Minnesota must lift its hospital moratorium

STATE POLICYMAKERS SHOULD:

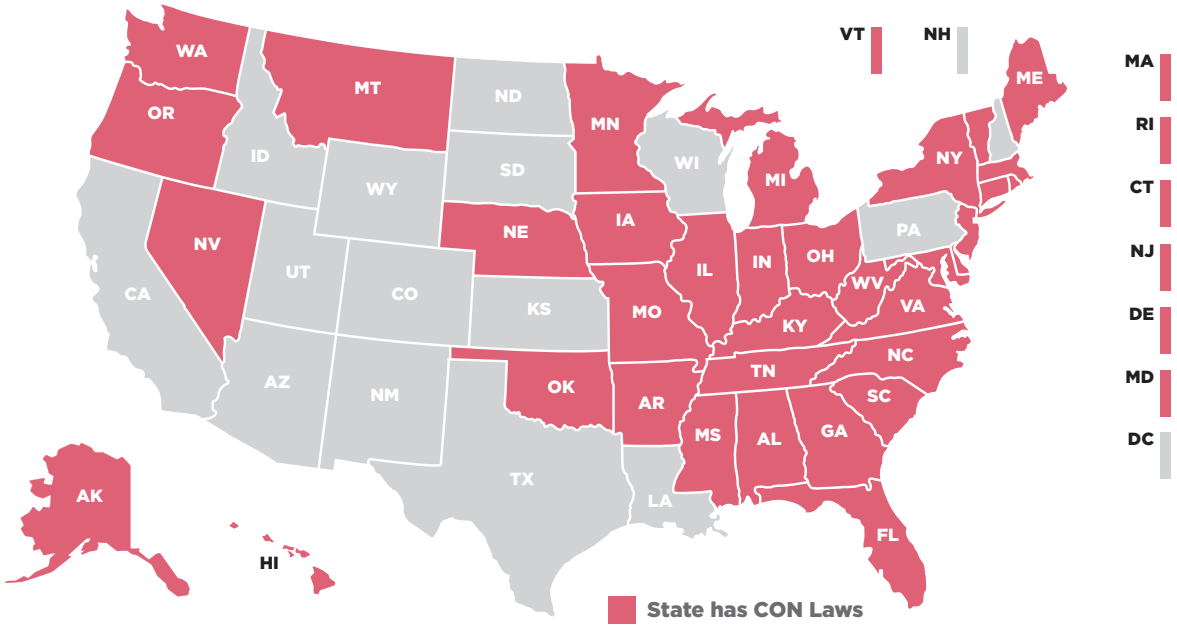
- **Abolish Minnesota's hospital construction moratorium**

On March 25, 2020, Governor Tim Walz announced a state-wide stay-at-home order running from March 27 to April 10. This was necessary, he said, because Minnesota's 235 adult Intensive Care Unit (ICU) beds were on course to be full six weeks into the COVID-19 pandemic. As the Delta Variant of COVID-19 surged in the summer of 2021, it was reported that Minnesota once again came close to maxing out its ICU capacity.

One reason for this shortage is Minnesota state law itself. Until 1984, the state operated what were called Certificate of Need (CON) laws for hospitals. These require government permission before a facility can expand, offer a new service, or purchase certain pieces of equipment. That year, Minnesota replaced its CON laws with a hospital construction moratorium, which works in a very similar, but even more restrictive, way. As Figure 1 shows, 35

FIGURE 1

STATES WITH CON LAWS OR SIMILAR REGULATIONS



SOURCE: NATIONAL ACADEMY FOR STATE HEALTH POLICY

states, including Minnesota, continue to operate extensive health care CON laws or similar barriers.

Minnesota's hospital construction moratorium prohibits the building of new hospitals as well as "any erection, building, alteration, reconstruction, modernization, improvement, extension, lease or other acquisition by or on behalf of a hospital that increases bed capacity of a hospital." Whenever hospitals or provider groups propose an exception to the moratorium, the Minnesota Legislature requires the Department of Health to conduct a "public interest review."

Researcher Patrick Moran explains:

> *In its review, the Department must consider whether the proposed facility would improve timely access to care or provide new specialized services, the financial impact of the proposed exception on existing hospitals, the impact on the ability of existing hospitals to maintain current staffing levels, the degree to which the facility would provide services to low-income patients, as well as the expressed views of all affected parties.* [Emphasis added]

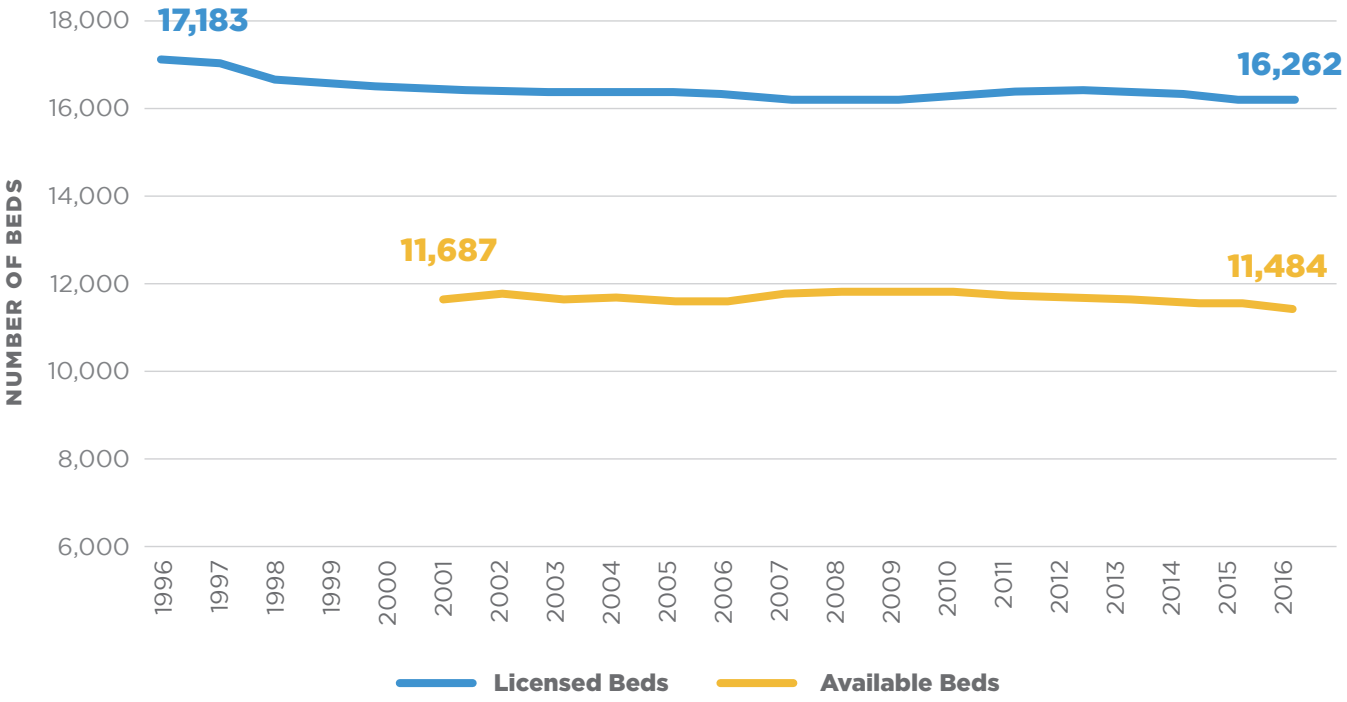
Moran continues:

> *These reviews must be completed within 90 days of the proposed project. However, the public interest review is not binding. The Minnesota Legislature ultimately decides which exceptions are allowed to go forward. Except for the fact that the Legislature makes the final determination about each project, the public interest review process for new hospitals and hospital beds closely resembles CON statutes in other states.* [Emphasis added]

The explicit purpose of the moratorium, as with CON laws more generally, is to restrict the number of hospital beds. Indeed, Moran says: "Policymakers hoped that the moratorium would be

FIGURE 2

Community Hospital Beds in Minnesota



SOURCE: MDH/HEALTH ECONOMICS PROGRAM ANALYSIS

more effective than CON in reducing the growth of hospital beds." It has been successful in this aim. In the twenty years from 1984 through 2004, 16 exceptions were granted permitting just 94 additional licensed beds in the state. As Figure 2 shows, between 1996 and 2016, the number of licensed beds in Minnesota actually fell by 921 while the population increased by 810,000. Exactly how "the Minnesota Department of Health has concluded that the moratorium is largely ineffective in restraining bed capacity," as Moran says, is something of mystery.

By fixing the supply of licensed beds, the moratorium makes them valuable commodities. Bed licenses can be held whether they're used or not so a health provider can buy a hospital with 400 beds (medium sized by Minnesota standards), close it, but still get to keep those licenses. Indeed, those with licenses for beds can shift them around in search of the best return. Moran explains:

> *Many hospitals have strategically "banked" beds, allowing them to circumvent the review process. In 2005, while there were only 11,650 available beds, there were 16,392 licensed beds in the state, allowing many hospitals to rely on unused bed capacity when they expand services.*

In 2019, according to Department of Health figures, just 71 percent of beds licensed in Minnesota were actually available.

Why do we have this system?

No doubt, many Minnesotans would ask why their state government would want to limit the expansion of hospital beds.

As with CON laws more generally, policymakers justify Minnesota's moratorium by claiming that, without it, medical providers would over-invest in capacity which would drive up prices, raise health care costs, and restrict access to these services for the poor.

This is a bizarre argument. The reason we don't have a McDonald's on every block isn't because state government prevents it but because it makes no economic sense for McDonald's to expand capacity with no regard to the demand for it. It makes no economic sense for anyone to do that, healthcare providers included.

Research has found that CON laws – or analogous laws like Minnesota's moratorium – fail to achieve these goals. A study by economists Thomas Stratmann and Jacob W. Russ found:

> *...no evidence that CON regulations increase indigent care, but they do find evidence that the regulations limit the provision of medical services. Consequently, the price of medical care is likely higher under CON regulations, while the poorest Americans see no increase in the availability of care.*

There is, in addition, evidence that states which have removed these rules have more hospitals and more ambulatory surgery centers per capita, more hospital beds, dialysis clinics, and hospice care facilities. Patients in non-CON states are more likely to utilize medical imaging technologies and less likely to leave their communities in search of care. Though CON advocates sometimes claim that the rules protect rural facilities, states without CON laws have more rural hospitals and more rural ambulatory surgery centers than states with CON laws.

Conclusions

None of this is to suggest that without the moratorium Minnesota would have 6,000 ICU beds idling at all times in readiness for a pandemic. The costs of doing so would be vast and absorb resources which could be better used elsewhere.

But we can be fairly confident that the number of ICU beds would be somewhat greater and our straits over the course of the COVID-19 pandemic would have been somewhat less dire. In the longer term, with a population growing – albeit slowly – and aging more quickly, it makes no sense at all to block the expansion of hospital bed capacity. The moratorium achieves none of its goals at too high a cost. It should go.

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