

# spotlight

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## CERTIFIED: THE NEED TO REPEAL CON

*Counter to their intent, Certificate of Need laws raise health care costs*

**KEY FACTS:** • Enacted in 1978, North Carolina's Certificate of Need (CON) law was one of many state CON laws adopted to comply with the federal Health Planning Resources Development Act of 1974.

- CON laws use central planning to try to reduce health care costs by keeping health care facilities from buying too much equipment, building too much capacity, and adding too many beds.



### CAROLINA CRONYISM

- Four decades' worth of data and research into CON laws have produced a recurring theme in the research literature: CON laws fail to lower health care costs; if anything, they raise them.

- In 1987 Congress repealed the mandate, and subsequently 14 states (but not North Carolina) ended their CON regimes.

- North Carolina hosts one of the most restrictive CON programs in the country, regulating 25 different services.

- While patients and rural communities are negatively impacted by CON restrictions (especially the poor, elderly, and those with emergencies), existing hospitals and medical service providers reap the benefits of CON laws insulating them from competition.

- Fewer than one-fourth (23 out of 100) of counties in North Carolina have more than one hospital. Seventeen counties still have no hospital.

- The cost in money and time just to apply to provide health care services in this state can be too great for smaller providers. Limiting beds, services, and competitors leads to higher profits for existing providers.

- At the end of 2012 a legislative committee recommended several reforms to CON, including allowing "market driven competition in the provision of health services." Bills based on those recommendations failed in 2013.

- State leaders could honor the intent behind CON — preventing unnecessary increases in health care costs — by repealing CON.

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Imagine opening the local newspaper and reading this about a potential new grocery:

**1** Choice Grocery has moved a crucial step closer towards opening a store in Holly Springs. Residents tired of long drives to North Raleigh and Cary have been seeking a nearby grocer for over a decade.

The latest development came Tuesday when a state official upheld an earlier ruling that approved Choice's application to locate a new grocery store in Holly Springs. The initial ruling was the first to document there is an officially "Certified Need" for a new grocer in that part of the state.

The ruling was hotly contested by grocery giant Ral-Mart, which complained that a new competitor would hurt its local monopoly and lead to lower prices and less profit. Ral-Mart has 30 days to contest the decision before the N.C. Court of Appeals.

You would probably think the article was a joke. If you took it seriously, you might wonder what business it could be of government's to preempt entrepreneurship by determining whether there is enough "need" for a proposed service. The grocer would be the risk-taker, betting on consumer interest. His investors and consumers would be the ones to provide the definitive answer of need.

You might even ask if the poor, inconvenienced shoppers in far-flung areas would say yes to the new store if given the chance, and marvel at the presumption of state government, looking out for the interests of existing grocers, preventing that chance.

It sounds like something out of a Soviet farce. Unfortunately, it's not too far removed from reality in North Carolina, one of the many states that still have Certificate of Need (CON) laws that put state officials in charge of restricting entry and expansion of, not food and household needs, but medical services.

### **Certifying "need": tidy theory, expensive practice**

Enacted in 1978, North Carolina's Certificate of Need (CON) law was one of many state CON laws adopted to comply with the mandates — and incentives — of the federal Health Planning Resources Development Act of 1974. The theory behind CON laws is that the economics of health care systems, unlike other markets, is such that more supply leads to higher prices. CON laws were established to address congressional suspicion that health care price inflation owed to health care facilities buying too much equipment, building too much capacity, and adding too many beds.<sup>1</sup>

Price inflation in health care was in fact taking place then. A prime culprit was the massive infusion of federal spending in health care. Medicare and Medicaid were enacted in 1965, and by 1970 federal spending in the health care system had increased sixfold.<sup>2</sup> Because those relied on cost-based reimbursement and third-party payers, health care providers faced little risk of overinvestment and overcapitalization, a problem addressed by reforms in the early 1980s that changed the payment system into a per-case prospective payment system.<sup>3</sup>

The thinking was that CON laws would prevent health care institutions from building too much and buying too much, and therefore being compelled to address their superfluous fixed costs through billing too much. Scrutiny from state health planning agencies, such as North Carolina's Division of Health Service Regulation, would help thread the needle between health care institutions' expansionary wants and their communities' actual health service needs.

The theory behind CON, based on the "exceptional market" notion<sup>4</sup> of health care, failed in its assumptions. A 2004 report by the U.S. Federal Trade Commission (FTC) and the Department of Justice (DOJ) found CON programs beset with "serious competitive concerns that generally outweigh CON programs' purported economic benefits."<sup>5</sup> (That the health care system in the U.S. has for decades borne little resemblance to a free market should go without saying.)

The FTC/DOJ report found “considerable evidence” that CON programs “can actually drive up prices by fostering anticompetitive barriers to entry” in the health care market. CON regulations result in several negative effects that raise rather than lower consumer prices, protect entrenched health care providers, and harm consumer welfare:

- The difficult process of obtaining a state-issued certificate of need is an effective barrier against new entrants in health care, shielding incumbent providers from competition
- This anticompetitive barrier works to hold supply below competitive levels and thereby keep prices artificially high
- CON programs also bar or delay new entrants offering higher quality services and newer innovations than incumbent providers, leaving consumers with lesser quality and higher priced options
- With incumbent providers shielded from competition, they have little impetus to control their own costs, leading to higher (oligopoly) prices<sup>6</sup>

In 1987 Congress repealed the mandate owing to two failures working in concert: not only were CON regulations decidedly not reducing health care costs, but also they were producing negative effects in local communities. Aggregate spending on health care had reached historic highs, exceeding 10 percent of GDP for the first time.<sup>7</sup>

In the ensuing years 14 states (but not North Carolina) ended their CON regimes.<sup>8</sup>

### **The ‘remarkable evaluative consensus’ that CON doesn’t work**

Four decades’ worth of data and research into CON laws have produced a recurring theme in the research literature: ***CON laws fail to lower health care costs; if anything, they raise them.***

A major study of the effect of CON laws was conducted by two Duke University researchers, Christopher J. Conover and Frank A. Sloan. Published in 1998 in the *Journal of Health Politics, Policy and Law*, the Conover/Sloan study was able to analyze the cost effects of states that dropped CON laws, to see whether their repeal led to the sort of increased health care costs the regulations were supposed to have been preventing. They found “no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations.”<sup>9</sup>

Under established CON programs, Conover and Sloan did find a small reduction in bed supply. They also found “higher costs per day and per admission, along with higher hospital profits.” They could find no effects of CON laws on quality of care and little empirical evidence to determine whether CON laws improved access.<sup>10</sup>

Researcher Patrick McGinley’s survey of academic literature into CON laws yielded a uniform result: “In searching the scholarly journals, one cannot find a single article that asserts that CON laws succeed in lowering health care costs. CON ‘has elicited a remarkable evaluative consensus -- that it does not work.’”<sup>11</sup>

As explained by Wes Cleveland, CON regulations expert at the American Medical Association (AMA), in testimony before the Interim Health Committee on Certificate of Need in West Virginia, this research consensus extends beyond peer-reviewed academic journal articles and also includes studies commissioned by state legislatures. They, too, “demonstrat[e] that CON programs have failed to achieve their purported purpose — to restrain health care costs. In fact, there is evidence showing that CON programs have actually *increased* health care costs.”<sup>12</sup> (Emphasis in original.)

Those detrimental cost effects are not limited to whether a CON program is in place, however. As Cleveland explained, states have considerable variety in their CON programs. The more restrictive the CON program, the worse its effect on health care costs in the state. He warned that West Virginia’s CON program was one of the most restrictive CON programs in the nation, and “only Alaska, New York, and **North Carolina** regulate more services” than West Virginia (emphasis added).<sup>13</sup>

“[R]estrictiveness correlates with increased health care costs,” Cleveland testified.<sup>14</sup>

## North Carolina's restrictive, expensive CON program

One of the most restrictive CON programs in the nation, North Carolina's CON law regulates 25 different health care services.<sup>15</sup> Here is how the state Division of Health Service Regulation (DHSR) describes the law:

The North Carolina Certificate of Need (CON) law prohibits health care 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. Prior approval is also required for the **initiation of certain medical services**. The law **restricts unnecessary increases in health care costs and limits unnecessary health services and facilities based on geographic, demographic and economic considerations**.<sup>16</sup> (Emphasis added.)

As conclusively demonstrated by the research literature, that final sentence is self-contradictory. Limiting health services and facilities cannot restrict unnecessary increases in health care costs; it causes them. North Carolina's highly limiting CON law applies to "[a]ll 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, and ambulatory surgical facilities" as well as certain upgrades and expansions of existing health service facilities or services.<sup>17</sup>

### *Protecting hospitals from competition at the expense of patients and communities*

Viewed in light of the correlation between restrictiveness and cost increases, North Carolina's CON program negatively affects health care consumers and local communities, especially small towns and rural areas. The impact is more than just artificially higher prices. The elderly, the poor, people under time constraints (mothers, small business owners, etc.), and — especially! — people with emergency medical needs are better served by having medical services nearby.

Who benefits from keeping medical services more disparate and scarce? Existing hospitals and medical service providers, who

Services regulated by North Carolina's CON law: How many other CON states also regulate them?	
Service regulated by CON in NC	Number of other CON states (and DC) regulating it
Acute Hospital Beds	27
Ambulatory Surgical Centers (ASC)	26
Burn Care	10
Cardiac Catheterization	25
Computed Tomography (CT) Scanners	12
Gamma Knives	14
Home Health	16
Hospice	17
Intermediate Care Facilities/Mental Retardation (ICF/MR)	21
Long Term Acute Care (LTAC)	27
Lithotripsy	14
Nursing Home Beds/Long Term Care Beds	36
Mobile Hi Technology (CT / MRI / PET, etc)	15
Magnetic Resonance Imaging (MRI) Scanners	18
Neo-Natal Intensive Care	22
Open Heart Surgery	24
Organ Transplants	20
Positron Emission Tomography (PET) Scanners	19
Psychiatric Services	25
Radiation Therapy	22
Rehabilitation	24
Renal Failure/Dialysis	11
Assisted Living & Residential Care Facilities	4
Subacute Services	12
Substance/Drug Abuse	18
Source: "Certificate of Need: State Health Laws and Programs," National Conference on State Legislatures, January 2011	

Key:

One-half or few other CON states regulate this service

One-third or fewer other CON states regulate this service

reap the benefit of CON laws insulating them from competition. That benefit may not be unintentional, however — as East Carolina University researchers Ellen S. Campbell and Gary M. Fournier found, the states most likely to enact CON regulations “were those with a highly concentrated hospital industry and increasing competitive pressures,” with hospitals largely favoring CON laws, which protect them from competition.<sup>18</sup>

As things stand now, fewer than one-fourth (23 out of 100) of counties in North Carolina have more than one hospital. Seventeen counties still have no hospital.<sup>19</sup>

Furthermore, North Carolina’s CON laws frequently intrude into service areas that most other CON states leave untouched by their CON programs. For example, only half of the 25 health care services regulated by CON laws in North Carolina are also regulated by majorities of other CON states (see Table 1). Five services regulated by North Carolina’s CON program — burn care (10 other CON states), CT scanners (12), renal failure/dialysis (11), subacute services (12), and assisted living and residential care facilities (only 4 other CON states) — are regulated in one-third or fewer of the other CON states.

The effect of limiting supply (of beds, medical equipment, even facilities) is higher hospital profits. Foundational economic theory holds that high profits entice competitors into a market, whose presence and competition lowers prices in the market. When the market is as closed to competition as it is under CON, however, the regulated entities — i.e., those already in the closed system and making the high profits — have a motivation to keep CON laws in place.

#### *Cartel is as cartel does*

What emerges is essentially a government-blessed cartel — an OPEC of sorts for health care services.<sup>20</sup> Health care economist Mark V. Pauly of the Wharton School at the University of Pennsylvania explained that 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.”<sup>21</sup> The FTC/DOJ study cited “considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry,” the key being that “Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent’s market.”<sup>22</sup> Health care experts Michael Cannon and Michael Tanner of the Cato Institute said that in CON states, “it is common for competitors to have much to say” in the public-comment period when rival hospitals, nursing homes, and other facilities seek state approval to expand.<sup>23</sup>

The Division of Health Service Regulation’s web page for comments on CON applications<sup>24</sup> provides a vivid illustration of this non-market-based competition at work. North Carolina’s CON process begins with the annual publication by the Medical Facilities Planning Branch of DHSR of the State Medical Facilities Plan (SMFP), wherein state planners list their determined needs for health care facilities, beds, services, etc. across the state. Aspiring providers send in applications competing to win state approval for filling those needs. Following a public comment period and review period, the CON section of DHSR grants certificates to winning providers.

For example, the 2013 SMFP identified a “need” for one additional Medicare-certified home health agency for Forsyth County. Several competing health care providers — Liberty Home Care VI, Maxim Healthcare Services, UniHealth Home Health and Forsyth County Healthcare Properties, and Well Care Home Health — submitted four applications to DHSR’s CON section, open for public comment until Sept. 3, 2013.<sup>25</sup>

On the next page is a screen shot of DHSR’s page of submitted comments concerning those applications. Each aspiring provider submitted comments against their competitors’ bids to explain why those fell short of the state’s review criteria while their own were superior. They necessarily aimed not to persuade potential investors and affected consumers, but government regulators. A similar tussle could be seen in June 2013 between two hospitals competing to fill the 2013 SMFP’s identified “need for one additional PET scanner in HSA II, which includes Caswell, Alamance,

Rockingham, Guilford, Randolph, Stokes, Forsyth, Davidson, Surry, Yadkin and Davie counties.”<sup>26</sup>

Losing applicants may (and inevitably do) appeal the decision with the Office of Administrative Hearings, and then to the North Carolina Court of Appeals. This last stage of wrangling with the government greatly adds to the cost of seeking to enter the health services market in North Carolina (not to mention, it also contributes to the already overburdened court system). From preparation consulting fees to application fees, public hearing consulting fees, expedited review, and appeals, the cost of the CON process for an application in 2009 ranged from a minimum of \$32,000 (barring expedited review and appeals) to over \$5.4 million.<sup>27</sup> The cost of the process in time can range from 90 days to two years or more.<sup>28</sup> Such potential high costs would effectively keep smaller potential providers away who could not afford that much for merely applying.

Screenshot of DHSR web site showing who provided public comments on CON applications				
August 1 Review Comments				
Comments for Reviews Beginning August 1, 2013				
County	Type of Review	Project ID#s	Applicants	Person or Facility Submitting Comments
Forsyth	Home Health Agency	G-10160-13	<a href="#">Liberty Home Care</a> (PDF, 45 KB)	<a href="#">Well Care</a> (PDF, 363 KB)
Forsyth	Home Health Agency	G-10156-13	<a href="#">Maxim</a> (PDF, 45 KB)	<a href="#">Well Care</a> (PDF, 270 KB)
Forsyth	Home Health Agency	G-10161-13	<a href="#">UniHealth</a> (PDF, 45 KB)	<a href="#">Well Care</a> (PDF, 347 KB)
Forsyth	Home Health Agency	G-10160-13 G-10161-13 G-10159-13	<a href="#">Liberty Home Care</a> <a href="#">UniHealth</a> <a href="#">Well Care</a> (PDF, 45 KB)	<a href="#">Maxim</a> (PDF, 2.19 MB)
Forsyth	Home Health Agency	G-10160-13 G-10156-13 G-10159-13	<a href="#">Liberty Home Care</a> <a href="#">Maxim</a> <a href="#">Well Care</a> (PDF, 45 KB)	<a href="#">UniHealth</a> (PDF, 32.75 MB)

Source: “Written Comments for CON Applications,” August 1 Review Comments, N.C. Division of Health Service Regulation, <http://ncdhhs.gov/dhsr/coneed/comments/index.html#august2013>

### The House Select Committee on Certificate of Need Process and Related Hospital Issues

Established by Speaker Thom Tillis in 2011, this committee was charged with reviewing the health planning process in North Carolina to determine “whether these programs are adequately serving their intended purpose of ensuring the availability of quality, cost effective health care services to North Carolina citizens.”<sup>29</sup>

With respect to CON, the committee offered several recommendations. Major recommendations included:

- a “full and a complete review of all new institutional health services regulated under Certificate of Need law to determine the need and rationale for each included service regulation”
- “exempting diagnostic centers from Certificate of Need Review and amending the Certificate of Need laws pertaining to single-specialty ambulatory surgery operating rooms”
- several adjustments to “statutory expenditure thresholds regarding expedited reviews, major medical equipment, and replacement equipment”
- several changes “to streamline the appeals process, to redefine the parties having standing to appeal, and to deter the bringing of frivolous, harassing, or meritless appeals”<sup>30</sup>

The proposed exemption of ambulatory surgery centers could save the state an estimated \$70.0 million to \$147.4 million in Medicaid and state health plan payments from 2014 to 2020. A similar change to CON law in 2005 that allowed endoscopy units to open saved the state around \$225 million in Medicare payments. Savings would accrue because reimbursement rates for hospitals are far greater than reimbursement rates for ambulatory surgery centers.<sup>31</sup>

Recommendation 19 urged the General Assembly to “study reform of the health care market and the health care delivery system in North Carolina to increase cost effectiveness and quality of care through the encouragement of market driven competition in the provision of health care services.”<sup>32</sup>

In 2013 two bills were introduced in the House that would have incorporated the committee’s recommendations. Neither was enacted. House Bill 177, “Amend Certificate of Need Laws,” which included the ambulatory service center exemption and the study of reform through market competition, passed the House 112-2 but failed to advance in the Senate, while House Bill 83, “Enact CON Committee Recommendations,” languished in committee. The Senate could, however, revisit H.B. 177 in the 2014 short session. <sup>33</sup>

### **Recommendation: Honor the intent behind CON by repealing it**

“The fundamental premise of the CON law,” declares DHSR, “is that increasing health care costs may be controlled by governmental restrictions on the unnecessary duplication of medical facilities.”<sup>34</sup>

The fundamental premise is hopelessly wrong. The goal of the CON law is still achievable — preventing unnecessary increases in the cost of health care services — but not by CON. As decades of research have conclusively demonstrated, CON makes higher health care costs more likely, not less.

CON’s fundamental premise has the relationship between competition and prices completely backwards. Competition, not central planning, is what would prevent artificial price increases.

Especially amid the uncertain environment and inflationary forces fostered by the federal Patient Protection and Affordable Care Act (a.k.a. “Obamacare”), keeping health care costs down is a worthy and important goal for state policymakers. CON is an area especially open for reform in North Carolina, since it is one of the most restrictive — and therefore most inflationary — in the country. Now is no time to promote a cartel.

State policymakers should, in short, give health care consumers — i.e., people with physical needs, including emergencies — what they really need: more choices, closer access, and lower costs. Repeal of CON would accomplish all three.

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### **End notes**

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2. Greg Scandlen, “Myth Busters #4: The Death of Health Planning,” Health Blog, National Center for Policy Analysis, July 27, 2011, [healthblog.ncpa.org/myth-busters-4-the-death-of-health-planning](http://healthblog.ncpa.org/myth-busters-4-the-death-of-health-planning).
3. See, e.g., discussion in Charles Gerena, “Putting on the Brakes: Certificate of need regulations try to steer health-care supplies, but it’s hard to keep them from fishtailing,” *Region Focus*, Federal Reserve Bank of Richmond, Spring 2004, [richmondfed.org/publications/research/region\\_focus/2004/spring/pdf/feature1.pdf](http://richmondfed.org/publications/research/region_focus/2004/spring/pdf/feature1.pdf).

4. Sentiments documented by “Improving Health Care,” FTC and DOJ, include that “[c]ompetition in health care is ... very different” from competition in other markets and that it “put[s] traditional economic theory on its head.” In “Certificate of Need,” NCSL, the argument pro CON regulations begins, “Advocates of CON programs say that health care cannot be considered a ‘typical’ economic product. They argue that many ‘market forces’ do not obey the same rules for health care services as they do for other product.”
5. “Improving Health Care,” FTC and DOJ.
6. “Improving Health Care,” FTC and DOJ.
7. Patrick McGinley, “Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a Managed Competition System,” *Florida State University Law Review*, Summer 1995, Vol. 23, No.1, [law.fsu.edu/journals/laureview/issues/231/mcginley.html](http://law.fsu.edu/journals/laureview/issues/231/mcginley.html).
8. “Certificate of Need,” NCSL.
9. Christopher J. Conover and Frank A. Sloan, “Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?,” *Journal of Health Politics, Policy and Law*, Vol. 23, No. 3, June 1998.
10. Conover and Sloan, “Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?”
11. McGinley, “Beyond Health Care Reform.”
12. Wes Cleveland, JD, American Medical Association, testimony presented to the Interim Health Committee on Certificate of Need (West Virginia), October 8, 2007, [ama-assn.org/resources/doc/clrpd/dr\\_own\\_statement.pdf](http://ama-assn.org/resources/doc/clrpd/dr_own_statement.pdf).
13. Cleveland testimony.
14. Cleveland testimony.
15. “Certificate of Need,” NCSL.
16. “Certificate of Need,” North Carolina Division of Health Service Regulation (DHSR), [ncdhhs.gov/dhsr/coneed/index.html](http://ncdhhs.gov/dhsr/coneed/index.html), accessed October 9, 2013.
17. “Certificate of Need,” DHSR.
18. Ellen S. Campbell and Gary M. Fournier, “Certificate-of-Need Deregulation and Indigent Hospital Care,” *Journal of Health Politics, Policy and Law*, Vol. 18, No. 4, 1993, p. 906.
19. “Hospitals by County: Hospitals Licensed by the State of North Carolina Department of Health and Human Services,” DHSR, [ncdhhs.gov/dhsr/data/hllistco.pdf](http://ncdhhs.gov/dhsr/data/hllistco.pdf), report current as of October 3, 2013. Counties without hospitals: Camden, Caswell, Clay, Currituck, Gates, Graham, Greene, Hoke, Hyde, Jones, Madison, Northampton, Pamlico, Perquimans, Tyrrell, Warren, and Yancey.
20. See discussion in Roy Cordato, “Certificate-of-Need Laws: It’s Time for Repeal,” Nathaniel Macon Research Series. No. 1, John Locke Foundation, November 28, 2005, [johnlocke.org/research/show/policy\\_reports/62](http://johnlocke.org/research/show/policy_reports/62).
21. As quoted by Terree Wasley, “Certificate of Need: Poor Healthcare Policy,” Mackinac Center for Public Policy, June 17, 1993, [mackinac.org/152](http://mackinac.org/152).
22. “Improving Health Care,” FTC and DOJ.
23. Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What’s Holding Back Health Care and How to Free It*, Cato Institute, Washington, D.C., 2005, p. 137.
24. “Written Comments for CON Applications,” DHSR, [ncdhhs.gov/dhsr/coneed/comments/index.html](http://ncdhhs.gov/dhsr/coneed/comments/index.html).
25. “Four in Forsyth County compete for home health agency,” Public Notice, DHSR, August 12, 2013, [ncdhhs.gov/dhsr/coneed/press\\_release/2013/08122013ForsythHomeHealth.pdf](http://ncdhhs.gov/dhsr/coneed/press_release/2013/08122013ForsythHomeHealth.pdf).
26. “Two compete for PET scanner in Forsyth County,” Public Notice, DHSR, May 31, 2013, [ncdhhs.gov/dhsr/coneed/press\\_release/2013/06032013ForsythPETScanner.pdf](http://ncdhhs.gov/dhsr/coneed/press_release/2013/06032013ForsythPETScanner.pdf).
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33. House Bill 177, “Amend Certificate of Need Laws,” [ncga.state.nc.us/gascripts/BillLookup/BillLookup.pl?Session=2013&BillID=h+177&submitButton=Go](http://ncga.state.nc.us/gascripts/BillLookup/BillLookup.pl?Session=2013&BillID=h+177&submitButton=Go); House Bill 83, “Enact CON Committee Recommendations,” [www.ncga.state.nc.us/gascripts/BillLookup/BillLookup.pl?Session=2013&BillID=h83&submitButton=Go](http://www.ncga.state.nc.us/gascripts/BillLookup/BillLookup.pl?Session=2013&BillID=h83&submitButton=Go).
34. “Certificate of Need,” DHSR.