Regulation rollbacks under COVID-19 could set new path for North Carolina

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April 10, 2020

The coronavirus did what years of lawmaking and lawsuits failed to do — pushed North Carolina to temporarily waive barriers on telemedicine and the controversial certificate of need laws that restrict the supply of health care.

Ambulatory surgery centers can now act as temporary hospitals. Out-of-state telemedicine providers can treat patients. Adult care homes, mental health facilities, kidney dialysis centers, and substance abuse centers can care for more patients. Hospitals can buy medical imaging equipment, after Gov. Roy Cooper signed a sweeping executive order Wednesday, April 8.

Cooper temporarily lifted regulations to prevent the surge of COVID-19 cases from overwhelming the state's health care system. Experts feared CON law restrictions on the supply of health care would cripple hospitals' ability to treat patients.

Cooper waived some of the most well-protected areas of CON laws — temporarily lifting state caps on medical equipment and facilities that hadn't budged for decades. Lawmakers pushed for CON reform for years, but annual attempts at reform flopped after lobbyists pushed back. The monetary thresholds that trigger CON laws haven't been adjusted for inflation since 1993.

Whether the reforms will outlast the virus will depend on lawmakers and a lawsuit against CON laws. Lawmakers promise to resurrect CON reform, and lawyers say the waivers will give their lawsuit newfound clarity in its fight to overturn part of CON restrictions. Relaxing an array of health care regulations to deliver relief during a crisis also raises questions about whether the rigid rules were needed at all.

"We have never faced emergency demand for health care like we do today, and we must act now," Cooper said in the news release. "If we do this work well, along with social distancing, our hospitals can handle the hardships of this pandemic."

Before Cooper suspended CON laws, hospitals couldn't add or relocate beds without applying for state permission from the State Health Coordinating Council. The council doesn't meet until June. Applying for permission can cost as much as $500,000.

"In the coming days and weeks, decisions about adding and transferring resources will require real-time decision-making," the order reads. "In some cases, expanding health care capacity will require temporarily waiving or suspending legal and regulatory constraints."

Wednesday's order also targeted the supply of health care workers. Telemedicine providers in other states can treat patients in North Carolina, giving patients access to telemedicine services across the nation.

"Doctors who wanted to help but couldn't because of this licensure requirement now can," said Jordan Roberts, John Locke Foundation health care policy analyst. "Everyone is realizing how crucial and important telehealth is going to be in the future. They're knocking down barriers, and this is a huge one. Long term, we've cemented telehealth into the future of health care delivery."

Doctors were worried about malpractice lawsuits. Cooper eased their fears. For now, anyway. The law already protects emergency management workers from liability, except in cases of willful misconduct, gross negligence, or bad faith.

The order encourages licensing boards to waive or modify enforcement of barriers on retirees, out-of-state providers, students, and skilled but unlicensed volunteers. Cooper also loosened regulations on in-home aides and adult care homes workers.

He waived state caps on hospital beds March 12. Wednesday's order cited predictions that the state would run out of hospital beds during the surge. North Carolina's models predict 250,000 residents will be infected with COVID-19 by the end of May, even with social distancing.

North Carolina had 2.1 hospital beds per 1,000 residents — putting the state behind the national average and on the lower end for developed countries in 2016. China had double North Carolina's bed capacity, with 4.3 beds per 1,000 residents.

North Carolina has three intensive care unit beds per 10,000 people, but nearly all of them are occupied, according to the state's most recent data.

"That's a direct consequence of more than 40 years of these laws," Roberts said. "Do we know that all counties would have beds? No. But can we assure them that they won't by keeping CON laws in place? Yes. We don't know how many more beds we'd have or where they would be. But we know the law artificially suppressed the supply."

States with CON laws have about 1.3 fewer hospital beds per 1,000 people than states without CON laws. That's almost 50% of the national average of 2.8 hospital beds, said Matthew Mitchell, Mercatus Center at George Mason University senior research fellow.

"That's huge. Put that into comparison with other countries, and that's giant," Mitchell said. "Only time will tell if temporary measures like this will have an impact. We have no idea if measures like this are too little, too late. But it certainly can't hurt."

Lawmakers will "definitely" resurrect CON reform, though first they will focus on the coronavirus, said Sen. Joyce Krawiec, R-Forsyth.

"Those are things we've been trying to get done for many years. Anytime regulations are eased, I'm happy with it. I just wish some of these things will be permanent," Krawiec said. "This has certainly drawn attention to how onerous these laws are and how they've limited our ability to provide health care for people. It shone a light on it."

The temporary waivers could revitalize attempts to overturn CON laws in court.

Multiple lawsuits have challenged CON over the years. Only the first succeeded, in 1973 when the N.C. Supreme Court struck down the first iteration of CON laws for “establishing a monopoly.” The most recent plaintiff, surgeon Dr. Gajendra Singh, dropped his broad constitutional challenge after his case became mired in procedural purgatory.

“It lays bare that CON laws have nothing to do with health or safety. It’s all about regulating supply,” said Singh’s Institute for Justice attorney Josh Windham. “That’s the whole point of the lawsuit — that North Carolina’s law has nothing to do with health or safety. It’s about protecting existing providers from competition from new providers.”

Providers must submit a request to the N.C. Division of Health Service Regulation to waive CON laws, describing the changes and certifying that the changes are necessary.

“There could be a lot of good lessons in this. We’re having to deregulate everything to be flexible,” said surgeon Jeffrey Singer, senior fellow at the Cato Institute. “If these regulations made us inflexible at a time of crisis, what sense is there in putting them back once the crisis is passed? Maybe they’re wrong. This is a chance to rethink things.”