Case Nos. S17A1317 and S17X1318

IN THE SUPREME COURT OF GEORGIA

WOMEN'S SURGICAL CENTER, LLC, et al.,

Petitioners and Cross-Appellees,

v.

CLYDE L. REESE, III, et al.,

Respondents and Cross-Appellants.

Fulton County Superior Court, Case No. 2015-CV-262659

AMICUS CURIAE BRIEF OF SCHOLARS OF CERTIFICATE-OF-NEED LAWS IN SUPPORT OF PETITIONERS AND CROSS-APPELLEES WOMEN'S SURGICAL CENTER, LLC, ET AL.

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INTERESTS OF AMICI CURIAE

Amici curiae are scholars of law, economics, and regulation, and have devoted significant academic attention to economic effects of regulation with a particular focus on certificate-of-need (CON) regulations. Amici thus have a strong interest in ensuring that this Court's approach reflects an accurate understanding of the economic effects of CON programs. Amici teach that a public policy program should be measured by its effects rather than its intentions or justifications. A review of the relevant economic literature concerning CON programs demonstrates that these programs represent a grant of monopoly and have all the corresponding effects that result from such monopolies. In short, CON programs are associated with fewer options, higher costs, and an overall lower quality of care.

The *amici curiae* are the following:[1]

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1 Institutional identifications are provided for informational purposes only. The views expressed in this brief are those of the *amici curiae*, and not necessarily their institutions.

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INTRODUCTION AND SUMMARY OF THE ARGUMENT

The Anti-Monopoly Clause of the Constitution of Georgia, GA. CONST. art. III, sec. VI, para. V, prohibits laws that have the effect of creating a monopoly. It states,

> The General Assembly shall not have the power to authorize any contract or agreement which may have the effect of or which is intended to have the effect of encouraging a monopoly, which is hereby declared to be unlawful and void.

For some time, both economists and jurists have looked suspiciously on the intentional creation of monopolies by either private conduct or legislation. This sentiment is at the foundation of modern antitrust law.[2] It is also at the heart of state policy against "defeating or lessening competition, or encouraging monopoly." *Exec. Town & County Servs. Inc. v. Young*, 258 Ga. 860, 863, 376 S.E.2d 190, 192

2 Robert Bork, *Legislative Intent and the Policy of the Sherman Act*, 9 JOURNAL OF LAW & ECONOMICS 7 (1966).

(1989). CON laws represent the very type of legislatively created monopoly that courts have been concerned about for more than four centuries and that Georgia's Anti-Monopoly Clause has sought to protect against. This concern is for good reason.

This brief will begin with a brief overview of the history of CON. Thereafter, the empirical research presented in this brief demonstrates that CON programs (1) limit the introduction and expansion of a wide variety of medical services and equipment, (2) are associated with fewer hospitals and ambulatory surgical centers, (3) are associated with lower-quality healthcare, and (4) increase healthcare costs. Although there are claimed benefits of CON regulations, there is little evidence that these goals are achieved and strong evidence that the costs outweigh the benefits.

ARGUMENT

I. A brief history of CON laws

CON laws are a state invention. The first CON program was adopted by the state of New York in 1964 as a way to strengthen regional health planning programs by creating a process for prior approval of certain capital expenditures.[3] Between 1964 and 1974, twenty-six other states adopted CON programs.[4]

However, with the passage of the National Health Planning and Resources Development Act of 1974, Congress made certain federal funds contingent on a state's enactment of CON programs. This created a strong incentive for the remaining states to implement CON programs. Over the following seven years, nearly every state without a CON program took steps to adopt certificate-of-need statutes. It was during this time that Georgia passed its CON laws.

In 1986—as evidence mounted that CON laws were failing to achieve their stated goals—Congress repealed the mandate. By 1988 eleven states had either repealed their CON programs or allowed them to expire, and other states had either raised their review thresholds or otherwise reduced the scope of their CON review. Today, fifteen states no longer have a CON program.

3 James Simpson, *State Certificate-of-Need Programs: The Current Status*, 75 AMERICAN JOURNAL OF PUBLIC HEALTH 1225 (1985).
4 Id.

II. Certificates of need represent a grant of monopoly, and are associated with all the expected effects of a monopoly

Monopoly, in the most basic sense, can be defined as the absence of competition.[5] This definition includes monopolies that arise naturally, those that arise through private action, and those that arise through state action. For more than four centuries, courts have viewed statutory grants of monopoly as unfavorably as monopolies achieved through private means. A definition of statutory monopolies, provided by Edward Coke, gives specific context for how far the understanding of monopoly has extended to include actions undertaken by fiat. Coke understood monopolies to include

> an institution, or allowance by the king by his grant, commission, or otherwise to any person or persons, bodies politique, or corporate, of or for the sole buying, selling, making, working, or using of any thing, whereby any person or persons, bodies politique, or corporate, are sought to be restrained of any freedome, or liberty that they had before, or hindred in their lawfull trade.[6]

There is good reason not to differentiate between monopolies created by state action and monopolies created by private action. In an economic sense, they are no different from one another.[7]

5 *See, e.g.*, IRVING FISHER, ELEMENTARY PRINCIPLES OF ECONOMICS (1923).

6 EDWARD COKE, THE THIRD PART OF THE INSTITUTES OF THE LAWS OF ENGLAND 181 (London, W. Clarke and Sons 1644).

7 In fact, many economists view state-created monopolies *more* suspiciously than they do private monopolies. Whereas a private monopolist may gain a monopoly by offering the highest-quality and/or lowest-cost product or service, a state-created monopolist is less likely to be the best provider. Private monopolies, moreover, are difficult to maintain because the above-normal profits invite entry. *See* MATTHEW MITCHELL, THE PATHOLOGY OF PRIVILEGE: THE ECONOMIC CONSEQUENCES OF GOVERNMENT FAVORITISM 21–25 (2012), available at http://mercatus.org/publication/pathology-privilege-economic-consequences-government-

Limits on competition, regardless of the source, have predictable outcomes: fewer choices, higher prices, poorer quality, and limited consumer welfare.[8] This has been recognized by courts and jurists going as far back as *Darcy v. Allein* (The Case of Monopolies) (1603) 77 Eng. Rep. 1260 (K.B.),[9] in which the court held invalid Queen Elizabeth's grant of a monopoly to Edward Darcy to import all playing cards into England. The Case of Monopolies is significant, as reported by Coke, as a display by the court of the advantages of competitive markets over monopolies. Moreover, it outlines the reasons why grants of monopoly are against the common law. As the court explains, such grants restrain producers from entering the market, thereby increasing prices and decreasing quality.[10] The court concludes that the Queen must have been mistaken in her grant because, while it was intended for the general welfare, a grant of monopoly is only for the benefit of the recipient.[11] Finally, as the court explains, to uphold the monopoly would be a "dangerous innovation."[12]

This Court has historically recognized the danger of such monopolies as well. In *Georgia Franchise Practices Comm'n v. Massey-Ferguson, Inc.*, 244 Ga. 800, 262 S.E.2d 106 (1979), this Court held that franchise laws designed "to

favoritism.

8 *See id.*

9 EDWARD COKE, 1 THE SELECTED WRITINGS AND SPEECHES OF SIR EDWARD COKE 394 (Steve Sheppard ed., Liberty Fund, 2003).

10 *Id.* at 398.

11 *Id.* at 400–401.

12 *Id.* at 401.

restrict competition and create a monopoly" were unconstitutional. *Id.* at 801, 262 S.E.2d at 107. In that case, the legislature had passed laws designed to specifically limit entry and competition in the the retail sale of motor vehicles.

This Court is not alone in this position. The South Carolina Supreme Court, for example, held earlier this year that, "[w]ithout any other supportable police power justification present, economic protectionism for a certain class of retailers is not a constitutionally sound basis for regulating. . . ." *Retail Services & Systems Inc. d/b/a Total Wine & More v. South Carolina Department of Revenue and ABC Stores of South Carolina*, S. Car. Opinion No. 27709 (Mar. 29, 2017). In that case, the state regulator attempted to enforce a three-license restriction against the business, which sought a fourth license. The state's argument that an additional license would harm small businesses was found to be nothing more than economic protectionism, which was an insufficient justification for denying an additional liquor license.

A grant of monopoly privileges through a CON program represents the same type of economic protectionism, particularly in the absence of any justification for health, safety, or another state police power. Although this Court has yet to take such a position on CON laws, the Supreme Court of the United States has noted that Georgia's CON program "does limit competition in the market for hospital

services in some respects." *F.T.C. v. Phoebe Putney Health System, Inc.*, 568 U.S. 216, 235 (2013).

As we outline below, the economic evidence suggests that when states limit competition through CON programs—as well-intentioned as these programs have been—this leads to the negative effects that could be easily predicted in a market dominated by a grant of monopoly. First, CON programs limit the introduction and expansion of a wide variety of medical services and equipment. Second, CON programs are associated with fewer choices. Third, the remaining choices tend to be lower quality. Finally, CON programs increase healthcare costs.

A. CON programs limit the introduction and expansion of a wide variety of medical services and equipment.

By definition, CON programs *restrict* supply, making them unlikely to ensure an adequate supply of healthcare resources.[13] Research on the supply of dialysis clinics[14] and hospice care facilities[15] finds that CON programs do, indeed, restrict the supply of both. George Mason University economist Thomas Stratmann led the most recent comprehensive study of the effect of CON programs on the supply of

13 As two economists put it, "To the extent that CON regulation is effective in reducing net investment in the industry, the economic effect is to shift the supply curve of the affected service back to the left." Jon M. Ford and David L. Kaserman, *Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry*, 59 SOUTHERN ECONOMIC JOURNAL 783 (1993).
14 *Id.*
15 Melissa D. A. Carlson et al., *Geographic Access to Hospice in the United States*, 13 JOURNAL OF PALLIATIVE MEDICINE 1331 (2010).

medical equipment.[16] Stratmann and his coauthor, Jacob Russ, report that there are on average 362 hospital beds per 100,000 people in the United States. Controlling for other factors, however, they find that states with CON programs have about 99 fewer hospital beds per 100,000 people than states without these regulations.

Moreover, they find that CON programs that specifically regulate acute hospital beds are associated with an average of about 131 fewer hospital beds per 100,000 people relative to non-CON states.[17] They also find that CON regulations reduce the number of hospitals with MRI machines by one to two hospitals per 500,000 people and that states that regulate MRI machines have, on average, 2.5 fewer hospitals providing MRI services than non-CON states.[18] Taking Georgia as an example, this means the state may have between 20 and 40 fewer hospitals offering MRI services than it would if it had no CON program.[19]

In separate research, Stratmann and his coauthor Matthew Baker find that patients in states with CON programs are more likely to travel longer distances in search of healthcare, a fact that has been documented by others.[20] Finally, they

16 Thomas Stratmann and Jacob W. Russ, *Do Certificate-of-Need Laws Increase Indigent Care?*, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (July 15, 2014), https://www.mercatus.org/publication/do-certificate-need-laws-increase-indigent-care.
17 An acute hospital bed is one intended for short-term use.
18 Stratmann and Russ, *supra* note 16.
19 Christopher Koopman, Thomas Stratmann, and Mohamad Elbarasse, *Certificate-of-Need Laws: Implications for Georgia*, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (Mar. 31, 2015), https://www.mercatus.org/publication/certificate-need-laws-implications-georgia.
20 Thomas Stratmann and Matthew C. Baker, *Winners and Losers from Barriers to Entry in the Healthcare Markets: Evidence from Certificate-of-Need Laws*, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (forthcoming and available upon request). For the previous research documenting this effect, *see* David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad,

assess the effect of CON regulations on nonhospital providers such as ambulatory surgical centers (ASCs), finding that—controlling for other factors—there are significantly fewer nonhospital providers of MRI and CT scans in CON states than in non-CON states.[21] This may explain why hospital providers have a stronger market share in CON states than in non-CON states.[22] It may also explain why hospitals tend to support CON regulation.[23]

B. *CON programs are associated with fewer hospitals and ambulatory surgical centers.*

CON programs were once intended to promote lower-cost hospital substitutes such as ambulatory surgical centers. In the National Health Planning and Resources Development Act, Congress explicitly declared that "there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care."[24] Ironically, many advocates of CON regulation now

Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery, 2 AMERICAN ECONOMIC JOURNAL: ECONOMIC POLICY __ (2010).

21 Stratmann and Baker, *supra* note 20.

22 *Id.*

23 In early research, national health planning consultants Ken Wing and A. G. Schneider identified this possibility. Ken Wing and A. G. Schneider, *National Health Planning and Resources Development Act of 1974: Implications for the Poor*, __ CLEARINGHOUSE REVIEW 691 (Feb. 1976) ("A certificate of need program can also be distorted into a tool for the protection of established provider interests."). *See also* George J. Stigler, *The Theory of Economic Regulation*, 2 BELL JOURNAL OF ECONOMICS AND MANAGEMENT SCIENCE 3 (1971); Ernesto Dal Bó, *Regulatory Capture: A Review*, 22 OXFORD REVIEW OF ECONOMIC POLICY 203 (2006); Patrick A. McLaughlin, Matthew D. Mitchell, and Ethan Roberts, *Regulatory Subsidies: How Regulations Can Become Privileges for Firms and Burdens for Consumers*, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (forthcoming).

24 Pub. L. No. 93-641, 88 Stat. 2226 (1975).

believe that ASCs and other hospital substitutes are a threat to the sustainability of hospitals and contend that CON laws are necessary to preserve community hospitals. Their concern is that ASCs cater to wealthier, less-complicated, and better-insured patients, "cream-skimming" these more profitable patients away from hospitals, diminishing the profitability and long-term sustainability of the affected hospitals.[25]

Research suggests that these restrictions significantly reduce access to alternative means of care, contrary to the original intent of CON advocates. Stratmann and Christopher Koopman, for example, find that states with ASC-specific CON restrictions have 14 percent fewer total ASCs per 100,000 residents and 13 percent fewer rural ASCs per 100,000 residents than non-CON states.[26] Additionally, Stratmann and Baker find that CON states have statistically significantly fewer nonhospital providers of medical imaging services than non-CON states.[27] Furthermore, these restrictions on hospital alternatives do not seem to lead to any more community hospitals, as proponents of the cream-skimming argument contend. In fact, Stratmann and Koopman find that, controlling for other factors, CON laws are associated with 30 percent fewer hospitals per 100,000

25 Ann Tynan et al., *General Hospitals, Specialty Hospitals and Financially Vulnerable Patients*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE: RESEARCH BRIEF NO. 11 (Apr. 2009).
26 Thomas Stratmann and Christopher Koopman, *Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals*, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (Feb. 18, 2016), https://www.mercatus.org/publication/entry-regulation-rural-health-care-certificate-of-need-laws-ambulatory-surgical-centers.
27 Stratmann and Baker, *supra* note 20.

residents *and* with 30 percent fewer rural hospitals per 100,000 residents.[28] Thus, CON regulations seem to restrict the supply of both hospitals and hospital substitutes.

Rural access to healthcare was also a priority of the National Health Planning and Resources Development Act, and many states continue to justify their CON programs by claiming that the regulations ensure care will be provided to residents in geographically underserved, economically depressed, or rural communities.[29] Theory, however, suggests that a supply restriction will decrease, not increase, access to care. And, as noted above, researchers have found that CON regulation is associated with longer travel distance to care.[30]

In recent research, Stratmann and Koopman explicitly address the question of rural access to hospitals and hospital substitutes such as ambulatory surgical centers.[31] Examining over 25 years' worth of data and controlling for other factors that might influence the number of hospitals, they find that states with CON programs not only have 30 percent fewer total hospitals per 100,000 residents, but also have 30 percent fewer rural hospitals per 100,000 residents compared with non-CON states. Moreover, their research finds that states with ASC-specific CON restrictions had on average 13 percent fewer rural ASCs per 100,000 residents

28 Stratmann and Koopman, *supra* note 26.
29 *See id.*
30 Cutler, Huckman, and Kolstad, *supra* note 20; Stratmann and Baker, *supra* note 20.
31 Stratmann and Koopman, *supra* note 26.

compared with non-CON states.[32] Their findings are consistent with previous research that found that CON programs correlate with less rural access to hospice care.[33] In short, there is no evidence to indicate that CON programs increase access to care. Instead, they may actually be limiting access for rural residents of CON states.

C. *CON programs are associated with lower-quality healthcare.*

Unlike other regulatory regimes in healthcare, such as occupational licensure and scope-of-practice rules, CON regulations do not specifically aim to improve quality.[34] That is, CON regulators do not attempt to assess whether providers are qualified to do their jobs. Nevertheless, CON advocates sometimes claim that because CON regulations reduce the number of institutions providing care, they will cause more procedures to be performed by the institutions that do obtain permission.[35] Thus, the argument goes, practitioners in CON states will tend to see

32 *Id.*

33 Carlson et al., *supra* note 15.

34 On whether these other types of regulations achieve their aim, *see generally* Morris M. Kleiner and Alan B. Krueger, *Analyzing the Extent and Influence of Occupational Licensing on the Labor Market*, 31 JOURNAL OF LABOR ECONOMICS S173 (2013); Morris M. Kleiner et al., *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service*, NBER WORKING PAPER NO. 19906 (2014); Patrick A. McLaughlin, Jerry Ellig, and Dima Yazji Shamoun, *Regulatory Reform in Florida: An Opportunity for Greater Competitiveness and Economic Efficiency*, 13 FLORIDA STATE UNIVERSITY BUSINESS REVIEW 95 (2014); Department of the Treasury Office of Economic Policy, Council of Economic Advisers, and Department of Labor, *Occupational Licensing: A Framework for Policymakers* (July 2015), https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf.

35 Mary S. Vaughan-Sarrazin et al., *Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States with and without Certificate of Need Regulation*, 288 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1859 (2002).

more patients with the same conditions and therefore might become more specialized and proficient.[36]

This theory must be weighed against competing theories that suggest that competition tends to increase quality, especially when regulations prevent price competition.[37] Much of the literature assessing the effect of CON regulation on quality tends to focus on individual conditions and procedures, and researchers have had a difficult time disentangling causation from correlation. These studies either suggest that CON regulation has no effect on quality[38] or come to varying conclusions about the effect.[39]

In recent research, Stratmann and David Wille attempt to overcome the shortcomings of these research designs in two ways.[40] First, they assess the effect

36 John Steen, *Regionalization for Quality: Certificate of Need and Licensure Standards*, AMERICAN HEALTH PLANNING ASSOCIATION (Mar. 2004), http://www.ahpanet.org/files/Regionalization%20for%20Quality.pdf.
37 Martin Gaynor, *What Do We Know About Competition and Quality in Health Care Markets?*, NBER WORKING PAPER NO. 12301 (2006).
38 Daniel Polsky et al., *The Effect of Entry Regulation in the Health Care Sector: The Case of Home Health*, 110 JOURNAL OF PUBLIC ECONOMICS 1 (2014).
39 Evidence about the effect of CON regulation on the quality of coronary artery bypass grafting is especially mixed. Mary S. Vaughan-Sarrazin and her coauthors find that CON regulation reduces mortality rates related to the procedure, David M. Cutler and his coauthors find that CON regulation increases mortality rates after the procedure, and Vivian Ho and her colleagues find that states that drop CON regulation see a temporary reduction in mortality rates related to the procedure relative to states that keep it. Mary S. Vaughan-Sarrazin et al., *Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States with and Without Certificate of Need Regulation*, 288 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1859 (2002); Cutler, Huckman, and Kolstad, *supra* note 20; Vivian Ho, Meei-Hsiang Ku-Goto, and James G. Jollis, *Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON*, 44 HEALTH SERVICES RESEARCH 483 (2009).
40 Thomas Stratmann and David Wille, *Certificate-of-Need Laws and Hospital Quality*, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (Sept. 27, 2016), https://www.mercatus.org/publications/certificate-need-laws-and-hospital-quality.

of CON regulation using data pertaining to multiple aspects of the patient experience, including readmission rates, mortality rates, and patient experience surveys. Second, they attempt to isolate the causal effect of CON regulation by comparing variation in hospital quality within markets that span CON and non-CON states. This allows them to control for market-specific differences that might otherwise confound estimates. They find that "in states where CON laws regulate provider entry into healthcare markets, incumbents tend to provide lower-quality services."[41] In particular, they find that deaths from treatable complications following surgery and mortality rates from heart failure, pneumonia, and heart attacks are all significantly higher among hospitals in CON states than in non-CON states. They also find that in states with four or more CON restrictions, such as Georgia, patients are less likely to rate hospitals highly.

D. *CON programs increase healthcare costs.*

As they are today, policymakers in 1974 were concerned about healthcare price inflation, and Congress hoped that CON regulations would address the problem.[42] Today, many states explicitly name cost control as a goal of their CON programs. Cost is a per-unit concept. It refers to the amount of money needed to

41 *Id.*
42 In the National Health Planning and Resources Development Act, Congress noted that "increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary." Pub. L. No. 93-641, 88 Stat. 2226.

produce one unit of a product or service. Economic theory predicts that a supply restriction such as CON regulation will increase per-unit costs by reducing supply. As economists Jon Ford and David Kaserman put it, "To the extent that CON regulation is effective in reducing net investment in the industry, the economic effect is to shift the supply curve of the affected service back to the left. . . . The effect of such supply shifts is to raise . . . [the] equilibrium price."[43] The empirical evidence on how CON regulation affects cost has been consistent with economic theory, showing that CON regulation tends to increase the per-unit cost of healthcare services.[44]

By decreasing the supply of healthcare, however, CON regulations also reduce the quantity of services consumed. So it is possible that CON regulations might reduce overall spending on healthcare services even if they increase the cost per unit of each service.[45] In recent research, Matthew Mitchell reviewed the

43 Ford and Kaserman, *supra* note 13, at 783–84.
44 Monica Noether, *Competition Among Hospitals*, 27 JOURNAL OF HEALTH ECONOMICS 205 (1988); David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey, *The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures*, 40 INQUIRY: A JOURNAL OF MEDICAL CARE ORGANIZATION, PROVISION AND FINANCING 146 (2003); Vivian Ho and Meei-Hsiang Ku-Goto, *State Deregulation and Medicare Costs for Acute Cardiac Care*, 70 MEDICAL CARE RESEARCH AND REVIEW 185 (2013); James Bailey, *Can Health Spending Be Reined In Through Supply Restraints? An Evaluation of Certificate-of-Need Laws*, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (Aug. 1, 2016), https://www.mercatus.org/publication/health-spending-reined-in-CON-laws.
45 In order for this to be the case, however, the demand for healthcare services would need to be elastic, and the evidence suggests that it is not elastic. Ford and Kaserman, *supra* note 13; Bailey, *supra* note 44.

literature on CON regulations and healthcare spending.[46] Seven studies find that CON regulation increases healthcare spending,[47] two find no statistically significant effect,[48] and two find that CON regulation increases some expenditures while reducing others.[49]

To date, only one study finds that CON regulation is associated with less healthcare spending.[50] In this case, however, the connection is tenuous. The author finds that CON regulation is associated with fewer hospital beds, and he finds that fewer hospital beds are associated with slightly slower growth in aggregate

46 Matthew D. Mitchell, *Do Certificate-of-Need Laws Limit Spending?*, MERCATUS CENTER AT GEORGE MASON UNIVERSITY (2016), https://www.mercatus.org/publication/do-certificate-need-laws-limit-spending.

47 Frank A. Sloan and Bruce Steinwald, *Effects of Regulation on Hospital Costs and Input Use,* 23 JOURNAL OF LAW & ECONOMICS 81 (1980); Joyce A. Lanning, Michael A. Morrisey, and Robert L. Ohsfeldt, *Endogenous Hospital Regulation and Its Effects on Hospital and Non-hospital Expenditures*, 3 JOURNAL OF REGULATORY ECONOMICS 137 (1991); John J. Antel, Robert L. Ohsfeldt, and Edmund R. Becker, *State Regulation and Hospital Costs*, 77 REVIEW OF ECONOMICS AND STATISTICS 147 (1995); Nancy A. Miller, Charlene Harrington, and Elizabeth Goldstein, *Access to Community-Based Long-Term Care: Medicaid's Role*, 14 JOURNAL OF AGING AND Health 138 (2002); Patrick A. Rivers, Myron D. Fottler, and Mustafa Zeedan Younis, *Does Certificate of Need Really Contain Hospital Costs in the United States?*, 66 HEALTH EDUCATION JOURNAL 1 (2007); Patrick A. Rivers, Myron D. Fottler, and Jemima A. Frimpong, *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 JOURNAL OF HEALTH CARE FINANCE 1 (2010); Bailey, *supra* note 44.

48 Frank A. Sloan, *Regulation and the Rising Cost of Hospital Care*, 63 REVIEW OF ECONOMICS AND STATISTICS 479 (1981); Grabowski, Ohsfeldt, and Morrisey, *supra* note 44.

49 Christopher J. Conover and Frank A. Sloan, *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 JOURNAL OF HEALTH POLITICS, POLICY AND LAW 455 (1998); Momotazur Rahman et al., *The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures*, 73 MEDICAL CARE RESEARCH AND REVIEW 85 (2016).

50 Fred J. Hellinger, *The Effect of Certificate-of-Need Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis*, 15 AMERICAN JOURNAL OF MANAGED CARE 737 (2009).

healthcare expenditures per capita. Importantly, however, he finds that "certificate-of-need programs did not have a direct effect on healthcare expenditures."[51]

III. There is no evidence that the costs of CON programs are outweighed by any benefits

If CON programs limit the overall supply of healthcare, reduce quality, and increase costs, perhaps they do so by ensuring that supply is more equitably distributed. Some have argued that CON programs were established with the partial intent of creating a quid pro quo: by restricting competition, the regulation increases the profit of some providers who, in return, might use some of this extra profit to subsidize medical services to the poor or underserved.[52] In 11 states, CON statutes explicitly include requirements for the provision of charity care; in others, the quid pro quo is widely assumed.[53]

While this presumed effect is theoretically possible, there is no evidence that hospitals in states with CON programs provide any more charity care or care to underserved communities than hospitals in states without CON programs. In fact, researchers have found that CON regulation seems to increase racial disparities in

51 *Id.* at 737.
52 Dwayne A. Banks, Stephen E. Foreman, and Theodore E. Keeler, *Cross-Subsidization in Hospital Care: Some Lessons from the Law and Economics of Regulation*, 9 HEALTH MATRIX: JOURNAL OF LAW-MEDICINE 1 (1999); Guy David et al., *Do Hospitals Cross-Subsidize?*, 37 JOURNAL OF HEALTH ECONOMICS 198 (2014).
53 *Free Care Compendium: National Snapshot*, COMMUNITYCATALYST.ORG, http://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/national-snapshot (last visited June 20, 2017).

the provision of certain services.[54] Stratmann and Russ examine the level of uncompensated care across CON and non-CON states and, controlling for other factors, find that CON regulation has had no effect.[55] What is more, as we outlined above, CON programs are a costly and poorly targeted means of ensuring charity care, especially when there are more direct means to achieve the same end. For example, twenty-six states simply reimburse providers for at least a portion of any uncompensated care they provide.[56]

Although most certainly well-intentioned, Georgia's CON program falls short. More importantly, intentions matter little. Queen Elizabeth believed a grant of a monopoly to Edward Darcy was in the public interest, but the practical effect was quite the opposite. Likewise, it is not the General Assembly's intentions that should determine the outcome in this case. Economic evidence indicates that the state's certificate-of-need program represents a grant of monopoly.

Given that the state constitution's Anti-Monopoly Clause is an explicit policy against encouraging monopoly, and the evidence supports the conclusion that CON laws lessen competition and encourage monopolies of established

54 Derek DeLia et al., *Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey*, 34 JOURNAL OF HEALTH POLITICS, POLICY AND LAW 63 (2009).
55 Stratmann and Russ, *supra* note 16, at 18 ("We do not find any evidence of an increase in indigent care. Our coefficients are small in magnitude, not statistically different from zero, and the direction of the effect changes across specifications.").
56 *Free Care Compendium*, *supra* note 53.

healthcare providers, this Court should hold the law unconstitutional under the Georgia Constitution.

Respectfully submitted, this 4th day of August, 2017

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CERTIFICATE OF SERVICE

I hereby certify that I have this day filed the foregoing **AMICUS CURIAE BRIEF OF SCHOLARS OF CERTIFICATE-OF-NEED LAWS IN SUPPORT OF PETITIONERS AND CROSS-APPELLEES WOMEN'S SURGICAL CENTER, LLC, ET AL.** with the Clerk of Court via the SCED e-filing system, and served all parties to this matter by depositing a true and correct copy of same in the United States mail, with adequate postage thereon, and addressed as follows:

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