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Competitor's Veto: State Certificate of Need Laws Violate State Prohibitions on Monopolies

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The views expressed are those of the author in her personal capacity and not in her official/professional capacity.

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Executive Summary

Over the past 50 years, most states enacted (and many still retain) Certificate-of-Need (CON) laws, whose stated purpose is to control medical costs by limiting the supply of services and facilities to only what is "needed," as determined by a state board or agency. Simply put, CON laws make it illegal for healthcare providers to offer services to patients, or to purchase certain medical equipment, without first getting permission from those providers already operating in the market. That permission is often denied—not because of any threat to public health, but solely to prevent legitimate economic competition.

Soon after the federal government encouraged states to adopt such laws in the 1970s, it became clear that this cost control experiment was a failure. The U.S. Federal Trade Commission and the Department of Justice, and several academic studies found that by eliminating competition, CON laws actually drove up costs, lowered quality, and limited the availability of needed services. As the American Medical Association succinctly put it: "CON laws represent a failed public policy."

Yet 38 states still have CON laws on their books, and continue to require government approval before building or expanding a healthcare facility or service—approval that can hinge on whether existing hospitals are willing to allow others to enter the market to compete against them.[1] This is primarily because existing providers benefit handsomely from CON laws, which allow them to block would-be competitors. Given the monopoly profits that CON laws enable incumbent providers to realize, these firms invest time and resources in preserving the anti-competitive power that these laws give them. As a result, most efforts to repeal CON laws have been unsuccessful in recent years.

But there may be hope in the courts. CON laws, after all, violate a host of constitutional provisions, including the anti-monopoly clauses found in several state constitutions. Enabling existing providers to use the law to bar others from entering an industry or offering a service is the very definition of a government-created monopoly. Few state courts have so far directly addressed whether CON laws violate state anti-monopoly clauses, but several have noted that they are inherently anticompetitive. This paper discusses how CON laws are designed to function in precisely the way prohibited by state constitutions.

I. Certificate-of-Need Laws

CON laws originated in the late 19th century to govern railroads and streetcars, and during the 1930s they were expanded, in one form or another, to govern a variety of industries. Among their primary justifications was the theory that competition was economically wasteful, and that state boards or agencies—sometimes staffed by members of the industry themselves—were better situated to determine society's needs.

In 1974, Congress enacted the "National Health Planning and Resources Development Act" (NHPRDA), which offered federal funding to states if they adopted CON laws. By 1980, all states

[1] National Conference of State Legislatures, "Intent and Structure of CON," https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.

except Louisiana had them in some variation. Soon, however, it became clear that these laws did not control healthcare costs as anticipated. Instead, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) found that by eliminating competition from the healthcare industry, CON laws actually drive up costs, reduce quality, and limit the availability of needed services. Congress therefore repealed NHPRDA in 1986, and many states abandoned their CON requirements as counterproductive.

Decades later, the FTC and DOJ stood by their finding that CON laws harm patients, publishing an extensive study in 2004 that showed that the primary beneficiaries of CON laws are not patients, but entrenched special interests—existing medical providers who use the system to protect themselves against competition. And although one common argument in favor of CONs is that they help ensure that medical providers will support charitable care—by barring competitors who will "skim the cream" by confining themselves to profitable service—the FTC found no evidence to support the theory that CON laws result in more charitable health care services. Instead, the primary beneficiaries of CON laws are existing providers, who use them to block competitors from encroaching on their markets. As FTC commissioner Maureen Ohlhausen said in a 2015 analysis, "CON laws insulate politically powerful incumbents from market forces."

Academic research backs these findings. An exhaustive 2016 study published by the Mercatus Center at George Mason University found that the cost of healthcare is higher, the quality is lower, and access is scarcer in states with CON laws. Even the American Medical Association, once a supporter of CON laws, has concluded that they "have failed to achieve their intended goal of containing costs," and that they restrict patient choice while doing nothing to improve the quality of care. Instead, CON laws "tend to be influenced heavily by political relationships."

Copious examples illustrate how CON laws protect entrenched businesses at the expense of applicants—and the public health. For example, in Hawaii, where healthcare services are so lacking on the outer islands that patients often have to be flown into Honolulu in order to get care, the state's CON law blocked a company that would have brought much-needed services to Maui. In 2006, a private hospital sought a CON to become the island's second full-service hospital, offering special pediatric and cardiac care that otherwise could only be provided by transporting patients to Honolulu. But the government-run hospital objected to the competition the private hospital would bring, and the state Department of Health rejected the private hospital's CON application. As a result, more than 350 cardiac cases per year must be treated off-island.

Mental health services have also suffered because of CON laws. In 2015, two existing mental health providers in Iowa used that state's CON law to block a private company's application for a certificate of need to build a 72-bed inpatient mental health facility without subsidies or assistance from taxpayers. Just two years before, those same existing providers had published a study warning that the area's "mental health care system is in crisis," that existing services were "insufficient," and that "[t]he needs of the sickest and the poorest of our community are not being met." Yet when faced with the possibility of competition entering the market to serve those needs, they managed to

stall a final decision on a certificate of need application for a new psychiatric hospital for more than two years.

In Oregon, a company seeking to build a privately-funded 100-bed in-patient psychiatric hospital near Portland was forced to battle existing mental health providers and state bureaucrats for years under that state's CON laws—to no avail. Oregon consistently ranks at or near the bottom among states in terms of access to mental health facilities and services. Indeed, under an agreement with the DOJ, Oregon was required to take steps to alleviate "emergency room boarding" of mental health patients—that is, the policy of keeping the mentally ill confined to emergency rooms. Yet opposition from the existing providers led the state's Health Authority to deny the new hospital's CON application, in part because competition would "have a negative financial impact on [existing] providers."

CON laws have also made it difficult to help those struggling with addiction. In Johnson City, Tennessee, a private company sought to open a methadone treatment center in 2013 to help treat addiction to heroin and other opioids. Tennessee has one of the nation's highest rates of opioid abuse, and treatment options in the area where the company sought to open were virtually nonexistent. The nearest methadone treatment center in the state was more than 100 miles away, and the closest one was across the state line in North Carolina, more than 50 miles away. Yet existing healthcare companies in the region opposed the application, so the Tennessee Health Services Development Agency rejected it, declaring "need has not been clearly established." Three years later, the same companies that opposed the CON application announced plans to open a new methadone clinic of their own, offering the reasons that their would-be competitor had offered when it sought a certificate of need. The Tennessee Health Services and Development Agency, which rejected the prior proposal three years earlier, unanimously approved the certificate for the existing providers a mere three months after it was filed.

CON laws can also operate to explicitly support government monopolies at the expense of private businesses and the public's well-being. For the past 17 years, ambulance services in Show Low, Arizona, have been provided by a privately-owned small business. In mid-2018, the local (public) fire district filed an application to replace the private company in a large portion of the service area. This would have had the consequence of replacing a respected private company with a government entity that has been losing money for years. Indeed, the overall financial health of fire districts in Arizona is extremely poor, and emergency services provided by taxpayer-funded fire districts tend to be more expensive than private providers. Consequently, the judge assigned to the case ruled in favor of the private company, finding that it served the taxpayers well. Yet the government appealed the decision to the Arizona Department of Health Services, whose director inexplicably disregarded the decision and sided instead with the fire district, a ruling that required her to ignore the detailed findings of fact made during the initial hearing.

Federal agency findings, academic research, and real-world examples all illustrate that CON laws do not benefit patients, doctors, or the public at large. Instead, they block competition in the healthcare market and prevent the provision of much-needed medical treatments. They are intrinsically

monopolistic, and thus they are prime targets for state constitutional provisions that prohibit the establishment or support of monopolies.

II. State Anti-Monopoly Clauses

Several states constitutions contain provisions that in one way or another forbid the creation of monopolies. Although these clauses vary in scope, they typically prohibit the state from creating or maintaining monopolies or restricting economic competition. Maryland's Anti-Monopoly Clause is one of the earliest and has existed in the same form since the state's founding. It provides that "monopolies are odious, contrary to the spirit of a free government, and the principles of commerce; and ought not to be suffered." North Carolina's anti-monopoly clause declares that "[p]erpetuities and monopolies are contrary to the genius of a free state and shall not be allowed." Some states use broader language, prohibiting laws that "authorize any contract or agreement which may have the effect of or which is intended to have the effect of encouraging a monopoly … or … defeating or lessening competition." Other provisions, such as Arizona's, encompass both state and private monopolistic activity: "Monopolies and trusts shall never be allowed in this state and no incorporated company, co-partnership or association of persons in this state shall directly or indirectly combine . . . to fix the prices, limit the production, or regulate the transportation of any product or commodity."

Regardless of their form, these provisions generally prohibit—in the Georgia Supreme Court's words—"'[a] privilege or peculiar advantage vested in one or more persons or companies, consisting in the exclusive right (or power) to carry on a particular business or trade.'"

III. Applying State Anti-Monopoly Clauses to CON Laws

As illustrated above, medical CON laws deprive doctors and medical providers of the right to serve patients with appropriate medical technology, and deprive patients of access to needed medical services, with the result of protecting existing medical providers from economic competition. Often, these laws prohibit medical professionals from serving patients if the state determines that existing providers are sufficient to meet an area's needs. Yet that determination is itself inherently monopolistic. CON laws typically do *not* make an applicant's ability to enter the business dependent upon that applicant's skills, qualifications, education, experience, or fitness to practice their profession. Instead, they prohibit new firms from entering the industry *regardless* of their qualifications and skill, based on a government agency's determination of public "need"—a determination that is often based on no objective criteria, and that instead often turns on the say-so of "affected parties," which means the firms that are already practicing in that industry.[2] Even applicants with extensive experience, a perfect safety record, and a superb education are often denied a CON, and thus barred from offering their services to patients, simply because existing providers do not want competition. And CON laws often do not require any consideration of

[2] *See, e.g.*, N.C. Gen. Stat. §§ l31E-185(a1)(2); 13lE-lS8(c); O.C.G.A. § 31-6-1 *et seq.* and GA. Comp. R. & Regs. 111-2-2-.01 *et seq.*

whether an applicant is competent or honest; after all, incompetent or dishonest practitioners are barred from practicing medicine by other laws.

For example, Georgia's CON law forbids certain types of clinics from opening—or from purchasing new medical equipment—without first proving that there is a "need for such services," that "existing alternatives" are unavailable in the "service area," and that the applicant "has a positive relationship to the existing health care delivery system."[3] What constitutes a "need"? The term is not defined, except that state regulations list a number of factors for state officials to take into consideration when someone applies for a CON. Needless to say, "positive relationship" is also undefined, as are other terms in the CON law, which allows state bureaucrats to decide whether or not a new clinic can open its doors—without objective standards and without regard to the applicant's skills or honesty.

What's more, CON laws have two kinds of effects which tend to encourage monopoly behavior—effects that economists call the "knowledge problem" and "rent-seeking." The knowledge problem refers to the inability of central planning authorities to determine economic needs in a dynamic world of countless unpredictable details. As Nobel laureate Friedrich Hayek observed, any industry is simply too complicated to be accurately predicted even by industry experts, let alone by government officials who may have no experience in that industry. Anticipating the future "needs" of a state's entire patient population is simply beyond the capacity of any company or bureaucracy. Rent seeking refers to the tendency of businesses that expect to obtain a profit from government action to invest their time and effort into lobbying the government with regard to that action. If the issuing of a CON to a new competitor will cost an existing company $1 million, then it is in that company's interest to invest up to $1 million in lobbying the government not to issue that CON. Rent seeking explains why regulatory agencies often end up acting not in the interest of the general public, but in the interest of industry insiders who have devoted their resources to persuading those agencies to act on their behalf.

In short, CON laws are the very definition of a monopoly—the very thing state anti-monopoly clauses were written to prohibit. By prohibiting free competition, not to protect public safety and welfare, but instead allow existing medical providers to block their own competition, CON laws create and foster monopoly in the medical industry. That is why one court has called CON laws a "Competitor's Veto,"[4] and many others have observed that CON laws are inherently anticompetitive, and "clearly contemplate…anticompetitive conduct."[5]

Under existing precedent in most states, economic freedom is typically afforded less protection in court than are rights such as freedom of speech, and restrictions on the right to earn a living are often upheld by courts on the theory that state lawmakers should enjoy broad discretion to determine how to regulate industries. This is particularly true in cases involving licensed professions

[3] Ga. Code § 31-6-42.Ga. Comp. R. & Regs. 111-2-2-.09.

[4] *Bruner v. Zawacki*, 997 F. Supp. 2d 691, 697 (E.D. Ky. 2014).

[5] *See, e.g., F.T.C. v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216, 235 (2013); *F.T.C. v. Hospital Bd. of Dir., Lee Cnty.*, 38 F.3d 1184, 1192 (11th Cir. 1994); *Martin v. Memorial Hosp. at Gulfport*, 86 F.3d 1391, 1393, 1398 (5th Cir. 1996).

that require a high degree of specialized skill and training, such as medicine. As a result, courts are usually reluctant to declare that laws regulating the medical industry are unconstitutional. Nevertheless, state constitutional provisions against monopolies make no distinction between medicine and any other industry, and state courts may not simply disregard the text of the state's fundamental law.

Georgia OB-GYN surgery

Georgia's CON laws require doctors to apply to the Georgia Department of Community Health for permission before they may add space to their clinics to serve more patients or buy certain kinds of medical equipment. As is often the case, the state's CON laws allow existing healthcare providers who do not want more competition to object whenever someone applies for a new CON.

Hugo Ribot and Malcolm Barfield are OB-GYN surgeons who own the Georgia Advanced Surgery Center for Women, in Cartersville, a small community 50 miles northwest of Atlanta. Their surgery center was designated a "Center of Excellence" —one of only a few in the entire country—by the American Association of Gynecological Laparoscopists, for their highly advanced surgical techniques, rigorous safety standards, and commitment to outstanding patient outcomes. Since opening in 2010, the doctors have performed hundreds of minimally invasive outpatient procedures—all with same-day patient discharge and no instances of infection, wound complication, or re-admission. These outstanding outcomes are achieved at lower prices than hospitals charge. Studies have shown that ambulatory surgery centers like Ribot's and Barfield's clinic decrease Medicare costs because they are paid a fraction of what is paid to hospitals for the same services.[6] Between 2008 and 2011, surgery centers saved the Medicare program and its beneficiaries $7.5 billion.

Ribot and Barfield wanted to serve more patients by adding a second operating room and letting other surgeons use their state-of-the-art facility. But the state's CON laws forbade them from adding a second operating room or from contracting with other doctors to use the existing facility without first getting government permission. Doing either without a CON would subject them to fines of $5,000–$25,000 *per day*.[7] So the doctors applied for a CON in October 2014.

After months of delay, the Georgia Department of Community Health denied their application in March 2015. The denial was not made on based on any safety concerns, but on the grounds that issuing them a CON "would not have a positive impact on the health care delivery system in the service area"[8]—in other words, that they would compete against existing hospitals, three of which had filed objections to their CON application.

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[6] American Journal of Gastroenterology, http://www.nature.com/ajg/journal/v108/n1/pdf/ajg2012183a.pdf.

[7] Petitioners' Opening Brief (Apr. 17, 2017), *Women's Surgical Center, LLC v. Reese*, S17A1317 (GA Sup. Ct.), available at https://goldwaterinstitute.org/wp-content/uploads/2017/07/Plaintiffs-Opening-Brief.pdf.

[8] *Id.*

As a result of the denial, the doctors' life-saving medical facility sat idle, meaning that patients were denied access to medical services simply to protect existing medical providers against economic competition.

Ribot and Barfield's story is just one of countless such instances. In fact, between 2011 and 2013, more than 20 percent of applications were either denied or withdrawn. Yet the total negative impact of the CON law on health care in Georgia is unknowable, because many applicants for CONs withdraw their applications as soon as objections are filed, knowing that an objection will almost certainly lead to a denial. Dozens of applications were withdrawn within during that time, including applications seeking permission to purchase new CT and MRI machines. And an untold number of applications never get filed in the first place, due to the high cost of filing an application. Ribot and Barfield's application, for example, cost tens of thousands of dollars in fees to a consultant who spent 200 hours gathering the required information and submitting the application.

Ribot and Barfield filed suit to challenge the state's CON law under the Georgia Constitution's anti-monopoly clause. Georgia courts had previously held that that clause forbade CON laws in the auto industry, setting important precedent that made the clause one of the strongest in the nation. Yet in 2017, the court backed away from its strict application of the antimonopoly clause and upheld the state CON laws. Although it acknowledged that the CON laws could have an impact on the medical providers seeking to enter the healthcare market, it nevertheless found that the anti-monopoly clause of the Georgia Constitution did not apply, because that clause includes certain narrowing language that other state anti-monopoly clauses lack. The Georgia provision prohibits the legislature from "authoriz[ing] any contract or agreement which may have the effect of or which is intended to have the effect of encouraging a monopoly"—which, the Court said, was not the same as a provision forbidding monopolies entirely. Since the CON laws do not specifically authorize *contracts* between service providers or anyone else that would encourage a monopoly, the court said, the restriction on Ribot and Barfield's rights was lawful.[9]

North Carolina medical imaging

Other states, however, have more protective provisions in their state constitutions. North Carolina's Anti-Monopoly Clause states, "Perpetuities and monopolies are contrary to the genius of a free state and shall not be allowed."[10] Because this language is not limited to contracts made by the state, as Georgia's appears to be, it should provide stronger protections against such monopolistic practices as CON laws.

[9] *Women's Surgical Center, LLC v. Reese*, S17A1317 (GA Sup. Ct. Oct. 16, 2017), available at https://www.gasupreme.us/wp-content/uploads/2017/10/s17a1317.pdf.

[10] N.C. Const. art. 1, § 34.

Dr. Gajendra Singh founded Forsyth Imaging Center in Winston-Salem in 2017, to deliver quality healthcare services at lower costs to his patients. Forsyth provides medical imaging services such as x-rays, ultrasounds, and MRI scans at a fraction of the prices charged by hospitals. But under North Carolina's CON law, licensed healthcare providers like Dr. Singh are prohibited from offering any "new institutional health service"—a term which includes "[t]he acquisition" of a "magnetic resonance imaging scanner"—unless they first get a CON from the state's Department of Health and Human Services.[11] And when Dr. Singh applied for one, he was turned down because existing providers (Dr. Singh's would-be competitors) already possess MRI machines, which according to the Department meant that no new MRI scanner would be needed in Forsyth County.[12] Thus, Dr. Singh is barred by from purchasing this diagnostic equipment for his practice—not because it would harm public health or because he is unqualified or incompetent, but solely to prevent economic competition against existing providers.

North Carolina's first CON law, enacted in 1971, was struck down by the North Carolina Supreme Court for violating the anti-monopoly clause, among other things.[13] Yet five years later, the state enacted another, substantially similar CON law,[14] in order to take advantage of federal subsidies. That law remains on the books today, despite half a dozen recent attempts to repeal it[15]—and it is now the subject of an ongoing lawsuit.[16]

North Carolina's current CON law requires the applicant to prove that (1) "[t]he population residing in the area served, or to be served, by the new institutional health service has a need for such services," (2) "[e]xisting alternatives for providing services in the service area" are unavailable, and (3) "[t]he proposed new institutional health service has a positive relationship to the existing health care delivery system in the service area."[17] Qualifications and safety are not included in the lengthy list of considerations in the CON process.[18] And state law provides no definition of a "positive relationship" to existing services—although the Department does not consider competing with existing services to create a "positive relationship." Even if the applicant could prove all of the required elements (a logical impossibility, given the lack of definitions), the CON laws also allow competing healthcare facilities to object to any applicant—without showing *any evidence*—and, astonishingly, do not allow the applicant to speak in rebuttal at the subsequent hearing.[19] Despite the

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[11] N.C. Gen. Stat. §§ 131E-178(a); 131E-176 (16)(f)(7).
[12] 2018 SMFP 165.
[13] *In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 551-52 (1973).
[14] N.C. Gen. Stat. §§ 131E-175, *et seq.*
[15] David Larson, "Certificate of need law will be tested in court," North State Journal (Dec. 12, 2019), http://nsjonline.com/article/2019/12/certificate-of-need-law-will-be-tested-in-court/.
[16] On November 15, 2019, a North Carolina superior court judge denied the North Carolina Department of Health and Human Services' motion to dismiss *Singh*. https://abc11.com/health/court-allows-lawsuit-which-could-set-upend-nc-medical-market/5709266/, but on January 10, 2020, the court granted the government's 12(b)(6) motion to dismiss with regard to, among other things, Plaintiff's claim that the CON law as applied to Dr. Singh violates the Anti-Monopoly Clause. The merits have not yet been reached, and the lawsuit is ongoing.
[17] O.C.G.A. § 31-6-42(a)(2), (3), (8); Ga. Comp. R. & Regs. 111-2-2.09(1)(b), (c), (h).
[18] See O.C.G.A. § 31-6-42.

[19] O.C.G.A. § 31-6-43(h); Ga. Comp. R. & Regs. 111-2-2.07(1)(h).

failure of the Georgia lawsuit, there is hope in North Carolina. After all, the state's anti-monopoly clause has been used successfully to strike down CON laws for other healthcare services. In 1969, a North Carolina appellate court held that although the licensure of ambulance services is a "valid and legitimate exercise of the police power," the CON law exceeded the state's authority because it tended to "turn the business over to a privileged class."[20] Four years later, the state's supreme court struck down an earlier version of the state's CON law, noting that while the legislature may license medical facilities and impose other regulations to ensure that they meet "reasonable minimum specifications," it cannot deny private parties the right to construct facilities for "the sole reason . . . that, in the opinion of the Commission, there are now in the area hospitals with bed capacity sufficient to meet the needs of the population."[21]

IV. A Way Forward

CON laws are, at best, an outmoded means of regulation which the federal government abandoned almost 40 years ago after a record of failure. They remain on the books today, not because they improve patient outcomes, but because benefit industry insiders who devote resources to defending them against any alteration or repeal—and because the general public is largely unaware of their existence. In such circumstances, it is proper to look to courts to defend the principles embodied in state constitutions against unjust and irrational legislation.

Unfortunately, courts are often reluctant to intervene in situations in which the legislature is regulating health care—a subject over which legislatures have traditionally had extensive authority. But that authority should always be focused primarily on protecting patients, rather than on securing special privileges to existing businesses. In the 1889 case of *Dent v. West Virginia*, the first case to uphold the constitutionality of medical licensing laws, the U.S. Supreme Court made clear that laws regulating medicine should be "appropriate to the calling or profession," and that whenever they "have no relation to such calling or profession" they can "operate to deprive one of his [constitutional] right to pursue a lawful vocation."[22] CON laws, which bar people from providing much-needed medical services for reasons that have no relationship to their honesty or skill, but simply to prevent legitimate economic competition, fail this test. Courts should take a stand in favor of protecting citizens against the injustice of government-established health care monopolies.

[20] *Whaley v. Lenoir Cnty.*, 168 S.E.2d 411, 414-18 (N.C. 1969).
[21] *In re Certificate of Need for Aston Park Hosp.*, 193 S.E.2d 729, 733-34 (N.C. 1973).
[22] *Dent v. State of W.Va.,* 129 U.S. 114, 122 (1889).