AMA
AMERICAN MEDICAL ASSOCIATION

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January 11, 2022

The Honorable Wes Climer
South Carolina Senate
404 Gressette Building
Columbia, SC 29201

Re: Senate Bill S 290 to Repeal Certificate of Need in South Carolina

Dear Senator Climer:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I am pleased to support Senate Bill 290 (S 290) that would fully repeal certificate of need (CON) in South Carolina.

South Carolina's purpose in enacting CON was to promote cost containment, prevent unnecessary duplication of health care facilities, and guide the establishment of health facilities and services to best serve public needs.[1]

Since the program has been in place, however, numerous studies have shown that CON laws have failed to achieve their intended goal of containing costs.[2] Instead, CON has taken on particular importance as a way to claim territory and to restrict the entry of new competitors.[3] It should go without saying that competition requires competitors. By restricting the entry of competitors, such as physician-owned facilities, CON laws have weakened the market's ability to contain health care costs, undercut consumer choice, and stifled innovation. Thus, the AMA joins the South Carolina Medical Association in urging the passage of S 290.

Only the full repeal of CON, as provided by S 290, will encourage more cost-effective, innovative, and higher quality health care options.

Legacy of a Cost-Based Health Care Reimbursement System

South Carolina (in 1971) and the federal government with the passage of the 1974 National Health Planning and Resources Development Act (NHPRDA)[4] adopted an odd approach to controlling health

[1] S. C. Code Ann. § 44-7-120 (2015).
[2] Michael A. Morrisey, *State Health Care Reform: Protecting the Provider*, in American Health Care: Government, Market Processes, and the Public Interest 243-66 (Roger D. Feldman ed., Transaction Publishers 2000); Furrow et. alia, Health Law Seventh Edition, 979-981 (2013).
[3] Ibid, Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics,* Research Brief 4, National Institute for Health Care Reform (May 2011).
[4] 42 USC Sections 300k-300t.

care costs–constricting supply.[5] The NHPRDA required states to adopt CON legislation to avoid losing certain federal funding. Eventually 49 states adopted CON laws.[6] These laws were enacted when the United States had a cost-based health care reimbursement system. The champions of CON thought that demand for medical treatment would increase as supply increases, and without lowering costs.[7] Health care institutions wanting to expand or to acquire new health technology had to obtain government approval–a "certificate of need"–from politically appointed health planning boards.

By 1987, however, the health care reimbursement system had changed substantially from the cost-based system existing in 1974, and the federal government abandoned the CON strategy by repealing the NHPRDA. The repeal freed states to alter or eliminate CON. As of today, 12 states have fully repealed their CON programs.[8] States like South Carolina that have thus far retained CON laws most often regulate hospitals, outpatient facilities, and long-term care facilities.[9]

Top Physician Concerns

Most commentary is highly critical of CON regulation on the grounds that it imposes obstacles to the efficient reorganization of health care markets, invites obstructionist behavior, is incompatible with the evolution of competitive health care markets, and invites abuse and corruption.[10] We highlight below some major concerns from the physician perspective.

The CON Process Suppresses Physician-Led Outpatient Facility Market Entry

The AMA has long advocated for the abolishment of CON. CON programs are a significant barrier to the market entry of freestanding physician-owned outpatient facilities, including ambulatory surgical centers (ASCs).[11] As a class of provider, physician-owned ASCs have been found in numerous studies of quality to have complication rates that are low and patient satisfaction that is high.[12] For example, a study published in *Health Affairs* concluded that ASCs, "provide a lower-cost alternative to hospitals as venues for outpatient surgeries."[13]

The efficiencies of ASCs and their added benefit of raising the performance of competing community hospitals also have been acknowledged by the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ):

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[5] The South Carolina program requires providers to obtain a CON from a state department before initiating a wide range of projects. Among the covered projects are the construction or expansion of acute care hospitals and ambulatory surgery facilities. S.C. Code Ann. §§ 44-7-130, 44-7-160 (2015). Additionally, facilities must obtain a CON before adding certain services, acquiring certain medical equipment, and making certain capital expenditures. S.C. Code Ann. § 44-7-160 (2015) In reviewing an application for a CON, the state department considers, among other factors, the need for the project. S.C. Code Ann §44-7-190 (2015); For a discussion of the history and coverage of CON in South Carolina, *see* State Testimony of Mathew D Mitchell of the Mercatus Center at George Mason University, "South Carolina's Certificate of Need Program: Lessons from Research" (May 10, 2021), available at https://www.mercatus.org/publications/certificate-need-laws/south-carolinas-certificate-need-program-lessons-research (Mercatus Lessons from Research).

[6] CHRISTINE L. WHITE ET AL., Antitrust and Healthcare: A Comprehensive Guide 527 (2013); Furrow, *supra* note 2.

[7] Fed. Trade Commission and U.S. Dept of Justice, IMPROVING HEALTHCARE: A DOSE OF COMPETTION, Ch.8 at 2 (2004)

[8] See, National Conference of State Legislatures, *Certificate of Need State Laws*. Available at https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

[9] Ibid. CON is still alive, in some form, in the District of Columbia and in 35 states, including South Carolina. *See, National Conference of State Legislatures at https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx*

[10] *See* discussion and citation to authorities in Furrow, Greaney et alia, Health Law, West, 979-981 (2013)

[11] ASCs are required to have a CON in South Carolina. *Sees supra,* footnote *5*

[12] *See* Casalino L *et al. Focused factories? Physician-owned Specialty Facilities*, Health Affairs (Millwood) 2003; 22 (6) 56-67

[13] *See* Munnich and Parente, *Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up*, Health Affairs, 33 no. 5 (2014): 764-769.

> Ambulatory surgery centers offered patients more convenient locations, shorter wait times, and lower coinsurance than hospital departments. Technological innovations, such as endoscopic surgery and advanced anesthetic agents, were a central factor in this success. Many traditional acute care hospitals have responded to these market innovations by improving the quality, variety, and value of their own surgical services, often developing on- or off-site ambulatory surgery centers of their own.[14]

Notwithstanding the potential of a physician-owned outpatient facility to offer new, lower cost, more convenient or higher quality services, the facility faces the added time, cost, and uncertainty of the CON approval process. To win approval, applicants must have the deep pockets to spend exorbitant amounts on lawyers and consultants to prepare CON applications.[15] The process for obtaining a CON can take years and can cost tens or even hundreds of thousands of dollars in preparation costs.[16] Ultimately, the process could prohibit entry or expansion outright if the CON is denied.[17] Consequently, the onerous cost and process of undergoing CON review and the uncertain outcome has a distinct chilling effect on physicians seeking to enter markets in competition with incumbent providers.[18] Thus, states such as South Carolina that require CONs for ambulatory surgical centers have, on average, *14 percent fewer such centers*.[19]

The South Carolina legislature should consider the benefit to consumers of repealing CON such that physician-owned outpatient facilities would stand a better chance of entering markets dominated by big hospitals. Moreover, these hospitals, faced with the ongoing threat of new competitor market entry, would be continuously motivated by the potential competition to improve service and lower prices.

The CON Process is a Hospital Tool for Blocking New Physician-Owned Facility Competition.

A National Institute for Health Care Reform study of CON concluded that, "hospitals initially had mixed views about the benefits of CON but banded together to support the process after realizing it was a valuable tool to block new physician-owned facilities."[20] The CON process places physicians wanting to expand or to enter markets in competition with local hospitals at a substantial disadvantage. Physician applicants must contend with a CON decision-making process that is controlled by local planning boards that are subject to the political pressures imposed by big local hospitals. Nationally recognized Northwestern Professor David Dranove, PhD, MBA, and University of Pennsylvania Professor Robert Lawton Burns, PhD, MBA, have studied the CON process and in their new book, observe that hospitals hold enormous sway in their local communities.[21] They are among the largest employers. All of this has given local hospitals political clout. According to Dranove and Burns, "planning board members gained nothing for their political handlers if they approved outsiders' proposals, and they would gain the enthusiastic support of their clout-heavy constituents if they said 'no.' All of this is still true today."[22]

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[14] Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform (September 15, 2008).
[15] See David Dranove and Lawton R. Burns, BIG MED: Megaproviders and the High Cost of Health Care in America 22-23, University of Chicago Press, 2021.
[16] Mercatus, Lessons from Research at 1.
[17] "In sum, not only have CON laws been generally unsuccessful at reducing health care costs, but they also impose additional costs of their own." Federal Trade Commission & Department of Justice, Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform (Sept. 15, 2008),
[18] Senate Interim Committee on Certificate of Need, State of Missouri, Report of the Senate Interim Committee on Certificate of Need 13-14 (Dec. 2006).
[19] Mercatus, Lessons from Research at Table 2
[20] Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics?* Research Brief 4, National Institute for Health Care Reform (May 2011)
[21] David Dranove and Lawton R. Burns, *supra* note 15.
[22] Ibid.

CON Creates Entry Barriers to Already Highly Concentrated Hospital Markets

Many hospital markets are highly concentrated and noncompetitive.[23] This is partly the result of significant hospital market consolidation occurring throughout the country.[24] Moreover, embedded hospital market concentration is fast becoming an intractable problem for which antitrust provides no remedy.[25] Fortunately, South Carolina can take steps to encourage new entry.[26] "Low hanging fruit" in this area would include removing barriers to health care facility market entry such as CON that the government itself has erected. The CON process is used by "have" hospitals with significant market share and resources to prevent outsiders from entering the state entirely.[27] In one study, hospitals acknowledge tracking CON applications as a way to "keep tabs" on competitors and block new entrants.[28]

The sorts of concerns discussed above explain why the FTC and DOJ have reviewed CON laws, including South Carolina's, and found them to be anticompetitive.[29] Accordingly, and most pertinently, the two antitrust enforcement agencies urged South Carolina to repeal its CON laws.[30]

The CON Restraints on Market Entry and Competition Cannot be Justified by Consumer Cost Savings, Improved Health Care Quality or Access

CON Laws Have Weakened the Market's Ability to Contain Health Care Costs

Competition in health care markets is not wasteful. Instead, it produces lower prices.[31] Because CON erects barriers to entry, it impedes competition. Consequently, the program has failed to achieve its

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[23] *See* Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions,* Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, (May 19, 2021).
[24]Id at 2; Emily Gee, *The High Price of Hospital Care*, Center for American Progress https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-care/.), Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012)
[25] *See e.g.,* Greaney, *The Affordable Care Act and Competition policy: Antidote or Placebo,* 89 OR. L. R EV 811 (2011). ("Antitrust does not break up legally acquired monopolies or oligopolies.")
[26] *Id.*
[27] Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics?* Research Brief 4, National Institute for Health Care Reform (May 2011)
[28] Ibid.
[29] *See, e.g.,* Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Caroline House Bill 3250 Jan. 11, 2016), https.//www.justice.gov/atr/file/812606/download; Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice to the Virginia Certificate of Public Need Work Group (Oct. 26, 2015), htlps://www.ftc.gov/system/files/documents/ advocacy documents/ joint-statement-federaltrade-commission-antitrust-division-u.s.deparbnent-justice-virginia-certificate-public-needwork-group/151026ftc-dojstmtva copnl.pdf; Letter from Marina Lao, Dir., Office of Policy Planning, Fed. Trade Comm'n, et al, to The Honorable Marilyn W. Avila, N.C. House of Representatives Guly 10, 2015), hltps://www.ftc.gov/system/files/documents/advocacy dotuments/ftc-staff-commentconcurring-comment-com.missioner-wright-regarding-north-carolina-house-bill200/150113ncconadv.pdf; Prepared Statement of the Federal Trade Commission Before the Florida State Senate (Apr. 2, 2008) [hereinafter FTC Florida Statement], https://www.ftc.gov/sites/default/files/documents/advocacy documents/fie-prepared~ statement-florida-senate-concerning-florida-certificate-need-laws/v080009florida.pdf; Statement of the Antitrust Division, U.S. Department of Justice, Before the Florida Senate Committee on Health & Human Services (Mar. 25, 2008), http://www.justice.gov/atr/comments-competitionhealthcare-and-certificates-need; Prepared Statement of the Federal Trade Commission Before the Standing Committee on Health, Education, & Social Services of the Alaska House of Representatives (Feb. 15, 2008) [hereinafter FTC Alaska Statement], https://www.ftc.gov/sites/default/files/documents/advocacy documents/ftc-writtentestimonv-alaska-house-representatives-concerning-aJaska-certif1Cate-need
[30]Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Caroline House Bill 3250 (Jan. 11, 2016), https.//www.justice.gov/atr/file/812606/download
[31] Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions,* Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, (May 19, 2021); Martin Gaynor & Robert Town, Competition in Health Care Markets, 2 Handbook of Health Economics 499,637 (2012), Martin Gaynor *et al*, The Industrial Organization of Health-Care Markets, 53 J. Econ. 2 Literature 235, 284 (2015)

intended goal of containing costs. This conclusion is supported by substantial health care economics research.[32]

For example, health economics scholar Michael A. Morrisey, PhD, has concluded that "while certificate of need has attracted many empirical studies, they find virtually no cost containment effects. However, they do show higher profits and restricted entry...."[33]

Moreover, a Center for Health Services Research study at Georgia State University found that states having the most rigorous CON regulation had levels of competition associated with higher costs.[34]

Finally, the Mercatus Center of George Mason University, a not-for-profit university-based research center, has studied the effects of CON in South Carolina. Critically, the Mercatus Center finds that the state's CON laws are associated with per capita health care spending that is higher than it would be without CON.[35]

CON Laws Have Harmed, Not Improved, the Quality of Health Care Services

As CON has failed as a cost containment mechanism, the primary justification for CON, therefore, must rest on an ability to improve or maintain quality and/or access to care.[36] There is however a common-sense flaw in relying upon alleged quality of care benefits to justify CON's anticompetitive effects. Health economists Christopher J. Conover, PhD, and Professor Frank A. Sloan, PhD, express it this way: "It may make little sense to rely on CON to carry out quality assurance functions that might be better approached by more direct and cost-effective means such as regulation and licensing and/or outcome reporting to the public." [37]

In any event, the Mercatus Center has considered whether CON impacts health care quality. It does, and not for the better. Specifically, the Mercatus Center reports that the most recent research,

> suggests that deaths from treatable complications following surgery and mortality rates from heart failure, pneumonia, and heart attacks are all statistically significantly higher among hospitals in CON states than hospitals in non-CON states. Also, in states with especially comprehensive programs such as South Carolina, patients are less likely to rate hospitals highly.[38]

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[32] See e.g., Patrick A. Rivers, et al., *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 J. HEALTH CARE FIN. 1, 11(2010) (finding a positive relationship between the stringency of CON laws and health care costs per adjusted admission and concluding that the "results, as well as those of several previous studies, indicate that [CON] programs do not only fail to contain [hospital costs], but may actually *increase* costs as well" *See also* discussion and sources cited in Furrow et. alia, Health Law Seventh Edition, 979-981(2013)

[33] Morrisey, *supra* note 2. *See also* Patrick A Rivers, Myron D. Fottler & Mustafa Z. Younis, Abstract, *Does Certificate of Need Really Contain Hospital Costs in the United States?* 66 Health Education Journal 3, 229-44 (Sept. 2007 ("CON laws had a positive, statistically significant relationship to hospital costs per adjusted admission. Findings suggest not only that CON do not really contain hospital costs but may actually increase them by reducing competition.")

[34] Center for Health Services Research, Georgia State University, Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program 7-9 (Oct. 2006)

[35] Certificate of Need Laws, South Carolina state profile, Mercatus Center, available at https://www.mercatus.org/publications/certificate-need-laws-south-carolina-0

[36] Christopher J. Conover & Frank A. Sloan, *Evaluation of Certificate of Need in Michigan*, Center for Health Policy, Law & Management., Duke University (May 2003).

[37] Ibid.

[38] Mercatus, Lessons from Research at Table 2 and Certificate of Need Laws, South Carolina state profile, Mercatus Center, available at https://www.mercatus.org/publications/certificate-need-laws-south-carolina-0

Finally, one national study found that, "[O]btaining CONs for new technology may take upward of 18 months, delaying facilities from offering the most-advanced equipment to patients and staff. Such issues also reportedly affect providers' ability in some states to recruit top-tier specialist physicians."[39]

CON Laws Have Not Improved Access to Health Care

Access to health care in rural areas is in critical condition.[40]And in South Carolina, more than a quarter of the population risks dying sooner from a preventable death simply because where they live is rural.[41] With more than 744,000 rural residents statewide, inadequate rural health care is a South Carolina crisis requiring a state solution.[42]

It is the AMA's belief that one tangible and truly impactful solution to the access to health care issue in South Carolina is to repeal CON. The Mercatus Center has concluded that CON programs are associated not just with fewer hospitals overall, but also with fewer rural hospitals, fewer rural ASCs, and fewer rural hospice care facilities.[43] Moreover, without CON, South Carolina would have 43 percent more rural hospitals than currently.[44] This simply cannot be ignored.

Conclusion

To be clear, CON represents a failed public policy. It may have made sense when most reimbursement was cost-based, and health care market participants would be paid for increasing supply regardless of demand and the actual needs of patients. Today, however, managed care forces providers and physicians to be efficient.

CON invites obstructionist behavior and is incompatible with the evolution of competitive health care markets.[45] In the changed and now competitive environment, the continued existence of CON, despite overwhelming evidence of its ineffectiveness as a cost control device, suggests that "something other than the public interest is being sought."[46]

Physicians are frustrated by CON programs that tend to be influenced heavily by political relationships, such as a provider's clout, organizational size, or overall wealth and resources, rather than policy objectives.[47] Ultimately, the CON laws undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs.[48]

The AMA strongly urges South Carolina to conclude that CON does not work and consequently to enact S 290 and repeal CON.

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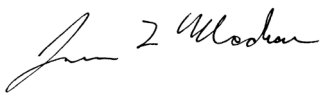
[39] Yee.et al., *supra* note 3
[40] See Clemson News, Jan 6, 2020, available at *https://news.clemson.edu/clemson-and-musc-working-to-improve-health-in-rural-south-carolina-2/*
[41] Ibid.
[42] Ibid.
[43] Mercatus, Lessons from Research at Table 2.
[44] Ibid.
[45] *See* ,e.g., Patrick McGinley, Beyond Health Care Reform: Reconsidering Certificate of Need Law in a Managed Competition System, 23 Fla St. U. L. Rev.141, 167-68 (1995)
[46] Morrisey, *supra* note 2.
[47] Yee et al., *supra* note 16.
[48] *See, e.g.,* Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Caroline House Bill 3250 Gan. 11, 2016). https.//www.justice.gov/atr/file/812606/download

Thank you for the opportunity to provide these comments. If you have any questions, please do not hesitate to contact Henry Allen, JD, MPA, Senior Attorney, AMA Advocacy Resource Center, at henry.allen@ama-assn.org.

Sincerely,



James L. Madara, MD

cc: South Carolina Medical Association
Gerald E. Harmon, MD
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