



INSTITUTE FOR JUSTICE

**Testimony of Jaimie Cavanaugh  
Attorney, Institute for Justice  
Georgia House Study Committee on Certificate of Need Reform  
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To Chair Parrish and Members of this Committee:

My name is Jaimie Cavanaugh and I'm an attorney with the Institute for Justice (IJ). For over a decade, IJ has been working to repeal and reform certificate of need (CON) laws around the country. I am a policy expert on CON, have litigated CON cases, and have supported CON repeal efforts in many states. I also published a comprehensive report comparing each state's CON laws in 2020.<sup>1</sup>

I want to talk about access to healthcare today. Proponents of CON laws often argue that the laws increase access to care, but the evidence doesn't support that claim.

House Resolution 603, the Resolution that created this Committee, points out that healthcare is very different today than it was nearly 50 years ago when Georgia adopted its CON laws. The healthcare landscape has changed, yet Georgia's certificate of need laws have not. Georgia, like many states, adopted CON laws in response to law<sup>2</sup> enacted by Congress in 1974. Congress wanted to lower healthcare spending and thought CON laws would decrease health expenditures. Congress passed a law that threatened to withhold federal funding to states that didn't adopt CON laws.

At that time, healthcare providers were reimbursed by government payors on a "cost-plus" basis. Under the cost-plus system, hospitals were reimbursed for their actual expenses. Congress believed that these reimbursements incentivized hospitals to open and expand without risk at the government's expense.<sup>3</sup> The purpose of CON laws was to decrease the number of hospitals in order to control costs. By their nature, CON laws cannot increase access to care. That's the exact opposite of what they were designed to do.

Healthcare reimbursements are different today. Hospitals and healthcare providers are typically reimbursed on a fee-for-service basis. They aren't reimbursed based on their actual costs. Instead, providers are reimbursed based on rates set by the government. So, the entire basis for enacting CON laws is gone.

In 1986, Congress acknowledged that CON laws had failed to deliver any benefits. Two years later, one of Georgia's Congressional reps, Representative James Rowland, urged Georgia to repeal its CON laws because the federal mandate was gone.

Representative Rowland explained how CON laws harmed Putnam County, saying they were “insensitive to the true needs of the community” and also calling the effect of CON laws on healthcare costs “dubious” at best.<sup>4</sup>

Representative Rowland was referring to the local hospital in Putnam County. The 50-bed hospital had been in Putnam County for 20 years when it sought a CON to renovate, *not* expand.<sup>5</sup> But the agency wouldn’t grant the CON unless the hospital agreed to remove ten beds. The hospital cited several reasons why that would be expensive and inefficient—the population in the county was growing, the change in beds wouldn’t decrease healthcare costs, and decreasing beds would leave the hospital with fewer spots for students in its nursing program at a time when the nation was facing a shortage of nurses. And it would be much more costly (or maybe even impossible), given the CON laws, to add those ten beds back in the future.<sup>6</sup>

But the agency refused to listen to reason, saying that the decrease in beds was necessary to get the region closer to compliance with its quota of beds. This is just one example of how CON laws decrease access to care by artificially reducing the supply of facilities and services.

Here’s another problem with access. In the previous example, the agency thought a formula on a piece of paper was more important than real-world input. The same thing is happening now. The Department of Community Health relies on inelastic formulas to predict when care is needed. But doctors and patients should decide when care is needed, not government officials.

Let’s take the example of home health agencies. The home health industry should be growing. Home health services are a lower cost alternative to in-patient stays and many people prefer receiving care in their own homes. With the population aging, need for home health services should be growing. But home health agencies are prohibited from opening in most of the state based on an inelastic formula.

For planning purposes, the Department has divided Georgia into 12 regions. To calculate the “need” for home health services, the Department relies on a formula that considers population projections at the county level and the number of patients who used home health care the previous year.<sup>7</sup> It uses these numbers to estimate how many patients might use home health services over the next two years. If the number of patients in need is at least 500, the Department will accept applications for home health agencies. Otherwise, a new agency that wants to open can’t even apply. The Department won’t consider the application. But when need reaches 250 patients, an existing agency can apply for a CON to expand. So, existing providers can continue expanding to prevent need from ever reaching 500 patients, leaving new providers permanently

locked out of the market. That's why many healthcare innovators locate in states without CON laws. Neighboring states, like Florida and South Carolina, are going to experience healthcare innovations that Georgians won't be able to access.

In its most recent forecast, the Department shows that only three out of 12 regions have a need for new home health agencies.<sup>8</sup> In reality, trusting past usage to predict future need is risky. By its nature, the formula can't capture unmet need—that is the number of people who aren't using home health services because none are available. The formula only accounts for patients who actually used home health services in the previous year. Thus, these predictions will under-represent demand if there is already a shortage in care. That's why "need" shouldn't be reduced to a black-and-white formula.

Another important issue with access is access to rural healthcare. To be clear, CON laws do not prevent rural hospital closures. It's hard to overcome the emotional arguments, because of course we all want to help rural hospitals, but the evidence shows that rural hospitals do better in states without CON laws. If anything, CON laws exacerbate problems for rural hospitals. One study found that states with CON laws have 30% fewer rural hospitals per capita and 14% fewer rural ambulatory surgical centers (ASCs) per capita.<sup>9</sup> Because there are fewer facilities available, residents in states with CON laws have to drive longer distances to access healthcare<sup>10</sup> and face longer wait times in emergency departments.<sup>11</sup>

Then, there's the argument that rural hospitals or safety-net hospitals rely on CON laws for cross-subsidies to make up for uninsured or underinsured patients. First, that argument doesn't make sense because CON laws were intended to *lower* healthcare costs, not increase costs. So, if we buy the argument about cross-subsidies, then we admit CON laws have failed to achieve their intended purposes. The cross-subsidy argument is a *post hoc* rationalization for CON laws. But second, there are more rural hospitals per capita *and* more rural ASCs per capita in states without CON laws. That means that competition between hospitals and surgery centers doesn't bankrupt rural hospitals. Instead, competition helps everyone excel. One study even found that safety-net hospitals have larger margins in states without CON laws.<sup>12</sup>

Tellingly, nine states with CON laws either exclude rural facilities from their CON programs or don't apply CON to hospitals at all. Excluding rural facilities from CON laws encourages providers to locate in rural communities. The states that exempt rural facilities from their CON programs are: AL,<sup>13</sup> KY,<sup>14</sup> OR,<sup>15</sup> TN, and WA.<sup>16</sup> While IN, MT, OH, and SC exempt hospitals from CON altogether. This is an acknowledgment of the fact that CON is not helping rural healthcare facilities.

And many rural states have gone further and eliminated their CON programs altogether. These are states like Idaho, Kansas, and the Dakotas. And Texas, the state with the largest rural population in the U.S., also has no CON laws.

But if none of the hard facts are convincing, remember that Georgia has had ten rural hospital closures since 2005. This is data collected by the Sheps Center at the University of North Carolina. In contrast, CO, MT, OR, UT, and WY have all had zero rural hospital closures. And none of those states have CON laws for rural hospitals. They might be on to something.

While there's never a single reason a rural hospital closes, CON is not a silver bullet. The available evidence shows it's the exact opposite—states that have repealed their CON laws have more rural healthcare facilities. The real-world policies of many other states confirm that CON is especially harmful to rural communities.

Other government agencies agree that CON laws limit access to care. Since 1986, when Congress repealed the federal inducement, federal agencies like the Federal Trade Commission and the Antitrust Division of the Department of Justice have called for states to repeal CON laws. Their message has been consistent across republican and democratic administrations. The U.S. Department for Health and Human Services, Department of the Treasury, and Department of Labor agree.

And the pandemic showed the dangers of using CON to limit access to healthcare. States with CON laws, including Georgia, were forced to quickly suspend or modify their CON programs because they prevented hospitals from responding to patient needs. If loosening CON restrictions worked during the pandemic, it can work anytime. Just as it works in Texas, Florida, California, and many other states that have fully repealed CON laws. Even suspending CON laws during the pandemic wasn't enough to level the playing field. Hospitals in states with CON laws were 27% more likely to run out of hospital beds than states without CON laws. There was no difference in this figure between CON states that relaxed their CON requirements during the pandemic and those that did not.<sup>17</sup> When the country needed access to more care, we didn't turn to CON laws—we did the opposite. Suppressing the supply of healthcare harms patients and it's bad for the economy.

Thank you for considering my testimony. I hope to continue working with this Committee and its members throughout this process and will be a resource however I can. Please contact me with any questions.

Sincerely,



Jaimie Cavanaugh  
Attorney

Institute for Justice  
[jcavanaugh@ij.org](mailto:jcavanaugh@ij.org)  
(c) 248-895-1555

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<sup>1</sup> Available at: <https://ij.org/report/conning-the-competition/>.

<sup>2</sup> Pub. L. No. 93-641, 88 Stat. 2225 (codified at 42 U.S.C. §§ 300k–300n-6 (1982)), amended by Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, §§ 1-129, 93 Stat. 592 (codified at 42 U.S.C. §§ 300k–300t (1976 & Supp. 1981)).

<sup>3</sup> Grace Bogart, *Iowans Need Change: The Case for Repeal of Iowa’s Certificate of Need Law*, 45 J. Corp. L. 221, 232 (2019).

<sup>4</sup> James McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a “Managed Competition” System*, 23 Fla. St. U. L. Rev. 141, 157–58 (1995).

<sup>5</sup> *Id.* at 158.

<sup>6</sup> *Id.* at 158–59.

<sup>7</sup> Ga. Comp. R. & Regs. 111-2-2-.32(3).

<sup>8</sup> Home Health Agency Services Need Projection Summary for Horizon Year 2025, available at <https://dch.georgia.gov/divisionsoffices/office-health-planning/need-projections>.

<sup>9</sup> Stratmann, T. & Koopman, C. (February 2016). Entry Regulation and Rural Health Care Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals, (Working Paper) *Mercatus Center at George Mason University*, available at <https://www.mercatus.org/research/working-papers/entry-regulation-and-rural-health-care-certificate-need-laws-ambulatory>.

<sup>10</sup> Cutler, D., et al., (2010). Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery, *American Economic Journal: Economic Policy* 2 51–76.

<sup>11</sup> Meyers, M. & Sheehan, K. (2020). The Impact of Certificate of Need Laws on Emergency Department Wait Times, *Journal of Private Enterprise* 35 59–75.

<sup>12</sup> Dobson, A., et al. (2007). An Evaluation of Illinois’ Certificate of Need Program. <https://cgfa.ilga.gov/Upload/LewinGroupEvalCertOfNeed.pdf>.

<sup>13</sup> In Alabama, an acute care hospital with fewer than 105 beds may open without a CON if it is more than 20 miles from the nearest acute care facility. Ala. Code § 22-21-263(a)(4). And rural hospitals can add new health services without a CON. Ala. Code § 22-21-263(a)(4).

<sup>14</sup> In Kentucky, rural health clinics may open without a CON. Ky. Rev. Stat. § 216B.020(3)(h), § 216B.020(1).

<sup>15</sup> In Oregon, rural hospitals may open without a CON. Or. Rev. Stat. §§ 442.315(8), 442.347.

<sup>16</sup> In Washington, rural hospitals can expand bed capacity without a CON. Wash. Admin. Code § 246-310-042(1)

<sup>17</sup> Mitchell, M., & Stratmann, T. (2021). The economics of a bed shortage: certificate-of-need regulation and hospital bed utilization during the COVID-19 pandemic. *Journal of Risk and Financial Management*, 15(1), 10.