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END CERTIFICATE OF NEED IN MISSOURI

By Patrick Ishmael

KEY FINDINGS

- A certificate of need (CON) law gives government the power to manage competition in a given industry through the allowance, or disallowance, of new providers, facility expansions, or certain services as defined by the law.
- Supporters of CON regimes contend that CON laws reduce health care costs and improve quality, but research on the topic suggests that they have a neutral or even negative impact on the cost and availability of services.
- CON should be repealed in Missouri. Government should not substitute its judgment of "need" for determinations by the marketplace itself for health care services—or any services, for that matter—especially when such determinations lead to supply restrictions, quality concerns, and upward cost pressures.

INTRODUCTION

"Jane Fonda" may not have been the first two words you were expecting in an essay about certificate of need (CON) laws in the Show-Me State, but when famed economist Milton Friedman tells you "Barbarella" was right about something—and that "something" touches the CON issue—it's hard to resist mentioning her name.

During one of Milton Friedman's famed campus visits in the 1970s, a young questioner mentioned that Fonda, a well-known liberal, had recently expressed her dismay at the extent to which big business had influence over the government.[1] The questioner asked if her concern was credible.

"Sure, there's a great deal of merit in the position she was taking," Friedman said, to the seeming surprise of the audience. He continued:

> You must distinguish sharply between being pro free enterprise, which I am, and being pro-business, which I am not. Those are two different things. The reason I am pro free enterprise, the reason I am for a free market on the political level, is primarily because I believe the problem in this world is to avoid a concentration of power, to have a dispersal of power, that unless we have a dispersal of power, we will not be able to maintain a free society.
>
> Now Jane Fonda is right, that if we have a system under which government is in a position to give large, and does give large favors, it is human nature for people to try and get those favors. . . . And in my opinion the only way you can prevent that and make sure that businesses operate in the public interest is to force them to engage in competition, one with the other.

Friedman cautioned that the solution to big business's self-serving influence over government wasn't bigger government; rather, he said that the "only effective cure is to reduce the scope of government, to get government out of the business."

There are many ways that businesses can marshal the power of government to serve their own interests, and one of those ways is through CON laws. Missouri currently has such a law regarding health care,[2] and whether that law should remain on the books should be the subject of greater legislative inquiry, in light of its theoretical and real-world shortcomings.

WHAT IS CERTIFICATE OF NEED?

A CON law gives government the power to manage competition in a given industry through the allowance, or disallowance, of new providers or services. Perhaps the best-known CON laws in the United States are in the health care industry. However, CON laws certainly are not exclusive to health care; in fact, until recently Missouri even had a CON requirement for movers.[3] But CON laws have had their biggest impact on health care policy.

Discussions about CON laws contemporaneous to their rise in the 1960s and 1970s offer an insight into why they became popular. In a *Virginia Law Review* article published in 1973, Duke Law professor Clark Havinghurst begins with a concern that is still commonly expressed today, nearly a half-century later (Emphasis mine): "**The high and rising cost of health care, particularly the spiraling of hospital costs at a rate six percent per year above the rate of inflation generally**, has prompted numerous proposals to improve the economic performance of the health care system."[4]

In response to this concern, Havinghurst noted that the "chief manifestation of regulatory cost-control techniques has been a pronounced trend toward the enactment of so-called 'certificate-of-need' laws in the states," and that such laws combine traditional health care policy considerations and public utility regulation, "plac[ing] extensive regulatory controls on entry into the health services industry and on new investments in health care facilities."[5]

Justifications for Certificate of Need Laws

CON supporters generally rely on two dubious propositions to justify the close oversight these regimes have over health market actors—oversight that can result in the denial of a certificate and the rejection of new health care services for a region.

First, supporters contend that CON reduces health care costs and improves quality. As a cost-saving mechanism in health care, CON is predicated on the presumption that

unfettered competition tends to increase the number of market suppliers, lowering prices and eventually making some services unprofitable, thus compelling some suppliers to leave the market entirely.[6] According to this argument, the supplier churn negatively impacts quality of care. New York's Metcalf–McCloskey Act, passed in 1964 and widely regarded as the grandfather of CON laws, was passed precisely for this reason. Its stated purpose was to reduce health care costs and improve care and access. Subsequent policy moves nationwide toward regional and statewide facility regulation find their origins in this New York law.

Notably, the proponents of CON laws concede that a competitive market—one which does not restrict supply, where new firms are permitted to enter the market—initially reduces prices. They claim, however, that in the end, unrestricted competition forces so many firms out of the market that those remaining have a kind of monopoly power.

Second, supporters believe that health care is better run as a "public utility" than left to be managed primarily by an open market.[7] This idea about centralized health care management is a recurring one in American political culture,[8] and the assumption—that health care services are best provided through some variation of a managed monopoly—echoes in many present-day health care laws, proposals and regulatory regimes. While more recent attempts at centralized control of health care have met with resistance, especially with regard to the Affordable Care Act (ACA), CON laws persist, even in places where the ACA has been strongly opposed.[9] One such place is Missouri.

A CLOSER LOOK AT CERTIFICATE OF NEED IN MISSOURI

The Law

For its part, Missouri has had a CON statute for its health care facilities on the books since 1979. The purpose of this policy is outlined more completely through state regulation, specifically 19 CSR 60-50.200:

> The purpose of the CON statute is to achieve the highest level of health for Missourians through **cost containment**, reasonable access, and public accountability. The goals are to— (A) Review proposed health care services; **(B) Contain health costs;** (C) Promote economic value; **(D) Evaluate competing interests; (E) Prevent unnecessary duplication;** and (F) Disseminate health-related information to affected parties [Emphasis mine]

Missouri Revised Statute 197.315 outlines that activities covered by the CON law includes "any person" who seeks to "develop or offer a new institutional health service." A "new institutional health service" is defined in 197.305 and includes:

> The acquisition, including acquisition by lease, of any **health care facility**, or **major medical equipment** costing in excess of the expenditure minimum. [Emphasis mine]

The term "health care facility," as covered by the CON law, is defined under Missouri Revised Statute 197.366 to include:

> (1) Facilities licensed under chapter 198 [Nursing Homes and Facilities];
>
> (2) Long-term care beds in a hospital as described in subdivision (3) of subsection 1 of section 198.012;
>
> (3) Long-term care hospitals or beds in a long-term care hospital meeting the requirements described in 42 CFR, section 412.23(e); and
>
> (4) Construction of a new hospital as defined in chapter 197.

Moreover, "major medical equipment" is ambiguously defined in the statute itself as "medical equipment used for the provision of medical and other health services," but it is more fully defined through regulation, specifically 19 CSR 60-50.300. To wit:

> Major medical equipment means any piece of equipment and collection of functionally related devices acquired to operate the equipment and additional related costs such as software, shielding, and installation, acquired over a twelve (12)-month period with an aggregate cost of one (1) million dollars or more, when the equipment is intended to provide the following diagnostic or treatment services and

> related variations, including, but not limited to: (A) Cardiac catheterization; (B) Computed tomography; (C) Gamma knife; (D) Lithotripsy; (E) Magnetic resonance imaging; (F) Linear accelerator; (G) Positron emission tomography/computed tomography; or (H) Evolving technology

The powers created by the statute and regulatory regime[10] are wielded by a committee of nine appointed members, itself called the Missouri Health Facilities Review Committee (MHFRC). The committee consists of:

> (1) Two members of the senate appointed by the president pro tem, who shall be from different political parties; and
>
> (2) Two members of the house of representatives appointed by the speaker, who shall be from different political parties; and
>
> (3) Five members appointed by the governor with the advice and consent of the senate, not more than three of whom shall be from the same political party.[11]

Although explicit provisions are included in the law to make the committee more or less bipartisan—including political party requirements and a ban on political donations to members of the committee from applicants—the fact that the CON committee is "bipartisan" does not make it "apolitical." Moreover, the inability of an interested party to donate to a Committee member, as is prohibited in Missouri's CON system, does not also mean the party cannot make donations *against* them, to say nothing of providing support that does not take the form of a "political donation."

These concerns are not meant to be an implicit endorsement of an alternative committee system devoid of political actors; even a bureau of nine unelected "experts" would still be substituting their judgment for millions of Missourians in the health care market. But whatever the basis for the committee's composition—whether based on bipartisanship, expertise, or something else—that committee replaces millions of individual consumer decisions and extensive consumer knowledge with a single bureaucracy. The question of whether that replacement is prudent is at the core of the CON debate.

The Process

The actual procedure used to issue a CON varies somewhat from state to state, but that process typically hews fairly closely to the procedure used in Missouri today. At least 30 days before the formal CON filing, an applicant must file a letter of intent to pursue a covered project, which includes things like a new health care facility or a significant reconstruction of an existing facility. Then the CON filing itself must be made at least 71 days before the MHFRC (which presides over Missouri's CON program) meets and considers such applications. The CON application must include, among other things, the requisite fees; a description of the project; proof of the financial feasibility of the project; a "consumer needs" analysis that demonstrates interaction with potential customers; a zip code analysis looking at the areas that would be served by the facility; and, astonishingly, a demonstration that competitors were given notice of the application.

Taken together, the filing process alone takes at least three to four months, with a decision on an application not required for potentially months afterward. However, that timeline does not include the time required to prepare such an extensive application—before the submission of the letter of intent or CON filing—or the time required to reattempt or rewrite a CON application should it be denied. The CON process is not just an enormous commitment of time for a given applicant; it can also be an enormous commitment of money to prepare and file, without a guarantee of ultimate acceptance.

Even when a committee decision might work against the purposes of the law, in the sense that it might not, say, "contain health costs" or "promote economic value," as a practical matter that decision can be difficult to overturn. Furthermore, since capital hates uncertainty— for instance, investors resist waiting on the sidelines for years while litigation decides whether an investment can be made—the effect of CON laws is to reduce the expansion of health care services, except in instances where applicants already have reason to believe the Committee is likely to approve a particular proposal.

Apart from convincing the committee members themselves of the necessity of the proposed services, other factors that influence whether a certificate will be issued create additional barriers to approval. For example, according to Missouri's Department of Health and Senior Services, the state has *thousands* of surplus CON-regulated "beds" —that is, spaces in health care facilities that could provide overnight services—beyond what the state "needs" in the aggregate.[12] That the state has placed limits on what services can be provided is implied under a CON rubric, but how those thresholds are created and where the limits are set can sway a decision about whether or not a CON proposal is attempted or approved and health care access extended.

Practically speaking, a nominal bed "surplus" places a significant burden on new entrants to prove that the state needs more health care services and influences whether projects are proposed at all. The argument for additional beds may be more compelling in some regions of the state than in others, depending on where bed "deficits" exist according to the state's accounting. In some regions, however, it can be next to impossible for a new provider to add to an area's health care inventory. That's a great situation for incumbent providers, where competition can be headed off even before a CON application has been made; it's not so great for challengers, or ultimately, for the public.

Clarendale of St. Peters

One project, Clarendale of St. Peters, captures the risks involved in undertaking a project subject to CON requirements. There, a proposed $12.5 million senior care center was taken to the MHFRC in early 2017 and was heard by the Committee in July 2017. On a 3-2 vote, the project was rejected.[13]

Peter Schwartz, AIA,[14] an architect for the project, later described the experience on Missouri's NoMoRedTape website,[15] writing that

> This denial came despite overwhelming local support for the project: unanimous Planning and Zoning approval, unanimous City Council approval, and nearly 50 letters of support written by St. Peters community leaders. The project would bring St. Charles County approximately 500 construction jobs, followed by 80 permanent jobs. Opposition to the project consisted exclusively of competitors and their lobbyists, attempting to influence a government committee to block fair competition—the kind of fair and healthy competition that increases choices for both consumers and workers.

Reached by phone, Schwartz said opponents at the hearing went so far to suggest not only that the addition of Clarendale's services in the region might draw current customers to the new facility, but also that Clarendale might also attract their employees, too. In other words, incumbent service providers wanted the state to protect them not only from competition for their customers, but also from competition for their employees. The Committee obliged.

Supporters of the project said that after including the other parts of the project dependent on the CON being granted, nearly $50 million in development had been rejected.

But that wasn't the end of this particular story; project backers resubmitted their application after the project was rejected, and the project was approved in January 2018 unanimously, 6-0. Schwartz also told me that the projects taken to each of the hearings—hearings conducted only six months apart—were identical, and that the biggest difference between the July 2017 hearing and the one in January 2018 was the member composition of the MHFRC and the organization of the opposition, which basically failed to show up for the second hearing.

The market circumstances—the "need" for Clarendale's services—didn't change. Rather, it appears as if the politics did.

THEORETICAL AND DATA-DRIVEN OBJECTIONS TO CERTIFICATE OF NEED LAWS

Proponents of market-oriented solutions generally view CON laws with skepticism because centralized, top-down approaches run against the historical successes of allowing market forces to provide goods and services.[16] One way to understand CON laws is to think of them as a kind

of licensing. Under licensing regimes, governments can control who can participate in a given field or undertake a certain activity, generally on the basis of competency. To get a driver's license, for instance, prospective drivers must first demonstrate that they can operate their vehicle safely and in compliance with the laws.

Where CON laws differ from traditional licensing systems is that "competency" is insufficient on its own to obtain that license or certificate; a prospective market participant must also demonstrate to the government that his or her services are needed by the public and not already satisfied by an incumbent interest. In the driving context, this would be like a truck driver going to the DMV for his license and having to prove that the state needs another commercial trucker on the road. "Sure, you can drive, but does society need another truck driver?"

If every profession were operated in this fashion, individuals and institutions, though competent in a given field, would have to prove there was a "need" before being allowed to offer a good or service to the public.[17] Such a permission-based system is often related to the notion that government has an expertise that can protect the public from substandard market participants and other market risks—that it is in the public interest for the government to act as a gatekeeper to providers. The result is that even a top-flight health care firm might not be able to invest in health care unless its proposal to do so satisfies the state's determinations for "need" in that particular field.[18]

One of the most powerful arguments for allowing markets to work, free from undue government interference, is that markets represent the *knowledge* of the crowd that no single market participant or government alone could ever have. A government-run approval system is severely limited in its ability to make good judgments about market needs, product pricing, and a whole host of other economic decisions that, if left to the crowd, could be resolved in comparatively short order.

Fortress and Frontier

Of course, debates over "knowledge" and "expertise" aren't the only factors at issue in committee-centric CON regimes; so too is the issue of whose interests CON regimes actually serve. The portrayal of the fight over concentrated economic control as one between a "fortress" (in this case, incumbent interests) and a "frontier" (insurgent interests) is one that has developed in free-market circles over many years, and in *Fortress and Frontier in American Health Care*, Robert Graboyes of the Mercatus Center discusses the contrasting regulatory perspectives in the health care industry:

> The Fortress is an institutional environment that aims to obviate risk and protect established producers (insiders) against competition from newcomers (outsiders). The Frontier, in contrast, tolerates risk and allows outsiders to compete against established insiders.[19]

As with licensing, the surface excuse for regulation is often the mitigation of risk to the public. But as Graboyes observes, there is also an obvious industry interest in limiting competition—to protect "insiders" against "outsiders" through government interference.

Importantly, protecting established actors in an industry does not imply the protection of market-based pricing for given goods and services, through which competition could drive down costs to consumers and expand access. Restrictions on supply tend to raise the prices charged by existing suppliers, disadvantaging suppliers who could be locked out of a market and disadvantaging consumers who now must spend more money on a good or service that could otherwise cost less.

This is the view not only of academics, but of the Federal government as well. In a report published in July 2004 titled "Improving Health Care: A Dose of Competition," the Department of Justice and the Federal Trade Commission summarized the findings of two years of hearings and independent agency research into health care market issues.[20] The agencies' conclusions about the effectiveness of CON and the intended beneficiaries of the CON system track neatly with Graboyes' more general observations:

> The Agencies believe that CON programs are generally not successful in containing health care costs and that they can pose anticompetitive risks. **As noted above, CON programs risk entrenching oligopolists and eroding consumer welfare.** The aim of controlling costs is laudable, but there appear to be other, more

> effective means of achieving this goal that do not pose anticompetitive risks. [Emphasis mine]

It is unsurprising, then, that specific research into the effect of Missouri's CON law on the state's health care market has found significant negative impacts on both health care competition and patient access. In a 2015 report issued on the consequences of CON specifically in Missouri by the Mercatus Center, study authors Christopher Koopman, Thomas Stratmann, and Mohamad Elbarasse found that:

> …there is no relationship between CON programs and increased access to health care for the poor. There are, however, serious consequences for continuing to enforce CON regulations. **In particular, for Missouri these programs could mean approximately 7,943 fewer hospital beds, between 12 and 24 fewer hospitals offering MRI services, and between 41 and 52 fewer hospitals offering computed tomography (CT) scans.** For those seeking quality health care throughout Missouri, this means less competition and fewer choices, without increased access to care for the poor.[21] [Emphasis mine]

Mercatus researchers have discovered similar results nationwide.[22] While research methods vary, contemporary research into CON laws has generally found that they are a neutral or negative proposition for the ultimate provision of services, both in terms of overall supply and cost benefits.[23,24]

Mercatus's findings also put a spotlight on two contradictory propositions: one offered by the state that says Missouri has too many beds, and the other by researchers who say the market would very well add to the bed supply to meet patient demand if allowed. State records indicate that Missouri has, on a statewide basis, a bed surplus of nearly 2,000 units; meanwhile, Mercatus estimates suggest that the state would have 8,000 additional beds without CON law, if market forces controlled rather than government. That is a substantial disagreement that could have far-reaching implications for patients whose interests could be underserved to the tune of thousands of beds statewide, and the downward price pressure the existence of these beds could generate.

This is no small matter for the state or consumers. If the market could in fact support thousands of additional beds, dozens of new MRI and CT services, and generally greater health care competition, then the CON is hurting patients in the state not only by denying them access to these services, but also by artificially raising prices for the services that already exist through the protection of incumbent health care provider interests.

Which brings us full circle to Milton Friedman, who blamed businesses themselves decades ago for undermining the market system: "You talk about preserving the free market system," Friedman told a questioner at another of his campus events. "Who has been destroying it?"

> The business community must take a large share of the responsibility. You must separate out being pro-free enterprise from being pro-business. … [A]lmost every businessman is in favor of free enterprise for everybody else, but special privilege and special government protection for himself.[25]

CON regimes too often act hand in glove with existing interests availing themselves of the "special privileges and special government protections" that such systems can afford them. Rather than being in the public interest, CON laws undermine it.

CONCLUSION

So, what should states, including Missouri, do about their CON laws? The short answer—one recommended not only by health care researchers, but by the Department of Justice and Federal Trade Commission[26] —is repeal. The irony is that if the original intent of CON programs was to ensure greater access to quality care at a lower cost, the evidence shows that the precise opposite has happened. And despite increasing recognition of the negative consequences of CON laws, they continue to linger in dozens of states, including the Show-Me State.[27]

The repeal of Missouri's CON laws offers lawmakers of all political stripes the rare opportunity to cross the aisle and advance the interests of both patients and providers in the process. Indeed, Jane Fonda and Milton Friedman were right about how risky it can be to let businesses leverage public power, whether directly or indirectly, to advance their own private interests. The market should decide whether a health care provider succeeds or fails; to allow

the government to manipulate that balance is to threaten not only those providers that could deliver more care to more places, but the health and pocketbooks of patients themselves.

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NOTES

1. Common Sense Capitalism video accessed April 03, 2019 at: https://youtu.be/0gFV7bQQClg.
2. Missouri Revised Statute Sections 197.300 to 197.367 represent Missouri's Certificate Need laws. Those CON laws apply to "[a]ny person who proposes to develop or offer a new institutional health service within the state," with the definition of "new institutional health service" outlined in MoRS 197.305.
3. Armstrong, A. Pacific Legal Foundation Scores Moving Victory. *The Objective Standard.* Accessed April 03, 2019 at: https://www.theobjectivestandard.com/2012/07/pacific-legal-foundation-scores-moving-victory/.
4. Havinghurst, C. Regulation of Health Facilities and Services by "Certificate of Need." Virginia Law Review 59:7, October 1973. Pp. 1143–1232. Accessed April 3, 2019, at: https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=1358&context=faculty_scholarship.
5. Ibid.
6. Stratmann, T., Russ, J. Do Certificate of Need Laws Increase Indigent Care? Mercatus Center. July 15, 2019. Accessed April 3, 2019, at: https://www.mercatus.org/publication/do-certificate-need-laws-increase-indigent-care.
7. There is a certain irony that the argument for CON relies on both an aversion to the presumed monopolization or oligopolization of health care service provision in the private market through attritioned competition, and a simultaneous predisposition toward a system that itself protects and produces monopolies and oligopolies through heavy state regulation.
8. Perr, J. Why the U.S. Should Treat Health Care Like a Utility, Not a Market. Daily Kos. January 5, 2014. Accessed April 3, 2019 at: https://www.dailykos.com/stories/2014/1/5/1266839/-Why-the-U-S-should-treat-health-care-like-a-utility-not-a-market.
9. Bluey, R. Missouri Voters Soundly Reject Obamacare. Heritage Foundation. August 4, 2010. Accessed April 3, 2019 at: https://www.heritage.org/health-care-reform/commentary/missouri-voters-soundly-reject-obamacare.
10. **197.320. Rules and regulations. —** The committee shall have the power to promulgate reasonable rules, regulations, criteria and standards in conformity with this section and chapter 536 to meet the objectives of sections 197.300 to 197.366 including the power to establish criteria and standards to review new types of equipment or service. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in sections 197.300 to 197.366 shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. All rulemaking authority delegated prior to August 28, 1999, is of no force and effect and repealed. Nothing in this section shall be interpreted to repeal or affect the validity of any rule filed or adopted prior to August 28, 1999, if it fully complied with all applicable provisions of law. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 1999, shall be invalid and void.
11. Missouri Revisor of Statutes. Accessed April 3, 2019 at: http://revisor.mo.gov/main/OneSection.aspx?section=197.310&bid=10383&hl=.

12. Information from Missouri Department of Health accessed April 3, 2019, at: https://health.mo.gov/information/boards/certificateofneed/pdf/icfsnfsum.pdf; https://health.mo.gov/information/boards/certificateofneed/pdf/rcfsum.pdf.

13. Information from Missouri Department of Health accessed April 3, 2019, at: https://health.mo.gov/information/boards/certificateofneed/pdf/decagful2017.pdf.

14. Schwartz is a member of the American Institute of Architects.

15. NoMoRedTape.com was a transparency initiative started in 2017 that solicited public comment for reforms of Missouri statutes and regulations.

16. Mitchell, M. Certificate-of-Need Laws Are They Achieving Their Goals? Mercatus Center. April 17, 2017. Accessed April 3, 2019, at: https://www.mercatus.org/publications/certificate-of-need-laws-goals.

17. Mo. Revised Statute 197.315. Certificate of need granted, when — forfeiture, grounds — application for certificate, fee — certificate not required, when. — 1. Any person who proposes to develop or offer a new institutional health service within the state must obtain a certificate of need from the committee prior to the time such services are offered.

18. For example, 19 CSR 60-50.450 lays out what "need" looks like for residential care facilities by defining it as 25 beds per 1000 people aged 65 or over, minus the beds already available. Why the limit is a nice round number like 25, and not 24, or 26, or 100, isn't clear. Notions of saturation, then, are premised on level of "need" the government declares is or is not satisfied. "Approval of additional residential care facilities/assisted living facilities (RCF/ALF) beds will be based on a service area need determined to be twenty-five (25) beds per one thousand (1000) population age sixty-five (65) and older minus the current supply of RCF/ALF beds shown in the Six-Quarter Occupancy of Residential Care and Assisted Living Facility Licensed and Available Beds as provided by the CONP which includes licensed and CON-approved beds"

19. Graboyes, R. Fortress and Frontier in American Health Care. Mercatus Center. October 2014. Accessed April 3, 2019 at: https://www.mercatus.org/system/files/Graboyes-Fortress-Frontier_3.pdf. P.4.

20. U.S. Department of Justice and Federal Trade Commission. Improving Health Care: A Dose of Competition. July 2004. Accessed April 3, 2019 at: https://www.justice.gov/sites/default/files/atr/legacy/2006/04/27/204694.pdf.

21. Koopman, C., Stratmann, T., Elbarasse M. Certificate-of-Need Laws: Implications for Missouri. Mercatus Center. May 11, 2005. Accessed April 3, 2019, at: https://www.mercatus.org/publication/certificate-need-laws-implications-missouri.

22. Koopman, C., Philpot, A. The State of Certificate-of-Need Laws in 2016. Mercatus Center. September 27, 2016. Accessed April 3, 2019, at: https://www.mercatus.org/publications/state-certificate-need-laws-2016.

23. Mitchell, M. Do Certificate-of-Need Laws Limit Spending? Mercatus Center. September 2006. Accessed April 3, 2019, at: https://www.mercatus.org/system/files/mercatus-mitchell-con-healthcare-spending-v3.pdf.

24. A lengthier discussion of methods for determining "need" is always possible. However, the purpose of this paper isn't to consider whether different methods can be used to determine "need"; clearly, they could. The issue is whether any of these methods should be imposed by government on anyone. I am not asserting the government's method for determining "need" should be replaced by someone else's. I'm asserting the government's method should be replaced by nothing.

25. Friedman http://www.slobodaiprosperitet.tv/en/node/869.

26. https://www.hfma.org/Content.aspx?id=52833.

27. CON-Certificate of Need State Laws. National Conference of State Legislators. February 28, 2019. Accessed April 3, 2019, at: http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.

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