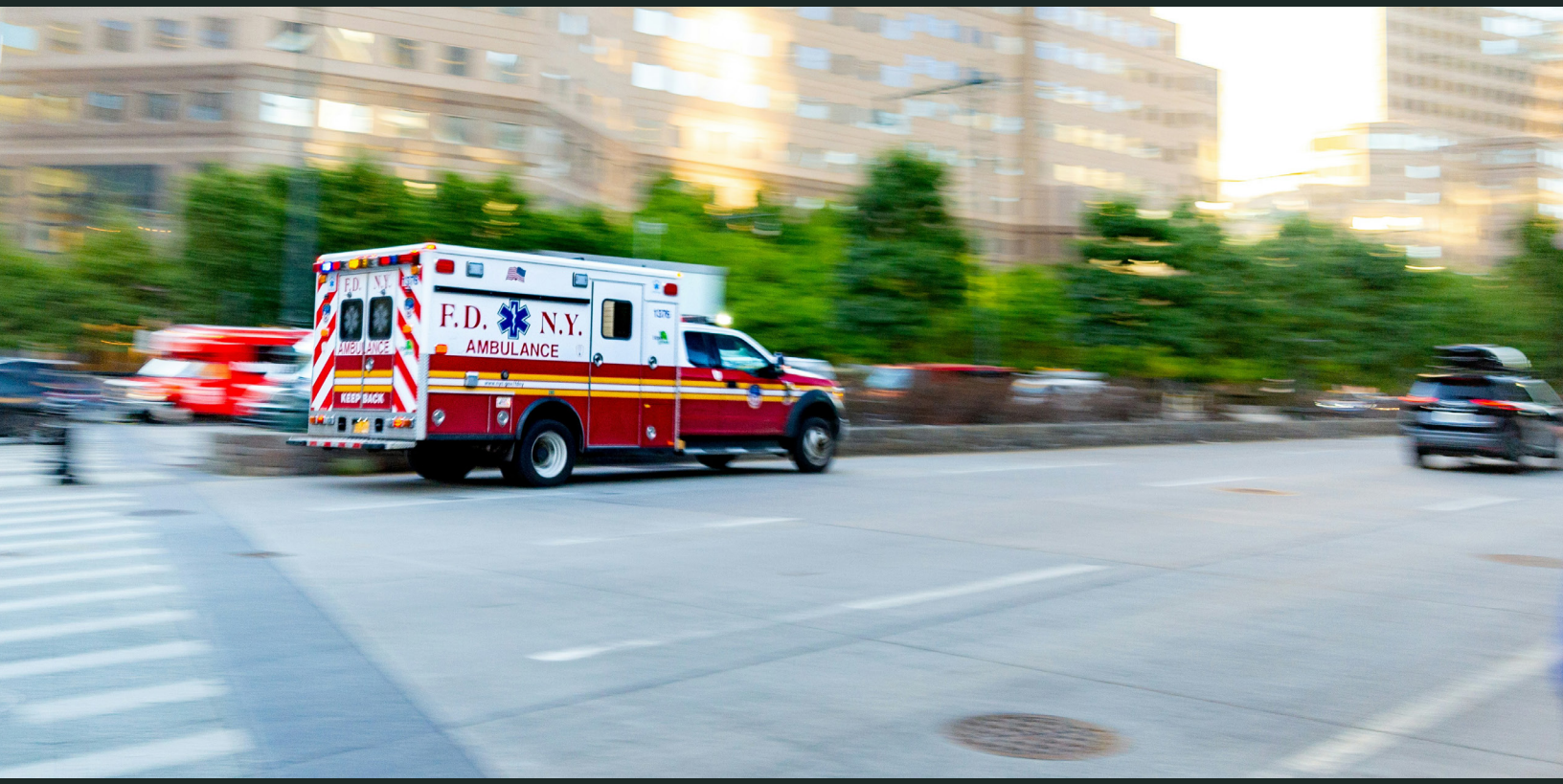


CERTIFICATE-OF-NEED LAWS ARE ASSOCIATED WITH WORSE ACCESS TO EMERGENCY CARE

Liam Sigaud

TIMELY ACCESS TO EMERGENCY MEDICAL CARE IS A key determinant of health outcomes following acute illness or traumatic injury.[1] In the United States, an estimated 422 emergency department visits occurred per 1,000 people in 2024.[2] An extensive infrastructure of emergency medical services (EMS) providers, ambulance services, and healthcare facilities exists to provide this potentially lifesaving care.

However, policymakers in many states are grappling with declining access to emergency care as the availability of EMS personnel deteriorates, ambulance services grow scarcer, and emergency departments shut down. Against this backdrop, state-level policies that restrict market entry for emergency medical care providers deserve scrutiny.

Certificate-of-need (CON) laws, which exist in 35 states, require providers to obtain permission from a government board before opening a new healthcare facility, expanding services, or making major capital expenditures. While conceived as a cost-containment tool to prevent the proliferation of underutilized healthcare infrastructure and to ensure equitable access to services,[3] the evidence tilts heavily against these regulations' claimed benefits. Research suggests that CON laws deepen shortages of emergency care and contribute to poor health outcomes.

Approval or denial of a CON is supposed to be based on objective and transparent criteria. However, the CON process is vulnerable to interference by powerful incumbent firms that have a strong financial interest in preserving their market dominance by stifling competition.[4] As a result, the healthcare system in CON states tends to be more aligned with the interests of large, well-connected healthcare firms than with the interests of the public or patients.

The evidence confirms that CON laws harm patients across many domains of care. However, there is little direct research linking CON laws and access to emergency medical care. This research in brief addresses this gap, showing that the availability of emergency departments, EMS providers, and ambulances is lower in CON states than in states without these regulations.

CON LAWS REDUCE ACCESS TO CARE

SINCE THEIR INTRODUCTION IN THE UNITED STATES IN 1964, CON laws have been studied extensively. Empirical research has consistently found that CON laws restrict healthcare supply by limiting market entry.[5]

CON laws are associated with fewer hospital facilities,[6] hospital beds,[7] ambulatory surgical centers,[8] open-heart surgery programs,[9] psychiatric care facilities,[10] facilities providing cancer surgery,[11] dialysis clinics,[12] and imaging devices.[13] Residents of CON states are more likely to seek care outside their county of residence;[14] they also tend to travel farther for care—including for coronary artery bypass graft surgery,[15] treatment for substance use disorders,[16] and hospice services.[17]

Other studies have measured the impact of CON laws by examining utilization rates among regulated services. Most analyses have found that CON laws reduce healthcare utilization, including inpatient psychiatric care,[18] cataract surgery,[19] home healthcare,[20] and joint repair procedures.[21] CON restrictions on substance abuse treatment facilities lead to higher utilization of hospital beds and higher rates of emergency department visits.[22]

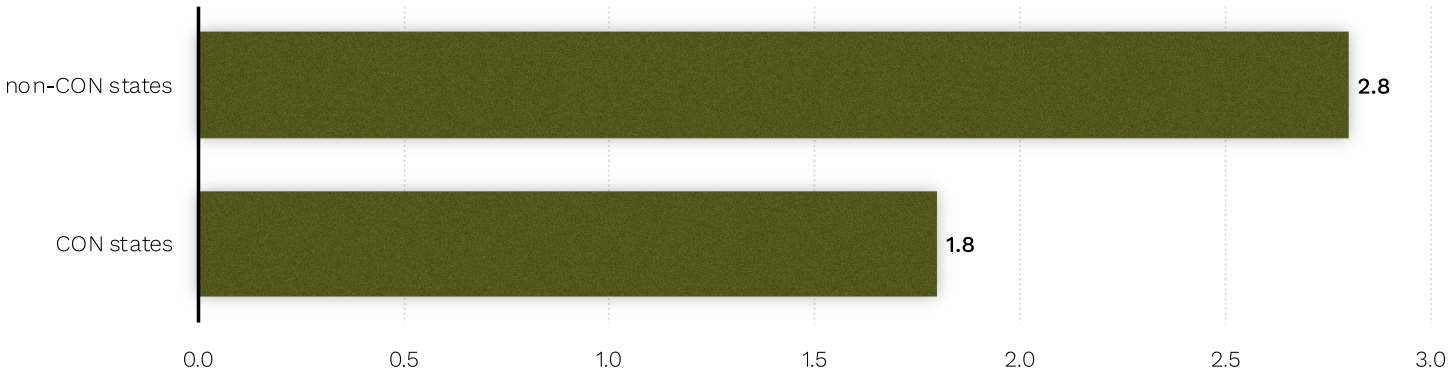
Supply constraints from CON laws were especially apparent during the COVID-19 pandemic. Facilities in states with CON restrictions on hospital beds had 12 percent higher bed utilization rates, had 58 percent more days in which more than 70 percent of their beds were used, and were 27 percent more likely to utilize all of their beds.[23] There is a well-established link between hospital capacity strain and increased risk of adverse patient outcomes.[24] At the same time, states with high healthcare use that lifted CON restrictions during the pandemic experienced lower mortality rates from both COVID-19 and non-COVID-19 causes.[25]

CON STATES HAVE WORSE ACCESS TO FACILITY-BASED EMERGENCY CARE

EMERGENCY DEPARTMENTS ARE THE BACKBONE OF the US emergency medical system, providing lifesaving care by connecting patients to advanced diagnostic and treatment resources. Figure 1 compares the average number of emergency departments in CON states and non-CON states in 2022, the latest year for which figures are available. The data capture both traditional hospital-based emergency departments and the growing number of free-standing emergency departments that are not connected to an inpatient facility.

CON states had 1.8 emergency departments per 100,000 people, on average, compared with 2.8 in non-CON states—a difference of 56 percent. For many communities, especially in rural areas, this lower density of emergency departments in CON states translates to longer ambulance transport times and worse health outcomes.

FIGURE 1. **Emergency Departments per 100,000 People by CON Status**



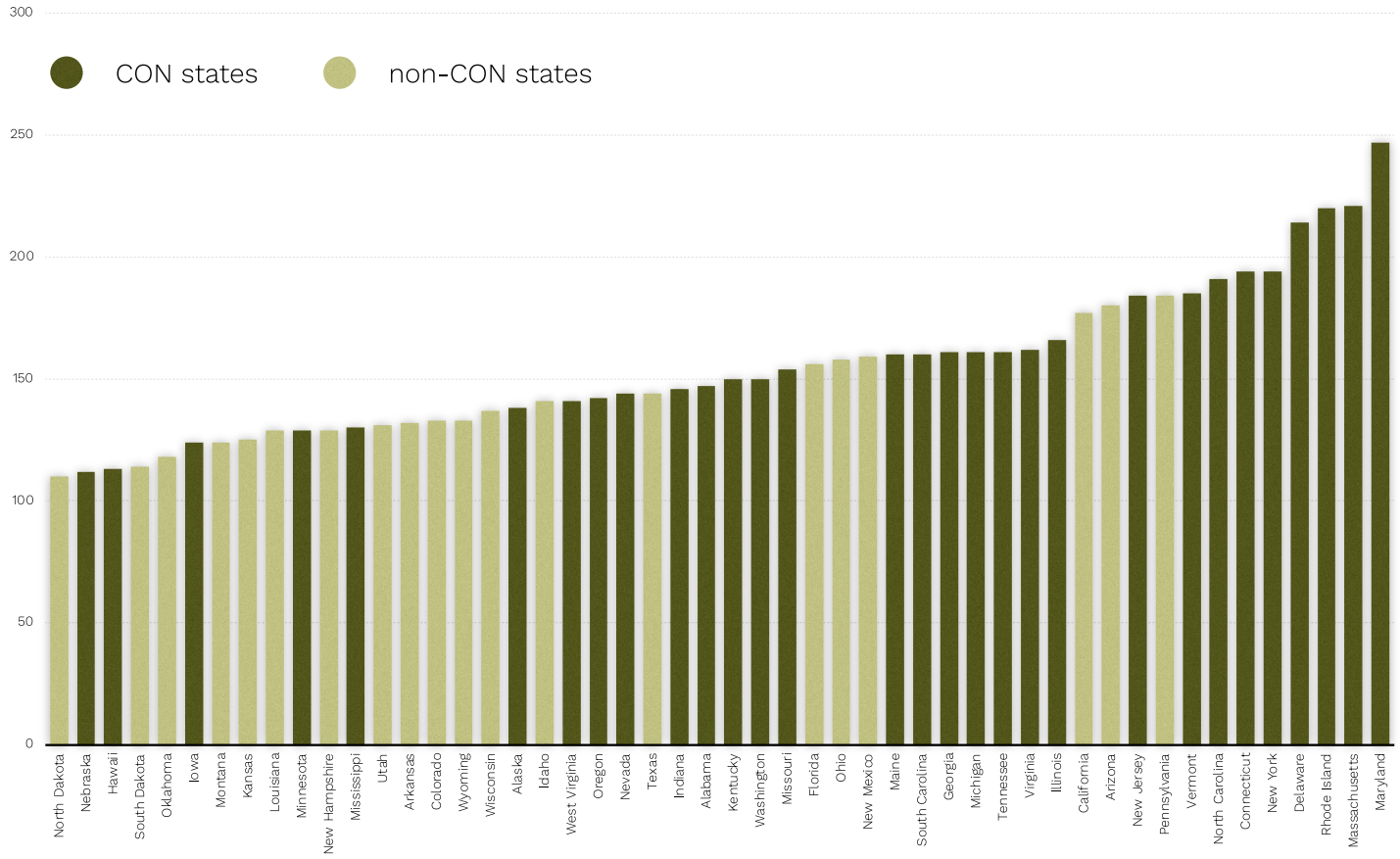
Notes: CON states are those classified by the Cicero Institute as having CON restrictions on medical outpatient services, medical inpatient services, or both. Non-CON states are those with no CON restrictions on medical outpatient or inpatient services.

Sources: Emergency Medicine Network, "2022 National Emergency Department Inventory–USA," accessed June 29, 2026, https://www.emnet-usa.org/research/studies/nedi/nedi2022/; Chris Jones and Tanner H. Jones, *A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Need Laws in All 50 States* (Cicero Institute, December 2024).

The sharp disparity in the number of emergency departments between CON and non-CON states is reflected in other metrics. For example, with fewer options available for care, patients in CON states are far more likely to experience congested waiting rooms and overcrowded facilities. Research consistently indicates that long wait times for emergency care are associated with an increased risk of adverse events in patients, including higher mortality.[26]

Figure 2 depicts median emergency department wait times by state and by CON status. The pattern is clear: CON states tend to have much longer emergency department wait times than non-CON states. For example, 9 of the 10 states with the longest wait times are CON states, whereas only 3 of the 10 states with the shortest wait times are CON states. This result echoes existing research, which has found that CON laws are associated with a statistically significant increase in median wait times for medical examination, pain medication administration, hospital admittance, and hospital discharge, even after adjusting for other relevant factors.[27]

FIGURE 2. **Emergency Department Wait Times by CON Status**



Notes: CON states are those classified by the Cicero Institute as having CON restrictions on medical outpatient services, medical inpatient services, or both. Non-CON states are those with no CON restrictions on medical outpatient or inpatient services. The District of Columbia is not shown owing to missing information in the source data.

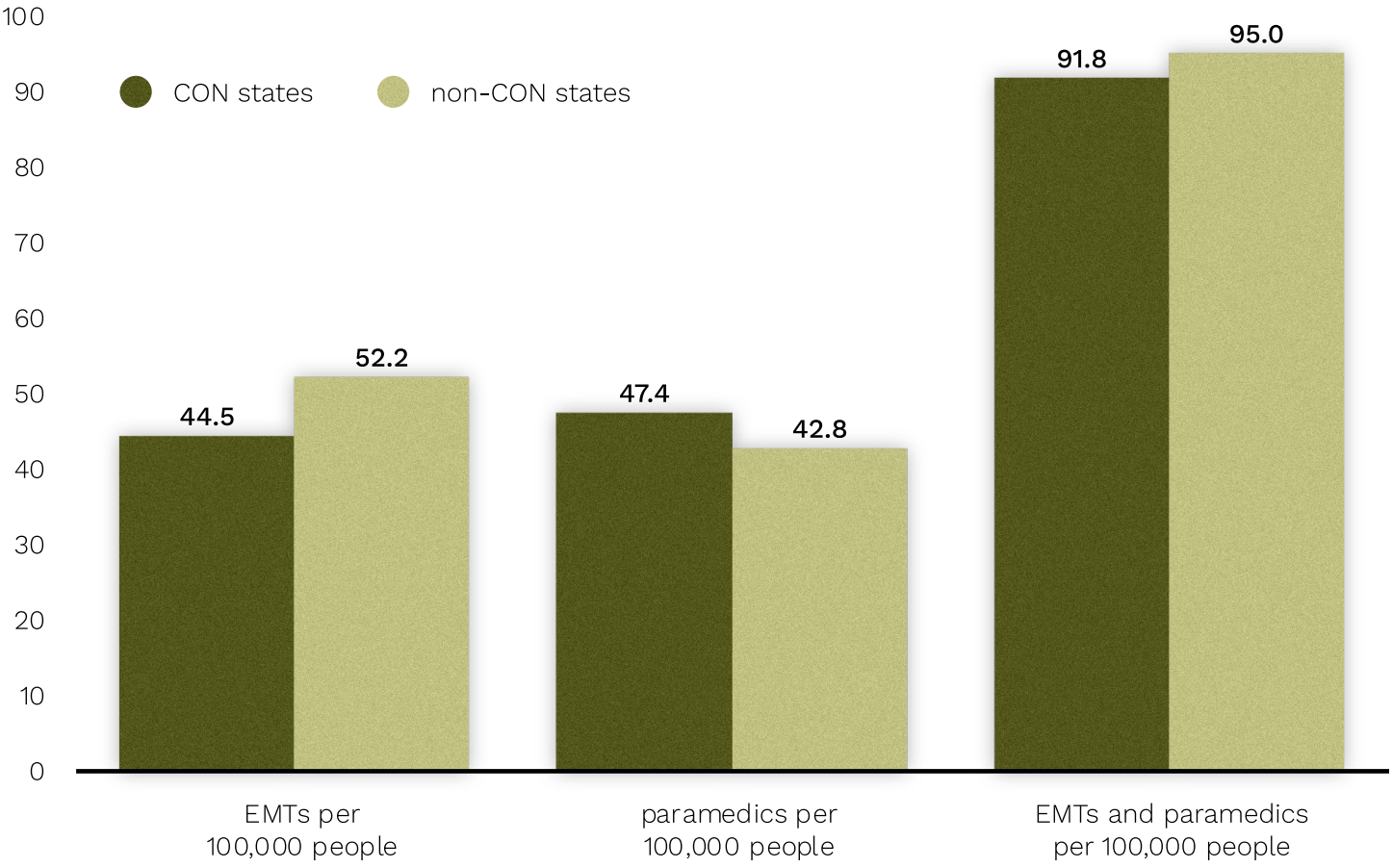
Sources: Centers for Medicare and Medicaid Services, "Timely and Effective Care" (dataset), last modified April 28, 2026; Chris Jones and Tanner H. Jones, *A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Need Laws in All 50 States* (Cicero Institute, 2024).

CON STATES HAVE FEWER EMS PROVIDERS AND REDUCED ACCESS TO AMBULANCE SERVICES

EMS PROVIDERS ARE OFTEN THE FIRST RESPONDERS to medical emergencies, delivering stabilizing care on the scene and transporting patients to emergency departments. Many states are facing shortages of EMS providers, leading to longer ambulance response times and worse outcomes for patients.

Figure 3 shows the average number of EMS providers per 100,000 population in CON and non-CON states. It uses 2024 data from the American Community Survey, the largest annual source of social and economic data on the US population. The figure shows separate results for the two primary EMS credential levels in the US: emergency medical technician (EMT) and paramedic. While EMTs are trained to provide basic life support, paramedics have a broader scope of practice, allowing them to perform more advanced procedures.

FIGURE 3. **Emergency Medical Providers per 100,000 Population by CON Status**



Notes: CON states are defined as those with CON restrictions on ground ambulance services, given that the majority of EMS providers work for public (e.g., fire department) or private ambulance services. Non-CON states are those with no CON restrictions on ground ambulance services.

Source: Census Bureau, *American Community Survey*, 2024 1-year Public Use Microdata Sample, Washington, DC.

On average, CON states have 44.5 EMTs per 100,000 people, 15 percent fewer than the 52.2 per 100,000 in non-CON states. At the same time, CON states have 11 percent more paramedics per 100,000 people (47.4 vs. 42.8) than non-CON states. Combining both provider types, the total supply of EMS providers in CON states (91.8 per 100,000) is 3 percent lower than in non-CON states (95.0 per 100,000).

The higher paramedic-to-EMT ratio in CON states is unlikely to improve outcomes for the majority of EMS calls, which involve conditions for which basic life support is clinically appropriate.[28] The bigger issue is that CON states have 3 percent fewer EMS providers, which tends to reduce ambulance response times.

Moreover, aggregate counts of EMS providers can mask important geographic disparities in access. Even when total EMS staffing is comparable across states, residents may live far from the nearest staffed ambulance station and face long response times in an emergency. To capture this dimension of access, Figure 4a reports the share of each state's population living in an ambulance desert—defined as an area where residents live more than 25 minutes from the nearest ambulance station.

FIGURE 4. **Access to Ambulance Services by CON Status**

Figure 4a. Percent of Population in Ambulance Desert

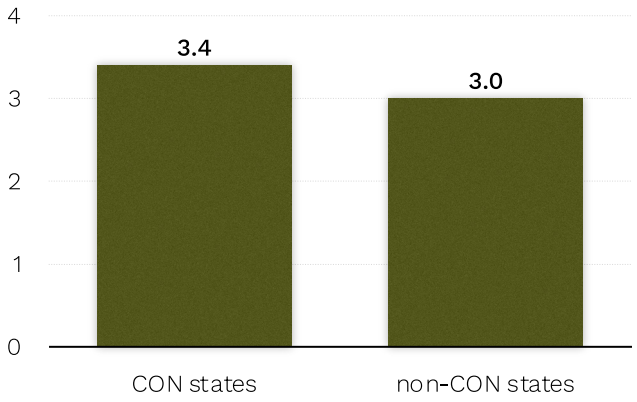
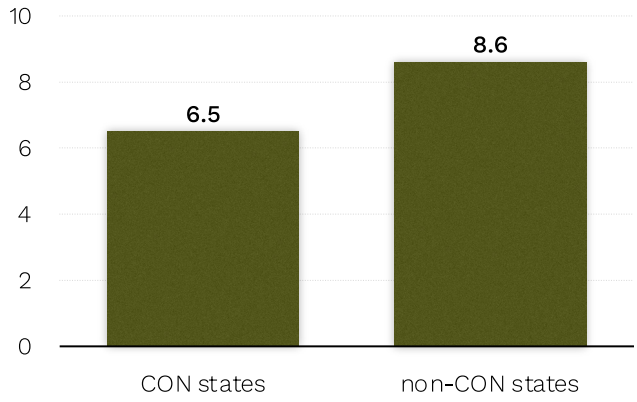


Figure 4b. Ambulance Stations per 100,000 People



Notes: CON states have CON restrictions on ground ambulance services. Non-CON states do not. The ambulance data cover the period 2021–2022. The analysis is based on the 41 states that provided data.

Source: Yvonne Jonk et al., *Ambulance Deserts: Geographic Disparities in the Provision of Ambulance Services* (Maine Rural Health Research Center, May 2023).

The pattern between CON and non-CON states mirrors the other measures examined in this brief. On average, 3.4 percent of the population in CON states lives in an ambulance desert, compared with 3.0 percent in non-CON states—a difference of 0.4 percentage points, or roughly 13 percent. An even larger disparity exists in the number of ambulance stations per 100,000 residents, as shown in Figure 4b: 6.5 in CON states, on average, which is 24 percent lower than the 8.6 in non-CON states.

Nationally, an estimated 4.5 million Americans live in an ambulance desert, including 2.3 million residents of rural counties.[29] For these rural populations, the consequences of regulatory barriers to ambulance services are not merely a matter of inconvenience or higher prices, but of whether emergency transportation will arrive in time to deliver potentially lifesaving care.

CON restrictions on ambulance services are not the sole determinant of ambulance station location. Still, by forcing prospective providers to undergo a complex and lengthy administrative process, CON laws raise the cost and uncertainty of establishing new service areas and restrict existing providers from expanding into underserved communities.

CONCLUSION

ACROSS A RANGE OF RELEVANT MEASURES, STATES with CON restrictions have less robust emergency medical systems that expose their populations to the risk of life-threatening delays in ambulance response times and emergency department care. Differences in emergency care infrastructure between CON and non-CON states likely reflect a range of factors. Still, this analysis is consistent with a large body of empirical evidence showing that CON laws impede entry into the healthcare market and reduce the supply of healthcare services. Eliminating these regulatory barriers could be a viable component of a multipronged strategy for addressing care shortages and improving patient health outcomes.

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3. Theoretically, CON laws could improve health equity in several ways. First, CON laws could help keep safety-net hospitals (i.e., those serving large shares of Medicaid and uninsured patients) financially viable by preventing competitors from cream-skimming their most lucrative patients. Second, CON laws could ensure broader geographic distribution of healthcare services by allowing regulators to limit the amount of capital investment flowing to wealthy suburban and urban markets and away from rural and low-income areas.

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