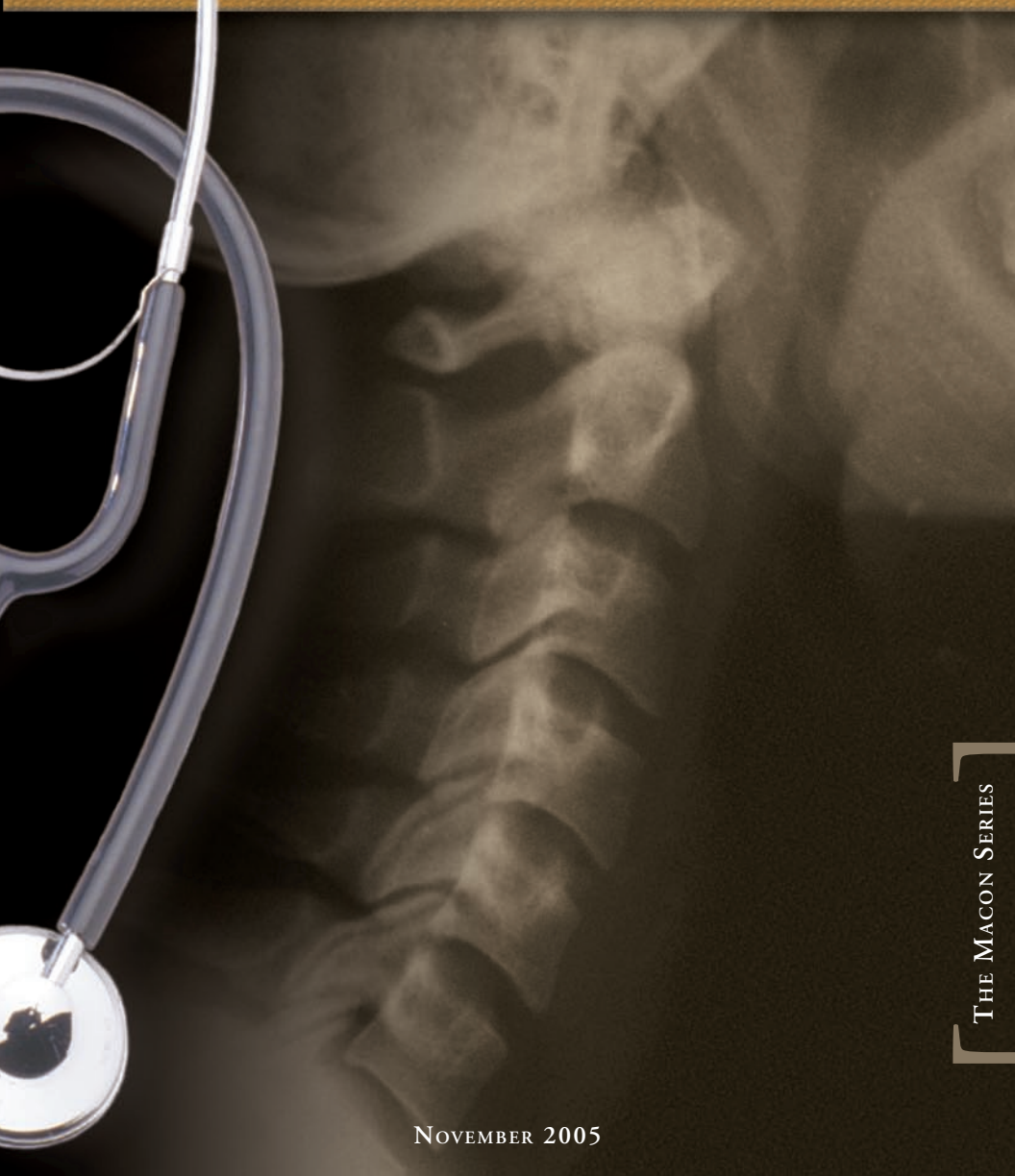
John Locke Foundation

Certificate-of-Need Laws
It's Time for Repeal

Dr. Roy Cordato



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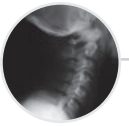

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This report on certificate-of-need regulation is the first in a series of annual research papers from the John Locke Foundation devoted to explaining the principles of free markets and applying them to current controversies in North Carolina. The Nathaniel Macon Research Series was created with the generous financial support of David R. Carr, Jr. of Durham, in memory of his friend and business partner George W. Brumley, III, who was a strong believer in the crucial role that robust, unfettered markets play in advancing human progress and promoting a free society. The Macon Series will examine closely the fiscal and regulatory policies of the state and whether they help or hinder individuals seeking to create or expand businesses and economic opportunities in North Carolina. The series is named after Nathaniel Macon, a North Carolinian and close political ally of Thomas Jefferson who served as Speaker of the House and U.S. Senator during the first few decades of the American Republic. Macon frequently argued, "That government is best which governs least."

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What's Wrong With This Picture?

Imagine an economic system where market competition was viewed as a wasteful activity that needed to be discouraged or even prohibited by government. In such a system, for example, if a Chinese immigrant family wanted to open a restaurant, it would first have to go to a government commission that would survey the economic landscape for Chinese restaurants to determine if there already might be "enough" such eateries in the area. The commission might have a formula that would look at data regarding how many Chinese restaurants exist per 100,000 or 50,000 or 25,000 in population; how many of those are strictly take-out restaurants and how many are eat-in or "sit-down" restaurants; and among those that are sit-down style, how many feature buffets and how many are strictly order-from-menu. The formula might also consider variations in price from restaurant to restaurant to determine how many are serving lower-income families and how many might be targeted to the gourmet Chinese food market.

After going through all this – a process that might take several years – the commission would then decide whether this particular Chinese restaurant is "needed" in the area. If it were not, this immigrant family would then be sent packing to decide on another way of earning a living. Or, it might be suggested that they try some other area where it has been determined there are too few Chinese restaurants to adequately serve the existing population.

If it is determined that, yes this community indeed does "need" one more Chinese restaurant, a "certificate" would be issued to the immigrant family. It would state that a restaurant of this type and size is "needed" and that the family has permission to set up shop. But of course the restaurant would have to be built to the exact specifications described in the original proposal and that was ultimately approved. It may not be able to offer take-out service if there are al-

ready "enough" take-out restaurants in the area. It would have to be built only to accommodate a certain number of tables because any more or any less would not fit the need as determined by the formula. The menu would have to be approved, because if the restaurant were also going to serve non-Chinese foods such as pizza or hamburgers – for those who might not like Chinese food – that would fall into a different category and those menu items would have to be passed through another formula and another process.

Most people would look at such a system and think "this is crazy, only a Soviet-style central planner could be happy with such a bureaucratic nightmare." Besides, we all understand it is competition that makes the consumers in the marketplace better off. Competition brings lower prices, more convenience, better quality, new technologies and innovations, and so on.

The system as described above will have its beneficiaries. Government workers charged with running the system clearly can do well because of its existence. But beyond this, what about existing restaurateurs who had already received one of these highly valued certificates and were operating a flourishing business? Wouldn't they like the idea that the local government had an entire division devoted to protecting them from competition? Wouldn't it be nice to not have to worry about customers being taken by some upstart Chinese restaurant with lower prices or fancier foods on its buffet? Sure, restaurant customers would probably be better off if anyone who wanted to could simply start a new restaurant, but people aren't aware of what they are not getting. Some customers might

Most people would look at such a system and think this is crazy, only a Soviet-style central planner could be happy with such a bureaucratic nightmare.

look around and say "gee, the town already has a couple of Chinese restaurants and there's never a wait to get in, so why is there a need for another one? Certainly a new one would be wasteful." Of course this would be said without knowing what a new restaurant would be like, what menu items it might offer, what prices it might charge, etc. Because people don't know what they don't know, even the consumers, who are always hurt by monopolies, might end up supporting this system.

The Reality of Certificates for Medical Care

The system described above is exactly the kind of system that North Carolina and 34 other states have with respect to medical-care facilities and equipment. If you are a health care entrepreneur and you want to do anything from adding a new wing or extra beds to an existing hospital, to opening an office that offers MRI, X-ray or other services, you need a "Certificate of Need" (CON) from the state. The function of CON is summarized as follows:

> "The North Carolina Certificate of Need Law prohibits healthcare providers from acquiring, replacing, or adding to their facilities and equipment, except in specified circumstances, without the prior approval of the Department of Health and Human Services...The law...limits unnecessary health services and facilities based on geographic, demographic and economic considerations... All new hospitals, psychiatric facilities, chemical dependency treatment facilities, nursing home facilities, adult care homes, kidney disease treatment centers, intermediate care facilities for mentally retarded, rehabilitation facilities, home health agencies, hospices, diagnostic centers, oncology treatment centers, and ambulatory surgical facilities must first obtain a CON before initiating development. In addition, a CON is required before any upgrading or expansion of existing health service facilities or services." [1]

If this sounds like the kind of central planning one might find in a socialist economy – it is. In North Carolina, the central planning authority is known as the Health Planning Development Agency,

part of the North Carolina Department of Health and Human Services. The role of this agency is to plan economic activity provided by medical-care facilities. This is done down to the most minute detail, circumventing the most basic function of private decision-making in a free enterprise system, i.e., the allocation of resources based on entrepreneurial insight and risk taking.

The purpose of the Health Planning Development Agency in implementing CON is to "develop policy, criteria, and standards for health service facilities planning; [ ] conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified [in the statute] and equipments as specific [in the statute], which shall include consideration of adequate geographic location of equipment or services; and develop a State Medical Facilities Plan." The Agency also has "the authority to review all records in any recording medium of any person or health service facility subject to agency review under these articles which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance..."[2]

North Carolina's Certificate-of-Need Law is, with few exceptions, an all inclusive and all intrusive blueprint for state government control of all supply and pricing decisions with respect to the provision of institutional health care facilities (see Appendix for a complete list of CON-regulated services in North Carolina and other states). The process that a potential hospital, nursing home, clinic, doctor's office or other supplier must go through to receive a CON is tedious and potentially very long. Depending on the number of reviews, the process can take anywhere from 90 days to over two years. If a denial

is appealed to the state Court of Appeals, the process can go well beyond this two-year period. As of the Summer of 2005, the CON approval process for the expansion of Good Hope Hospital in Harnett County, North Carolina has been dragging on for over four years. The law has fostered a contentious political and legal battle between Good Hope and other hospitals in the area that also involves Harnett County, the Town of Lillington and the City of Dunn. While this political warfare is taking place, costing millions of dollars, the people of the area could be benefiting from additional health care facilities.

CON Process:

Task			# Days to receive feedback
Submit letter of intent			0
Review period begins			0
CON Section makes decision			90-150
Denied/Approved =>	Petitions allowable for 30 days		120-180
	Judge makes recommendation =>	CON Section makes final decision	120-450
	Denied/Approved =>	NC Court of Appeals	Indefinite?

Source: Compiled by author using information from http://facility-services.state.nc.us/conpage.htm.

An April 2005 article in the *Triangle Business Journal* tells the story of a partnership of three neurologists who have spent three years and over $250,000 in an attempt to set up an MRI imaging center

in Garner, North Carolina. In this case the CON process has led to a battle between these doctors and hospitals in the region. This is not a healthy economic contest among suppliers of a service attempting to better serve health care customers, but rather a battle to win the favor of a government bureaucracy in an attempt to gain or keep a monopolistic cartel. Out of complete frustration, this group of neurologists is giving up. Competition for MRI services is denied and potential patients in Garner and the surrounding areas are deprived of taking advantage of the alternative that this physicians group was attempting to offer.[3]

It is quite clear that all important aspects of the production, distribution, and sale of health care services in North Carolina, and most other states, have been removed from the competitive free enterprise system and placed under the authority of a command-and-control government bureaucracy. And like all other bureaucracies, it promotes factionalism and division and allows some groups and institutions to suppress the activities of others. The market is run by government fiat rather than entrepreneurial insight and patient preferences.

History, Justification, and Application of CON

The origins of CON in North Carolina, and many of the other states that have such a system, rest in a long since repealed federal government mandate. In 1974, Congress passed the National Health Planning and Resources Development Act. The Act stated that in order to receive federal funding from programs like Medicare and Medicaid, new health care facilities, and additions to existing facilities, needed approval from a state agency established to issue certificates of need. All states were told to have such programs in place by 1980.

This was seen as a way of controlling health care costs. At the time, reimbursements for services were being made on the basis of

costs of production. It was thought that facilities were being built and equipment was being purchased unnecessarily simply because the hospitals knew the facilities would ultimately be paid for through increased fees. In a market setting where health care providers need to compete for cost-conscious purchasers of services, even if those purchasers are insurance companies, higher costs cannot simply be passed along in higher prices. New facilities would be built or new equipment would be purchased only if the market prices for the services that would be generated could justify the added costs. As with any business, expansions would be made only if it was thought they could be justified by actual demand. This is what entrepreneurship is all about: spotting actual or potential unfilled demand and organizing resources in new ways in order to meet it. If the demand isn't there, losses will be incurred and plans would have to be revised.

The government payment system at the time did encourage inefficient investment because it took the risk out of the process. Costs were recouped regardless of any failure to accurately estimate demand. Indeed the so-called "cost plus" system of reimbursement took away the need to consider future demand at all. The result was a classic case of an initial government intervention into market decision-making – in this case the Medicare and Medicaid programs – creating distortions of its own, which in turn are used to justify additional interventions: the CON program. As is typical, the new interventions lead to their own set of problems.

In 1987 Congress repealed its mandate and stopped subsidizing states that implemented it. This came after the federal government abandoned its cost-based reimbursement system and switched to paying a predetermined amount based on the kind of treatment. Since that time, 15 states have dropped their CON program, allowing for competition. North Carolina is one of 35 states, plus the District of Columbia, that continues with centralized planning of the health care facilities market.

Although cost containment, as noted, was and continues to be the primary justification for CON, there are other reasons given for keeping these laws in place. The most prominent are related to the provision of care for the indigent and include the arguments that:[4]

- Removal of CON will place a greater burden on the disadvantaged. The fear is that market forces will lead to certain segments of the population and those living in rural areas, being underserved.
- Removal will favor for-profit hospitals, which may be less willing to provide indigent care.
- Removal will lead to a proliferation of "low volume" facilities, which are associated by some with lower-quality care.

As an historical footnote, in the 1960s and early 1970s, prior to the federal mandate, more than 20 states had decided to implement CON laws independently, allegedly for cost-control reasons. According to Charles Gerena, writing for the Federal Reserve Bank of Richmond, these pre-mandate laws were implemented "in response to hospital operators who favored centralized health planning."[5] This is consistent with the economics of CON, to be discussed later, which suggests that in reality, CON is a cartel enforcement device that protects incumbent providers from new entrants and competition. According to East Carolina University researchers Campbell and Fournier, "there are reasons to suspect that CON may have been adopted for other purposes...the states most likely to enact CON...were those with a highly concentrated hospital industry and increasing competitive pressures...hospitals were largely in favor of CON regulation, which is understandable considering that it protected them

North Carolina is one of 35 states, plus the District of Columbia, that continues with centralized planning of the healthcare-facilities market.

from competition."[6] Much like existing restaurant owners in our opening example, having a government bureaucracy whose goal is to protect your business from upstarts is a nice perk.

In reality, the continuation of CON regulations cannot be justified either theoretically or empirically. In fact, from the perspective of sound economics, the reverse is true. If one desired to devise a policy for any market whose purpose would be to reduce efficiency, raise costs and prices, and reduce product quality, the existing CON programs would be highly recommended.

If You Like OPEC, You'll Love CON

When it comes to crude oil, it is indisputable that the ability to raise prices and therefore energy costs, rests with the power to restrict output and production. When President Bush met with Prince Abdullah of Saudi Arabia on April 25, 2005 to discuss high oil prices, the question immediately turned to the Organization of Petroleum Exporting Countries (OPEC), which raises prices by restricting production. Saudi Arabia, the largest oil producer in the world and the leader of OPEC, is seen as having the power to expand production and bring prices down.

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Ironically, for those who support CON laws, it is thought that medical-care markets operate in the exact opposite manner, that the way to keep costs down is to restrict the supply of medical facilities and equipment. For example, if one wants MRI services to be less expensive, we need to have fewer MRI machines; if we want hospital stays to be cheaper, then what is needed is fewer hospital rooms.

As pointed out by The National Academy for State Health Policy in describing CON regulations: "Efforts to control the supply of services are well demonstrated by state Certificate of Need programs, which seek to limit the acquisition and dissemination of substantial investments in technology and capacity. These limitations are imposed in an effort...to hold down the volume of services provided and the cost."[7] In fact though, it is just as wrong-headed to think that limiting the supply of health care equipment and facilities can reduce health care costs, as it would be to think that oil prices could be brought down with further reductions in oil production.

There is possibly no proposition in economics that is more accepted than the idea that if you want to reduce the cost of something, you foster an environment that encourages open competition and entrepreneurship and discourages monopoly. But the role of competition goes well beyond this. Rivalry among businesses – and health care providers are no exception – stimulates new technologies and innovative and more efficient ways of delivering goods and services to customers. Existing providers continuously have to keep their costs low and their products desirable in order to fend off potential competitors looking for an opportunity to earn profits. These potential competitors, like the neurologists discussed previously who wish to provide MRI services, are always looking for ways to outperform existing providers. According to the *Triangle Business Journal*, these doctors had planned to offer greater convenience, newer technology, and lower prices than existing MRI facilities, which are predominantly owned and operated by full-service hospitals. They planned to locate in Garner, North Carolina, which has no MRI facilities,

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making these services more convenient to patients and other doctors in the community. Furthermore, according to Dr. Daljit Buttar, one of the neurologist/entrepreneurs who has been fighting for the right to compete, their plan was to charge lower prices than the hospitals and to offer a new technology that provided a better view of the body.

As noted, CON laws turn the simple economic truths about the relationship between competition and lower prices and higher quality on their head. Proponents of CON laws do not refute the economics by presenting an alternative economic framework that would explain why an actual free market in medical-care facilities and equipment would not behave as economic theory would predict. Instead they suggest that standard economics should not be used as the basis for analysis at all, even though what is being assessed is at the heart of what economic science is about – market price and output formation and the efficient allocation of scarce resources.

What is and isn't excess capacity has to be determined in the marketplace and will be revealed through the system of profit and loss.

For example, The American Health Planning Association (AHPA), in criticizing a recent report by the Federal Trade Commission (FTC), disparagingly notes that the FTC grounds its opposition to CON laws in "orthodox economic doctrine." The AHPA suggests that to rely on standard economic theory, as opposed, I presume, to some non-orthodox economic theory or possibly some other social science, is to ground the analysis in "an article of faith."[8] This would be comparable to complaining that much of medicine and the analysis of patients' conditions by doctors is grounded in "orthodox" theories of biology and human anatomy.

In large part, the idea that increased supply leads to higher prices and costs stems from a basic premise that is clearly false; namely that

service duplication within a geographical area (defined by government planners) is inefficient and therefore cost enhancing. In justifying North Carolina's law, it is stated that "the costly proliferation of *unnecessary* health service facilities results in *costly duplication* and *underuse* of facilities, with the availability of excess capacity leading to *unnecessary* use of expensive resources and *over utilization* of healthcare services"[9] [emphasis added]. First, note the presumptuous and paternalistic attitude of the legislators formulating this statement. They claim to know better than health care consumers, their doctors, and facility operators, how "necessary" facilities are and that these market participants are "overutilizing" the health care that is available to them.[10] It should also be noted that the utter confusion of this statement is demonstrated by the fact that in the same sentence, it claims the free market somehow leads to both "the *underuse* of facilities" and the "*over utilization* of healthcare services" (huh?).

But more importantly, in a fundamental sense, the statement is proclaiming that monopoly is good. Facility duplication is at the heart of competition. Indeed, the definition of a monopoly market is one where there is no duplication. And this is why customers in monopoly markets lose. They are denied the option of turning to others who are providing "duplicated" services when the monopoly providers act like monopolists. Consider once again our team of neurologists. Would there be "excess MRI capacity" if they were allowed to enter the MRI market in Wake County? Apparently, some state bureaucrats, who are not market participants themselves, believe there would be. But the concept is meaningless. For example, because many Chinese restaurants, at a point in time, have empty tables, or some movie theaters have empty chairs, it doesn't mean there is inefficient excess capacity of restaurants or theaters. The new MRI facility would lead to more choice for patients and more competition for their health care dollars. Indeed, at the lower prices that could be generated, people who might forgo MRI exams for less expensive, but also less effective methods of diagnosis, may be able to take

advantage of the more advanced technology. What is and isn't excess capacity has to be determined in the marketplace and will be revealed through the system of profit and loss. Certainly there is no way for a health care central planner to second-guess the correct result.

The Evidence on CON and Costs

Not surprisingly, the evidence matches the economic theory. Since the 1980s when states were set free from the federal requirement to have CON laws, numerous studies have examined the change in health care costs as states eliminated their laws. If CON were "working" as advertised, then one would expect to see a rise in health care costs when the laws were eliminated. But in fact this is not the case. One of the most recent and widely referenced studies was written by Duke University Professors Christopher Conover and Frank Sloan and published in 1998 in the *Journal of Health Politics, Policy, and Law*.[11]

Their results are consistent with "orthodox" economics. Output restrictions lead to higher, not lower costs, and higher profits for existing providers. The authors point out that for hospitals, CON laws resulted in a 2 percent reduction in bed supply *and* "higher costs per day and per admission, along with higher hospital profits," exactly what economic theory would predict. The study did find a modest reduction in per capita "acute care" spending, which it attributed to CON laws. Interestingly, the study "was unable to detect a statistically significant effect of removing CON on these same expenditures." But overall, the study found no decrease in per capita health care spending attributable to CON.

Overall, the study found that CON *was responsible for a 13.6 percent increase in per capita spending on personal health care services.*

An earlier study showed even more dramatic results. This study examined data through 1982 and found that CON was associated with a 20.6 percent increase in hospital spending and a 9 percent increase in spending on other health care. Overall, the study found that CON was responsible for a 13.6 percent increase in per capita spending on personal health care services.[12]

Over the last two decades, the Federal Trade Commission has done several studies on the impact of CON laws, both nationally and for specific states. The FTC's consistent conclusion can be summarized in the language from its most recent study released jointly with the Department of Justice in July 2004. "The Agencies believe that CON programs can pose serious competitive concerns that generally outweigh CON programs' purported economic benefits. Where CON programs are intended to control health care costs, there is considerable evidence that they can actually drive up prices by fostering anticompetitive barriers to entry."[13]

In 1989, similar testimony was given to the North Carolina Goals and State Policy Board by FTC staff. The staff testified that "evidence does not support the view that Certificate of Need regulation reduces the costs of providing healthcare services...consumers would most likely be better served if CON regulations were removed."[14] As one study reports, "in researching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering healthcare costs."[15]

CON as a Hidden Health Care Tax

While the discussion to this point has focused on the economics of CON, it should be pointed out that there are other fallback arguments for these regulations that relate to the provision of care to the indigent. Oddly enough, the arguments from this perspective actually contradict the "cost saving" case for CON. The argument is that entry restrictions, and the higher prices and profits that go along with them, are necessary to induce providers to provide free indigent

care. As summarized in a study by Campbell and Fournier, "CON policies have...been pursued with the implicit aim of 'cross subsidization,' that is, regulators have used their power to issue licenses and restrict competition in order to create an incentive to hospitals to provide high levels of care to the indigent population."[16]

What this means is that CON laws are used to create a hidden tax. The cost of health care and the profits to health care providers are purposely kept high by granting monopoly privileges. It is then expected that these excess profits will be used to provide free health care to the indigent. Health care customers are forced to pay a premium created by CON laws and the proceeds from this premium are used to pay for indigent care. If nothing else, this is dishonest. If a social and political goal is to see to it that those who cannot afford health care have their needs taken care of, then the costs of that policy should be up front and explicit. This is the only way the electorate can make informed decisions regarding public policy. If it is deemed that those who are paying for health care services should bear the burden of also paying for care given to the indigent, then an explicit excise tax should be placed as a line item on all health care invoices, and CON laws should be abolished. If CON laws are being used to hide this tax from the electorate, then not only are they inconsistent with sound economics, they are also inconsistent with an open and democratic political process.

If CON laws are being used to hide this tax from the electorate, then not only are they inconsistent with sound economics, they are also inconsistent with an open and democratic political process.

Another way in which CON imposes a hidden tax on the health care system relates to the resources hospitals and other health care entrepreneurs must devote to obtaining the certificate. The process of obtaining a CON is not only time consuming but expensive. As

noted previously, in the case involving the group of neurologists from Garner seeking a CON for MRI equipment, over $250,000 was spent on what was ultimately a futile effort. This is not money that was spent on equipment or improving neurological services to patients. It was money spent to gain permission from the state to offer services to patients. Like any other tax, it is an additional cost of doing business that ultimately raises health care expenses across the board. This $250,000 is just one instance from many battles to gain CON "licenses" that are continuously being fought across North Carolina. As also mentioned previously, it has been reported that the effort by Good Hope Hospital in Harnett County has cost in the millions.[17]

HEALTH CARE POLICY: BREAKING THE CONSUMPTION/PAYMENT LINK

Is health care over-priced? In many, if not most cases, the answer is yes. But this is not a problem that CON regulations can address. In fact, as argued previously, such laws are likely to contribute to the problem. The reason why health care may be overpriced is that, in most cases, what economists call "the consumption/payment link" is broken.

Because of government entitlement programs and the nature of modern health insurance, most people do not directly pay their own health care expenses. In 2002 over 84 percent of all personal health care expenditures were made by someone other than the person receiving the care.[18] Unlike the market for other goods and services, health care is consumed by the patient and, minus a copay or deductible, paid for by state and local government or by an insurance company operating a health care plan. Hence, the "consumption/payment link" that is typical of the clothing market, the computer market, or most other buyer/seller arrangements, is broken in the health care market.

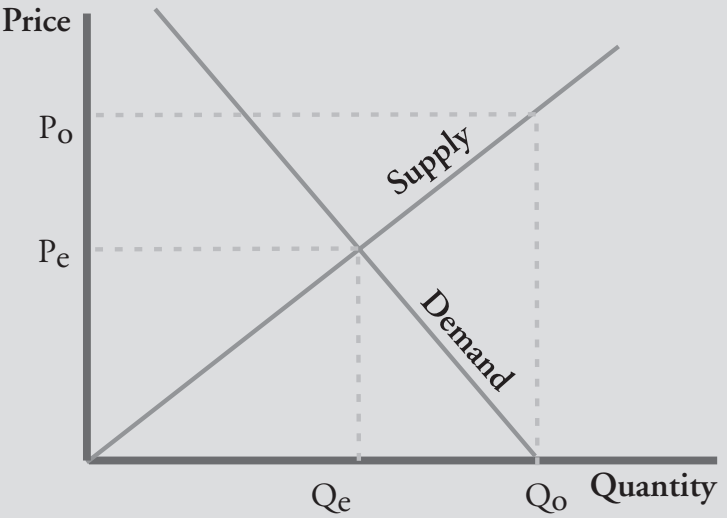
How is Health Care Like an All-You-Can-Eat Buffet or a Free Shopping Spree?

This arrangement causes health care to be over-priced because it leads to health care being over-consumed. People will generally consume more of any product when the amount paid is unrelated to the amount consumed. Furthermore, they will consume relatively more of what would otherwise be the highest-priced or higher-valued options. This is why people tend to "over-eat" at all-you-can-eat buffets. It also explains why, if there are crab legs or sirloin steaks on this buffet, people will tend to consume relatively more of those items than the hot dogs or beans.

Imagine if a grocery store operated like health care. Instead of walking up and down the aisles seeing different prices for different food items and making tradeoffs between prices and different kinds of products, we were all on an employer-paid-for "food insurance" plan. Whenever we needed groceries, we drove to the local supermarket and paid a fixed co-pay at the door. Once inside, we could simply take all the food products "we needed." As a food consumer, how might we behave? Would we take only "what we needed" or all that we could carry out? Would we go directly to the hot dogs and canned beans or would we find ourselves eating significantly more filet mignon and lobster? Clearly, the "purchase" of food overall and the proportion of lobster and high-priced cuts of meat relative to hot dogs and beans would increase. This would send the overall price of food and the "food insurance" premiums and co-pays through the roof. This is exactly what has been happening for decades in the health care market. [For a simple diagrammatical explanation of the economics involved in this phenomena see Diagram 1 on next page.]

DIAGRAM 1:

Breaking the Consumption/Payment Link



The graph shows the extreme case when the product is consumed by one person and the payment is made entirely by a third party. In a typical market, price would settle at P_e and the amount consumed would be Q_e. This is "market equilibrium" where quantity and price offered by the supplier is equal to the quantity and price that is acceptable to the demander. This is not typical of health care markets. The graph also shows the result when the price to the consumer is zero. At zero price, the consumer will want to purchase not Q_e but Q_o. But the supplier will only be willing to bring forth this greater supply of health care services at a higher price. In the graph above P_o shows the amount the supplier would need to receive in order to bring forth this greater quantity of services. In health care markets, depending on how much deductibles and co-pays are, the quantity consumed will be somewhere between Q_e and Q_o and the price will lie somewhere between P_e and P_o.

The Problem of Low Deductibles

The fact that many plans have low deductibles with routine health care problems being paid by insurance, rather than only high-cost operations and catastrophic conditions, also fuels the costs of health care. In the 1940s, '50s, and '60s, most people referred to health care insurance as "hospitalization insurance." This is because insurance mostly covered high-cost health problems that required operations and stays in the hospital. The effect of what is now called "first dollar coverage" or near first dollar coverage, i.e., plans with very low deductibles, can be seen if we imagine the effects of auto insurance that not only covered damage from accidents, but oil changes and tune-ups as well. If people showed up for an oil change and showed the mechanic an insurance card, the service shop would clearly be less concerned about keeping the price competitive, and the car owner would be less concerned about getting the best deal. The prices of oil changes, tune-ups, etc., would be much higher than they are today.

Isn't the Free Market Failing?

The current consumption and payment arrangements are not the result of a free market for health care, but a failed set of government policies. As noted, most people do not pay directly for their own health care, but it goes beyond that. They don't even pay directly for, or even own their own health insurance policy, like they would with auto or homeowners insurance. Taxpayer-funded programs like Medicare and Medicaid pay nearly 45 percent of all health care bills.[19] The rest is mostly paid for by group health insurance policies that are owned by employers. For most types of insurance, such as auto, homeowners, and life, premiums are associated with the risks posed by the owners of the policy, i.e., those who are covered by the policy. The problem of over-consumption is tempered by the policy owner's desire to keep his or her premiums low. This market check is

not in place for health insurance. Those who are insured are not paying individual premiums for their insurance, and the amount being paid in premiums is not related to the risk associated with insuring individual policyholders. As noted, with few exceptions, there *are* no individual policyholders.

All the usual checks that would occur in a free market are missing. There are a number of reasons for this but the most important is related to the way health insurance is treated for income tax purposes. The tax code penalizes the individual ownership of health insurance policies and encourages the ownership of group policies by employers. Since WWII, health insurance provided by employers is considered a tax-free benefit to the employee, while personally owned health insurance plans must be paid for with after-tax income.[20] This has led to very generous and expensive low- or no-deductible plans offered by employers. In many cases a tax-free dollar offered in the form of a low- or no-deductible health insurance benefit is more valuable to an employee than a taxable dollar offered in the form of wages. So we end up in a situation where public policy has led to both an over-use of health insurance and health care services.

The current consumption and payment arrangements are not the result of a free market for health care, but a failed set of government policies.

The public policy answer to this problem is arriving, albeit tentatively and slowly, in the form of "health savings accounts" (HSAs), which were made legal as part of the Medicare Reform Act passed in 2003. The entire point of these accounts is to reconnect the consumption/payment link. These plans allow employers to offer high-deductible insurance plans to their employees, which have lower premiums. The employer then deposits a fixed amount each year into an individual HSA that is owned by the employee and where both the

amount deposited and any interest earned is tax exempt. The money in this account can be used to pay for expenses up to the deductible as well as other health care costs. In addition, any amount left in an HSA can be willed to the owner's heirs, who are not required to use this money for health care expenses. The important point is that any amount from this account that is not spent remains the property of the employee, to be used for either future health care problems, retirement income, or to make their children and grandchildren better off.

This approach reconnects consumption and payment for most routine health care related costs. A dollar spent on health care services now is a dollar that cannot be used later. As in other areas of income allocation, people will consider tradeoffs. By in part reconnecting the consumption/payment link, HSAs provide people with an incentive to be smarter and more cost-conscious health care consumers. In addition, this approach returns insurance to its original purpose: to manage risk of catastrophic medical expenses as opposed to being a form of "pre-payment" for routine medical services.

CON and the Impossibility of Central Planning

As has been noted at several points throughout this paper, CON regulations are an attempt at complete central planning of investment in health care related facilities. The underlying premise is twofold. First is that individuals and companies acting in a free market will misallocate health care resources. As stated directly in North Carolina's CON law, 'if left to the market place to allocate health service facilities and health care services, geographical maldistribution of these facilities and services would occur..." and "the proliferation of unnecessary healthcare facilities [will] result in costly duplication."[21]

The second premise behind the law, implied by all that the law empowers the state to do, is that the state, through centralized

bureaucratic allocation of health care investment, can improve on market results, and better serve the public's health care needs. The point here is that even if the first premise, as tenuous as it is, is accepted, there is no reason to assume that a large-scale intervention, such as authorized by CON laws, can do anything to improve the situation.

This second assumption ignores all that the economics profession has learned over the last 50 years regarding command-and-control methods of resource allocation and the central planning of both economies in general and specific markets within economic systems. All of the reasons economists typically give regarding why economic central planning fails, apply to CON regulations.

In a free market, resource allocation is driven by entrepreneurs who try to predict what consumer demand is and will be for the future. Before a physicians group invests in MRI equipment, for example, they would want to be sure the community of patients they serve would bring forth enough business to eventually make that investment pay off. They have powerful market incentives to get it right. If their market analysis is wrong, they lose money and their entire practice suffers. In other words, the best judges as to whether the service will be "needed" are the entrepreneurs and investors themselves. It is the profit-and-loss system that works to efficiently allocate investment and to provide the information necessary for making wise investments. In the absence of CON, these medical entrepreneurs would be operating in all aspects of the health care market. Hospitals will continuously re-evaluate their circumstances to determine if new birthing rooms are needed, or an expanded emergency room is nec-

In a free market, resource allocation is driven by entrepreneurs who try to predict what consumer demand is and will be for the future.

essary, or if a new helicopter evacuation unit would be worthwhile. The key is that, in each of these cases, they have a strong incentive to accurately assess the market and the community's "needs." If they can't, they lose money and must divert revenues and resources from other, more worthwhile parts of their operations.

A good entrepreneurial decision is one that accurately assesses health care consumers' needs and survives the competitive pressures of the marketplace.

CON laws substitute bureaucratic decision-making for the market's entrepreneurial assessments. The problem is that the government decision-makers have no basis for gathering accurate market information and, furthermore, they have no incentive to make sure investments get made in the right places, at the right times, and in the right amounts. Unlike the case with private entrepreneurs, if their decisions prove to be wrong, there are no personal consequences borne by the planners responsible. In fact, there is no real way of determining after the fact whether or not a proper decision has been made. Whether or not a market decision makes economic sense is determined as part of the competitive economic process itself. A good entrepreneurial decision is one that accurately assesses health care consumers' needs and survives the competitive pressures of the marketplace. That is, it is a decision that satisfies consumer needs at least as well as, if not better than, existing and potential competitors.

For those who are granted membership in the CON-sponsored cartel, the real tests of the marketplace are foregone. In other words, the market forces that would ultimately determine whether a particular investment by a hospital, clinic, physician's practice, etc. truly served the needs of the community, are blocked. The bureaucrats that decide on CON do not, indeed cannot, actually determine whether

there is a need that will best be filled by a particular applicant because they are outside the market process that actually generates that information.

Economist Friedrich Hayek in his Nobel Laureate lecture, "The Pretense of Knowledge," argued that central planners, like those charged with determining who should and should not get to provide medical services, can only "pretend" to have the information necessary to make the kinds of decisions they claim to be making. At best, any determination of "need" by such planners will be arbitrary and will not reflect actual market conditions. At worst, these planners can become witting or unwitting tools of entrenched interests who wish to keep competition out of the market. As University of Pennsylvania analyst Mark Pauly noted, CON programs "tended to be 'captured' or dominated by the hospitals they were intended to regulate, and that those hospitals used regulation to keep out competition."[22]

The bureaucrats that decide on CON *do not, indeed cannot, actually determine whether there is a need that will best be filled by a particular applicant because they are outside the market process that actually generates that information.*

Conclusion

Certificate-of-Need Laws in North Carolina and other states should be repealed. State governments should not be aiding and abetting monopolies or their formation, or acting as a cartel enforcement mechanism for established health care interests. This is especially true in health care markets, where competition, which is widely recognized by economists as **the** most effective tool for driving costs down, is sorely needed. It is competition that provides the incentives to discover new technologies and new efficiencies for delivering those technologies to patients.

The idea that in the area of health care services, free market competition can't work as a means of cost control, is not grounded in either economic theory or empirical evidence. Indeed, in areas where competition is allowed to flourish, such as optometry, the customer is well served with plenty of options and competitive pricing. Furthermore, believing also that CON laws and the bureaucrats that administer them can do a better job than the competitive market process, is not only wishful thinking, it is the economic equivalent of believing the Earth is flat. Somehow, legislators have convinced themselves we can have the results of open competition by creating monopolies – as Orwell said, love is hate and war is peace.

Health care provision around the world is controlled by varying degrees of government central planning. Consequently, all systems tend to be dominated by different forms of health care market malfunctions. In countries like Canada and Great Britain, there are long queues and bottlenecks for vital services and treatments. In the United States, there are problems associated with high costs and affordability. None of these countries allow free markets and open competition. Government command-and-control has failed; it is time to let the free market work.

END NOTES

(1) "North Carolina Division of Facility Services, Certificate of Need Section, Overview of CON Process," found at http://facility-services.state.nc.us/conpage.htm

(2) North Carolina General Statute. 131E, Article 9, §175-190, found at http://www.ncga.state.nc.us/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_131E/Article_9.html

(3) Lee Weisbecker, "Doctor claims state's CON rules favor hospitals," *Triangle Business Journal*, April 29, 2005.

(4) Christopher J.Conover and Frank Sloan, "Does Removing Certificate of Need Regulations Lead to a Surge in Healthcare Spending?" *Journal of Health Politics*, *Policy and Law*, Vol. 23, No.3, June 1998.

(5) Charles Gerena, "Putting on the Brakes," *Region Focus*, Spring 2004, Federal Reserve Bank of Richmond. Found at www.richmondfed.org/publications/economic_research/region_focus/spring_2004/feature1.cfm

(6) Ellen S. Campbell and Gary Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care,"*Journal of Health Politics, Policy and Law*, Vol. 18, No. 4, 1993, p. 906.

(7) Ellen Jane Schneiter, et. al. "Rising Healthcare Costs: State Health Cost Containment Approaches," National Academy for State Health Policy, June 2002, p. 4.

(8) See "The Federal Trade Commission and Certificate of Need Regulations: An AHP Critique, January 2005, http://www.ahpanet.org/Con_issues.html and "Improving Healthcare: A Dose of Competition," a report by the Federal Trade Commission and the Department of Justice, 2004, www.ftc.gov. It should be pointed out that among economists "Marxist" and socialist economics is considered to be the most prominent of the non-orthodox or "heterodox" approaches to economic analysis. It will be argued below that CON are indeed grounded in fundamental principles of what is called "market socialism."

(9) Article 9, Certificate of Need, p.1. As will be discussed at length below, health care services are over-utilized, but not as a result of "the open market" but interventions that distort the market.

(10) In the section below titled "The Impossibility of Central Planning" this will be referred to as "a pretense of knowledge" which is a term coined by Nobel Prize-winning economist Friedrich Hayek.

(11) Op. cit. at note 6.

(12) Joyce A. Lanning and Michael Morrisey and Robert Ohsfeldt, "Endogenous Hospital Regulation and its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics*, Vol, 3, No. 2, 1991 as cited in Ibid.

(13) "Improving Healthcare: A Dose of Competition," a report by the Federal Trade Commission and the Department of Justice, July, 2004, http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf

(14) From FTC press release found at http://www.ftc.gov/opa/predawn/F89/nc-con.txt.

(15) Patrick John McGinley, "Beyond Healthcare Reform: Reconsidering Certificate-of-Need Laws in a Managed Competition System," *Florida State University Law Review*, Vol. 23, No. 1, 1995.

(16) Campbell ES, Fournier GM, "Certificate-of-need Deregulation and Indigent Hospital Care," *Journal of Health Politics, Policy and Law*, Vol. 18, No. 4, 1993. Abstract found at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=8120351&dopt=Abstract

(17) From conversations with reporters covering the story for *The Daily Record* of Dunn, N.C.

(18) See http://www.census.gov/prod/2004pubs/04statab/health.pdf, table no. 120. "Personal Healthcare Expenditures by Object and Source of Payment: 2002"

(19) Ibid.

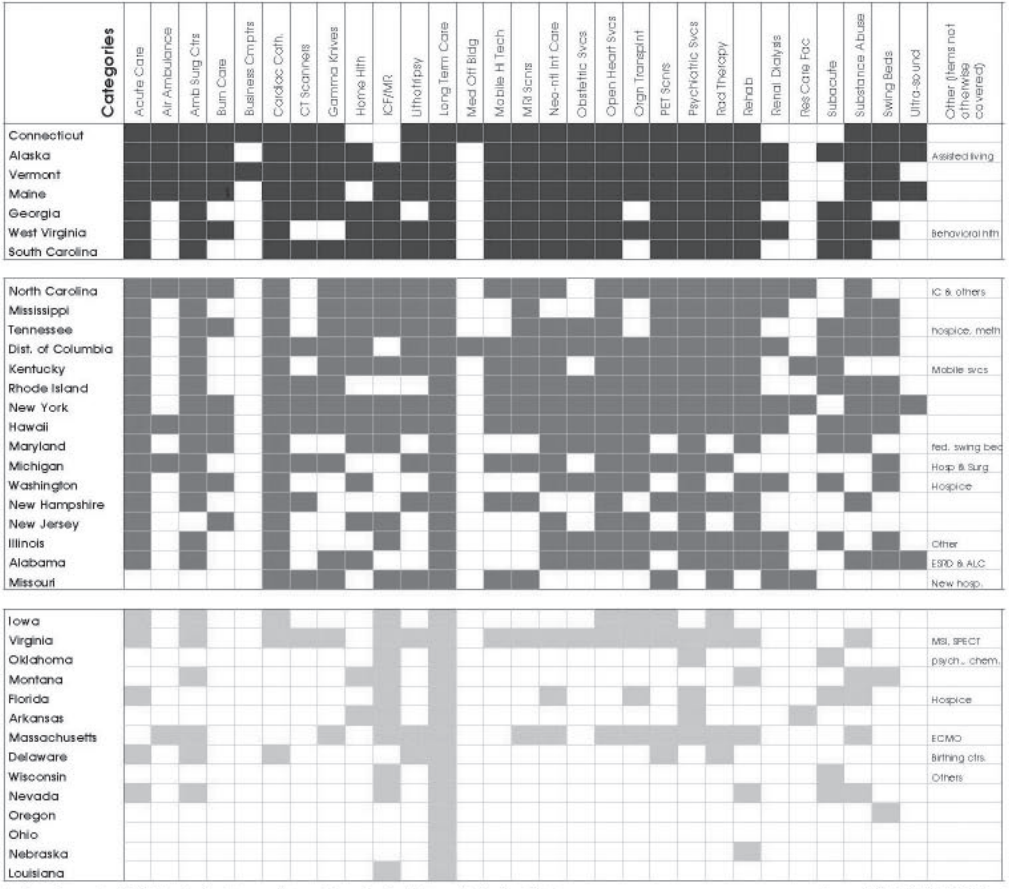
(20) This policy was implemented during WWII in order to get around strict controls on money wages. Tax-free benefits were then used as a way of attracting better employees.

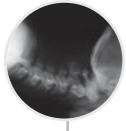
(21) Op. cit. at note 2.

(22) As quoted by Terree Wasley, "Certificate of Need: Poor Healthcare Policy," Mackinac Center for Public Policy, June 17, 1993.

CON Regulated Services by State

(this information is summarized from the 2004 National Directory of Health Planning, Policy and Regulatory Agencies, the fifteenth edition published by the American Health Planning Association)





About the Author

Roy Cordato is Vice President for Research and Resident Scholar at the John Locke Foundation. He is also Visiting Faculty at the Economics Department at North Carolina State University where he is advisor to a student club and teaches "Political Economy of the Market Process," a course that he designed. From 1993-2000 he served as the Lundy Professor of Business Philosophy at Campbell University in Buies Creek, NC. From 1987 to 1993 he was Senior Economist at the Institute for Research on the Economics of Taxation (IRET) in Washington, D.C. He has served as full-time economics faculty at the University of Hartford and at Auburn University, and as adjunct faculty at Johns Hopkins University.

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