

Certificates of Need: An Oklahoma CON that Needs Repealing

By Byron Schlomach, Per Bylund, and Vance H. Fried

Introduction

Certificate of Need laws in Oklahoma require that potential new nursing homes and psychiatric facilities prove a lack of supply of services by existing providers. Consequently, Oklahomans suffer from artificially high costs, lower quality, and limited availability of these types of health care. While originally a measure to reduce costs, these requirements block innovation and quality service in a market that is already suffering from poor levels of innovation and high costs. Certificate of Need laws were put in place all over the country in reaction to a federal law to control health care costs after Medicare and Medicaid were instituted in 1965. Due to changes in how such services are reimbursed, these laws became obsolete decades ago. Many states have completely repealed their CON laws. Oklahoma should do the same.

Certificate of Need (CON) laws require a business contemplating entering or expanding in an industry to first get permission from the government to do so. Significant changes in ownership and management in existing facilities also often require a CON approval from government, as is the case in Oklahoma. To get a CON for expansion, a business must prove that its services are needed. That is, it has to prove that other businesses already in the industry will not otherwise fully provide the service for existing or expected demand.

Regulation through CON and CON-like laws is mostly applied to health care. Hospitals, ambulance services, nursing homes, and special treatment facilities have all been subjected

to CON regulation in various states and at different times around the nation. New York was the first state to enact such a law in 1964, affecting hospitals and nursing homes. By 1968, the American Hospital Association was promoting CON laws.¹ Then, the spread of CON laws went into overdrive in 1974 with a federal mandate that required all 50 states to control health care facilities spending.

Public policy had effectively obligated taxpayers to pay for health care facilities (explained in more detail below), whether they were needed or not, so it was believed that some mechanism was needed to limit taxpayers' exposure to costly over-investment. By 1975, 20 states had CON laws and by 1980, Louisiana was the only state that

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did not have a CON law. Most of these laws were in response to the federal mandate, which was repealed in 1987.² During this time, the most famous CON law issue arose in Oklahoma with Oral Roberts' attempt to open the City of Faith Hospital in Tulsa. At that time, Oklahoma still had a CON statute that applied generally to hospitals.³ Since 1987, many states have repealed their CON laws, which is also true of Oklahoma, which repealed all but two of its CON statutes.⁴

One of Oklahoma's remaining CON statutes applies to long-term care facilities, mainly nursing homes and facilities for the developmentally disabled. The other CON statute applies to psychiatric and chemical dependency facilities. While not clear from the statute, CON laws only apply to those chemical dependency treatment beds located in licensed facilities. Until a rule change in the last decade, all in-patient drug treatment facilities were subject to the CON law. Now, the CON law only applies to such beds located in hospitals.⁵

CON laws are often connected to licensing laws, but are not a necessary part of licensing. Many argue that licensing laws for health care exist to protect the health and safety of patients by prescribing mandatory levels of service, staffing, facilities, and other issues. In most cases, health care facilities are subject to licensing laws without CON requirements. The CON process in Oklahoma is substantially a licensing process PLUS the requirement that proof be provided that the market needs new or expanded capacity.⁶

While the details and extent of licensing laws is subject to good-faith debate, CON laws are not. CON laws exist simply to benefit industry insiders at the expense of society. No matter how qualified a new entrant may be, they must show that the market "needs" them, with need arbitrarily defined by statute and rule with industry input. As a result of CON laws, patients are forced to do business with the existing facilities even if they could potentially deal with a new facility that would provide higher quality and/or lower cost.

As already noted, the ostensible reason for the federal planning mandate, and the original CON law in New York, was cost control. It was made

necessary by cost-plus pricing, one of the costliest possible contracting agreements government can use and the method used to contract early in the history of Medicare and Medicaid. Under cost-plus, a private contractor is guaranteed a percentage profit based on costs the contractor incurs. This method of contracting encourages private contracted parties to maximize, rather than minimize, costs for the simple reason that a larger net profit results from higher costs.

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The predictable result of the cost-plus system under Medicare and Medicaid was costs of the programs rising much faster than originally anticipated, as no-longer financially constrained consumers more readily used health services, and providers naturally took advantage. The government response, also predictable, was blunt force. Instead of recognizing the folly of offering a valuable service for "free," under a contract guaranteeing profits based on costs only providers controlled, the response was to attempt to counter the government-created incentives with government-created regulation.⁷

Though the inflationary incentives of having a deep-pocketed third party (the U.S. taxpayer) pay health providers for patient care remain, the highly inflationary cost-plus system is long gone, replaced largely by prices dictated by government. Consequently, it is more difficult for providers to automatically profit by demonstrating high and rising costs, the method of cost inflation that CON laws are specifically designed to combat. CON laws are entirely unsuited to the task of fighting health care price inflation under today's circumstances.

Since CON laws were designed to prevent investment, they arbitrarily define upper bounds of

investment in the markets CON laws regulate. In Oklahoma, the standard that must be met to open a new nursing home facility is expressed in two ways. First, agency rule says that new beds should not increase the number of beds per 1,000 persons age 75 and above to more than 179 and sets an “optimal target ratio” at 152 beds per 1,000. Second, an 85 percent occupancy rate in a facility’s service area is to be maintained. Service areas within Tulsa and Oklahoma City and contiguous areas are defined as the area within a 7.5 mile radius of the facility. In rural areas, the radius is extended to 15 miles.⁸ Between the number of existing nursing homes and their occupancy rates, obtaining a CON for a new or expanded facility is nearly impossible.⁹

Regulations allow long-term care facilities for the developmentally disabled with 16 and fewer beds to open with relatively little opportunity for existing facility owners to challenge. Larger facilities would find it very difficult to open or expand given regulations that require an existing facility to have a 95 percent occupancy rate prior to expansion and a general rule to keep the maximum number of beds at 84 per 100,000 population.¹⁰ Because there is very little activity in psychiatric treatment facility CON applications, it is difficult to judge how restrictive that area is as compared to nursing homes, but one attempt to open a new facility met a good deal of opposition.¹¹

CON Laws As Part of a Bigger Cost Problem in Health Care

The biggest concern regarding health care lies with medical services’ high costs, which have risen faster than inflation for decades and caused concerns about the availability of health insurance, which is only a payment method and not health care itself. The root causes of the rapid rise in health care costs lie in government policies that have increased the demand for health care exponentially while simultaneously restricting supply. To an economist, the ad hoc explanation that improved technology drives up health care costs sounds like fingernails on a chalkboard. Improved technology has never driven up costs in any other industry. There is no reason to expect an exception to this rule in health care.¹²

The supply of health care has been restricted

since the beginning of the 20th century by licensing laws that, in the name of quality and consumer protection, have served to protect licensees from easier competition.¹³ Facilities licensing, CON laws, as well as strict controls over the supply of medications have a similar impact. Taken together, these supply restrictions are very significant, and contribute to rising health care costs, especially considering increases in demand that have resulted from individuals no longer paying their own health care bills.

In 1960, roughly half of all spending on health care was done out-of-pocket by patients. By 2006, only an eighth of health care costs were covered out-of-pocket. Health insurance and federal programs make up all the difference and then some, displacing state programs as well as private spending. Medicare and Medicaid started with federal legislation in 1965, but even by 1960, health insurance represented a fifth of health care spending, driven by federal income tax law that exempts benefits from taxation.¹⁴ Employer-provided health insurance is tax avoidance and a direct result of federal government income tax policy. With third parties in the guise of government and employer-sponsored pre-paid health care plans (what we now call insurance) paying our health care bills, patients and providers have responded to the obvious incentives. This demand-inducing policy combined with supply-restricting regulations like CON laws have pushed health care prices to rise faster than inflation.¹⁵

Monopolistic Impact

CON laws regulate entry or expansion in the areas of the health care industry affected by these laws. Economically, by restricting business entry and expansion, CON laws: 1) restrict the supply of service, 2) increase the price of service, 3) negatively impact the quality of service, and 4) increase the profits of “insiders” who are approved to provide the regulated service. In other words, CON laws have effects similar to that of monopoly power in a market. Monopolies intentionally restrict supply so as to raise price without fear of inviting entry by other firms, a fear CON laws alleviate. This, in turn, causes monopolies to earn abnormally high profits

and, due to the lack of competition, monopolies can allow quality of service to slide.

A true monopoly is characterized by a single firm supplying a unique good or service, but many firms can unite and act like a monopoly when they are able to organize themselves as a cartel. Cartels restrict supply by having each member agree to a restricted production quota and/or exclusive operational territory. In a true free market setting, cartels do not last. There is an incentive for one or more of the members to cheat by producing more than its allotment and creating a windfall for that member by increasing supply and depressing price only slightly or by encroaching on another's territory. When enough members cheat, the cartel dissolves into market competition. But, when cartels are enforced by government rules like CON laws, which legally enforce restricted quotas and territories, a cartel's monopoly-like power can last for decades. The incentives that would break up cartels are undermined as market shares are protected by government fiat.¹⁶

A pertinent example of government-enforced cartel-like behavior is New York City's taxi service. There, the primary mechanism for restricting supply is the taxi medallion, a piece of hardware a taxi must have in order to legally operate. New York City limits the number of medallions so that new entry into the taxi industry is not allowed at all. The result has long been complaints of dirty cars, surly drivers, excessive waits for taxis, and no innovation. The best evidence that quality of service has suffered is in the quick success of upstart Uber, a company that is not part of New York's "taxi cartel." Customers have flocked to Uber after reports of clean cars, polite drivers, short waits, and more, while the New York City cab industry is feeling profound effects.¹⁷

Cartel Behavior

The authors of this paper do not allege that businesses subject to CON in Oklahoma are meeting to set quotas and control output price. They do not need to do so in order to control their market. The CON law, by legally restricting the entry of new firms to provide psychiatric services and long-term care under the limits noted above, have basically the same effect, as demonstrated

below. The big difference between CON laws and a market-based cartel is that a market cartel has no legal way to enforce the agreement. The Oklahoma State Department of Health enforces the CON laws, and CON laws allow already-existing companies to legally enforce the cartel.

One indicator of monopoly-like phenomena is to look at long-term care facilities for the developmentally disabled. Every county in Oklahoma appears to have its own local monopoly (or nearly so) in this type of facility, as can be seen by looking at facilities' names, evidence of cartel-created exclusive territories.¹⁸ Most of the facilities for the developmentally disabled are small, which is partly because opening larger facilities is a practical impossibility under the rule that existing facilities' occupancy exceed 95 percent before expansion can occur and the limits on the number of beds per 100,000 population. Almost half of these facilities were completely full in July of 2013 (which is the latest data available). Many of the rest were well over 90 percent full, although almost paradoxically, the statewide occupancy rate was 79 percent due to a few relatively large facilities not being completely full. This last statistic alone makes it unlikely that new facilities larger than 16 beds will be approved under the state's CON law.¹⁹

Craig County's nine small developmentally disabled facilities were fully occupied, as were Canadian's two, LeFlore's two, and Ottawa's four. Hughes County's six facilities were 97 percent occupied. Oklahoma County's five facilities were at 95 percent, as were the 12 facilities in Okfuskee

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County and the 13 in Pontotoc. Counties with relatively large facilities saw lower occupancy rates,

like the one in Seminole at 67 percent. Of the nineteen counties with developmentally disabled facilities, five had occupancy rates below 80 percent, but ten were above 90 percent.²⁰ CON regulations keep occupancy high but entry into the industry limited.

One of the criteria for obtaining a Certificate of Need in Oklahoma is to specify one's service area. This does not necessarily mean there will be no competition within that area, but it is apparent that the CON law helps to control the amount of competition much the same way cartels carve up territories for their members. The high developmentally disabled treatment occupancy rates in many counties suggest relatively tight supply, which is expected in a monopolistic situation. Overall, the data suggest that long-term care facilities for the disabled suffer a decided lack of competition in the state, especially since they appear to be restricted from accomplishing economies of scale. This, in turn, suggests costs remain high while quality and innovation suffer.

Nursing homes have a much lower statewide occupancy rate of 66 percent and greater diversity of ownership within counties, judging by the names of the facilities, although Department of Health CON application files show a good deal of industry consolidation.²² This has not, however, translated into high quality. Oklahoma ranks among the top ten in the number of deficiencies and fines incurred by nursing homes. In addition, serious deficiencies have resulted in numerous suspensions of payments by the federal government to nursing homes in Oklahoma. Despite this sorry performance, potential high-quality entrants are blocked by the state's low occupancy rate and agency rules meant to keep occupancy within a given service area at an 85 percent minimum. Incumbents have an incentive to maintain excess capacity as a way to block entry under the regulation.

While CON regulations allow small-scale entry in the developmentally disabled area, occupancy remains high and county-level monopolies appear to prevail as large-scale facilities are blocked from opening. On the other hand CON regulation provides an incentive to keep occupancy rates low in the nursing home arena even as it is nearly

impossible to open entirely new facilities. The rules do allow nursing homes to add some beds without have to acquire a CON to do so, making it possible to keep capacity high enough to block entry.

Nursing homes appear to see the most CON regulation activity. This is important for Oklahoma's taxpayers as well as nursing home patients given that 67 percent of nursing home revenues come from Medicaid, which is significantly state-funded.²³ Nursing home facilities throughout the nation are licensed, as they are in Oklahoma.²⁴ Licensing itself restricts entry by new firms into an industry. This, along with price and poor quality performance in Oklahoma, begs the question of just what the benefit of CON is supposed to be. It does not appear to accrue to the general public given that one of its likely effects is to push up the price of a publicly-provided service.

Psychiatric and drug dependence treatment facilities reported by the Department of Health are all located in hospitals and, with a few exceptions, have a good deal of capacity. However, there is controversy over the Department of Health's occupancy figures. Notably, the Midwest Regional Medical Center has alleged that the state's statistics are inaccurate and that there is, in fact, a severe shortage of psychiatric beds.²⁵

CON laws are particularly pernicious in the way they prevent high quality service from being offered in a market. They do so by allowing already-existing firms to limit competition by essentially vetoing entry into the market by new service providers. This is done by requiring anyone proposing new facilities to "demonstrate that existing psychiatric and chemical dependency service beds are not and will not be adequate to meet the needs in the service area" and to "demonstrate that alternative or substitute services are not and will not be available or are and will be inadequate to meet the needs of the population."²⁶

The requirements from administrative rules stated above, consistent with statute and which also apply to long-term care, essentially provide incumbent firms warning of potential entrants' plans and allow the incumbent firms to decide whether they might counter entrants' moves by proposing their own expansions.²⁷ In most

industries, competitors are not given notice far in advance of potential entry, especially notice that includes detailed financials and business plans. Rather than counter new entry with innovation or expanded capacity, though, on the rare occasion that someone dares attempt to enter a market regulated by CON, incumbent firms inundate the Department of Health with protests, often regarding trivial, technical issues, but issues that are, nonetheless, consistent with burdens of proof imposed by the law.

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Without an effective threat of competition from new entry, incumbent firms can neglect quality, held to account mainly by government inspections and regulation, which is often inefficient and ineffective. The state generally sees only one entirely new long-term care facility approved each year.²⁸ This speaks to restrictiveness of the law in that facilities age and must be replaced and updated. The easiest way to accomplish this is with entirely new replacement, complete with new technologies, often with new entrants providing the impetus to change and improve. This stasis in nursing home facilities occurs at the same time the aged population is increasing. It is also happening at a time when technology is rapidly changing, making it easier and more accurate to monitor patients with technology rather than by personnel. These developments will only be slower in being implemented in a non-competitive environment.

Oklahoma's Department of Health is required by law to make it easy for existing companies to be informed of developments regarding their competitors by publishing lists of the latest CON

applications. Under the law, even changes of ownership of a facility must receive permission by way of a Certificate of Need.²⁹ Some other actions like minor management changes and the addition of a small number of beds are exempted from CON requirements, but even these must be reported, and are listed on the department's monthly "The Notice" publication, which is readily available online.³⁰ CON applications, which include extensive financial disclosures, are a matter of public record. Applications can be, and are, reviewable by the public.

Consider the case of one specialized Alzheimer's residential treatment facility for Claremore, Oklahoma called Autumn Wood, proposed early in 2009. Though the facility would have to be licensed anyway, it took seven months for the Department of Health to be satisfied with the information provided and approve the CON application. Even so, at least three competing nursing homes, Claremore Nursing Home, Inola Health Care Center, and Amity Care, legally intervened, alleging that technicalities rendered the approval illegal. Eventually, a judge ruled in favor of the new facility, which finally received its Certificate of Need eleven months after its initial application filing.³¹

Autumn Wood was fortunate. A similar facility called Hometown Memory Care, proposed in 2013 for Poteau, Oklahoma, received CON approval after 14 months, only to eventually withdraw its application after almost two years in process. As with Autumn Wood, multiple protests of the approval by other nursing home operators were filed. These included: the Oaks Healthcare Center, Talihina Manor, Pocola Nursing Home, Medi-Home of Arkoma, Heavener Nursing Home, Vista Nursing Home and Vian Nursing and Rehabilitation. Numerous technical issues were raised in what appears to be something like throwing random things against a wall until something sticks. Complaints included claims that there was not enough financial information provided, inadequate operating history, incomplete operating plan, inadequacy of a licensed administrator, and an already saturated service area. Despite an intention to serve Alzheimer's patients still at home and not

previously served, the proposer clearly did not have the deep pockets to fight off all the challenges and, after almost two years, gave up. The file at the Oklahoma State Department of Health is about 7.5 inches thick.³²

Another application for a nursing facility called Epworth Living at the Ranch to establish a facility aimed at Oklahoma State University Alumni, was held up due to protests by other nursing homes. The business plan called for establishing a nursing home as part of continuous-care retirement community, one in which independent residents transition to a nursing home and end-of-life care. The nursing home was to be open to the general public, helping to provide cash flow. Due to protests from other nursing homes, eventually a different application was approved, called Epworth Living Community. The project, only now being built, was delayed some months due to the CON process and the intervention of the legislature. It was only approved because the legislature passed a carefully tailored amendment to the CON law that allowed a nursing home associated with a non-profit life-care facility and sized at only 20 percent of the residential facility's capacity to open. Only half of the beds in that facility can be filled from the general community for seven years, after which new patients must come from the life-care community.³³ Given the trouble this politically well-connected effort ran into due to the CON law, which included a former congressman, those not politically well connected are likely frozen out of the process altogether.³⁴

What Acquisitions of Existing Facilities Say about CON

Acquisitions by lease and through outright purchase are the most common CON applications reported in "The Notice," the statutorily-required publication informing the public of CON actions. As noted above, it is almost impossible to open an entirely new facility since, regulations indicate no need for new ones. Most CON acquisition applications are approved within four to six months, a long time by market standards, as investors stand still on planned investments waiting for government permission to proceed. It is not uncommon to

see some of these held up as application filings are deemed incomplete, only to be denied when completed. Denials might be reconsidered by administrative judges and approved or reversed through settlement agreements.

Acquisitions, which one might think would be relatively straightforward, can be held up for considerable periods. Agency research and investigations on acquisitions includes whether any complaints have ever been made against a buyer's other facilities as well as finances and credentials. The acquisition of three nursing homes by the same parties, Meeker Nursing Center, McCloud Nursing Center and Harrah Nursing Center, was originally filed and then disappeared from "The Notice" within 5 months in 2012. The same transaction was attempted in 2013 only to see the application denied seven months later. Agency files show an approval on a sort of probationary condition that no new applications would be sought for two years and that training for the new owners would be required. This settlement was agreed to almost two years after the initial CON application was filed.³⁵ Similar probationary settlements were made with acquisitions concerning Wadley Care Center, Care Living Center, and Bradford Village.³⁶

One might wonder why anyone would be willing to go through months of legal bills and back-and-forth with government agencies just to come to a ham-stringing settlement agreement to buy and operate a nursing home. The answer is very much similar to why someone would, at one time, pay well over \$1 million for a taxi medallion in New York City. The supply is fixed, making it likely that a long-term care or psychiatric treatment facility will only gain in value.³⁷

Repeal CON Laws

Certificate-of-Need economic regulation limits opportunity for would-be entrepreneurs and innovators. It limits options for those who could benefit from potential innovations and the benefits of competition, which include lower pricing, improved quality, and greater service availability. At the same time, CON laws enrich those who are already in the industry. In effect, CON laws act as

a transfer program from patients and taxpayers to providers, not just to pay for services rendered, but to pay a premium for services made scarcer than they ought to be by poor public policy. Studies show that, at best, CON laws have failed in their mission to control costs for taxpayer-financed public health programs. At worst, they have predictably done just the opposite by causing higher costs.³⁸

Since CON laws reached their peak around 1980, more than a dozen states have repealed them entirely.³⁹ The main reason such laws persist is that special interests - those already in an industry made relatively non-competitive by CON laws - want to see them remain. These are influential leaders in the health care industries that are impacted by CON laws and who reap the benefits from learning about new entrants' plans. Consider the history of CON. By 1968, health care industry decision makers had recognized that CON laws provided an additional blanket of security from competition for them, and the American Hospital Association (AHA) began actively advocating for their passage. This was six years before the federal mandate. It makes no sense to believe that the AHA was advocating for a system to keep hospitals from raising prices. What does make sense is that cost control was a pretext for using government to limit competition, always in the name of patient protection, of course. In fact, one study found that "Mature CON programs ... result in a slight (2 percent) reduction in bed supply but higher costs per day and per admission, along with higher hospital profits."⁴⁰

The most politically powerful argument for CON laws is that they allow a government agency tasked with protecting people the opportunity to gate-

keep who is allowed to participate in an industry that directly impacts vulnerable individuals' health. The aged, people with psychiatric issues, and the developmentally disabled are very vulnerable and not in a good position to protect themselves. But the same could be said about restaurant patrons, most of whom never see their food being stored and prepared. Yet, harm to restaurant patrons is not prevalent, which is why it makes the news when it happens. The key is to have laws that allow family members ready access to those under care, and repeal of CON in no way disallows regulation to protect peoples' health.

More fundamentally, CON laws are not the same as licensing laws. Licensing laws for health care, many argue, rightly or wrongly, protect the health and safety of patients. While the details and extent of licensing laws is subject to good-faith debate, CON laws clearly do not serve a public purpose. Rather, they exist to limit competition. They are examples of cronyism (also referred to as second-order or legal corruption) where select private parties benefit at the expense of other private parties (potential competitors) and society as a whole.

CON has always been more about gaining and securing market power than about protecting taxpayers from high costs. Repealing CON is an easy first step in scaling back regulation in America's heavily regulated and high-cost health care industry. As health care delivery becomes increasingly innovative, with mobile technology making patient monitoring less labor intensive, these regulations only get in the way of higher quality, lower-cost care.

End Notes

- ¹ “Certificate of Need: State Health Laws and Programs,” website, National Conference of State Legislatures, September 2015, accessed October 21, 2015, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.
- ² Ibid. “How State Certificate-of-Need (CON) Laws Affect Access to Health Care,” website, Mercatus Center, May 12, 2015, accessed October 21, 2015, <https://medium.com/@mercatus/how-state-certificate-of-need-con-laws-impact-access-to-health-care-b8d3ec84242f>.
- ³ “Four Years of Donations Built \$120 Million Hospital of Faith,” New York Times, October 20, 1981, accessed November 3, 2015, <http://www.nytimes.com/1981/10/20/us/four-years-of-donations-built-120-million-hospital-of-faith.html>.
- ⁴ Title 63, Oklahoma Statutes, §1-850 et seq. and Title 63, Oklahoma Statutes, §1-880 et seq.
- ⁵ Interview, Darlene Simmons, October 23, 2015.
- ⁶ Ibid.
- ⁷ Goodman, John C. and Gerald L. Musgrave, Patient Power (Washington, D.C.: Cato Institute, 1993), 191, http://www.ncpa.org/pdfs/sp_pp_Part_II.pdf.
- ⁸ Oklahoma Administrative Code Title 310, §630-1-2 and §630-1-3, accessed October 27, 2015, <http://www.ok.gov/health2/documents/HRDS-HFS-CON%20Beds%20Ch%20630%20Title%20310.pdf>.
- ⁹ Interviews with Oklahoma State Department of Health employees Darlene Simmons, October 23, 2015 and Michael Todd, October 27, 2015.
- ¹⁰ Oklahoma Administrative Code Title 310, §625-1-1, §625-1-4(a), and §625-1-4(d), accessed November 3, 2015, <http://www.ok.gov/health2/documents/HRDS-HFS-Ch%20625%20CON%20ICF-MR.pdf>.
- ¹¹ OSDH CON application file for Midwest City Regional Medical Center #14-017.
- ¹² The rare exception would be if the change in technology so fundamentally alters the product so as to engender much higher demand. In such case, it is likely the good or service has been so fundamentally transformed that it nearly constitutes something entirely new so that prior market comparisons are rendered inapplicable.
- ¹³ Schlomach, Byron, Six Reforms to Occupational Licensing Laws to Increase Jobs and Lower Costs (Phoenix, AZ: Goldwater Institute Policy Report No. 247, July 2012), accessed, October 22, 2015, https://goldwater-media.s3.amazonaws.com/cms_page_media/2015/2/2/Policy%20Report%20247%20Licensing.pdf.
- ¹⁴ The widespread practice of giving benefits began during WWII as a means to compete for skilled labor when federal wage controls prevented wage competition for labor.
- ¹⁵ Schlomach, Removing the Middleman, 16-17.
- ¹⁶ Drug cartels are organized according to territories. Their enforcement mechanism is through violent brutality. True “free” markets are not characterized by violent coercion.
- ¹⁷ Van Zuylen-Wood, Simon, “The Struggles of New York City’s Taxi King,” Bloomberg Business, August 27, 2015, <http://www.bloomberg.com/features/2015-taxi-medallion-king/>.
- ¹⁸ Occupancy statistics, Oklahoma State Department of Health, accessed October 22, 2015, <http://www.ok.gov/health2/documents/Census%20by%20County%20Feb-Jul%202013.pdf>.
- ¹⁹ Oklahoma Administrative Code Title 310, §625-1-1, §625-1-4(a), and §625-1-4(d), accessed November 3, 2015, <http://www.ok.gov/health2/documents/HRDS-HFS-Ch%20625%20CON%20ICF-MR.pdf>.
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- ²¹ Ibid.
- ²² Oklahoma Nursing Home Ratings, website, Oklahoma Watch, accessed October 22, 2015, <http://oklahomawatchdata.org/static/nursing/>.
- ²³ SoonerCare in Motion (Oklahoma City, OK: Oklahoma Health Care Authority, Annual Report, 2014), 67, file:///C:/Users/1889%20Institute/Downloads/AR2014_for%20Web.pdf.
- ²⁴ Federal law generally requires licensing in or order for states to see a flow of funds from Medicaid and Medicare.
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- ²⁶ Oklahoma Administrative Code Title 310, §635-1-5 and §635-1-6, accessed October 22, 2015, <http://www.ok.gov/health2/documents/HRDS-HFS-CON%20Psy-Chem%20Beds%20Ch%20635.pdf>.
- ²⁷ Certificate of Need Application for Standard Review, official document, Oklahoma State Department of Health, accessed October 22, 2015, <http://www.ok.gov/health2/documents/HRDS-HFS-ODH%20615.pdf>.

- ²⁸ Protective Health Services 2015 Annual Review, (Oklahoma City, OK: Oklahoma State Department of Health), 58, 62, accessed October 22, 2015, <http://www.ok.gov/health2/documents/PHS-Fact%20Sheets.pdf>.
- ²⁹ To be fair, such requirements might exist under a pure licensing regime.
- ³⁰ “The Notice”: A Health Resources Development Service Monthly Report of Active Projects, website, Oklahoma State Department of Health, accessed October 22, 2015, http://www.ok.gov/health/Protective_Health/Health_Resources_Development_Service/Health_Facility_Systems_/The_Notice/.
- ³¹ The Notice (Oklahoma City, OK: Health Facility Systems, Oklahoma State Department of Health, January 2011), http://www.ok.gov/health/Protective_Health/Health_Resources_Development_Service/Health_Facility_Systems_/The_Notice/.
- ³² The Notice (April 2015) and OSDH CON application file for Hometown Memory Care #13-009.
- ³³ The Notice (December 2013 and May 2014), Interview, Michael Todd. See also Title 63, Oklahoma Statutes, §1-853.1.
- ³⁴ Charles, Michelle, “The Ranch Senior Living Community to Break Ground in July,” Stillwater News Press, April 30, 2015, accessed November 3, 2015, http://www.stwnewspress.com/news/the-ranch-senior-living-community-to-break-ground-in-july/article_aced5c1e-ee2-11e4-9e66-1f968d732181.html.
- ³⁵ OSDH CON application for Harrah Nursing Center #13-027. It was evident from “The Notice” that the Meeker and Harrah Nursing Centers acquisitions had the same issues, so only the Harrah file was consulted.
- ³⁶ OSDH CON application files for Wadley Care Center #14-013, Care Living Center #14-001, and Bradford Village #13-018.
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