healthcare System].

132. *Id.*

133. *Id.* at 51.

134. Mitchell, *supra* note 12.

135. Erickson, *supra* note 120.

136. Mitchell, *supra* note 12.

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. Tennessee General Assembly Passes CON Reform Bill, *supra* note 40.

Tennessee General Assembly unveiled significant changes to Tennessee's CON requirements.[142] The legislation, Public Chapter No. 557, HBO948/SB1281, was signed into law on May 26, 2021, and went into effect on October 1, 2021.[143] This law adds to the substantial modifications made to the CON program in 2016.[144] Under the new law, the Tennessee Health Services and Development Agency's executive director must develop a plan to consolidate the licensing and CON approval functions, currently conducted by two separate agencies, into a new Health Facilities Commission.[145] This accomplishes the legislature's goal of having an agency that oversees the operation of healthcare facilities from their origin through their operation.[146] In addition, healthcare providers can expect the updated requirements to target the following goals: (1) improve access to healthcare services in rural and indigent communities; (2) increase mental health and substance abuse treatment options; and (3) remedy systematic healthcare delivery issues amplified during the COVID-19 pandemic.[147]

Tennessee's new CON law repealed requirements in many areas. Notably, the new law no longer classifies mental health hospitals as "healthcare institutions" that fall under CON regulation.[148] Although certificates will be required for establishing a non-residential treatment center for opiate addiction, the new law allows psychiatric services to be initiated on a licensed hospital campus without first obtaining CON approval.[149] This change will be instrumental in increasing the availability of mental health services to vulnerable populations.[150]

Furthermore, the new law aims to improve care in rural counties by eliminating CON obstacles to build a hospital in counties that are classified as economically distressed and that lack a licensed hospital.[151] In a July 2020 report, the Tennessee Department of Economic & Community Development listed eleven counties in Tennessee that would qualify as economically distressed.[152] The new law also allows previously licensed, general acute care hospitals to reopen in counties that fall within a certain tier or that are located

142. *Id.*

143. Tennessee General Assembly Passes CON Reform Bill, *supra* note 40; Michael Brent et al., *Tennessee Makes Major Changes to CON Law*, NAT'L L. REV., (June 21, 2021), https://www.natlawreview.com/article/tennessee-makes-major-changes-to-con-law [https://perma.cc/353B-NB7Q].

144. Tennessee General Assembly Passes CON Reform Bill, *supra* note 40.

145. Brent et al., *supra* note 143.

146. *Id.*

147. Tennessee General Assembly Passes CON Reform Bill, *supra* note 40.

148. *Id.*

149. *Id.*; H.R. 948, 112th Leg., Reg. Sess. (Tenn. 2021).

150. Brent et al., *supra* note 143.

151. H.R. 948; Tennessee General Assembly Passes CON Reform Bill, *supra* note 40.

152. TENN. DEP'T OF ECON. & CMTY. DEV., DISTRESSED COUNTIES MAP, (July 1, 2020), https://tnecd.com/wp-content/uploads/2019/07/DistressedCountiesMap_FY21.pdf [https://perma.cc/G26S-XRRU] [hereinafter Distressed Counties Map]; Tennessee General Assembly Passes CON Reform Bill, *supra* note 40.

in counties with less than 49,000 people.[153] The Tennessee Department of Health may renew a hospital's license as long as the hospital will operate in a substantially similar manner as it previously did, and the hospital is obligated to apply for CON certificate within twelve months of seeking licensure renewal.[154] While the impact of these reforms remains to be seen, the legislature hopes the revised CON law will facilitate improved access to mental and rural healthcare by removing regulatory barriers.[155]

II. THE CASE TO PUT CON LAWS TO REST

States originally believed CON laws would provide an effective mechanism to both control healthcare costs and improve services to indigent and rural populations.[156] However, CON laws routinely fail to lower healthcare costs, improve quality, or increase access in rural communities.[157] Congress acknowledged these failures by repealing the National Health Planning and Resources Development Act in 1987.[158] As a result, a handful of states followed suit and repealed their CON laws enacted after the 1974 federal mandate.[159] Shockingly, over forty years have passed and roughly thirty-five states still cling to their version of CON laws—despite their negative effects.[160] More recently, the COVID-19 pandemic further illuminated the issues with access to hospital beds in CON states.[161]

Now, state policymakers should be motivated to dismantle the dysfunctional CON law system.[162] States can do better to improve mental healthcare, increase access in rural communities, encourage transparency surrounding indigent care funding, and eliminate the political interests entangled in CON laws.[163] Therefore, states should fully repeal their CON laws and instead make indigent healthcare funding information publicly available.

A. The Pros Do Not Outweigh the CONs

Although CON programs are supposed to prevent high healthcare costs, evidence suggests that CON programs actually create an anti-competitive market by restricting the number of entrants.[164] In turn, the lack

153. Tennessee General Assembly Passes CON Reform Bill, *supra* note 40; Distressed Counties Map, *supra* note 152.

154. Tennessee General Assembly Passes CON Reform Bill, *supra* note 40.

155. *See id.*

156. Ohlhausen, *supra* note 10, at 50–53 (discussing states' views of CON laws).

157. *Id.* at 51–53; *see also* Mitchell, *supra* note 12.

158. Ohlhausen, *supra* note 10, at 51–53 (discussing CON failures).

159. *Id.* at 51, 52.

160. *Id.* at 52.

161. *See* Mitchell et al., *supra* note 110.

162. Ohlhausen, *supra* note 10, at 52–53 (discussing lawmaking possibilities).

163. *Id.*; *see also* Mitchell, *supra* note 12.

164. A Dose of Competition, *supra* note 17.

of competition drives prices up and limits patient choice.[165] CON laws create costly barriers to entry for healthcare providers and entities, instead of controlling costs, improving quality, or increasing access.[166]

To justify CON programs, proponents contended that "competition in health care is . . . very different" in comparison to other markets.[167] In that, healthcare is not a "typical" economic product because patients do not shop around for healthcare services in the same way they shop for other goods or services.[168] Most healthcare services are recommended and prescribed by physicians, not patients.[169] However, opponents recognize that CON laws go against basic economic theory by creating an artificial shortage of facilities; while the expectation was that prices would stabilize or decline, the reduction in competition between facilities actually kept prices higher than normal.[170]

As aforementioned, states enacted CON laws within the context of a "cost-plus" reimbursement system. Since the 1970s though, the payor system has dramatically changed in the United States.[171] The federal government created universal reimbursement rates for Medicare and Medicaid patients, and private insurers negotiate the prices with providers.[172] With the current payor system, providers no longer have an incentive to invest in frivolous capital improvements. Therefore, the problem that CON laws set out to solve no longer exists with the same prevalence.[173]

1. Failure to Control Costs

Generally, marketplace competition is healthy because it keeps prices fair for consumers, incentivizes quality service, and encourages innovation.[174] Because CON laws inherently create a significant barrier to entry, competition is stifled and prices remain uncontrolled. In a 2016 study, researchers found that CON laws actually raise healthcare spending by 3.1% to 5.0% based on data from the National Health Expenditure Accounts.[175] Researchers concluded that while the demand for healthcare stays consistent, the supply of healthcare facilities remains restricted by CON programs.[176] This matches basic economic theory—when supply decreases and demand

165. *Id.* at 2, 4.
166. Reforming America's Healthcare System, *supra* note 131, at 54.
167. A Dose of Competition, *supra* note 17.
168. Reforming America's Healthcare System, *supra* note 131, at 54.
169. *Id.* at 10.
170. Ohlhausen, *supra* note 10, at 51. (discussing market theory and healthcare)
171. *Id.*
172. *Id.*
173. *Id.*
174. *Id.* at 51, 53.
175. James Bailey, *Can Health Spending Be Reined in through Supply Constraints? An Evaluation of Certificate-of-Need Laws*, MERCATUS CTR. AT GEO. MASON UNIV. (Aug. 1, 2016), https://www.mercatus.org/publications/certificate-need/can-health-spending-be-reined-through-supply-constraints-evaluation [https://perma.cc/8VKQ-PE4N].
176. *Id.*

remains steady, prices will subsequently increase.[177] Additionally, researchers found that states who repealed their CON programs saw a 0.8% decrease in spending each year, which plateaued at a 4.0% reduction after five years since repealing.[178] Overall, the study showed that policymakers seeking to curb the increase in healthcare spending should consider repealing all CON laws, instead of continuing the expensive and time-intensive process of CON approval.[179]

2. Failure to Improve Quality of Healthcare

Contrary to the claims of proponents, the Department of Health and Human Services found no evidence suggesting that CON programs improve quality of care.[180] Generally, proponents of CON programs argue that the quality of care at a healthcare facility is based on "volume-outcome relationships" rather than how CON laws directly impact the quality of patient care.[181] Volume-outcome relationships are "the extent to which quality of care is related to how often a particular healthcare institution or provider performs a given procedure."[182] Studies yield mixed results about volume/outcome evidence. Better quality outcomes have been linked to more complex surgeries, but evidence suggests that the volume effects may not overcome the larger negative impact that CON laws have on quality for more routine surgeries and procedures.[183] Instead, the most useful studies directly analyze the impact of CON laws on quality metrics. The bulk of this research suggests that repealing or reducing CON laws is not likely to lower the quality of care but may actually improve it.[184]

In another 2016 study, researchers developed an empirical framework to evaluate whether states with CON programs offer higher quality care to patients.[185] Across nine quality indicators, the results suggested that states with CON programs provided average or below quality care in comparison to states without CON programs.[186] For example, thirty-day mortality rates for patients with pneumonia, heart failure, or heart attacks in CON states were between 2.5% to 5% higher than the average mortality rates in hospitals in non-CON states.[187]

177. *Id.*
178. *Id.*
179. *Id.*
180. Reforming America's Healthcare System, *supra* note 131, at 54.
181. *Id.*
182. *Id.*
183. *Id.*
184. *See id.*
185. Thomas Stratmann & David Willie, *Certificate-of-Need Laws and Hospital Quality*, MERCATUS CTR. AT GEO. MASON UNIV. 46 (Sept. 2016), https://www.mercatus.org/system/files/mercatus-stratmann-wille-con-hospital-quality-v1.pdf [https://perma.cc/W243-LNHP].
186. *Id.*
187. *See id.* at 46–47.

3. The Impact of Political Pressures

"CON laws insulate politically powerful incumbents from market forces, and those providers naturally are loathe to give up the special government preferences that CON laws bestow."[188] Healthcare providers that successfully obtain CON approval for a new facility or equipment have the upper hand to control of the healthcare market in their area. The power to control pushes healthcare providers to try to manipulate the CON approval process.[189] In some states, healthcare providers may be able to influence the approval process by supporting political and governmental figures that can sway the decision of CON regulators.[190] Political campaign donations are one way that healthcare providers manipulate the approval process. Notably, these are major expenses to CON programs that have not been factored into research on the actual costs of CON laws.[191]

As an example, Keiferbaum Design and Build made a deal with a member of the Illinois Planning Board to share profits from a hospital building contract if the member secured CON approval. Although the contract was slated for rejection, it was approved by the Board after Keiferbaum's use of political influence.[192] Another example of abuse in the CON approval process occurred when Richard Scrushy, CEO of HealthSouth Corporation, bribed Alabama's governor with $500,000 for a seat on the Certificate of Need Review Board.[193] Scrushy then used his power to make decisions that benefitted HealthSouth.[194] It is clear that CON laws invite the possibility of harmful political entanglement.

B. CON Laws Fail to Increase Access to Rural and Indigent Healthcare

Rural communities face greater obstacles to accessing healthcare than urban areas.[195] Longer travel distances and provider shortages contribute to the challenges rural citizens face.[196] While proponents of CON laws contend that state regulation of healthcare entities in rural areas will provide

188. *See* Flatten, *supra* note 1, at 4 (*quoting* Maureen Ohlhausen, FTC Commissioner).

189. Thomas Stratmann, *The Effect of Interest Group Pressure on Favorable Regulatory Decisions*, MERCATUS CTR. AT GEO. MASON UNIV. (Aug. 29, 2017), https://www.mercatus.org/publications/corporate-welfare/effect-interest-group-pressure-favorable-regulatory-decisions [https://perma.cc/JGV6-XU3X].

190. *Id.*

191. *Id.*

192. *Id.*

193. BARRY R. FURROW ET AL., HEALTH LAW 832 (8th ed. 2018).

194. *Id.*

195. Stratmann, *supra* note 189.

196. *Id.*

indigent people with greater access to healthcare services, the evidence refutes this argument.[197]

To understand if CON laws are well-suited to promote better healthcare for rural communities, an overview of market forces is helpful.[198] Antitrust laws try to prevent harm in competitive marketplaces.[199] Two companies conducting the same business in the same market can have two very different positions based on their relative market shares.[200] To translate, CON laws impact rural and indigent healthcare differently based on the specific market and the providers available in the respective area.[201]

In markets where the population has been steady or declining over time, CON laws do not benefit providers much because the likelihood of new participants entering the market is low.[202] For example, Detroit has seen a significant population decrease since the 1960s, so providers in that area are less likely to reap substantial benefits from CON laws.[203] However, markets with strong population growth and healthcare demand are likely seeing higher barriers to entry.[204] The illusion of an artificial scarcity provides significant benefits to providers who can charge higher prices for healthcare services.[205] CON laws essentially circumvent natural market forces and protect existing providers.[206]

When CON laws first surfaced, one of the primary justifications was controlling price increases by reducing the potential for duplicative services.[207] In practice, this translated to blocking healthcare providers from offering innovative services to rural communities.[208] A CON must be obtained in order for facilities to increase bed capacity to provide the innovative services. Therefore, it is harder for rural communities to access care because they are required to drive farther distances, wait longer for appointment times, and spend more for care.[209]

In addition, "rural residents in CON states have higher levels of . . . Medicare spending per beneficiary, hospital readmission rates, ambulance

197. Ohlhausen, *supra* note 10, at 53 (discussing evidence refuting the proponents of CON laws).

198. *Id.* at 52.

199. *Id.*

200. *Id.*

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.*

205. Ohlhausen, *supra* note 10, at 52.

206. *Id.*

207. Thomas Stratmann & Matthew C. Baker, *Examining Certificate-of-Need Laws in the Context of the Rural Health Crisis*, MERCATUS CTR. AT GEO. MASON UNIV. (July 29, 2020), https://www.mercatus.org/publications/healthcare/examining-certificate-need-laws-context-rural-health-crisis [https://perma.cc/BCB3-DMTT].

208. *Id.*

209. *Id.*

utilization, and emergency room utiliziation."[210] This 2020 Mercatus Center Study encouraged policymakers to reconsider the value that CON laws bring to their state's healthcare goals.[211] The current outcomes of CON laws are the complete opposite of the original goals the laws were enacted to address over forty years ago.[212] In fact, repealing CON laws may increase the number of hospitals in rural states because there are currently 13% fewer hospitals per capita between rural states with CON laws versus rural states without CON laws.[213]

Furthermore, a 2014 Mercatus Center Study investigating CON laws and indigent care found no evidence that CON laws improve access to indigent care.[214] Instead, this study concludes that healthcare costs are likely higher in states with CON laws, while the rural and indigent population fails to have better access to care.[215] Specifically, there is little evidence that Medicaid patients actually receive the CON law cross-subsidy.[216] Therefore, Medicaid patients end up with higher healthcare costs and lower reimbursement rates.[217]

CON programs have been promoted on the premise that less competition will allow healthcare providers to increase profits by charging higher prices for services.[218] Then, the extra profits generated would cross-subsidize healthcare for the indigent and medically underserved populations.[219] This position has recognized weaknesses. First, the idea that the extra profit would subsidize indigent care is counterintuitive to the apparent purpose of CON laws to control costs in communities.[220] Second, CON laws create a costly barrier to entry that stifles innovation and expansion, while also preventing access to quality healthcare.[221] Third, research does not show that hospitals are more financially stable in CON states over non-CON states.[222] Instead, there is evidence that shows that healthcare providers in CON states do not honor the cross-subsidization process of charity care—which completely undermines the purported goal of increasing indigent care access.[223]

---

210. *Id.*
211. *Id.*
212. *Id.*
213. *Id.*
214. Thomas Stratmann, *Do Certificate-of-Need Laws Improve Indigent Care?*, MERCATUS CTR. AT GEO. MASON UNIV. (July 15, 2014), https://www.mercatus.org/publications/corporate-welfare/do-certificate-need-laws-increase-indigent-care [https://perma.cc/2TEB-YSX3].
215. *Id.*
216. *Id.*
217. *Id.*
218. Reforming America's Healthcare System, *supra* note 131.
219. *Id.*
220. *Id.*
221. *Id.*
222. *Id.*
223. *Id.*

Although most CON laws promote indigent and rural healthcare as a pillar of the program, no one truly knows which providers are reaping the benefits monetarily and how those funds get funneled back to providing indigent care.[224] The lack of transparency leaves the public in the dark about the allocation of resources to indigent care through CON laws.[225] Therefore, the idea that CON laws increase healthcare access for indigent and rural communities works as a convenient shield to transparency.[226]

C. CON Laws Fail to Improve Mental Healthcare Access

Mental healthcare is just one facet—albeit an important one—of the healthcare resources that is severely lacking in indigent and rural communities. According to a 2019 National Survey on Drug Use and Health, approximately 7.3 million non-metropolitan (i.e. rural) adults reported having a mental illness, and nearly 1.6 million of those non-metropolitan adults reported experiencing suicidal thoughts during the previous year.[227] Despite the similarity in prevalence of mental health issues between metropolitan and non-metropolitan adults, there is a stark contrast in access to mental health resources.[228] Providing mental healthcare in rural areas presents unique challenges with access, availability, and acceptability.[229] Access to mental health services is difficult for rural residents who have to make long treks to care facilities.[230] In addition, there is a chronic shortage of mental health providers in rural areas. Because of this provider shortage, there tends to be a stigma surrounding the need for mental healthcare, and patients have less choices on where to receive care.[231]

CON laws contribute to the shortage of mental health services in rural communities by controlling which providers enter the market. As an illustration, imagine that Smallville is a rural city with several surrounding towns. In Smallville, there are two outpatient mental health facilities: Facility A and Facility B. Recognizing the need for greater access to intensive mental healthcare in its community, Facility A decides to add an in-patient care unit. Now, the greater Smallville area can access more essential mental health services at Facility A. Unfortunately for Facility B, natural market forces have driven patients from Facility B to Facility A because of their expanded services. To compete, Facility B opens an in-patient wing at its mental health facility. To the detriment of both facilities, the number of in-patient beds now

224. Ohlhausen, *supra* note 10, at 53.
225. *Id.*
226. *Id.*
227. *Rural Mental Health*, RURAL HEALTH INFORMATION HUB (last updated Oct. 20, 2021), https://www.ruralhealthinfo.org/topics/mental-health [https://perma.cc/VEQ7-4YCL].
228. *Id.*
229. *Id.*
230. *Id.*
231. *Id.*

exceeds the demand. Both facilities will lose money on empty beds and could ultimately be forced to close.

Repealing CON laws would be one way to increase the mental health services offered in rural communities.[232] Even a partial repeal of CON requirements on mental health facilities would facilitate some needed change.[233] For example, Tennessee lifted the CON requirements on mental health facilities and opioid addiction centers in recent 2021 legislation.[234] As a result, mental health services and psychiatric services should become more accessible.

III. PROPOSED SOLUTION

CON laws should be repealed in every state where they remain in effect, and states should instead implement transparent funding and programs to improve indigent and mental healthcare services in rural areas.

A. State Legislatures Should Repeal Existing CON laws

Thirty-five states and the District of Columbia currently maintain some form of CON laws.[235] Since the federal government repealed the National Health Planning and Resources and Development Act in 1987, twelve states fully repealed their CON laws.[236] Three other states do not maintain a formal CON program but have approval processes that operate like CON laws.[237]

Over the years, the FTC has issued numerous reports advocating for the repeal of CON laws.[238] These reports have primarily been state focused, such as a 2019 letter urging Alaska to repeal its CON laws.[239] In 2004, a joint report from the FTC and DOJ urged states to decrease barriers to entry to

232. Matthew D. Mitchell & Elise Amez-Droz, *Phasing Out Certificate-of-Need Laws: A Menu of Options*, MERCATUS CTR. AT GEO. MASON UNIV. (Feb. 25, 2020), https://www.mercatus.org/publications/healthcare/phasing-out-certificate-need-laws-menu-options#fullrepeal [https://perma.cc/4K34-CGHK].

233. *Id.*

234. Brent et al., *supra* note 143.

235. Certificate of Need (CON) State Laws, *supra* note 4.

236. *Id.*

237. *Id.*

238. *Certificate of Need (CON) State Laws*, *supra* note 4; FED. TRADE COMM'N, COMPETITION IN THE HEALTHCARE MARKETPLACE (last visited Jan. 16, 2022), https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care [https://perma.cc/8JPE-M4P5].

239. Daniel Gilman & David Schmidt, *Statement of the Federal Trade Commission to the Alaska Senate Committee on Health & Social Services on Certificate of Need Laws and SB 1*, FED. TRADE COMM'N (March 27, 2019), https://www.ftc.gov/system/files/documents/advocacy_documents/statement-federal-trade-commission-alaska-senate-committee-health-social-services-certificate-need/v0800007_commission_testimoney_re_alaska_senate_committee_032719.pdf [https://perma.cc/JRB8-WMWL]; Ohlhausen, *supra* note 10.

allow more providers to enter the healthcare market.[240] This recommendation stemmed from serious concerns about CON laws fostering anti-competitive practices.[241] The FTC recognizes the numerous policy concerns that states must evaluate when creating healthcare legislation.[242] The FTC recognizes that states face policy challenges when crafting healthcare reforms. Despite those political hurdles, CON laws' negative effects on competition and benefits are substantial.[243] States should evaluate if their citizens are best served by CON laws and seriously consider repealing them.[244] If policymakers fail to act in the best interests of their citizens, courts may need to step in to protect the general welfare of the public.

The benefits of removing regulatory barriers include expanding access to care and decreasing risks of anti-competitive practices.[245] The 2004 joint report from the FTC and DOJ recommended two actions for states to take in lieu of CON laws.[246] First, "states should consider adopting the recommendation of the Institute of Medicine to broaden the membership of state licensure boards."[247] State licensing boards are composed primarily of licensed providers—although some states require a broader representation of healthcare professionals.[248] When state licensing boards exclude allied healthcare professionals from direct access to patients, this creates a strain on competitive practices.[249] If state licensure boards maintained a broader membership, including professionals from healthcare administration, economics, education, and research, there is a stronger likelihood that competitive practices would be protected.[250] In addition, a broad array of healthcare professionals would be less likely to unreasonably increase prices or limit access to healthcare through practices like CON laws.[251]

Second, "states should consider implementing uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish to move in-state."[252] Services like telemedicine can increase access, lower healthcare costs, and improve quality.[253] In order to create the competitive environment that telemedicine fosters, states should consider uniform licensure regulations or reciprocity compacts.[254] Both of these methods would protect consumers and

240. A Dose of Competition, *supra* note 17.
241. *Id.*
242. Gilman & Schmidt, *supra* note 239.
243. *Id.*
244. *Id.*
245. A Dose of Competition, *supra* note 17.
246. *Id.*
247. *Id.*
248. *Id.*
249. *Id.*
250. *Id.*
251. *Id.*
252. *Id.*
253. *Id.*
254. *Id.*

reduce barriers to telemedicine, and as a result could greatly improve indigent care and mental healthcare in rural areas.[255] These considerations would also apply to out-of-state providers who want to move their practice to another state.[256]

B. States Should Provide Rural Communities With Indigent and Mental Health Services

In addition to repealing their CON laws, states should create an indigent care fund that is managed transparently.[257] When originally enacted, one of the primary goals of CON laws was to increase care for indigent and disadvantaged populations.[258] Because CON laws allow providers to charge insurance companies more, it creates a cross-subsidy where wealthier patients with private insurance subsidize patients without insurance.[259]

Because most CON laws mandate that healthcare providers perform a certain amount of indigent care, proponents argue that this extra "windfall" to providers allows them to provide care to the indigent population.[260] However, nobody knows which providers are receiving these "windfalls" of money from CON laws.[261] Without transparency, there is no way to measure if the windfall actually gets allocated to indigent care services.[262] Additionally, there is no available measure of the costs to providers to care for indigent patients in comparison to the value of the CON protections.[263] The lack of oversight in this area leaves the purported benefits of CON laws to indigent care completely unknown.[264]

In a society where the government takes money to fund public programs, the actions and results of those programs should be transparent.[265] The government funnels money from private payors to healthcare providers through the protection of CON laws, but there is no accountability for where and how much money is transferred.[266] The vast majority of citizens are unaware of whether they live in a state with CON laws. They likely are unaware of the ways that CON laws impact their access to healthcare, the cost of healthcare, and the quality of healthcare in their state. Policymakers should consider the best interests of their citizens and repeal their CON laws to bring back natural competitive market forces.

---

255. *See id.*
256. *Id.*
257. Ohlhausen, *supra* note 10, at 53.
258. *Id.*
259. *Id.* at 52.
260. *Id.*
261. *Id.* at 53.
262. *Id.*
263. *Id.*
264. *Id.*
265. *Id.*
266. *Id.*

One method of increasing indigent care is ensuring that citizens eligible for Medicaid are properly enrolled in the programs for which they qualify.[267] In states that have not expanded Medicaid, some individuals fall into the "coverage gap."[268] The coverage gap includes adults who have incomes below the poverty line but above their state's eligibility for Medicaid.[269] In 2019, more than two million adults fell into the coverage gap that resulted from states who did not expand Medicaid.[270] If the twelve states who have not expanded Medicaid decided to expand it, then the coverage gap would virtually disappear and these two million adults would be insured.[271] Interestingly, eight of the twelve states that have not expanded Medicaid also have CON laws.[272] Although expanding Medicaid would be one step towards providing indigent care, it would not necessarily be a total fix for access and quality of care, especially in rural areas.[273]

In addition, states should implement mental health and indigent care programs that directly impact disadvantaged populations and that operate in a transparent way so that the public knows where resources are going.[274] Mental health services offered through telemedicine could be one method of reaching rural populations.[275] Furthermore, states could offer loan repayment programs and state tax waivers to mental health providers who would be willing to offer care in rural communities. Clinical rotations could also be established in rural communities during graduate programs to expose students to the need for mental health services outside of bigger cities.[276] These are just a few alternatives states could utilize to increase mental health services in rural communities. Tennessee is a great example of a state that recently removed CON regulation of mental health facilities in an effort to increase care in rural communities.[277]

Thus, policymakers should seriously consider repealing CON laws completely and rethink the way that mental health and indigent care programs are administered.

---

267. *Eligibility*, MEDICAID.GOV (last visited Jan. 16, 2022), https://www.medicaid.gov/medicaid/eligibility/index.html [https://perma.cc/X44J-NB53].

268. *Id.*

269. Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ [https://perma.cc/7V5L-5NQT].

270. *See id.*

271. *Id.*

272. *See id.* This statistic includes Wisconsin which operates an informal variation of a CON program.

273. Ohlhausen, *supra* note 10, at 51.

274. Rural Health Information Hub, *supra* note 227.

275. *Id.*

276. *Id.*

277. Tennessee General Assembly Passes CON Reform Bill, *supra* note 40.

CONCLUSION

It is time for state policymakers to repeal CON laws. Although policymakers originally wanted to help states reduce healthcare costs, CON laws have proven to be flawed. These arcane, bureaucratic laws fail to meet their intended purpose of controlling healthcare costs and increasing access to patients, especially those in disadvantaged populations. Instead, over the past forty years, CON laws have been proven to increase healthcare spending within their respective states because there is a lack of competition to influence natural market forces. Plus, this creates access issues, particularly in rural areas, and it stifles the need for innovation and better technologies.

Defenders of CON laws claim that the "windfall" money some providers receive is used to fund rural and indigent care. However, absent any additional transparency there is no guarantee that the money has actually been allocated for these purposes. Citizens deserve more transparency from states with CON laws. Most citizens do not know what a CON is or how it affects cost, access, and quality of healthcare in their respective states.

The COVID-19 pandemic brought these issues to the forefront of healthcare policy as hospitals in states with CON laws took emergency measures to increase their hospital bed capacity. The pace at which legislatures stalled CON laws and issued emergency CONs revealed that these laws are primarily motivated by politics. If CON laws are that dispensable, then policymakers should consider whether CON laws actually serve their purpose of sustaining healthcare access in the first place.

Citizens deserve more and policymakers can do better. The solution to overhauling and repealing CON laws begins at the legislature. Because versions of CON laws still exist in thirty-five states and the District of Columbia, the removal of CON laws in every state will likely take a significant amount of time. Some states have minimal regulations left while others maintain a robust CON program. Repealing CON laws will likely not have an immediate effect, but over time those repeals could revive a competitive healthcare market, encourage providers to be price transparent, and in turn generate higher quality services. In turn, healthcare providers will be forced to earn their patients by providing the type of quality healthcare that citizens need, otherwise patients can choose to take their business to other competitors in the market. Instead of CON laws, state policymakers should consider funding indigent and rural healthcare programs directly and publicly. Citizens deserve to know where the resources are being allocated, and policymakers need to be held accountable outside of political entanglements.

While repealing CON laws is not a novel solution, the COVID-19 pandemic showcased why that policy change is more crucial than ever before. Thus, policymakers should act swiftly to repeal CON laws to bring back competition to the healthcare space. Together, these efforts will steer states back to creating healthcare regulations that are focused on the patients.