Regulation CATO INSTITUTE

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CONTRIBUTING WRITERS
Art Carden, David R. Henderson, George Leef, Pierre Lemieux, Vern McKinley, Phil R. Murray

DESIGN AND LAYOUT
David Herbick Design

PUBLISHER
Peter Goettler
President and CEO, Cato Institute

Regulation was first published in July 1977 "because the extension of regulation is piecemeal, the sources and targets diverse, the language complex and often opaque, and the volume overwhelming." Regulation is devoted to analyzing the implications of government regulatory policy and its effects on our public and private endeavors.

BRIEFLY NOTED

CON and Ambulatory Surgical Centers

BY THOMAS STRATMANN, MARKUS BJOERKHEIM, AND CHRISTOPHER KOOPMAN

Certificate-of-Need (CON) laws restrict entry and/or expansion of healthcare facilities in 35 states. These laws require hospitals, nursing homes, ambulatory surgical centers (ASCs), and other healthcare providers to obtain regulatory approval before opening a new practice, expanding, or making certain capital investments. Thus, CON laws effectively create barriers to entry that limit competition among medical providers.

The evidence is overwhelming that individuals in states with CON laws have reduced access to medical care and the medical care in those states is higher-cost and lower-quality than in states without CON laws. However, the majority of this research shows correlations but does not show that CON laws *cause* reduced access, higher expenditures, and lower quality.

We test whether this relationship is causal. Between 1991 and 2019, six states repealed their CON laws on ASCs. We take advantage of this and employ a difference-in-difference design using several unbiased estimators to determine whether CON laws are the cause of reduced accessibility of healthcare services. Our findings show this is the case. Repealing ASC CON laws cause a statewide increase in ASCs per capita of 44–47 percent and, contrary to the goal of preserving healthcare access in rural and underserved regions, we find that repeal increases ASCs per capita 92–112 percent in rural communities.

THOMAS STRATMANN is Distinguished University Professor in Economics at George Mason University. MARKUS BJOERKHEIM is a postdoctoral research fellow in the Mercatus Center at George Mason University. CHRISTOPHER KOOPMAN is executive director of the Center for Growth and Opportunity at Utah State University and a senior affiliated scholar at the Mercatus Center. This article is based on their working paper, "The Causal Effect of Repealing Certificate-of-Need Laws for Ambulatory Surgical Centers: Does Access to Medical Services Increase?" GMU Working Paper in Economics No. 24-23, June 1, 2024.

Our findings also shed light on why CON laws have failed to achieve the goal of reducing healthcare spending. Because of cost differences, Medicare typically reimburses providers substantially more for a surgery performed in an in-patient or hospital, relative to out-patient, setting. For instance, Medicare reimburses around $2,900 for a knee arthroscopy performed in a hospital outpatient department compared to only $1,650 for the same procedure in an ASC. By limiting the number of available ASCs, CON laws not only reduce competition between ASCs but also direct surgeries, many of which are inelastically demanded, to the substantially more expensive hospital setting, increasing healthcare expenditures and burdening taxpayers.

Background / In 1980, most surgeries took place in hospitals as in-patient procedures, with only 16 percent performed on an outpatient basis in a few hundred ASCs nationwide. Facilitated by technological innovations in anesthesiology and less invasive surgical techniques, the market for surgeries looks dramatically different today. Some 80 percent of surgeries take place in outpatient settings across almost 6,000 surgical centers nationwide. CON laws are impeding this shift in 28 states, preventing patients' ability to access convenient high-quality surgeries.

A rationale for restricting ASCs' entry is to prevent them from taking

the most profitable patients away from rural hospitals, what is sometimes called "cream-skimming." CON advocates claim that limiting ASC entry reduces cream-skimming, assuring hospitals' viability and access to essential services that require cross subsidy. These arguments that CON ensures healthcare access in rural areas has remained a central justification of state CON legislation.

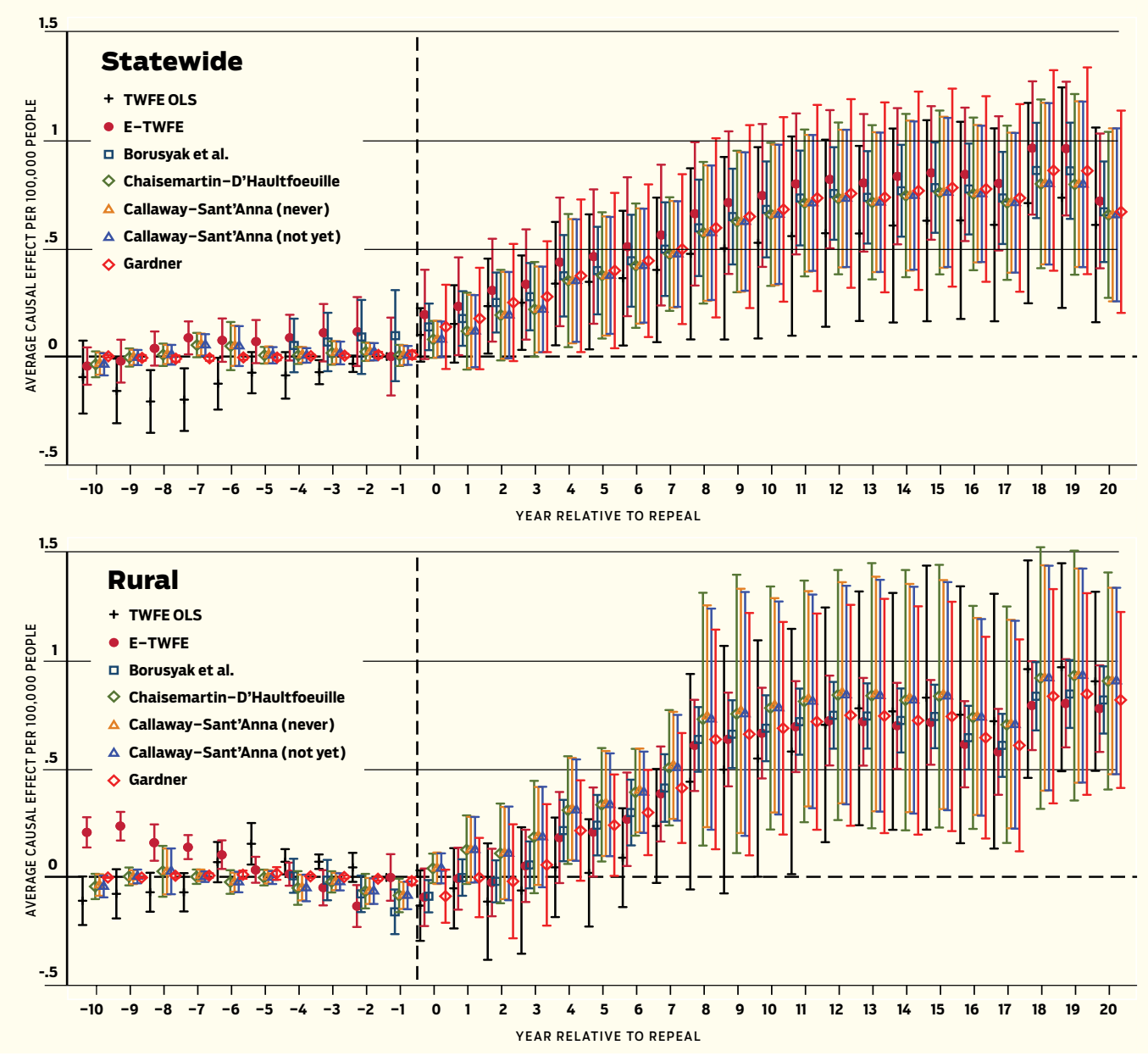
We test the implications of the cream-skimming hypothesis. Does repeal of ASC CON laws increase hospital closures or reduce medical services? Our findings do not support the arguments of CON advocates who claim the laws reduce cream-skimming by ASCs and prevent hospital closures. The repeal of CON laws does not appear to have negative effects on access to hospital services. Rather, we find suggestive evidence that repeal facilitates access to rural hospital services by reducing the size and potentially the frequency of hospital service reductions.

Brief history / Policymakers enacted CON laws to control healthcare costs, regulate the level of capital investments, increase charity care, protect the quality of medical services, and protect rural access to medical care.

In 1964, New York became the first state to pass a CON law. Between 1964

Figure 1

Event Study Results of Effects of ASC-CON Repeal on Ambulatory Surgical Centers



and 1974, 26 other states adopted CON legislation. In 1974 the federal government made the availability of some federal funds contingent on the enactment of state CON legislation with the passage of the National Health Planning and Resources Development Act of 1974 (NHPRDA). By 1982, every state except Louisiana had passed a CON law regulating hospitals, nursing homes, dialysis facilities, and ASCs.

As evidence accumulated that CON laws were failing to achieve their goals, several states, including Texas, Arizona, and Utah, repealed them. In 1986, Congress repealed the NHPRDA, ending the federal government's subsidization of state CON laws. After that, more states repealed their CON laws. By the end of the 1980s, 12 states had eliminated at least some of their CON laws (Arizona, California, Colorado, Idaho, Kansas, Minnesota, New Mexico, South Dakota, Texas, Utah, Wisconsin, and Wyoming). Between 1990 and 2000, three states followed (Indiana, North Dakota, and Pennsylvania). Since 2000, Wisconsin, New Hampshire, Florida, South Carolina, and Montana have eliminated all or most of their CON laws.

After federal repeal, many states adopted rural access to medical services as a primary rationale for maintaining their CON laws. For example, before they were repealed, Pennsylvania's CON laws required the "identification of the clinically related health services necessary to serve the health needs of the population of this Commonwealth, including those medically underserved areas in rural and inner-city locations." The North Carolina CON statute states that "access to healthcare services and healthcare facilities is critical to the welfare of rural North Carolinians, and to the continued viability of rural communities, and that the needs of rural North Carolinians should be considered in the certificate of need review process." A stated goal of Virginia's CON law is to support the "geographical distribution of medical facilities and to promote the availability and accessibility of proven technologies." And one of the justifications for West Virginia's CON laws is that they provide "some protection for small rural hospitals ... by ensuring the availability and accessibility of services and to some extent the financial viability of the facility."

Those states that retain CON laws claim that when more profitable patients use ASCs, hospitals' ability to cross-subsidize charity care and provide other essential services is reduced. Thus, those policymakers argue, entry restrictions preserve rural access to medical services.

Hypotheses / While CON laws can influence healthcare markets along several margins, we ask whether ASC-specific CON laws act as barriers to entry, given that these laws aim to reduce the number of ASCs in a state. If CON laws are barriers to entry, we predict their repeal will lead to increased ASCs per capita operating in the state. Given the explicit rationale for CON laws to provide access to medical care in rural areas, we add the hypothesis that repealing ASC CONs results in more ASCs in rural areas.

Additionally, CON advocates claim that limits to ASC entry reduce cream-skimming, which protects the viability of incumbent hospitals in rural areas and prevents them from closing. Similar reasoning predicts that this prevents rural hospitals from reducing the services they offer. Examples include hospitals that close their inpatient units but continue to operate at a reduced capacity, converting to standalone emergency departments, outpatient care centers, or specialized medical facilities.

Thus, we test these hypotheses:

- **Hypothesis 1**: Repealing ASC CON laws increases ASCs per capita statewide.
- **Hypothesis 2**: Repealing ASC CON laws increases ASCs per capita in rural areas.
- **Hypothesis 3**: Repealing ASC CON laws increases hospital closures or reduces hospital services in rural areas.

Data and empirical strategy / We test Hypotheses 1 and 2 using a difference-in-difference design, where the treatment group comprises six states that repealed ASC CON laws between 1991 and 2019: Pennsylvania (1996), Ohio (1997), Nebraska (1999), New Jersey (2000), Missouri (2002), and New Hampshire (2016). States that kept their CON laws throughout our sample period comprise the control group. We estimate the effect of repeal on two annual state-level measures: the number of operating ASCs per 100,000 state population and the number of operating ASCs per 100,000 rural population from 1991 to 2019.

We test Hypothesis 3 by comparing the repeal states to states with CON laws on four measures of reductions in healthcare access over the years 2005–2019: rural hospital closures, service reductions, beds closed, and beds closed in service reductions, all measured per 100,000 rural population. We control for variables such as the rural population as a percentage of the state in 2005, the average unemployment rate from 2005 to 2019, and the percentage change in the rural, Black, Hispanic, and elderly populations between 2005 and 2019. To control for changes to residents' health status, we include the percentage change in mortality rates from lung cancer or diabetes among residents age 18 and older between 2005 and 2016.

Findings / Repealing ASC-specific CON laws increased ASCs per capita by 44–47 percent statewide, depending on the specific estimators used. In rural areas, ASC CON repeal caused ASCs per capita to increase 92–112 percent, again depending on the specific estimators. The effect of CON laws for ASCs is to reduce patient access to a more accessible, lower-cost, high-quality alternative to hospital-based surgeries. See Figures 1 and 2.

According to the cream-skimming hypothesis, unrestricted entry for hospital substitutes such as ASCs allows entrants to selectively provide services to the most profitable patients, thereby threatening hospitals' financial pros-

pects. While our models cannot test this claim directly, they test the implications stemming from the cream-skimming hypothesis. Specifically, does CON repeal increase hospital closures and reduce services in rural areas? The point estimates on CON repeal do not support the prediction that ASC entry results in hospital closures or hospital service reductions. Rather, we find suggestive evidence that repealing ASC CONs improves access to hospital services (Stratmann et al. 2024).

One explanation for this suggestive evidence is that ASCs and hospitals serve complementary roles in healthcare markets. ASC entry allows hospitals to focus on surgeries and medical services that are not feasible in ASC settings. This differentiation could lead hospitals to specialize in more complex—and potentially more profitable—surgeries and make the hospital attractive for medical providers specializing in these services.

Another explanation for our findings is that unrestricted ASC entry mitigates one reason hospitals close, i.e., lack of qualified staff. Surgeon departure is the only physician specialty that predicts rural hospital closures, suggesting they are incentivized to continue working when they can also form an ASC. R

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MFN Clauses and TV Programming

BY IKE BRANNON

Previously in *Regulation*, I wrote about government intervention in the television programming (i.e., channels and networks) and distribution (e.g., cable and satellite service providers) market. (See "The Innovation Won't Be Televised," Fall 2017.) At the time, "unbundling" (government requiring distributors to allow consumers to purchase channels à la carte instead of as a bundle) was all the rage among policymakers, while "cord-cutting" and internet streaming were the ideas of wild-eyed futurists.

GETTY IMAGES

Much has changed since then, including the migration of many consumers from traditional cable and satellite service to streaming. One thing that has not changed, and that I discussed at length in my article, is the use of "most favored nations" (MFN) clauses and their effects on beloved independent programming providers like Hallmark Channel and Reelz. Regulators are now maneuvering to remedy this.

In markets, an MFN clause in a contract between two parties gives one party the legal right to terms and benefits equal to those received by anyone else who enters into a similar contract with the other party. So, for instance, if a provider is offering a good to one purchaser at a discounted rate, that provider must offer the same rate to other purchasers that have an MFN clause in their contracts. In the pay TV market, an MFN clause is a promise from a programming provider that every distrib-

IKE BRANNON is a senior fellow with the Jack Kemp Foundation and a contributing editor to *Regulation*.

utor can receive the same deal—or the same specific provision—offered to any other distributor.

MFNs limit the ability of independent programmers to take advantage of the opportunity that cord-cutting affords them to reach audiences without a distributor intermediary, while concomitantly constraining the independents' growth in the traditional cable/satellite sector. As a result, MFNs effectively reduce the amount (and diversity) of programming consumers have access to. A recent Notice of Proposed Rulemaking by the Federal Communications Commission would largely do away with MFN use in this market. Such a development would benefit those media consumers who still get most of their content from cable or satellite systems.

The industry / The number of available video offerings has grown exponentially over the last four decades. That growth has accelerated of late with the rapid expansion of video streaming over the internet—and outside of the traditional cable and satellite distributors. Today there are hundreds of video programming networks, and billions of dollars are spent each year producing and acquiring the rights to shows, movies, sporting events, and myriad other types of content for distribution.

MFNs limit the ability of independent programmers to take advantage of cord-cutting to reach audiences without a distributor intermediary.

There are four major distributors (or "Multichannel Video Programming Distributors") in the United States through which a majority of households get their video programming: Comcast, Charter, AT&T/DirecTV, and DISH. Despite the dramatic trend toward internet streaming of programming, 56 million households still access video programming networks via a cable or satellite distributor subscription, representing 43 percent of all US households.

Two major factors drive distributor costs: the capital investment and service costs for deploying and maintaining their systems and the cost of acquiring content. Distributors negotiate carriage rights with the programming networks and typically pay a monthly per-subscriber "carriage fee" for each channel. Programming networks make their money both from the fees as well as the advertising they sell on their channels.

Most programming channels are members of network families, many of which are owned by major distributors. For instance, Comcast owns NBC, CNBC, Bravo, E!, and a few other networks. Large multimedia companies also own suites of networks: Disney owns ABC, Lifetime, A&E, the Disney Channel, and ESPN and its sister networks. Fox, Viacom, Time Warner/Discovery, A&E, and AMC are other multimedia companies that have multiple networks. These entities negotiate the carriage fees for their entire lineup of channels as a package.

The small number of cable and satellite distributors can leverage their collective oligopsonistic market power to pay lower prices than if there were real per-channel competition. An effective oligopsony would result in fewer program networks and fewer programs. The distributors wouldn't necessarily pass those lower costs onto consumers because there are no market forces nudging them to do so.

However, the oligopsonistic distributors mainly negotiate with an oligopolistic group of multimedia companies that own most of the networks: 97 of the 108 most-watched channels are owned by one of the major multimedia companies. Oligopolies—much like monopolies—extract higher prices from buyers and concomitantly sell less than the efficient amount.

Table 1 compares the fees paid by distributors to selected independent

Table 1

Ratings and Per-Subscriber Carriage Fees for Various Bundled and Unbundled Channels

First Quarter, 2024

Ranking	Network	Ownership	Monthly
7	History	Hearst/Disney	$0.37
8	Hallmark	Independent	$0.10
9	TNT	Warner Bros./Discovery	$2.97
10	CNN	Warner Bros./Discovery	$1.30
11	INSP (formerly Inspiration Network)	Independent	$0.00
12	USA	Comcast	$1.93
13	TLC	Warner Bros./Discovery	$0.31
26	BET	Viacom	$0.32
27	AMC	AMC	$0.61
28	Reelz	Independent	$0.08
69	The Weather Channel	Entertainment Studios	$0.19
70	UPtv	Independent	$0.06
71	Great American Family	Independent	$0.03
72	VH1	Viacom	$0.31

Source: Nielsen NPower National TV Toolbox

channels as well as to comparably rated channels owned by oligopolies. The table shows that ratings and household delivery do not directly translate into the value of subscriber fees that distributors grant to independent networks. The independent networks receive a fraction of the monthly subscriber fees paid to networks with similar or lower Nielsen ratings owned by large multimedia companies. The bargaining power of the large programming conglomerates allows them to extract higher fees for their channels.

Independents and MFN clauses / While oligopolies and oligopsonies by themselves can lead to suboptimal outcomes, the presence of both creates a bilateral oligopoly whereby each side's market power tempers the other, and the market price can approach the efficient market outcome, benefiting consumers.

However, the bilateral oligopolistic outcome does not benefit the independent networks whose rights are sold alone by their company, unbundled with any other offerings. They have no market power when negotiating their carriage fees with the distributors, and the terms intended to govern the bilateral oligopoly—particularly MFN clauses—put the independents at a disadvantage.

For example, if Comcast pays the Tribune Corporation 13¢ a month per customer to carry WGN, and Charter offers to pay Tribune 10¢ a month to carry WGN but would provide it a favorable channel placement, Comcast would get to pay 10¢ as well—and without being required to match the favorable channel placement. Essentially, the MFN amplifies the economic losses from a reduction in monthly payments.

MFNs give distributors too much power over the independent channels by precluding customized pricing arrangements with distributors. For instance, an independent network that wants to offer a short-term low introductory rate to a distributor in exchange for a commitment to launch the network on its system cannot do so because other large distributors could demand the same low carriage fee. MFNs effectively preclude independent networks from providing streaming distributors with launch incentives.

Table 2
Regression Summary Results

Independent Network	-0.432** (-2.021)
Comcast	-0.280 (-1.021)
Fox	-0.360 (-1.043)
Sports Network	1.181*** (5.424)
Constant	-0.052 (-0.498)

Notes: *t*-statistics in parentheses; * $P \leq 0.1$, ** $P \leq 0.05$, *** $P \leq 0.01$

Opening up the market / Economic theory suggests that countenancing MFNs facilitates bilateral monopolies in this market, but they harm the market for independent networks, resulting in fewer independent networks. The data show independent networks receive significantly lower carriage fees compared to networks with similar or lower ratings that are owned by large multimedia companies with multiple other networks or networks that are vertically integrated with a large distributor.

I obtained 2024 data on 118 different networks that included each network's carriage fees, average ratings, and ownership status. I ran a regression analysis with carriage fees as the dependent variable and ratings as the primary independent variable. I also included three dummy variables for sports channels, channels in the Comcast package, and channels in the Fox package. The regression includes a dummy variable that equals 1 if the network is independent.

The results show that being an independent channel is associated with a subscriber fee that is 43¢ per month lower on average than an equivalent station owned by one of the large distributors. The difference is significant at the 95 percent confidence interval. Table 2 displays the regression results. It appears that MFNs have served to depress carriage fees for independent networks.

Conclusion / The video market has changed radically in the last decade. More consumers are opting to go without cable or a satellite dish to obtain programming directly from a network. However, the increasing cultural significance of sports and the ingrained habits of older viewers to watch television shows when they first appear on a network suggest there are no immediate prospects for the current business model of cable or satellite systems to wither away.

Providing the additional lever of MFN status to enhance market power for the distributors that already have a surfeit of it hurts the independents and dampens the incentives for new networks to be formed, except for those conceived by the established multimedia entities.

Promoting multiple diverse independent voices has been a cornerstone of US communications policy since the enactment of the Communications Act in 1934. The barriers to enter the national video marketplace are high. In addition to raising the tens of millions of dollars necessary to obtain or develop programming, a new network needs to obtain the necessary carriage agreements with *all* the major distributors. As a result of these and other marketplace factors, entrepreneurs struggle to launch new independent networks, and many of the existing ones struggle to fund original programming or are going out of business.

The advances in information technology have made it less costly to create and distribute new content. But the oligopolistic structure of the industry and the contractual constraints imposed on programming networks make it more difficult for new independent stations to get their programming to large numbers of potential viewers. Ending MFNs in this market would benefit consumers. *R*