No. 22-42

# In The Supreme Court of the United States

DIPENDRA TIWARI; KISHOR SAPKOTA; GRACE HOME CARE, INC.,

*Petitioners,*

v.

ERIC FRIEDLANDER, in his official capacity as Secretary of the Kentucky Cabinet for Health and Family Services; ADAM MATHER, in his official capacity as Inspector General of Kentucky,

*Respondents,*

and

KENTUCKY HOSPITAL ASSOCIATION,

*Intervenor-Respondent.*

**On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit**

## BRIEF OF *AMICI CURIAE* SCHOLARS OF LAW & ECONOMICS IN SUPPORT OF PETITIONERS


LUKE HASSKAMP
BONA LAW PC
4275 Executive Square
Suite 200
La Jolla, CA 92037
(858) 964-4589
luke.hasskamp@bonalawpc.com

AARON GOTT
*Counsel of Record*
BONA LAW PC
331 2nd Avenue South,
Suite 420
Minneapolis, MN 55401
(612) 284-5001
aaron.gott@bonalawpc.com

*Counsel for Amici Curiae*



COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

TABLE OF CONTENTS

# TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Page

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

## INTERESTS OF *AMICI CURIAE*[1]

*Amici curiae* are economists who have studied certificate-of-need (CON) regimes for years. Given the academic attention *amici* have devoted to the subject, they have an interest in ensuring that the Court's approach reflects an accurate understating of CON laws and their effects.

*Amici* emphasize in their research and teaching that a public policy should be measured by its effects rather than its intentions or justifications. *Amici* have observed many attempts to justify CON regulation over the years, including assertions that it restrains spending, enhances access to care, improves quality, or protects vulnerable populations. Neither economic theory nor empirical evidence provides adequate support for any of these claims. Instead, the balance of evidence suggests CON laws increase spending, reduce access to care, and fail to enhance the quality of services.

**Matthew D. Mitchell**
*Senior Research Fellow*,
Mercatus Center at George Mason University

**Christopher J. Conover**
*Research Scholar (Retired)*, Duke University
*Adjunct Scholar (Retired)*,
American Enterprise Institute

---

[1] No counsel for any party authored this brief in whole or in part, and no person other than *amici* or their counsel have made any monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for each party received timely notice of *amici*'s intent to file and have consented to the filing of this brief by email.

**Thomas P. Miller**
*Senior Fellow*, American Enterprise Institute
*Senior Lecturing Fellow*,
Duke University School of Law

**Michael A. Morrisey**
*Professor Emeritus of Health Policy & Management*, Texas A&M University
*Professor Emeritus of Economics*,
University of Alabama at Birmingham

**Thomas Stratmann**
*University Professor of Economics and Law*,
George Mason University

**James Bailey**
*Associate Professor of Economics*,
Providence College

## SUMMARY OF ARGUMENT

In Kentucky and 34 other states, a glaring exception to the national policy in favor of competition governs the supply of health care services through certificate-of-need laws.[2] Under a CON regime, a provider who wishes to offer a new service, expand an existing service, or acquire certain equipment must prove to a regulator that the service is "needed." CON regimes are problematic for at least three reasons. First, they are unusual because it is unreasonable to expect

[2] Matthew D. Mitchell, Anne Philpot, and Jessica McBirney, *The State of Certificate-of-Need Laws in 2020* (Mercatus Ctr. at George Mason Univ. 2021).

them to achieve their stated goals. In fact, standard economic theory suggests they are likely to *undermine* each of their aims. Second, because CONs have been adopted by different states at different times, we have a surfeit of data from which to ascertain their effects. This data suggests that CON regimes do not, in fact, achieve their stated aims. Third, CON regimes are problematic because they manifestly serve a narrow interest at the expense of the public. *Amici* discuss these points in detail below to provide context that may help the Court determine whether to grant certiorari in this case.

## ARGUMENT

### I. STANDARD ECONOMIC THEORY SUGGESTS CON REGIMES ARE UNLIKELY TO ACHIEVE THEIR GOALS

Public policies are sometimes characterized as "working in theory, but not in practice." CON regimes neither work in theory nor in practice. Economic theory suggests that CON regimes are unlikely to achieve stated goals and that, instead, the anticompetitive conditions introduced by CON regimes will restrict supply, increase prices, and decrease quality.

While other regulations are meant to address market imperfections such as asymmetric information or externalities, CON regulations *introduce* a market imperfection by limiting competition and—in the extreme case—by creating local monopolies. Like any barrier to

market entry, CON regulation can limit competition. But CON regulations have some especially anticompetitive features.

In many states a CON can be denied if a regulator believes that the new service will "duplicate" an existing service, all but ensuring a local monopoly. Employees of existing providers—that is, would-be competitors—often sit on CON boards creating clear conflicts of interest. And in most CON states, the process allows incumbent providers to challenge the applications of would-be competitors.[3] These peculiar arrangements allow existing businesses a veto over their competitors, giving CON regulations the nickname "competitor's veto."

When incumbent providers challenge a competitor's application, the protest will sometimes be withdrawn after applicants agree to serve a smaller geographic area that does not infringe on the territory of an existing provider. This is nothing short of a market allocation agreement, a *per se* unlawful violation of the Sherman Act. Standard economic theory teaches that this sort of collusion via geographic segmentation harms consumers while enriching colluders. Territorial collusion is considered inefficient because it reduces overall economic surplus (the loss in consumer welfare and the welfare of would-be competitors is greater than the gain in producer welfare).[4]

---

[3] Ky. Rev. Stat. Ann. § 216B.085 (Michie 1996).

[4] Steven E. Landsburg, *Price Theory and Applications* 327 (Cengage Learning, 9th ed. 2013).

The most common goals of CON regulation—found on state CON websites and articulated by the regulations' defenders—are to contain costs, to ensure adequate and equitable access, and to improve quality. Standard economic theory suggests that the regulations are ill-suited to achieve these laudable ends. Instead, theory suggests that a supply restriction will tend to raise costs per service, increase overall spending if demand is inelastic, reduce access to care, and, in all likelihood, undermine quality.

## II. THE EMPIRICAL EVIDENCE SHOWS THAT CERTIFICATE-OF-NEED REGIMES DO NOT ACHIEVE THEIR GOALS

The federal government once encouraged states to adopt CON regulations by threatening to withhold federal funds from states without CON regimes. This inducement went into effect in 1975. In 1986, Congress repealed the CON mandate citing evidence that CON regimes failed to lower health care costs.[5] Almost immediately, twelve states eliminated their CON programs.

Fifteen states have now eliminated need reviews for most or all aspects of health care.[6] The most recent full repeal was New Hampshire in 2016. Several other states have pared their programs back by exempting the technologies and services subject to CON, by

---

[5] 100 Stat. 3799, Pub. L. 99-660, § 701 (1986).

[6] Mitchell, *supra* note 2.

raising the investment threshold that necessitates a certificate, or by some other reform.[7]

About 40 percent of Americans now live in states with either no or a limited CON regime.[8] Using multivariable regression analyses that control for possibly confounding factors (e.g., local demographic characteristics and economic conditions), researchers have compared cost, access, and quality outcomes in these states with conditions in states that continue to maintain CON regimes. They have also examined outcomes in states that have removed their programs or pared them back, typically comparing outcomes in these states with those in states that have maintained their programs. The literature is extensive.

For this brief, we reviewed 71 of these studies. In this section we focus on studies that test the stated goals of need review: cost containment, access, and quality. In the next section, we discuss papers showing that these rules serve the narrow interests of incumbent providers.

Since it was the original stated rationale, we begin with spending. We can think about health care

---

[7] The most recent sweeping reforms occurred in Florida and Montana. C.S./H.B. 21, Hospital Licensure, 2019 Leg., https://www.flsenate.gov/Session/Bill/2019/21/ByCategory (Fla. 2019); H.B. 231, Revise Laws Relating to Certificate of Need, 67th Leg. (Mont. 2021).

[8] Author's calculation, using Census population data and CON regulation data. *State Population Totals: 2010-2019*, https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-total.html (accessed July 30, 2021); Mitchell, *supra* note 2.

spending in two ways: spending per service and total spending. Spending per service, which might refer to costs, charges, or reimbursements, is analogous to a market price.[9] It refers to an amount spent *per service provided*. Total spending, on the other hand, is analogous to an annual budget. It represents on amount spent on a service over a given period (it is often stated in per capita or per patient terms). We address both in turn.

### A. CON Regimes Do Not Restrain Spending Per Service

Figure 1 summarizes the empirical findings on CON and spending per service. Thirteen studies evaluated the effect of CON review on spending per service. None finds clear evidence that CON reduces spending per service. Six studies (46 percent) find no effect, mixed effects, or statistically insignificant effects.[10] For

---

[9] Cost is the amount that a provider spends per service. Charge is the list price of the service before any negotiation with insurers or payors. And reimbursement is the actual amount paid per service.

[10] Most of these studies find no effect. Charlene Harrington et al., *The Effect of Certificate of Need and Moratoria Policy on Change in Nursing Home Beds in the United States*, 35 Medical Care, Issue 6, 574–88 (1997); David C. Grabowski et al., *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, Issue 2, 146–57 (Summer 2003); Abhinav Khanna et al., *Certificate of Need Programs, Intensity Modulated Radiation Therapy Use and the Cost of Prostate Cancer Care*, 189 Journal of Urology, Issue 1, 75–79 (Jan. 2013); James B. Bailey et al., *Certificate of Need Laws and Health Care Prices*, 43 Journal of Health Care Finance, Issue 4 (2017);

example, CON laws appear to have no effect on Medicaid nursing home reimbursement rates.[11] Nor do they seem to affect per diem Medicaid nursing home charges or per diem Medicaid long-term care charges.[12]

Seven studies (54 percent) find that CON is associated with *higher* spending per service.[13] For example,

---

Jourdan M. Cancienne et al., *Certificate-of-Need Programs Are Associated with a Reduced Incidence, Expenditure, and Rate of Complications with Respect to Knee Arthroscopy in the Medicare Population*, 16 HSS Journal: The Musculoskeletal Journal of Hospital for Special Surgery, Supp. 2, 264–71 (Dec. 2020); Chason Ziino et al., *Utilization and Reimbursement Trends Based on Certificate of Need in Single-Level Cervical Discectomy*, 29 Journal of the American Academy of Orthopaedic Surgeons 10 (May 15, 2021).

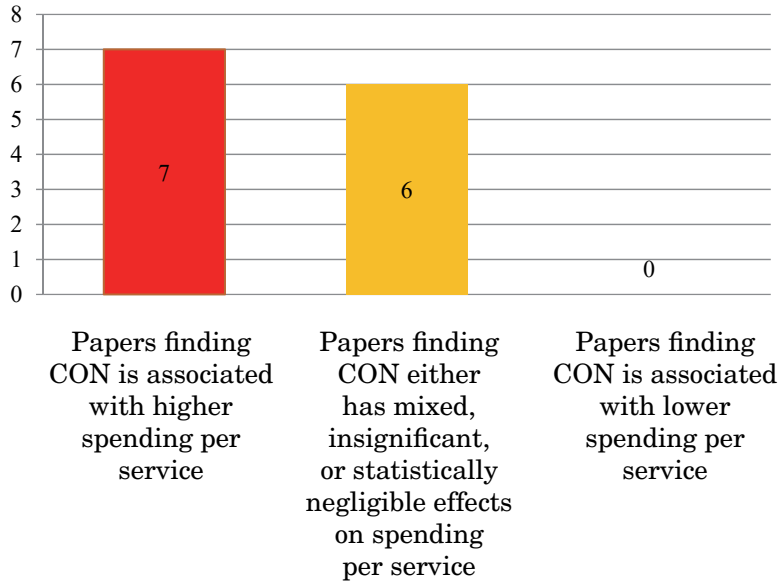
[11] Harrington et al., *supra* note 10.

[12] David C. Grabowski et al., *supra* note 10.

[13] Keith B. Anderson and David I. Kass, *Certificate of Need Regulation of Entry Into Home Health Care: A Multi-Product Cost Function Analysis*, FTC (1986); Monica Noether, *Competition Among Hospitals*, 7 Journal of Health Economics, Issue 3, 259–84 (Sept. 1988); Vivian Ho and Meei-Hsiang Ku-Goto, *State Deregulation and Medicare Costs for Acute Cardiac Care*, 70 Medical Care Research and Review, Issue 2, 185–205 (Apr. 2013); James B. Bailey*, Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate-of-Need Laws*, Mercatus Working Paper, Mercatus Ctr. at George Mason Univ. (Aug. 1, 2016) (hereinafter Mercatus Working Paper); James A. Browne et al., *Certificate-of-Need State Laws and Total Knee Arthroplasty*, 33 The Journal of Arthroplasty, Issue 7, 2020–24 (July 1, 2018); Chason Ziino et al., *Does ACDF Utilization and Reimbursement Change Based on Certificate of Need Status?*, 33 Clinical Spine Surgery, Issue 3 (Apr. 2020); Olivia A. Schultz et al., *Assessing the Efficacy of Certificate of Need Laws Through Total Joint Arthroplasty*, 43 Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, Issue 1, 1–7 (Feb. 1, 2021).

one study finds that reimbursement costs for coronary artery bypass grafts fell 2.8 percent in Ohio and 8.8 percent in Pennsylvania following repeal.[14] Another finds that hospital charges are 5.5 percent lower five years after repeal.[15] Medicare reimbursements for total knee arthroplasty are 5 percent to 10 percent lower in non-CON states than in CON states.[16] And spinal surgery reimbursements have fallen faster in non-CON states than in CON states.[17]

Figure 1. Studies Assessing the Effect of CON on Spending Per Service




[14] Ho and Ku-Goto, *supra* note 13.

[15] Bailey, *supra* note 13.

[16] Browne et al., *supra* note 13.

[17] Ziino et al., *supra* note 13.

In short, the empirical research supports the basic economic intuition that a supply restriction will not reduce spending per service. As predicted by the theory, CON laws seem to increase per-service spending in many settings.

### B. CON Regimes Do Not Restrain Total Spending

Figure 2 summarizes the findings from the empirical literature on CON and total spending. Eighteen studies examine the effect of CON review on total spending. As with the literature on spending per service, no studies find clear evidence that CON reduces total spending.

Seven studies (39 percent) find mixed, negligible, or statistically insignificant effects of CON on total spending.[18] One study, for example, found CON had no

---

[18] Frank A. Sloan, *Regulation and the Rising Cost of Hospital Care*, 63 Review of Economics and Statistics, Issue 4, 479–87 (Nov. 1, 1981); 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, Issue 3, 455–81 (June 1, 1998); Vivian Ho*, Does Certificate of Need Affect Cardiac Outcomes and Costs?*, 6 International Journal of Health Care Finance and Economics, Issue 4, 300–24 (Mar. 6, 2007); 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, Issue 10, 737–44 (Oct. 2009); 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, Issue 1, 85–105 (Feb. 2016); Christopher J. Conover and Frank A. Sloan, *Evaluation of Certificate of Need in Michigan, Volume II: Technical Appendices*, Duke University Ctr. for Health Policy, Law

statistically significant effect on total per capita spending and that there was no surge in spending after CON repeal.[19] Another found that while CON limited growth in hospital beds, this did not seem to translate into lower health expenditures per capita.[20]

Eleven studies (61 percent), on the other hand, find CON review is associated with higher spending.[21]

---

and Management (2003); Daniel Polsky et al., *The Effect of Entry Regulation in the Health Care Sector: The Case of Home Health*, 110 Journal of Public Economics 1–14 (Feb. 2014).

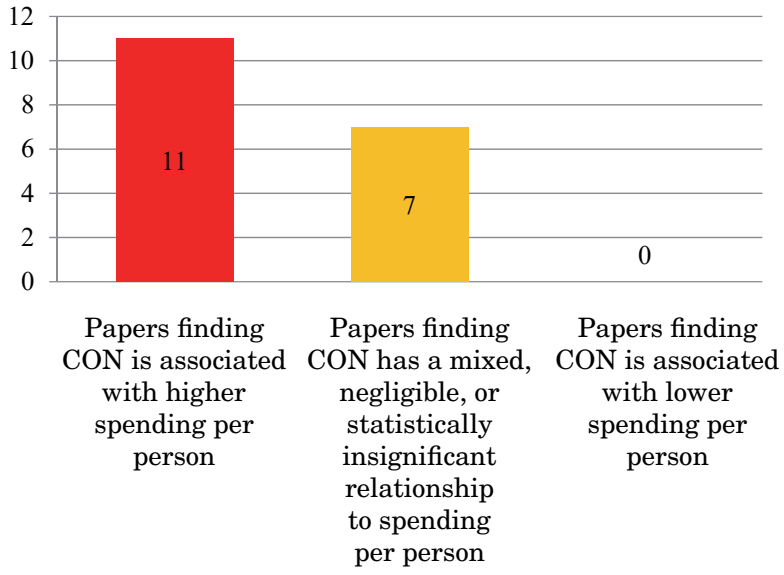
[19] Conover and Sloan, *supra* note 18.

[20] Hellinger, *supra* note 18.

[21] Frank A. Sloan and Bruce Steinwald, *Effects of Regulation on Hospital Costs and Input Use*, 23 Journal of Law & Economics, 1, 81–109 (1980); Daniel Sherman, *Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis*, FTC Staff Report of the Bureau of Economics (Jan. 1988); Joyce A. Lanning et al., *Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures*, 3 Journal of Regulatory Economics 137–59 (June 1991); John J. Antel et al., *State Regulation and Hospital Costs*, 77 Review of Economics and Statistics, Issue 3, 416–22 (1995); Nancy A. Miller et al., *Access to Community-Based Long-Term Care: Medicaid's Role*, 14 Journal of Aging and Health, Issue 1, 138–59 (Feb. 2002); Patrick A. Rivers, *Does Certificate of Need Really Contain Hospital Costs in the United States*, 3 Health Education Journal 229–44 (Sept. 1, 2007); Patrick A. Rivers, *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 Journal of Health Care Finance, Issue 4, 1–16 (2010); James B. Bailey and Tom Hamami, *Competition and Health-Care Spending: Theory and Application to Certificate of Need Laws*, WP 19-38, Fed. Reserve Bank of Phila. (Oct. 2019); Bailey, *supra* note 13; Susan L. Ettner et al., *Certificate of Need and the Cost of Competition in Home Healthcare Markets*, Home Health Care Services Quarterly 2, 51–64 (June 2020); Thomas Stratmann and Matthew Baker, *Examining Certificate-of-Need Laws in the Context of the Rural Health Crisis*, Mercatus Working Paper (July 29, 2020).

One found that CON is associated with 20.6 percent higher hospital spending per capita.[22] Another found that Medicaid community-based care expenditures per capita are higher in CON states.[23] Hospital expenditures per adjusted admission are also higher in CON states.[24] States that eliminate CON spend 5 percent less per capita on healthcare.[25] And Medicare spending per rural beneficiary is about $295 higher in CON states.[26]

Figure 2. Studies Assessing the Effect of CON on Spending Per Person




[22] Lanning et al., *supra* note 21; Bailey and Hamami, *supra* note 21.

[23] Miller et al., *supra* note 21.

[24] Rivers et al., *supra* note 21.

[25] Bailey, *supra* note 13.

[26] Stratmann and Baker, *supra* note 21.

There is no evidence CON laws achieve the stated purpose of restraining spending. If anything, they likely increase spending.

### C. CON Regimes Limit Access to Care

The most common way to study CON and access is to see if the regulation relates to the availability of services in an area. Thirty studies have examined access by counting the number of providers or pieces of equipment in an area or by measuring patient travel time to these services. *See* Figure 3. Of the 30 assessments, 28 studies (93 percent) find that CON is associated with diminished availability of services.[27] Two

---

[27] Paul L. Joskow, *The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital*, 11 Bell Journal of Economics, Issue 2, 421–47 (1980); Jon M. Ford and Kaserman, *Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry*, 59 Southern Econ. Journal, Issue 4, 783–91 (Apr. 1993); Harrington et al., *supra* note 10; Thomas D'Aunno, *The Role of Institutional and Market Forces in Divergent Organizational Change*, 45 Administrative Science Quarterly, Issue 4, 679–703 (2000); Jamie L. Robinson et al., *Certificate of Need and the Quality of Cardiac Surgery*, 16 American Journal of Medical Quality, Issue 5, 155–60 (2001); Iona Popescu et al., *Certificate of Need Regulations and Use of Coronary Revascularization After Acute Myocardial Infarction*, 295 Journal of the American Medical Association, Issue 18, 2141–47 (May 10, 2006); Vivian Ho et al., *Cardiac Certificate of Need Regulations and the Availability and Use of Revascularization Services*, 154 American Heart Journal, Issue 4, 767–75 (Oct. 2007); Marah N. Short et al., *Certificate of Need Regulations and the Availability and Use of Cancer Resections*, 15 Annals of Surgical Oncology, Issue 7, 1837–45 (July 2008); Hellinger, *supra* note 18; Jonathan T. Kolstad, *Essays on Information, Competition and Quality in Health Care Provider Markets*, Ph.D. Dissertation, Harvard Univ. (2009); Vivian Ho et al., *Certificate of Need (CON): Controversy over the*

*Contributions of CON*, 44 Health Services Research, Issue 2, Pt 1, 483–500 (Apr. 2009); David M. Cutler et al., *Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery*, 2 American Econ. Journal: Economic Policy, Issue 1, 51–76 (Feb. 2010); Mary S. Vaughan et al., *Trends during 1993-2004 in the Availability and Use of Revascularization after Acute Myocardial Infarction in Markets Affected by Certificate of Need Regulations*, 67 Medical Care Research and Review: MCRR Issue 2, 213–31 (Apr. 2010); Melissa D.A. Carlson et al., Geographic Access to Hospice in the United States, 13 Journal of Palliative Medicine Issue 11, 1331–38 (Nov. 2010); Traci L. Eichmann and Rexford E. Santerre, *Do Hospital Chief Executive Officers Extract Rents from Certificate of Need Laws*, 37 Journal of Health Care Finance, Issue 4, 1–14 (Jan. 1, 2011); Scott A. Lorch et al., *The Impact of Certificate of Need Programs on Neonatal Intensive Care Units*, Journal of Perinatology: Official Journal of the California Perinatal Association 1 (Jan. 2012); Polsky et al., *supra* note 18; Thomas Stratmann and Jacob Russ, *Do Certificate-of-Need Laws Increase Indigent Care?*, Mercatus Working Paper (July 2014); Suhui Li and Avi Dor, *How Do Hospitals Respond to Market Entry? Evidence from a Deregulated Market for Cardiac Revascularization*, 24 Health Economics, Issue 8, 990–1008 (Aug. 2015); Thomas Stratmann and Christopher Koopman, *Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community*, Mercatus Working Paper (Feb. 18, 2016); Jordan Harris and Dasha Kolyaskina, *Certificate of Need: Kentucky's CON Regulations and Their Impact on Ambulance Care*, Pegasus Institute (July 2018); Molly S. Myers and Kathleen M. Sheehan, *The Impact of Certificate of Need Laws on Emergency Department Wait Times*, 35 Journal of Private Enterprise, Issue 1, 59–75 (Spring 2020); Matthew D. Mitchell, James B. Bailey and Thomas Stratmann, *Raising the Bar: ICU Beds and Certificates of Need*, Mercatus Ctr. at George Mason Univ. (Apr. 29, 2020); James B. Bailey et al., *Certificate of Need and Substance Use Treatment*, SSRN Scholarly Paper, Social Science Research Network (Dec. 29, 2020); Ettner et al., *supra* note 21; Matthew C. Baker and Thomas Stratmann, *Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws*, Mercatus Working Paper (2017); James B. Bailey and Eleanor Lewin, *Certificate of Need and Inpatient Psychiatric*

studies (7 percent) find mixed results.[28] No studies find clear evidence that CON increases the availability of services.

According to these findings, the average patient in a CON-regime state has access to 30 percent fewer hospitals; 14 percent fewer ambulatory surgery centers (ASCs); 30 percent fewer *rural* hospitals; 13 percent fewer *rural* ASCs;[29] 25 percent fewer open-heart surgery programs;[30] 46 percent fewer facilities offering coronary artery bypass grafts (CABG);[31] 20 percent fewer psychiatric care facilities;[32] fewer hospitals offering revascularization;[33] fewer dialysis clinics;[34] fewer hospitals per cancer incident;[35] fewer neonatal

---

*Services*, Social Science Research Network working paper (2021); Matthew D. Mitchell and Thomas Stratmann, *The Economics of a Bed Shortage: Certificate-of-Need Regulation and Hospital Bed Utilization during the COVID-19 Pandemic*, 15 Journal of Risk and Financial Management, Issue 1, 10 (Jan. 2022).

[28] Shihyun Noh and Catherine H. Brown, *Factors Associated with the Number of Substance Abuse Nonprofits in the U.S. States: Focusing on Medicaid Expansion, Certificate of Need, and Ownership*, 9 Nonprofit Policy Forum, Issue 2 (July 1, 2018); Joshua N. Herb et al., *Travel Time to Radiation Oncology Facilities in the United States and the Influence of Certificate of Need Policies*, 109 International Journal of Radiation Oncology, Biology, Physics, Issue 2, 344–51 (Feb. 1, 2021).

[29] Stratmann and Koopman, *supra* note 27.

[30] Robinson et al., *supra* note 27.

[31] Kolstad, *supra* note 27.

[32] Bailey and Lewin, *supra* note 27.

[33] Popescu et al., *supra* note 27.

[34] Ford and Kaserman, *supra* note 27.

[35] Short et al., *supra* note 27.

intensive care units;[36] and fewer alcohol and drug abuse facilities.[37]

Patients in CON states have access to fewer medical imaging devices[38] and fewer hospital beds.[39] They were also more likely to encounter bed shortages during COVID.[40] Patients in these states face longer wait times,[41] must typically drive further to obtain care,[42] and are more likely to leave their states to obtain care.[43]

---

[36] Lorch et al., *supra* note 27.

[37] Bailey et al., *supra* note 27.

[38] Stratmann and Russ, *supra* note 27.

[39] Harrington et al., *supra* note 10; Hellinger, *supra* note 18; Eichmann and Santerre, *supra* note 27; Lorch et al., *supra* note 27; Stratmann and Russ, *supra* note 27.

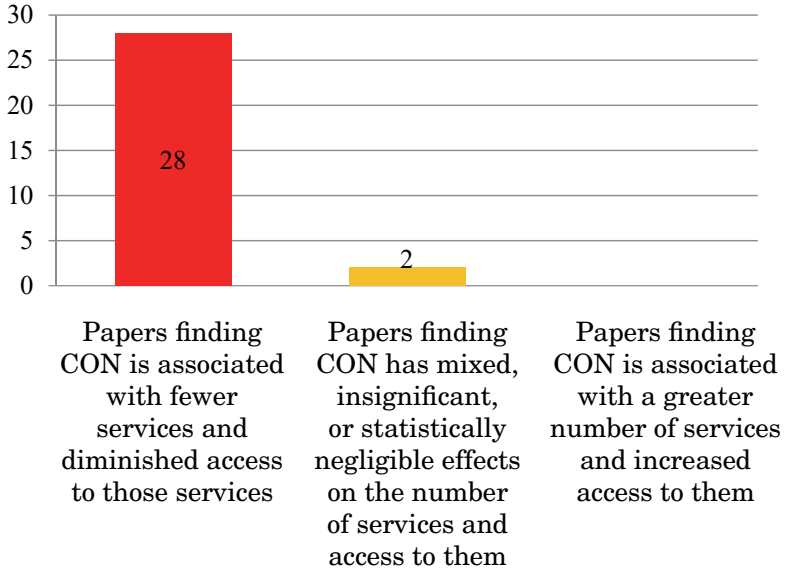
[40] Mitchell, Bailey and Stratmann, *supra* note 27; Mitchell and Stratmann, *supra* note 27.

[41] Myers and Sheehan, *supra* note 27.

[42] Carlson et al., *supra* note 27.

[43] Baker and Stratmann, *supra* note 27.

Figure 3. Studies Assessing the
Effect of CON on Availability of Services




### D. CON Regimes Likely Undermine the Quality of Care

Thirty papers examine the relationship between CON and quality. The results are presented in Figure 5. Four studies (13 percent) find a positive association between CON and quality and all four are in technical fields.[44] Twelve studies (40 percent) find that need review either has mixed or statistically insignificant

[44] Vaughan et al., *supra* note 27; Joseph S. Ross et al., *Certificate of Need Regulation and Cardiac Catheterization Appropriateness After Acute Myocardial Infarction*, 115 Circulation, Issue 8 (Feb. 27, 2007); Lorch et al., *supra* note 27; Cancienne et al., *supra* note 10.

effects on quality (typically the latter).[45] Fourteen studies (47 percent) find that CON is associated with diminished quality.[46] In the typical CON state,

---

[45] Robinson et al., *supra* note 27; Vivian Ho, *Certificate of Need, Volume, and Percutaneous Transluminal Coronary Angioplasty Outcomes*, 147 Am. Heart J., Issue 3, 442–508 (Mar. 2004); Popescu et al., *supra* note 27; Verdi J. DiSesa et al., *Contemporary Impact of State Certificate-of-Need Regulations for Cardiac Surgery: An Analysis Using the Society of Thoracic Surgeons' National Cardiac Surgery Database*, 114 Circulation, Issue 20, 2122–29 (Nov. 14, 2006); Ho, *supra* note 18; Lorch, *supra* note 27; Polsky et al., *supra* note 18; Browne et al., *supra* note 13; James B. Bailey, *The Effect of Certificate of Need Laws on All-Cause Mortality*, 53 Health Services Research, Issue 1, 49–62 (Feb. 2018); Aaron J. Casp et al., *Certificate-of-Need State Laws and Total Hip Arthroplasty*, 34 J. Arthroplasty, Issue 3, 401–07 (Mar. 2019); Tarik Yuce et al., *Association of State Certificate of Need Regulation With Procedural Volume, Market Share, and Outcomes Among Medicare Beneficiaries*, 324 JAMA, Issue 20, 2058–68 (2020); Schultz et al., *supra* note 13.

[46] Stephen M. Shortell and Edward F.X. Hughes, *The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients*, 318 New England Journal of Medicine, 17 Issue, 1100–07 (Apr. 28, 1988); Jacqueline S. Zinn, *Market Competition and the Quality of Nursing Home Care*, 19 Journal of Health Politics, Policy and Law, Issue 3, 555–82 (1994); Vivian Ho et al., *supra* note 27; Kolstad, *supra* note 27; Cutler et al., *supra* note 27; Aaron D. Falchook and Ronald C. Chen, *Association Between Certificate of Need Legislation and Radiation Therapy Use Among Elderly Patients With Early Cancers*, 91 International Journal of Radiation Oncology, Biology, Physics, Issue 2, 448–50 (Feb. 1, 2015); Li and Dor, *supra* note 27; Thomas Stratmann and David Wille, *Certificate of Need Laws and Hospital Quality* Mercatus Working Paper (Sept. 2016); Robert L. Ohsfeldt and Pengxiang Li, *State Entry Regulation and Home Health Agency Quality Ratings*, 53 Journal of Regulatory Economics, Issue 1, 1–19 (2018); Stratmann and Baker, *supra* note 21; Bingxiao Wu et al., *Reporting: Evidence from Home Health Compare*, 28 Health Economics, Issue 4, 492–516 (Apr. 2019);

Medicare patients in CON states face 5 to 6 percent higher mortality rates[47] while the general population experiences higher mortality rates following heart attack, heart failure, and pneumonia.[48] Patients in these states have higher readmission rates,[49] are more likely to die from post-surgery complications,[50] and are less likely to give their hospitals top ratings.[51] Nursing homes tend to get lower survey scores in CON states than in non-CON states,[52] and nursing home patients are more likely to be restrained in CON states than in non-CON states.[53] Home health agencies also receive lower scores in CON states than in non-CON states,[54] and home health agency clients are less likely to see improvements in mobility.[55] Finally, surgeries are more

---

Bichaka Fayissa et al., *Certificate-of-Need Regulation and Healthcare Service Quality: Evidence from the Nursing Home Industry*, 8 Healthcare, Issue 4 (Oct. 23, 2020); Kevin Chiu, *The Impact of Certificate of Need Laws on Heart Attack Mortality: Evidence from County Borders*, Journal of Health Economics (2021); Sriparna Ghosh et al., *Certificate-of-Need Laws and Healthcare Utilization During COVID-19 Pandemic*, SSRN Scholarly Paper, Social Science Research Network, https://doi.org/10.2139/ssrn.3663547 (July 29, 2020).

[47] Shortell and Hughes, *supra* note 46.

[48] Stratmann and Wille, *supra* note 46.

[49] Polsky et al., *supra* note 18; Stratmann and Wille, *supra* note 27.

[50] Stratmann and Wille, *supra* note 46.

[51] *Id.*

[52] Fayissa et al., *supra* note 46.

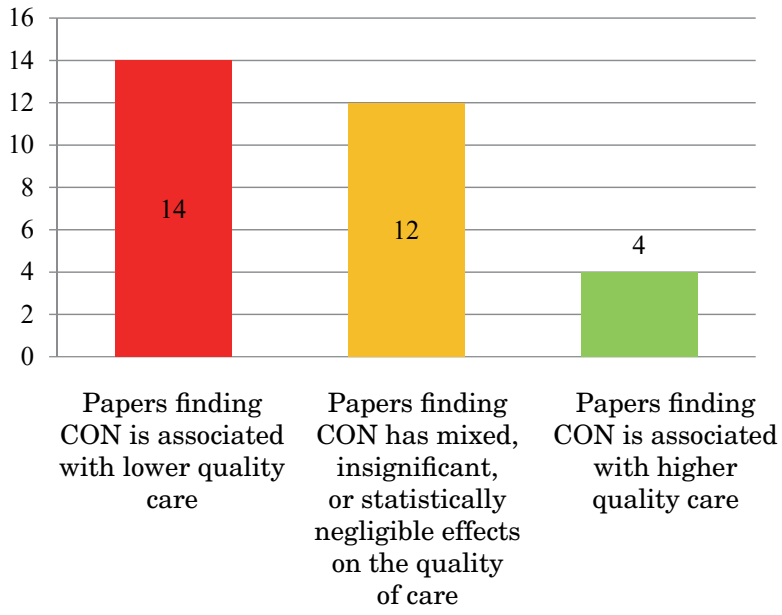
[53] Zinn, *supra* note 46.

[54] Ohsfeldt and Li, *supra* note 46.

[55] Wu et al., *supra* note 46.

likely to be performed by lower-quality surgeons in CON states than in non-CON states.[56]

Figure 4. Studies Assessing the Effect of CON on the Quality of Care




Thus, there is some evidence that need review can enhance quality, but these findings have been limited to technical fields where there may be a link between volume and quality. Moreover, nearly four times as many studies find that CON undermines quality than find that it enhances quality.

---

[56] Cutler et al., *supra* note 27.

## III. CON REGIMES MANIFESTLY SERVE A NARROW INTEREST AT THE EXPENSE OF THE GENERAL PUBLIC

The balance of evidence reviewed so far suggests that CON regulation fails to serve the general interest. The regulation does not reduce spending. It does not enhance access. And in most instances, it does not improve quality. In fact, the evidence presented here shows that, if anything, the regulation undermines each of these goals. Why, then, does it persist? The most obvious explanation is that it serves the narrow interests of incumbent providers by protecting them from competition. There are four reasons to believe this.

First, it is well documented that the already-approved incumbent providers in need review states see more business. Ten studies find that need review enhances average provider volume.[57]

Second, CONS are anticompetitive. Polsky and his coauthors compare home health markets in states with and without need review regulations using a measure of market concentration.[58] They find the average home health agency market is moderately concentrated in non-CON states and highly concentrated in CON states.

---

[57] Vaughan et al., *supra* note 27; Vivian Ho, *supra* note 45; DiSesa et al., *supra* note 45; Short et al., *supra* note 27; Ho et al., *supra* note 27; Browne et al., *supra* note 13; Casp et al., *supra* note 45; Cancienne et al., *supra* note 10; Ettner et al., *supra* note 21.

[58] Polsky et al., *supra* note 18.

Third, provider profits fall in states that remove need review regulations, recovering profitability after a few years.[59] This, combined with the fierce opposition to deregulation by industry insiders, suggests that the rules do indeed protect incumbent profits.

Fourth, researchers find that hospital CEO pay is significantly higher in states with CONs than in states without.[60]

The well-documented anticompetitive effects of CON review suggest that antitrust authorities in the FTC and the DOJ are right to believe that these rules monopolize local markets at the expense of consumer welfare.

## CONCLUSION

Standard economic theory holds that the public welfare is best served by an open and competitive market. Open health care markets lead to greater access to care, lower prices, and higher quality of care.

The empirical evidence presented by the 71 peer-reviewed studies of CON regimes surveyed by *amici* bear this out and show that CON regimes undermine each of these goals. They also show that CON regimes' most conspicuous effect is to generate profit for

---

[59] Cutler, *supra* note 27.

[60] Eichmann and Santerre, *supra* note 27.

incumbent providers at the expense of consumers and would-be competitors.

*Amici* demonstrate that CON regimes do not work in economic theory or in practice through empirical evidence. It is difficult to rationalize their existence even under the most deferential standard of review.

August 12, 2022

Respectfully submitted,

AARON GOTT
*Counsel of Record*
BONA LAW PC
331 2nd Avenue South, Suite 420
Minneapolis, MN 55401
(612) 284-5001
aaron.gott@bonalawpc.com

LUKE HASSKAMP
BONA LAW PC
4275 Executive Square, Suite 200
La Jolla, CA 92037
(858) 964-4589
luke.hasskamp@bonalawpc.com

*Counsel for Amici Curiae*