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FOR WEST VIRGINIA POLICY

CERTIFICATE OF NEED LAWS IN WEST VIRGINIA

What They Are. What They Actually Do. And What You're Being Told.

A Certificate of Need (CON) is a government permission slip. In West Virginia, any hospital, clinic, or surgery center must get state approval before opening, expanding, or purchasing major equipment and existing providers can formally challenge a competitor's application. The West Virginia Hospital Association (WVHA) says this system protects patients. Here's what the record actually shows.

"CON keeps healthcare costs down. WV ranks 6th for lowest hospital costs per inpatient day."

The statistic is accurate. The attribution to CON is not. West Virginia's own hospital association argues that WV's health costs are driven by its poor population health, low wages, and high government-payer mix. That logic cuts both ways. If demographics drive costs up, they also explain costs down. You can't credit CON for low inpatient costs and blame demographics for high per-capita spending. The WVHA does exactly that. Meanwhile, 60% of studies comparing CON and non-CON states find CON is associated with higher spending per service, not lower.[1] **Researchers estimate West Virginians pay roughly $232 more per person per year because of these laws.[2]**

"75% of WV patients are on government programs that pay below cost, competition won't work here."

This figure is misleading. PEIA (the state employee health plan) is not Medicaid. State law *(W. Va. Code § 5-16-5(c)(1))* requires PEIA to reimburse hospitals at a minimum of 110% of Medicare rates, making it function closer to a commercial payer. Bundling PEIA with Medicaid to construct a "75% government payer" figure misrepresents the actual mix. More fundamentally, the "cross-subsidy" defense has been debunked: the Congressional Budget Office found in 2022 that a hospital's share of Medicare and Medicaid patients has **no relationship** to higher commercial prices.[3] The Colorado Department of Health Care Policy and Financing similarly concluded in 2020 that cost-shifting is "no longer a plausible or justifiable rationale for [hospital] price increases."[4]

"Without CON, out-of-state for-profits will cherry-pick profitable patients and rural hospitals will collapse"

States without CON laws have **30% more hospitals** per 100,000 residents and **30% more rural hospitals.**[5] When six states repealed their ASC CON laws, rural ambulatory surgery centers grew **92–112%** and researchers found no evidence that hospital closures followed.[6] The Mercatus Center estimates WV would have 42% more hospitals and 43% more rural hospitals without its CON program.[7] CON restricts supply by design. Fewer facilities means longer drives, longer waits, and worse outcomes—especially for rural patients.

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[1] Mitchell, Matthew D. "Certificate-of-Need Laws in Healthcare: A Comprehensive Review of the Literature." Southern Economic Journal 91, no. 1 (2025): 6–43 (as cited in Cavanaugh and Mitchell, Certificate of Need Reform: Answering the Fears, Pacific Legal Foundation, August 2025).

[2] Bailey, James. "Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate-of-Need Laws." Mercatus Working Paper, Mercatus Center at George Mason University, 2016 (as cited in Mitchell et al., Certificate-of-Need Laws: West Virginia State Profile, Mercatus Center, November 2020).

[3] Congressional Budget Office. The Prices That Commercial Health Insurers and Medicaid Pay for Hospitals' and Physicians' Services. January 2022.

[4] Colorado Department of Health Care Policy and Financing. Colorado Hospital Cost Shift Analysis. January 2020.

[5] Baker, Matthew C. and Thomas Stratmann. "Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws." Socio-Economic Planning Sciences 77 (2021): 101007.

[6] Stratmann, Thomas, Markus Bjoerkheim, and Christopher Koopman. "The Causal Effect of Repealing Certificate-of-Need Laws for Ambulatory Surgical Centers." Southern Economic Journal 92, no. 2 (2023): 1–24. See also: Cato Institute. "Certificate of Need and Ambulatory Surgical Centers." Cato Regulation, Fall 2024.

[7] Stratmann, Thomas and Christopher Koopman. "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals." Mercatus Working Paper, 2016, as cited in Mitchell et al., Certificate-of-Need Laws: West Virginia State Profile, Mercatus Center, November 2020.

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"Alecto proves what happens without oversight, an out-of-state company bought two WV hospitals and closed them."

The WVHA's own materials acknowledge that Alecto acquired one of those hospitals through **a CON exemption the legislature granted in 2016.** The closure happened under CON law, through a process the WVHA participates in. If anything, the Alecto story shows that CON's protections are politically negotiable—not durable safeguards for patients. It is not a cautionary tale about what happens without CON. **It is a cautionary tale about what happened with it.**[8]

"CON has been reformed. The 2023 changes show the system can adapt."

The WVHA's own statutory history document shows the legislature raised the capital expenditure threshold requiring CON review from $5 million to $100 million in 2023, and exempted inpatient hospital services from CON review entirely. If CON were truly essential, why did the association support gutting most of its scope? The CON requirements that remain are the ones that protect the most valuable market entry points for incumbent systems.[9]

"CON ensures charity care for patients who can't pay."

Research finds no meaningful difference in charity care provision between CON and non-CON states.[10] West Virginia's dominant non-profit hospital systems receive tens of millions in annual tax exemptions and then devote **less than 1% of net patient revenue to charity care.**[11] Their own IRS filings show they identified patients eligible for free care under their financial assistance policies, then sent them to collections anyway in multiple consecutive years.

"Local WV non-profits are accountable to communities. CON keeps healthcare dollars in-state."

The WVHA's 2025 board of trustees includes the CEOs of Vandalia Health and WVU Medicine—the two dominant systems that benefit most from blocking market entry. The organization claiming to represent patients is run by the executives who profit from limiting patient options. Meanwhile, Greenbrier Valley Medical Center had 12 consecutive years of positive operating margins before Vandalia acquired it. In one year after acquisition: operating expenses surged 75%, labor costs more than doubled, the margin went deeply negative, and the county's only maternity ward was closed and called a "sustainability" issue. Per NASHP Hospital Cost Tool data (FY 2023).[12]

< 1% *share of net patient revenue WV non-profit hospitals devote to charity care*

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[8] West Virginia Hospital Association. Certificate of Need in West Virginia Healthcare: Our State & People Depend on It. WVHA, 2025; Certificate of Need Statutory Changes Over the Last 10 Years. WVHA, 2025.
[9] West Virginia Hospital Association. Certificate of Need Statutory Changes Over the Last 10 Years. WVHA, 2025.
[10] Cantor, Joel C. et al. "Reducing Racial Disparities in Coronary Angiography." Health Affairs 28, no. 5 (2009): 1521–31; DeLia, Derek et al. "Effects of Regulation and Competition on Health Care Disparities." Journal of Health Politics, Policy and Law 34, no. 1 (2009): 63–91 (as cited in Mitchell et al., Certificate-of-Need Laws: West Virginia State Profile, Mercatus Center, November 2020).
[11] Dobrinsky, Jessica. Who's Caring for West Virginia? A Comprehensive Review on Hospital Charity Care in West Virginia. Cardinal Institute for West Virginia Policy, 2025. Data drawn from NASHP Hospital Cost Tool (FY 2021–2022), IRS Form 990 Schedule H (FY 2019–2023), and Cicero Institute. Nonprofit Hospitals and Community Benefits: State Accountability Rankings. March 2025.
[12] NASHP Hospital Cost Tool, drawing on CMS Medicare Cost Reports, FY 2023.

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"CON protects Critical Access Hospital status for 21 rural WV hospitals."

CAH status is a federal Medicare reimbursement designation; it determines how hospitals get paid, not whether patients get care. The WVHA's argument here is that without CON, new entry near a CAH could trigger a redesignation review and cost that hospital its cost-based reimbursement. That mechanism applies only to new hospital construction within a specific proximity threshold—not to imaging centers, ASCs, home health agencies, or any of the other service categories CON currently restricts statewide. The WVHA is using a reimbursement concern that applies to 21 rural hospitals to justify blocking market entry across the entire state. That's not a patient protection argument. That's a revenue protection argument.[13]

The Bottom Line

The FTC and DOJ have called CON laws anticompetitive since 2004.[14] Every presidential administration since Reagan has called for repeal. Fifteen states—covering 40% of the U.S. population—have repealed their programs. West Virginia has the most expansive CON program in the region, covering 24 service categories. West Virginians have some of the worst health outcomes in the country and the highest rates of medical debt. Their hospitals give back less than 1 cent of charity care for every dollar they take in.

CON doesn't protect patients. It protects market share.

Want to go deeper?
Read our health policy research.

This FAQ draws on a body of research from the Cardinal Institute examining how West Virginia's healthcare system got here—and what it would take to fix it.

Convicting CON: DeCONstruction—The full case against West Virginia's CON laws: how they block market entry, enable consolidation, and harm rural access.

The Payer Mix Narrative—How hospitals use a misleading statistic to oppose competition and deflect accountability.

Who's Caring for West Virginia?—A data-driven review of hospital charity care in WV. Non-profits spend less than 1% of revenue on the care they promised to provide while sending patients to collections.

Free Market Reforms for PEIA—How West Virginia's public employee health plan became structurally broken, and what market-based solutions look like.

When Regulation Replaces Markets: WV's PBM Experiment—Why the attempt to fix prescription drug costs added complexity instead of solving the problem.

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[13] West Virginia Hospital Association. CON Talking Points. WVHA, 2025; Mitchell, Matthew D. et al. Certificate-of-Need Laws: West Virginia State Profile. Mercatus Center at George Mason University, November 2020; W. Va. Code § 16-2D-1 et seq.

[14] Federal Trade Commission and U.S. Department of Justice. Improving Health Care: A Dose of Competition, Chapter 8. 2004. See also FTC and DOJ Joint Statement to the Virginia Certificate of Public Need Work Group, October 2015.