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Lessons COVID-19 Taught: How the Global Pandemic Demonstrated that State Healthcare Regulations Can Kill

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Lessons COVID-19 Taught

HOW THE GLOBAL PANDEMIC DEMONSTRATED THAT STATE HEALTHCARE REGULATIONS CAN KILL

INTRODUCTION

Healthcare in the United States is among the most expensive in the world.[1] From 1960 to 2018, annual healthcare costs have increased from "$147 per person"[2] to "about $11,000 per person."[3] The Centers for Medicare and Medicaid Services (CMS) anticipate that "by 2028, such costs will climb to . . . about $18,000 per person."[4] In similar fashion, and sometimes to a greater degree, New York has experienced a precipitous rise in healthcare related expenses, a decades old problem that persists despite heavy-handed regulations aimed at reducing costs. In New York, between 2014 and 2018, the cumulative growth in healthcare spending per person increased by 28.4 percent—10 percent higher than the nation, which experienced an 18.4 percent increase.[5]

Though this trend is nothing new as regulators have battled for decades to curb the rising cost of healthcare. Starting in the mid-1960s, legislators believed that rising healthcare costs in the United States were attributable to costly, yet unnecessary, developmental projects.[6] The assumption was that this conduct

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[1] *Why Are Americans Paying More for Healthcare?*, PETER G. PETERSON FOUND. BLOG (Apr. 20, 2020), https://www.pgpf.org/blog/2020/04/why-are-americans-paying-more-for-healthcare [https://perma.cc/9WPH-MP5H].

[2] Aaron C. Caitlin & Cathy A. Cowan, *History of Health Spending in the United States*, CTRS. FOR MEDICARE & MEDICAID SERVS. 4 (Nov. 19, 2015), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf [https://perma.cc/4BZX-C4LC].

[3] *Why Are Americans Paying More for Healthcare?*, *supra* note 1.

[4] *Id.*

[5] *2018 Health Care Cost and Utilization Report*, HEALTH CARE COST INST., https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report [https://perma.cc/RPN7-R7MZ].

[6] *See* Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, ANTITRUST, Fall 2015, at 50, 50–51. Development projects include constructing or establishing new facilities, adding or removing hospital beds, acquiring major medical equipment, adding or removing services, and renovating existing facilities. *See CON-Certificate of Need State Laws*, NAT'L CONF. OF STATE LEGISLATURES

created a healthcare system that was saturated with much more supply than demand,[7] pushing healthcare providers to recoup the costs of their investments using alternative means.[8] As a result, healthcare providers began shifting the costs of these investments to their patients, placing the burden of the underused yet pricey equipment and facilities onto the backs of the consumers.[9] Beginning in 1964, in response to this shift, New York implemented the nation's first certificate of need (CON) law to curb the rising costs of healthcare.[10] In the simplest of terms, CON laws are "government-mandated permission slip[s]"[11] that are required to establish, expand, disband, renovate, and in some cases alter the hours of operation for healthcare establishments.[12] Today, thirty-five states use some form of a CON law,[13] which all have at least one thing in common: they are all designed to restrict "unnecessary" investment.[14]

Out of the thirty-five states that still employ CON laws today, New York's law tends to be among the most complex in the nation.[15] In fact, according to the Institute for Justice, which has divided healthcare goods and services into six categories, New York is one of only eight states that regulates all six categories.[16] For example, New York's CON law requires that healthcare facilities like hospitals, nursing homes, long term home

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(Dec. 1, 2019), https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx [https://perma.cc/UE3A-Z5XX].

[7] Christopher J. Conover & James Bailey, *Certificate of Need Laws: A Systematic Review and Cost-effectiveness Analysis*, BMC HEALTH SERVS. RSCH. 2–3 (Aug. 14, 2020), https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-020-05563-1.pdf [https://perma.cc/M5UH-JCBL].

[8] Ohlhausen, *supra* note 6, at 51.

[9] *Id.*

[10] *Id.*

[11] JAIMIE CAVANAUGH ET AL., INST. OF JUST., CONNING THE COMPETITION: A NATIONWIDE SURVEY OF CERTIFICATE OF NEED LAWS 1 (2020).

[12] *See generally id.* (surveying CON laws in thirty-nine jurisdictions across the nation).

[13] Eric Oliver, *35 States Have CON Laws—Here's What They're Doing*, BECKER'S ASC REV. (May 5, 2020), https://www.beckersasc.com/asc-coding-billing-and-collections/35-states-have-con-laws-here-s-what-they-re-doing.html#:~:text=Certificate%2Dof%2Dneed%20laws%20were,National%20Conference%20of%20State%20Legislatures [https://perma.cc/8JVM-GHSZ].

[14] Matthew Mitchell, *It's Time for States to Ditch Certificate of Need Laws*, U.S. NEWS & WORLD REP. (July 9, 2021), https://www.usnews.com/news/best-states/articles/2021-07-09/on-the-heels-of-the-pandemic-states-should-get-rid-of-certificate-of-need-laws [https://perma.cc/Y4PM-P9HR].

[15] CAVANAUGH ET AL., *supra* note 11, at 138.

[16] *Id.* at 132–42 (noting that there are six broad categories of things that can be regulated by CON laws: hospital beds, beds outside hospitals, equipment, facilities/buildings, services, and emergency medical transport). The Institute for Justice is a nonprofit, public interest law firm that focuses on litigation to limit the size and reach of government power. *About Us*, INST. FOR JUST., https://ij.org/about-us/ [https://perma.cc/RA2L-MH4D].

healthcare programs, and hospices apply for and receive a CON before they are allowed to construct or establish new facilities, add or remove hospital beds, acquire major medical equipment, add or remove services, or renovate existing facilities.[17]

Nevertheless, as ardent as New York has been in their implementation of their CON law, healthcare costs have continued to rise.[18] Though this is not necessarily surprising as there is a dearth of evidence showing that CON laws have ever substantively achieved their goals.[19] To the contrary, most data indicates that CON laws have effectively raised healthcare costs[20] and resulted in decreased access to healthcare,[21] especially in New York.[22] As a general rule, when CON laws limit supply it becomes much more difficult to adequately respond to the needs of patients, particularly when a pandemic level event dramatically increases the demand for healthcare services.[23] This inelasticity of the healthcare system may have proved to be deadly.

On March 12, 2020, former New York Governor Andrew Cuomo issued Executive Order 202.1, which suspended New York's CON law through April 11, 2020 as part of an effort to make what had been a historically rigid system more adaptable

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[17] *See* Ohlhausen, *supra* note 6.

[18] *Why Are Americans Paying More for Healthcare?*, *supra* note 1.

[19] Matthew D. Mitchell & Christopher Koopman, *40 Years of Certificate-of-Need Laws Across America*, MERCATUS CTR. (Sept. 27, 2016), https://www.mercatus.org/publications/corporate-welfare/40-years-certificate-need-laws-across-america [https://perma.cc/2LG9-ELKC].

[20] MATTHEW D. MITCHELL, MERCATUS CTR. AT GEORGE MASON UNIV., CERTIFICATE-OF-NEED LAWS: ARE THEY ACHIEVING THEIR GOALS? 5 (2017), https://www.mercatus.org/system/files/mitchell-con-qa-mop-mercatus-v2.pdf [https://perma.cc/4YEB-DBEY] (noting that "[t]he empirical evidence on how CON regulation affects cost has been consistent with economic theory, showing that CON regulation tends to increase the cost of healthcare services"); *see also* James Bailey et al., *Certificate of Need Laws and Health Care Prices*, J. HEALTH CARE FIN. 2 (2017), http://healthfinancejournal.com/index.php/johcf/article/view/128/132 [https://perma.cc/36TW-WSR6] (stating cautiously that "[s]tates with CON programs experience health care prices that are 3[percent] higher than non-CON states, 13.8[percent] higher after controlling for other differences across these states").

[21] Thomas Stratmann & Christopher Koopman, *Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals* 16 (Mercatus Ctr. at George Mason Univ., Mercatus Working Paper, 2016), https://www.mercatus.org/system/files/Stratmann-Rural-Health-Care-v1.pdf [https://perma.cc/S3F7-YAZ8] ("[W]hen controlling for demographics and year-specific effects, we find that the presence of a CON program is associated with 30 percent . . . fewer hospitals per capita across an entire state . . . .").

[22] THOMAS STRATMANN ET AL., MERCATUS CTR. AT GEORGE MASON UNIV., CERTIFICATE-OF-NEED-LAWS: NEW YORK STATE PROFILE 1 (2017), https://www.mercatus.org/system/files/new_york_state_profile.pdf [https://perma.cc/DGM6-B35L].

[23] Eric Boehm, *America Doesn't Have Enough Hospital Beds to Fight the Coronavirus. Protectionist Health Care Regulations Are One Reason Why*, REASON (Mar. 13, 2020, 12:10 PM), https://reason.com/2020/03/13/america-doesnt-have-enough-hospital-beds-to-fight-the-coronavirus-certificate-of-need-laws-are-one-reason-why/ [https://perma.cc/K2DY-7BQR].

to the ever-changing nature of COVID-19.[24] Though, this may have been too little too late. Due to New York's restrictive CON law, there were thousands of needless deaths because the law barred new and innovative healthcare facilities from opening,[25] restricted hospital bed capacity,[26] and limited the number of fully functional ventilators that hospitals in New York were allowed to utilize, because those ventilators had been deemed "unnecessary" under New York's CON law.[27]

Even before the COVID-19 pandemic took the stage, the Federal Trade Commission, the US Department of Justice,[28] the Bureau of Economics,[29] the US Department of Health and Human Services,[30] and the Antitrust Division of the Department of Justice[31] all condemned CON laws and have explicitly called for their repeal.[32] Yet, they continue to be a thorn in the collective side of over half of the United States.[33]

More often than not, the arguments for the repeal of CON laws use antitrust law—a legal framework and area of law which is designed to "promote vigorous competition and protect consumers from anticompetitive mergers and business practices."[34] Antitrust laws are designed to "protect economic freedom and opportunity by promoting free and fair competition

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[24] N.Y. COMP. CODES R. & REGS. tit. 9, § 8.202.1 (2020).

[25] N.Y. PUB. HEALTH LAW § 2801-a(3) (McKinney 2020).

[26] *CON Review Types As Determined by Facility Type*, N.Y.S. DEP'T OF HEALTH, https://health.ny.gov/facilities/cons/more_information/review_process.htm [https://perma.cc/4CJX-UGX5].

[27] *See* N.Y. COMP. CODES R. & REGS. tit. 10, § 709.17 (2020).

[28] U.S. DEP'T OF JUST. & FED. TRADE COMM'N, JOINT STATEMENT OF THE ANTITRUST DIVISION OF THE U.S. DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION ON CERTIFICATE-OF-NEED LAWS AND ALASKA SENATE BILL 62 (2017) [hereinafter US DOJ & FTC JOINT STATEMENT], https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006_ftc-doj_comment_on_alaska_senate_bill_re_state_con_law.pdf [https://perma.cc/LZ7H-LBFR].

[29] DANIEL SHERMAN, BUREAU OF ECON., FED. TRADE COMM'N, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS 58 (1988), https://www.ftc.gov/sites/default/files/documents/reports/effect-state-certificate-need-laws-hospital-costs-economic-policy-analysis/232120.pdf [https://perma.cc/SY97-CJ6P].

[30] *See* ALEX M. AZAR ET AL., U.S. DEP'T OF HEALTH & HUM. SERVS., U.S. DEP'T OF THE TREASURY, U.S. DEP'T. OF LAB., REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 59 (2018) [hereinafter REFORMING AMERICA'S HEALTHCARE SYSTEM], https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf [https://perma.cc/A6JV-PKZH].

[31] DOJ & FTC JOINT STATEMENT, *supra* note 28, at 62.

[32] *See* Christopher Koopman & Anne Philpot, *The State of Certificate-of-Need Laws in 2016*, MERCATUS CTR. (Sept. 27, 2016), https://www.mercatus.org/publications/corporate-welfare/state-certificate-need-laws-2016 [https://perma.cc/UT86-CF8W].

[33] *See* Oliver, *supra* note 13.

[34] *Guide to Antitrust Laws*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws [https://perma.cc/9NVB-7XLJ].

in the marketplace."[35] Indeed, antitrust laws are concerned about maintaining a competitive marketplace because a competitive marketplace "allow[s] a nation's resources to be used to [their] best effect in the production of goods and services."[36] Antitrust laws do this by prohibiting behavior that damns the free flow of the market's natural forces.[37]

Though CON laws could be analyzed or challenged under the commerce clause or due process clause,[38] this note will analyze New York's CON law using an antitrust framework, as antitrust law is uniquely designed to handle the issues that arise when dealing with the anticompetitive effects of CON laws.[39] However, this note will do more than apply the current antitrust framework to New York's CON law: it will call for a radical change to certain antitrust doctrines.

It should be noted that while there are many statutory foundations upon which US antitrust law is built, this note will focus only on the first two sections of the Sherman Act of 1890. Section 1 of the Sherman Act is used to analyze concerted actions involving contracts, combinations, or conspiracies[40] made between two or more actors that unreasonably restrains trade.[41] In the absence of evidence of an explicit agreement to restrain trade between actors, a court normally looks at indirect evidence to find a tacit agreement.[42] Section 2 of the Sherman Act is

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[35] *Mission: Antitrust Laws*, U.S. DEP'T OF JUST., https://www.justice.gov/atr/mission#:~:text=The%20goal%20of%20the%20antitrust,better%20quality%20and%20greater%20choice [https://perma.cc/T9LE-GCXJ].

[36] Nick Godfrey, Why Is Competition Important for Growth and Poverty Reduction? 4 (Mar. 27–28, 2008) (unpublished manuscript, submitted to the OECD Global Forum on International Investment) (on file with author).

[37] *See Antitrust Enforcement and the Consumer*, U.S. DEP'T OF JUST., https://www.justice.gov/atr/file/800691/download [https://perma.cc/Z9H5-5EQS].

[38] Some have argued that CON laws violate the commerce clause because they "impermissibly discriminate[ ] against interstate commerce." Joshua Tinajero, *The Need to Repeal Certificate of Need Laws to Improve America's Health Care System: A Dormant Commerce Clause Analysis*, 37 J. LEGAL MED. 597, 598 (2017). Others have argued, unsuccessfully in most cases, that CON laws violate the equal protection clause because they treat some healthcare providers differently than others, and the due process clause by effectively denying some, as they argue, the right to make a living. *See* Tiwari v. Friendlander, No. 319-CV-00884GNS-CHL, 2021 WL 1407953, at *5, *10 (W.D. Ky. Apr. 14, 2021).

[39] The anticompetitive effects of CON laws are discussed later in this note. However, for the sake of clarity, those effects generally are: (1) decreased access to healthcare and a limited supply of equipment and services, (2) decreased physical and financial access to healthcare services, and (3) increased healthcare costs. *See infra* Section III.

[40] 15 U.S.C. § 1.

[41] NORMAN A. ARMSTRONG, JR. ET AL., SHERMAN ACT SECTION 1 FUNDAMENTALS 1 (2019).

[42] *See* William E. Kovacic et al., *Plus Factors and Agreement in Antitrust Law*, 110 MICH. L. REV. 393, 396–97 (2011).

concerned with "abuses of monopoly power[,] . . . attempts to monopolize, and conspiracies to monopolize."[43]

Though there are differences between the analyses required for Sherman Sections 1 and 2, each are analyzed using the burden shifting mechanism known as the "rule of reason."[44] The rule of reason weighs the procompetitive benefits of an actor's conduct with its anticompetitive effects.[45] This balancing allows the court to scrutinize alleged anticompetitive conduct using a fact specific,[46] case-by-case analysis[47] rather than implementing an overly broad ban on conduct that might have procompetitive benefits.[48]

However, there is one specific area where the court will not analyze conduct using the rule of reason: government regulations.[49] Government regulations enjoy what is known as "*Parker* immunity."[50] *Parker* immunity applies "when it is clear that the challenged anticompetitive conduct is undertaken

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[43] Michele Floyd, Practice Note, *Antitrust Claims: Identification and Analysis*, LEXISNEXIS PRACTICAL L. (Mar. 8, 2018) (emphasis omitted), https://plus.lexis.com/api/permalink/eb068f24-9a0e-4915-8057-f9b485d37f2f/?context=1530671 [https://perma.cc/W4YK-ZFS2]. A monopoly is generally seen as "the control of a market for goods or services by a single supplier or owner." *Monopoly*, BOUVIER LAW DICTIONARY (2012).

[44] Herbert Hovenkamp, *The Rule of Reason*, 70 FLA. L. REV. 81, 85 (2018).

[45] Dane Stuhlsatz, *Florida's Certificate of Need: A Prescription for Government-Private Collusion and Antitrust Violation*, 13 FLA. L. REV. 241, 243 (2018).

[46] Snell & Wilmer, *U.S. Supreme Court Unanimously Rules Against NCAA in Antitrust Case, Providing Valuable Insights on the Rule of Reason Standard*, JD SUPRA (June 23, 2021), https://www.jdsupra.com/legalnews/u-s-supreme-court-unanimously-rules-1930875/ [https://perma.cc/9B85-CBTA].

[47] *The Rule of Reason*, OSU EHISTORY, https://ehistory.osu.edu/exhibitions/1912/trusts/theruleofreason [https://perma.cc/HN7M-VC79].

[48] King & Spalding, *Sixth Circuit Confirms Rule of Reason Analysis Applies to Alleged Group Boycott*, JD SUPRA (May 1, 2019), https://www.jdsupra.com/legalnews/sixth-circuit-confirms-rule-of-reason-92059/ [https://perma.cc/CP8K-XW3Z].

[49] Richard J. Hoskins, *States and Municipalities with Federal Antitrust Immunity Unlikely to Be Affected by Market Participant Exception*, SCHIFF HARDIN (May 20, 2020), https://www.schiffhardin.com/insights/publications/2020/states-and-municipalities-with-federal-antitrust-immunity-unlikely-to-be-affected-by-market-participant-exception [https://perma.cc/84DE-ZFRS].

[50] Parker v. Brown, 317 U.S. 341, 350–51 (1943) ("We find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature. In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress."); *see, e.g.*, City of Columbia v. Omni Outdoor Advert., Inc., 499 U.S. 365 (1991) (holding that the municipality of Columbia, South Carolina could displace competition by enacting zoning ordinances that restricted billboard construction for all but one entity that held 95 percent of the market and enjoyed close associations with city officials.); Town of Hallie v. City of Eau Claire, 471 U.S. 34 (1985) (holding that where a city acquires a monopoly with respect to the provision of sewage treatment services, ties those services to sewage collection and transportation services, and subsequently refuses to supply such services to the petitioner towns, such actions are protected by the *Parker* immunity doctrine.).

pursuant to a regulatory scheme that is 'the State's own.'"[51] In other words, so long as the regulation is promulgated by the state and is otherwise valid under constitutional and statutory law, the regulation is immune from any antitrust scrutiny.[52] This is true even for municipal laws, so long as those municipal laws were authorized by the state, and if the anticompetitive effects of the laws were a foreseeable result of the state's authorization.[53] Indeed, *Parker* immunity protects the government from antitrust scrutiny for actions that would otherwise violate antitrust laws if those actions were undertaken by private entities.[54]

State regulatory schemes arguably have more ability to harm consumers than any other anticompetitive business practice,[55] yet these regulations remain under the protective shield of the *Parker* immunity doctrine.[56] Thus, barring judicial departure from long-established precedent, CON laws cannot be challenged in court via antitrust law due to the *Parker* immunity doctrine.

Accordingly, this note will suggest a solution to this paradox: *Parker v. Brown*[57] should be overturned, and the blanket immunity that it provides to government regulation should be replaced with an analytical framework similar to the rule of reason that is used in antitrust cases. Doing so would permit government regulations some degree of deference, while still allowing those regulations to be analyzed and evaluated on a case-by-case basis. This solution would ensure that the basic premise of the US economic policies—namely, a vigorously free and competitive marketplace—is allowed to flourish. Such a solution would also provide consumers with a higher quality, cheaper, and more flexible healthcare system that is truly capable of responding to their needs, particularly in times of crisis.

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[51] Fed. Trade Comm'n v. Phoebe Putney Health Sys., 568 U.S. 216, 225 (2013) (quoting Fed. Trade Comm'n v. Ticor Title Ins. Co., 504 U.S. 621, 635 (1992)).

[52] *See supra* note 50.

[53] Hoskins, *supra* note 49.

[54] *Parker*, 317 U.S. at 350.

[55] As a general matter, when the government occupies a central regulatory role that controls every aspect of our lives, as it does in the United States, more regulation creates a greater likelihood of harm for consumers, particularly those that occupy the lower strata of the socioeconomic table. Adam A. Millsap, *How Too Much Regulation Hurts America's Poor*, FORBES (July 23, 2019, 8:47 AM), https://www.forbes.com/sites/adammillsap/2019/07/23/how-too-much-regulation-hurts-americas-poor/?sh=486884ea271f [https://perma.cc/K5MK-KFT8].

[56] *See Phoebe Putney Health Sys.*, 568 U.S. at 225.

[57] *Parker*, 317 U.S. 341.

Part I of this note provides a general background of CON laws, with a focus on New York's CON law and the current issues surrounding these laws. Part II discusses the current issues of CON laws as demonstrated by New York's response to the COVID-19 pandemic, focusing on how New York's CON law has made healthcare less accessible, less innovative, and less affordable. Part III provides an overview of antitrust law and establishes it as the framework of analysis. Part IV asserts that *Parker* should be overturned and that government regulations should be analyzed under the rule of reason burden-shifting framework.

I. BACKGROUND

A. History of CON Laws

In the mid-1960s, the consensus among legislators throughout the United States was that the expensive nature of healthcare was the result of "wasteful, over-investment in duplicative health care facilities,"[58] particularly in geographic areas that had no "need"[59] for such investment.[60] It was assumed that these expensive and superfluous investments forced healthcare facilities to pass the purchase costs of their unnecessary investments to their patients, thereby raising costs and pushing healthcare financially out of the reach of the poor.[61]

Such costly overinvestment primarily occurred in wealthier areas as part of a bid by the healthcare facilities to attract wealthier patrons with the latest and greatest medical equipment and facilities, thus diverting funds that could have been used to pay for developments in low-income communities.[62] To lawmakers and economists alike, such wasteful overinvestment was thought to stem from the "cost plus" reimbursement system which was widely used during this time.[63]

Under a cost-plus reimbursement scheme, an insurance company pays for a portion of the hospitals total expenses that can be attributed to the insurance company's customers rather than directly for the patient's care, hence the term "cost" in "cost-plus."[64]

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[58] Ohlhausen, *supra* note 6, at 50.

[59] *See* Ohlhausen, *supra* note 6.

[60] *Certificate of Need Laws*: *Support*, BALLOTPEDIA, https://ballotpedia.org/Certificate_of_need_laws [https://perma.cc/SX39-FFLY].

[61] *Id.*

[62] *See id.*

[63] *See* Ohlhausen, *supra* note 6, at 51.

[64] JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS 164 (1992). For example,

The "plus" factor represents additional payments made by the insurance company to the hospital; this "plus" factor typically encompasses payments for "the value of working capital and equity capital."[65] Thus, a cost-plus system permits a hospital to almost guarantee itself a profit because it determines the costs.[66] This cost-plus system effectively eliminated any incentive "for providers to control costs and avoid excessive, unnecessary spending."[67] Enter CON laws, which were born to alleviate the rising healthcare prices born out of this cost-plus system.[68]

To help wrap our minds around the situation that CON laws were designed to remedy, note the following hypothetical.[69] Imagine that Prospect Hospital purchases the newest, and arguably the best, MRI machine on the market. As a result, more patients begin choosing Prospect Hospital over the other three hospitals in the area. To combat Prospect Hospital's growing success and to recoup lost revenues, the other three hospitals purchase the same MRI machine. However, weeks after the other three hospitals choose to purchase the newest MRI machine, demand for MRI machines declines, leaving the hospitals with expensive, unused machines. To compensate, the hospitals raise their prices to offset the expensive purchases, therefore placing the burden of these expensive, idle machines on the consumer. CON laws are designed to prevent situations like this, where redundant[70] healthcare services result in avoidably[71] higher consumer costs; that is, in theory. Case in point: New York's CON law.

> [i]f, on the average, 30 percent of the patient-days of a particular hospital are accounted for by Blue Cross patients, Blue Cross will pay 30 percent of the hospital's total costs. Cost is determined by various accounting techniques, about which there can be much bickering. Usually, a "plus" factor is thrown in to cover the value of working capital and equity capital. Hence the term "cost-plus."

Id.

[65] *Id.* "Working capital" is typically the difference between an entity's current assets and current liabilities. *What Is Working Capital—And Why Is It Important?*, BANK OF AM.: BUS. ADVANTAGE, https://www.bankofamerica.com/smallbusiness/business-financing/learn/what-is-working-capital/ [https://perma.cc/3MD4-TWUB]. "Equity capital" is usually the funds given by an investor to a business in exchange for stock. *Equity Capital Definition*, ACCT. TOOLS (Apr. 15, 2021), https://www.accountingtools.com/articles/what-is-equity-capital.html [https://perma.cc/NQN4-K6ZG].

[66] *See* Luis Villar, *How Medicare Ruined American Healthcare*, MEDPAGE TODAY (July 29, 2019), https://www.medpagetoday.com/publichealthpolicy/healthpolicy/81272 [https://perma.cc/E9MP-TZ2R].

[67] Ohlhausen, *supra* note 6, at 51.

[68] *Id.*

[69] Hypothetical adapted from Ohlhausen, *supra* note 6, at 50–51.

[70] *Id.*

[71] Pub. Health & Health Plan. Council, *A Mission and Vision for Certificate of Need in the 21st Century*, N.Y.S. DEP'T OF HEALTH 1 (2012) [hereinafter PHHPC, *A Mission and Vision for Certificate of Need*], https://on.ny.gov/3ovzBw5 [https://perma.cc/7QMF-JY88].

B. New York's CON Law Program

New York's CON law program was the first statewide program to be implemented in the United States.[72] New York adopted their CON law in 1964 to eliminate market inefficiencies created by the cost-plus reimbursement system.[73] Specifically, New York's CON law attempted to reduce healthcare expenses by eliminating services and facilities that the state deemed redundant.[74] In 1974, as CON laws gained favor, the federal government mandated the establishment of state CON programs,[75] designed, like New York's, to "promote[] the alignment of health care resources with community health needs," thereby reducing the overall cost of healthcare.[76]

Proponents of New York's CON law emphasize that the law is designed to "assure[] that [the State's] healthcare delivery systems are accessible, . . . cost-effective," and supportive of "beneficial innovation."[77] To that end, New York's CON law requires that healthcare facilities like hospitals, nursing homes, long term home healthcare programs, and hospices apply for and receive a CON before they are allowed to construct or establish new facilities, acquire major medical equipment, add or remove services, or renovate existing facilities.[78]

The application and approval process to receive a CON is long, complicated, and expensive.[79] In New York, once a CON application is submitted, it will undergo one of the following types of review: (1) full, (2) administrative, or (3) limited.[80] Each type of review requires varying intensities of evaluation. Moreover, the type of review done by the Department of Health depends on the variety and size of the facility, as well as the nature of the proposed project.[81] Hospitals, nursing homes, diagnostic and treatment centers, and midwifery birth centers are required to undergo a full review for certain types of proposals, such as adding beds ("regardless of cost") and

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[72] CAVANAUGH ET AL., *supra* note 11, at 5.

[73] *See* Ohlhausen, *supra* note 6, at 51.

[74] *Id.*

[75] *Id.*

[76] Pub. Health & Health Plan. Council, *A Mission and Vision for Certificate of Need*, *supra* note 71, at 1.

[77] *Id.*

[78] Ohlhausen, *supra* note 6.

[79] Anastasia Boden & Annie Philpot, *Certificate of Need Laws Limited Healthcare Capacities in the Years Leading Up to COVID-19*, PAC. LEGAL BLOG (Apr. 8, 2020), https://pacificlegal.org/certificate-of-need-laws-healthcare-capacity-covid-19/ [https://perma.cc/RS6T-YBJ7].

[80] *CON Review Types As Determined by Facility Type*, *supra* note 26.

[81] *Id.*

converting hospital beds to a bed category that does not "already exist[] in the facility."[82]

The full review must "includ[e] a recommendation or decision of the Public Health and Health Planning Council" (PHHPC).[83] A full review also requires that an application be reviewed by both Department of Health and PHHPC staff before the application is sent to the Commissioner of Health.[84] However, the PHHPC has the final say regarding changes in ownership and the establishment of new facilities.[85] In contrast, administrative and limited reviews are only reviewed by Department of Health staff before being sent to the Commissioner of Health.[86] Administrative review is given to projects with a total cost greater than $15 million and less than $30 million for general hospitals.[87] Limited review is given to projects with a total cost less than or equal to $15 million for general hospitals and less than or equal to $6 million for all other medical facilities requesting to, for example, perform minor construction, acquire, install, or modify certain medical equipment and decertify facility beds or services.[88]

Moreover, the broad requirement for CON review applies to the establishment, renovation, acquisition of medical equipment, addition or subtraction of services, change in ownership, or modification of services with no differentiation between public and private entities.[89] Certain exceptions are given to religious institutions that rely on spiritual means for healing.[90] Nonetheless, following review, approval of a CON application rests either on the shoulders of the PHHPC or the Commissioner of Health,[91] but the final decision rests with the Commissioner of Health when the application involves major construction or specialized services.[92] Alternatively, the decision is PHHPC's when the application involves the establishment of a new facility or a change in ownership.[93]

Yet, no matter who makes the ultimate decision, an application's approval relies solely on the determination that

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[82] *Id.*

[83] *Id.*

[84] CAVANAUGH ET AL., *supra* note 11, at 131.

[85] *CON Review Types As Determined by Facility Type*, *supra* note 26.

[86] CAVANAUGH ET AL., *supra* note 11, at 131.

[87] *CON Review Types As Determined by Facility Type*, *supra* note 26.

[88] *Id.*

[89] *See CON Review Types As Determined by Facility Type*, *supra* note 26.

[90] *See* N.Y. PUB. HEALTH LAW § 2801(1) (McKinney 2019).

[91] *The CON Process*, N.Y.S. DEP'T OF HEALTH (May 2009), https://www.health.ny.gov/facilities/cons/more_information/process.htm [https://perma.cc/74PY-A4G9].

[92] *Id.*

[93] *Id.*

there is an adequate public need,[94] that the project is financially feasible,[95] that the entity or entities requesting a CON are qualified and competent (i.e., licenses, education, history of legal actions),[96] and that the physical details of the project (architectural and engineering) comply with state law.[97] Given that the onerous application and review process is reliant on such subjective criteria as "adequate public need," "financial feasibility," and the "competency" of the individual(s) requesting a certificate, it is little wonder that the implementation of New York's CON law has struggled to achieve its stated goals.

II. CURRENT ISSUES WITH CON LAWS, AS DEMONSTRATED BY NEW YORK'S CON LAW

Even though New York's CON law was enacted to create and maintain a healthcare market that is accessible, cost-effective, and supportive of innovation,[98] it has routinely failed to accomplish these goals.[99] Economists, antitrust lawyers, and health market specialists have studied CON laws, including New York's, for decades.[100] The data indicates that CON laws throughout the United States almost always fall drastically short of their expressed goals, oftentimes making things worse for the consumer.[101]

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[94] *Certificate of Need Review Criteria*, N.Y.S. DEP'T OF HEALTH (May 2005), https://www.health.ny.gov/facilities/cons/more_information/review_criteria.htm [https://perma.cc/LFN3-TLRA]; *see also* Off. of Health Sys. Mgmt., *Schedule 3, Certificate of Need Application*, N.Y.S. DEP'T OF HEALTH, [hereinafter *Schedule 3, Certificate of Need Application*], https://www.health.ny.gov/facilities/cons/application_revisions/docs/schedule_3.pdf [https://perma.cc/X2U2-JYBZ] (outlining information that applicants must provide to prove adequate public need).

[95] *Id.*

[96] *Id.*; Off. of Health Sys. Mgmt., *Schedule 20, Personal Certificate of Need Application: Qualifying Information*, N.Y.S. DEP'T OF HEALTH, https://www.health.ny.gov/facilities/cons/application_revisions/docs/schedule_20.pdf [https://perma.cc/A9BK-GPNK].

[97] *See Certificate of Need Review Criteria*, *supra* note 94.

[98] Pub. Health & Health Plan. Council, *A Mission and Vision for Certificate of Need*, *supra* note 71, at 1.

[99] Thomas Stratmann et al., *Certificate-of-Need Laws: How CON Laws Affect Spending, Access, and Quality Across the States*, MERCATUS CTR. (Aug. 29, 2017), https://www.mercatus.org/publications/corporate-welfare/certificate-need-laws-2017-how-con-laws-affect-spending-access-and [https://perma.cc/RLY2-R9K4].

[100] *See id.*

[101] *Id.* For example, in Hawaii, CON laws limited the hospital's ability to treat serious medical issues such as children that are born prematurely or cardiac cases. Malia Blom, *'Certificate of Need' Laws Are Certifiably Unnecessary*, HILL (Nov. 27, 2017, 1:00 PM), https://thehill.com/opinion/healthcare/361971-certificate-of-need-laws-are-certifiably-unnecessary [https://perma.cc/RB84-EUFX]. Such a limitation resulted in roughly 350 off-island transports per year due to a lack of available services. *Id.* CON laws have also made it more difficult for the parents of special-needs children to obtain needed medical services in their county of residence. Elise Amez-Droz & Lyndi Schrecengost, *The Human Cost of Outdated Regulations*, DISCOURSE (Sept. 15, 2020),

This Part will show how New York's CON law has not only failed to achieve its goals of a more cost-effective, affordable, and innovative healthcare market, but that it has made New York's healthcare market less accessible, less innovative, and less affordable.

A. Decreased Access to Healthcare and Limited Supply of Equipment and Services

One of the core purposes undergirding New York's CON law was to make healthcare more accessible,[102] particularly for those that experience disparities based on race and ethnicity.[103] New York's CON law has had an effect on two types of access.[104] First, there is physical access. An individual's physical access to a needed healthcare service depends on "personal mobility . . . availability of transportation" and geographic location.[105] Second is one's financial ability to access healthcare.[106] One's financial ability to access healthcare services depends on "the prices charged by the providers,"[107] and how much money the individual must spend.

1. Decreased Physical and Financial Access to Healthcare Services

To close the physical access gap, New York, like other states,[108] appears to use its CON law to create what is essentially a *quid-pro-quo* incentive system to encourage healthcare providers to offer services in otherwise underserved areas. First, the State of New York, through the state's CON law, restricts

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https://www.discoursemagazine.com/economics/2020/09/15/the-human-cost-of-outdated-regulations/ [https://perma.cc/CZ2C-WW6B].

[102] Pub. Health & Health Plan. Council, *A Mission and Vision for Certificate of Need*, *supra* note 71; *see* Ohlhausen, *supra* note 6.

[103] PUB. HEALTH & HEALTH PLAN. COUNCIL, REPORT OF THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL ON REDESIGNING CERTIFICATE OF NEED AND HEALTH PLANNING 45 (2012).

[104] Jean-Frederic Levesque et al., *Patient-centred Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations*, 12 INT'L J. FOR EQUITY 1, 5 (2013), https://equityhealthj.biomedcentral.com/articles/10.1186/1475-9276-12-18 [https://perma.cc/P836-2FSX] (There are other types of access, such as the "[a]bility to perceive . . . to seek . . . to engage"; though this note will only focus on the "[a]bility to reach" and the "[a]bility to pay"—in other words, the ability to physically access, and the ability to pay for healthcare services.).

[105] *Id.* at 6.

[106] *Id.* at 7.

[107] *Id.*

[108] Gary M. Fournier & Ellen S. Campbell, *Indigent Care as Quid Pro Quo in Hospital Regulation*, 87 REV. ECON. & STAT. 593, 673 (2005).

healthcare development and investment to reduce costs.[109] The state then requires healthcare providers to invest the money that they presumably would have used on the unnecessary developmental projects to fund otherwise neglected populations and regions.[110] This practice is referred to as the "cross-subsidization" of charity care.[111] Naturally, this appears to be against the best interests of the healthcare providers. But, in exchange for healthcare providers foregoing potential profit by investing in charity care, New York offers protection from competition via regulatory barriers to entry[112] that are baked into New York's CON law program.

This can be seen clearly by returning to our hypothetical. Imagine that business is great and Prospect Hospital's patients are now asking for services that involve the use of a CAT scanner, but the hospital is unable to purchase a CAT scanner, leaving the hospital with a surplus of cash and demand, but no machine. Moreover, the state authorities require that, in order to purchase a CAT scanner, one must go through the CON application process. Meanwhile, other hospitals in the area have CAT scanners, but many of Prospect's patients cannot afford to travel to those hospitals. Prospect could go through the CON application process in an attempt to convince the state authorities that a CAT scanner would benefit the public, but the application process is long and expensive, and a favorable result is not guaranteed. In reality, Prospect would most likely just be shelling out cash in a futile attempt to change the state authorities' minds given that the state has already determined that the "needs" of their respective area have not changed. But all is not lost. Indeed, Prospect can use some of that cash to expand their services into the neglected communities around them and receive some benefits from the state that could compensate for their inability to serve their patients by buying a CAT scanner.

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[109] Pub. Health & Health Plan. Council, *A Mission and Vision for Certificate of Need*, *supra* note 71, at 2.

[110] *Hospital Accountability Project, Free Care Compendium: New York*, CMTY. CATALYST, https://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care/states/new-york [https://perma.cc/3KC2-SF7X]. This incentive structure requires the hospital to police itself given that the hospital is only required to generally provide "charity care" for individuals that fall into certain income brackets. *See* Amanda Gallipeau, *NYS Hospital Financial Assistance Law—Hospitals Must Provide Charity Care Assistance Program*, NY HEALTH ACCESS (Sept. 9, 2020), http://www.wnylc.com/health/entry/69/ [https://perma.cc/F8PZ-R7A9].

[111] Christopher Garmon, *Hospital Competition and Charity Care* 17 (Bureau of Econ., Fed. Trade Comm'n, Working Paper No. 285, 2006).

[112] *See* Thomas Stratmann & Matthew C. Baker, *Barriers to Entry in the Healthcare Markets Winners and Losers from Certificate-of-Need Laws* 27 (Mercatus Ctr. at George Mason Univ., Mercatus Working Paper No. 1180, 2017).

But why would Prospect, along with the other large hospitals throughout the city, not petition the state to get rid of the CON law? Perhaps because, in exchange for Prospect investing in charity care, the state creates a barrier to entry for Prospect's competitors via the CON process. Indeed, to open any facility that would compete with Prospect, one must go through the highly subjective CON application process.[113] Thus, while Prospect must forego facility improvement and expansion (or at the very least, spend more money and time getting each improvement or expansion approved), Prospect is also insulated from competition by the CON law.

In fact, studies suggest that this cross-subsidization of charity care does not actually benefit underserved communities.[114] Studies that have measured the effect that CON laws have on one's physical ability to access healthcare services shows that states with CON laws, "on a per capita basis . . . have 30 percent fewer hospitals, 30 percent fewer rural hospitals, 14 percent fewer ambulatory surgical centers, and 13 percent fewer rural ambulatory surgical centers."[115] In New York, studies show that, per every 10,000 people, rural and micropolitan areas[116] have the fewest primary care providers (PCPs), standing, respectively, at just 3.4 and 10.8 per every 10,000 people.[117] Even in dense metropolitan areas,[118] access to PCPs is relatively low.[119] Thus, while the cross-subsidization of charity care is intended to provide greater access to underserved communities, the data above suggests that, at best, cross-subsidization of charity care does not have a positive effect on the underserved communities' access to healthcare. Studies also indicate that states, including New York, that have CON laws and also require the cross-

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[113] *See supra* Section I.B.

[114] *Hospital Accountability Project, Free Care Compendium: New York*, *supra* note 110 (noting that the distribution mechanism of New York's legal requirement of charity care "has received some recent criticism for lack of accountability and connection to charity care actually provided").

[115] Thomas Stratmann & Matthew C. Baker, *Examining Certificate-of-Need Laws in the Context of the Rural Health Crisis* 1, 11 (Mercatus Ctr. at George Mason Univ., Mercatus Working Paper No. 1130, 2020).

[116] PRIMARY CARE DEV. CORP., RURAL ACCESS TO PRIMARY CARE IN NEW YORK STATE 2019 REPORT 6 (2019), https://www.pcdc.org/wp-content/uploads/Resources/Rural-Access-to-Primary-Care-in-New-York-State-_-2019-Report.pdf [https://perma.cc/72U7-GD3U] (defining "rural" areas as areas with less than 2,500 persons, and "micropolitan" areas as areas with 10,000–49,999 persons).

[117] *Id.* at 11.

[118] *Id.* at 6 (defining "metropolitan" areas as areas with 50,000 or more persons).

[119] PRIMARY CARE DEV. CORP., POINTS ON CARE: THE INTERSECTION OF COVID-19 AND CHRONIC DISEASE IN NEW YORK CITY UNDERSCORES THE IMMEDIATE NEED TO STRENGTHEN PRIMARY CARE SYSTEMS TO AVOID DEEPENING HEALTH DISPARITIES 4 (2020), https://www.pcdc.org/wp-content/uploads/Points-on-Care-_-Issue-3-COVID-_-FINAL.pdf [https://perma.cc/JXG9-A93G].

subsidization of charity care have "increase[d] racial disparities in the provision [of care] of certain services."[120]

There is also a financial gap between New Yorkers and healthcare even though New York's CON law was supposed to close this gap by lowering healthcare's cost. As demonstrated by a survey done in 2019, around 52 percent of New Yorkers struggled to afford healthcare.[121] Moreover, 76 percent of New Yorkers are concerned that they will either struggle to, or be unable to, afford healthcare services in the future.[122] Indeed, surveys such as this demonstrate that, as the cost of healthcare continues to climb,[123] a common worry among all New Yorkers, regardless of income, is that they will struggle to afford necessary healthcare services.[124]

In reality, there seems to be no persuasive or authoritative evidence that CON laws in their half-century of existence have increased or improved one's physical access to healthcare in any state, New York included.[125] Rather, the evidence seems to indicate that the poor remain without healthcare because of either geographic or financial limitations.

2. Consequences of Decreased Access to Healthcare Services, As Demonstrated by COVID-19

There has, perhaps, never been a more illustrative example of the law's harmful access-restricting effects than that of New York's response to the COVID-19 pandemic.[126] At the height of COVID-19's initial wave in 2020, emergency dispatchers in New York City handled, in a single day, more than seven thousand emergency calls—"a volume not seen since the Sept. 11

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[120] *See* Mitchell, *supra* note 20, at 4. Such disparities are partially attributable to CON laws, at least until the CON laws are changed to permit entry into the market, because CON laws restrict the services that hospitals and healthcare facilities can provide based on bureaucrats' subjective determinations. Derek DeLia et al., *Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey*, 34 J. HEALTH POL., POL'Y, & L. 63, 63, 66, 69 (2009). In other words, altering CON laws to solve for racial disparities is an unnecessarily complex solution for a problem that free market systems could solve for.

[121] Altarum, *New Yorkers Struggle to Afford High Healthcare Costs; Support a Range of Government Solutions Across Party Lines*, DATA BRIEF NO. 37, Mar. 2019, at 1.

[122] *Id.*

[123] *See supra* Introduction.

[124] Altarum, *supra* note 121, at 1.

[125] REFORMING AMERICA'S HEALTHCARE SYSTEM, *supra* note 30, at 54.

[126] *See* Deborah Brown & Andrea Cohen, *Revisiting the Role of Law and Politics in Pandemic Response at NYC Health + Hospitals*, HEALTH AFFS. BLOG (July 16, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200715.913628/full/ [https://perma.cc/8KBU-RHJT].

attacks."[127] That volume lasted for eight straight days.[128] Amid the chaos, as the virus stretched out its arms to encircle all five boroughs of the city, ambulance wait times skyrocketed, nearly doubling in March of 2020 as compared to the previous month,[129] thus ambulance wait times also increased.[130]

These longer wait times inevitably led to more deaths, as those suffering from severe COVID cases died because they did not have timely access to the necessary equipment or services.[131] However, what is perhaps more disturbing is that even in the midst of skyrocketing wait times private ambulance companies were barred from helping under New York's CON law.[132] Instead, private ambulance operators were "forced to stand by as [their] communit[ies] suffered."[133] Why exactly were these ambulance companies not permitted to help in the labor strapped fight against COVID-19? Their CON applications were denied because they could not prove "to the government's satisfaction that their services were 'needed.'"[134] Indeed, the government deemed their services "unnecessary."

Unfortunately, New York's CON law did not stop at restricting private ambulance services. For instance, New York's CON law limits the number of hospital beds a healthcare facility can have,[135] the medical equipment it can possess,[136] and perhaps most importantly during the COVID-19 pandemic, the number of ventilators at its disposal.[137] It is no wonder then that as COVID-19 ravaged New York, the death count rose quickly[138] as there was

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[127] Ali Watkins, *N.Y.C.'s 911 System Is Overwhelmed. 'I'm Terrified,' a Paramedic Says*, N.Y. TIMES (Mar. 28, 2020), https://www.nytimes.com/2020/03/28/nyregion/nyc-coronavirus-ems.html [https://perma.cc/9K56-LH28].

[128] *NYC Paramedics Overwhelmed by Coronavirus Cases: "We've Had 9/11-type Calls for Eight Days,"* CBS NEWS (Mar. 31, 2020, 10:46 AM), https://www.cbsnews.com/news/coronavirus-pandemic-nyc-ems-first-responders-overwhelmed-covid-19-nyu-langone-hospital/ [https://perma.cc/MFS3-4GSS].

[129] Susan Edelman, *New Yorkers Are Dying as Ambulance Response Times Surge Amid Coronavirus*, N.Y. POST (Apr. 11, 2020, 2:17 PM), https://nypost.com/2020/04/11/new-yorkers-are-dying-as-ambulance-response-times-surge-amid-coronavirus/ [https://perma.cc/4SBH-NDSG].

[130] *Id.*

[131] *See id.*

[132] N.Y. PUB. HEALTH LAW § 3005(6) (McKinney 2019).

[133] Anastasia Boden & Mollie Williams, *Government's Ambulance Chasers*, WALL ST. J. (Apr. 29, 2020, 6:13 PM), https://nypost.com/2020/04/11/new-yorkers-are-dying-as-ambulance-response-times-surge-amid-coronavirus/ [https://perma.cc/H3ZG-RNNT].

[134] *Id.*

[135] *CON Review Types As Determined by Facility Type*, *supra* note 26.

[136] *Id.*

[137] N.Y. COMP. CODES R. & REGS. tit. 10, § 709.17 (2020).

[138] *See* Shalini Ramachandran et al., *How New York's Coronavirus Response Made the Pandemic Worse*, WALL ST. J. (June 11, 2020), https://www.wsj.com/articles/how-new-yorks-coronavirus-response-made-the-pandemic-worse-11591908426 [https://perma.cc/2ELR-6PND].

a shortage of beds, medical equipment, and ventilators.[139] Realizing that New York's healthcare system was being overwhelmed, then Governor Andrew Cuomo issued Executive Order 202.1 on March 12, 2020, which suspended New York's CON law through April 11, 2020.[140] But, the damage had already been done. Many New Yorkers were left without emergency medical transportation to get to the hospital, access to a bed if they got to the hospital, and access to a fully functional ventilator if their condition worsened while in the hospital.[141]

Thus, even though New York's CON law was intended to ensure increased accessibility to healthcare,[142] the COVID-19 pandemic revealed exactly how inaccessible healthcare services can be when their supply is artificially restricted.[143] But the saddest part of it all is that the hardest hit populations in the city were the very communities that CON laws were supposed to help: the poor. Poorer communities in Queens experienced a COVID case rate 6.4 times higher than surrounding areas that had greater access to PCPs.[144] This can likely be attributed to the fact that individuals living in the East Village of Manhattan enjoy 79.1 times more PCPs per 10,000 residents than those living in the poorer communities in Queens.[145] Broader citywide statistics reveal that early in 2020, at the height of the initial COVID-19 wave in NYC, zip codes where around a third of the population live at or below the poverty line experienced more than twice as many deaths per 100,000 people than areas whose residents were more affluent.[146] This demonstrates just how harmful an artificially controlled and therefore inelastic healthcare system can be to the most vulnerable among us.

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[139] Sally Goldenberg et al., *New York Hospitals Still Searching for Equipment*, POLITICO (Apr. 14, 2020, 5:07 AM), https://www.politico.com/states/new-york/albany/story/2020/04/13/hospitals-still-searching-for-equipment-despite-glimmers-of-hope-1275602 [https://perma.cc/S47R-PL64].

[140] N.Y. COMP. CODES R. & REGS. tit. 9, § 8.202.1 (2020).

[141] *See* Brian M. Rosenthal et al., *Why Surviving the Virus Might Come Down to Which Hospital Admits You*, N.Y. TIMES (July 1, 2020), https://www.nytimes.com/2020/07/01/nyregion/Coronavirus-hospitals.html [https://perma.cc/3QH9-UVA6].

[142] Pub. Health & Health Plan. Council, *A Mission and Vision for Certificate of Need*, *supra* note 71, at 1.

[143] Boehm, *supra* note 23.

[144] *Id.*

[145] PRIMARY CARE DEV. CORP., *supra* note 119, at 4.

[146] Erin Durkin, *NYC's Poorest Neighborhoods Have Highest Death Rates from Coronavirus*, POLITICO (May 18, 2020), https://www.politico.com/states/new-york/city-hall/story/2020/05/18/poorest-nyc-neighborhoods-have-highest-death-rates-from-coronavirus-1284519 [https://perma.cc/KTZ5-EZLB].

B. Stifled Innovation

CON laws subdue innovation within the medical industry because they not only limit entry into the market but also stymie the adoption of new technologies.[147] For example, New York's CON law requires the approval of the Commissioner of Health for nearly every change, modification, or deletion of services.[148] Thus, if any new or even incumbent provider wanted to obtain the latest and greatest MRI machine, which would theoretically benefit the provider's customers, New York's CON law requires administrative review and approval,[149] which would slow if not completely impede the adoption of new technological advances. Moreover, if a provider wanted to start offering adult or pediatric cardiac surgery, New York's CON law would require a full review and approval.[150] The same is true for any approved healthcare facility in New York that wanted to update an already approved service; they would need the state's blessing to do so.[151] Indeed, every administrative barrier slows, and in some cases stops, the adoption of new, beneficial technology.

Moreover, where laws, such as CON laws, slow the adoption and implementation of new technology, the quality of care decreases.[152] Indeed, in a heavily regulated market one cannot adequately respond and adapt to the ever-changing nature of technology because antiquated laws impedes the progression of technology.[153] Thus, because CON laws require approval to enter, change, update, add or modify services,[154] they naturally slow, or completely stop, the implementation of new technology and therefore stifle the enjoyment that

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[147] REFORMING AMERICA'S HEALTHCARE SYSTEM, *supra* note 30, at 54; *see also* Stratmann & Baker, *supra* note 112, at 27 (noting that "[o]ur results provide evidence that market entry for new hospital and nonhospital providers is limited by CON laws, whereas incumbent hospital providers remain largely unaffected. The magnitude of the coefficients implies that the association of the CON policy with new hospital and nonhospital providers is substantial, ranging from -25 percent to -76 percent, depending on the type of scan and the type of provider. For incumbent hospitals, the effect is nearly zero.").

[148] *See CON Review Types As Determined by Facility Type*, *supra* note 26.

[149] *See* CAVANAUGH ET AL., *supra* note 11, at 135.

[150] *Id.* at 134.

[151] *Id.* at 135.

[152] *See* Steven B. Caudill et al., *Certificate-of-Need Regulation and the Diffusion of Innovations: A Random Coefficient Model*, 10 J. APPLIED ECONOMETRICS 73, 77 (1995) (observing that "[t]he alleged purpose of certificate-of-need regulation is to ensure quality and reduce costs. It is difficult, however, to reconcile this alleged purpose with the findings reported here. Where regulatory controls retard the rate of adoption of new technologies (medical or otherwise), quality is likely to be sacrificed.").

[153] *See* Mark D Fenwick et al., *Regulation Tomorrow: What Happens When Technology Is Faster than the Law?*, AM. U. BUS. L. REV. 561, 563 (2017).

[154] *See CON Review Types As Determined by Facility Type*, *supra* note 26.

technological progression can provide by clogging the arteries of our system via intrusive regulation.[155] But, it is not necessarily the hospitals that are on the hook, it is the patient who must live with a lower quality good or service.[156]

C. Increased Healthcare Costs

A central focus of New York's CON law is to assure that healthcare within New York is "*cost-effective*."[157] To accomplish this, the New York Department of Health, which administers the state's CON law, uses the law to curb rising "health care costs" by "limiting investment in duplicate beds, services and medical equipment."[158] The law does this, as proponents claim, by limiting the competitive market forces to lower costs.[159]

Generally, proponents of CON laws believe that, contrary to general economic theory (which holds that competition lowers prices[160] and increases quality[161]), the healthcare market is different from any other market because competition within healthcare tends to increase costs for consumers.[162] CON law advocates assert that, in the healthcare industry, "competition simply isn't working."[163] Indeed, some advocates state that a regulation centric system such as Medicaid or "Medicare controls costs much more effectively than private insurers."[164]

Applying this proregulation reasoning, New York's CON law creates barriers to entry within the state's healthcare marketplace, making it much more difficult for new, and perhaps more innovative and cost-effective healthcare services to compete with the incumbent healthcare service providers.[165]

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[155] Caudill et al., *supra* note 152, at 77.

[156] *Id.*

[157] Pub. Health & Health Plan. Council, *A Mission and Vision for Certificate of Need*, *supra* note 71, at 1 (emphasis added).

[158] *Certificate of Need*, N.Y.S. DEP'T OF HEALTH, https://www.health.ny.gov/facilities/cons/ [https://perma.cc/ZPS9-G4V3].

[159] *See* Gerald Friedman, *Why Market Competition Has Not Brought Down Health Care Costs*, CONVERSATION (June 29, 2017, 7:50 PM), https://theconversation.com/why-market-competition-has-not-brought-down-health-care-costs-78971 [https://perma.cc/M7RR-74SQ].

[160] *See* Matia Busso & Sebastian Galiani, *The Casual Effect of Competition on Prices and Quality: Evidence from a Field Experiment* 26 (Nat'l Bureau of Econ. Rsch., Working Paper No. 20054, 2018).

[161] *See* Richard Gil & Myongjin Kim, *Does Competition Increase Quality? Evidence from the US Airline Industry* 77 INT'L J. INDUS. ORG. 1, 18 (2021).

[162] *See* Friedman, *supra* note 159.

[163] Diane Archer, *No Competition: The Price of a Highly Concentrated Health Care Market*, HEALTH AFFS. BLOG (Mar. 06, 2013), https://www.healthaffairs.org/do/10.1377/hblog20130306.028873/full/ [https://perma.cc/3MGH-SFCU].

[164] *Id.*

[165] *See* Stratmann & Baker, *supra* note 112, at 3–4.

Ultimately, this type of conduct restrains the competitive forces that would otherwise drive down the costs to the consumer.[166] Nevertheless, CON law advocates actively promote such restraints because, in their minds, a decrease in competitive forces within healthcare leads to lower overall costs for the consumer.[167]

Yet, there is a great deal of economic and legal literature that disagrees with the assertion that healthcare markets are so different that competition works negative, rather than positive, effects within the marketplace.[168] Indeed, the consensus is that the suppression of marketplace competition almost always leads to "increase[d] . . . price and reductions in output."[169] Moreover, there is a remarkable absence of data showing that CON laws have in fact made healthcare costs lower; in truth, the large majority of scholarly sources indicate that CON laws have raised prices.[170]

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[166] *Id.*

[167] *See* Renee Flaherty & Daryl James, *This Health Care Law Bars Competition and Drives Up Prices, Even as a Pandemic Rages*, REASON (July 20, 2020, 10:15 AM), https://reason.com/2020/07/20/this-health-care-law-bars-competition-and-drives-up-prices-even-as-a-pandemic-rages/ [https://perma.cc/Q6MX-GP6P] (one advocate noted that "while market competition is generally healthy for most industries . . . the state's certificate of need requirements for healthcare recognize that unregulated increases in some healthcare services can result in unnecessary duplication of services, higher-cost care and lower quality of care.").

[168] *See* Patrick A. Rivers & Saundra H. Glover, *Health Care Competition, Strategic Mission, and Patient Satisfaction: Research Model and Propositions*, 22 J. HEALTH ORG. & MGMT. 1, 2 (2008) (noting that "[c]ompetition [within the health care market] generally eliminates inefficiencies that would otherwise yield high production costs, which are ultimately transferred to patients via high health service and delivery costs"); *see also* Lisa Marie Potter, *Competition Keeps Health-Care Costs Low, Researchers Find*, STAN. MED. NEWS CTR. (Oct. 21, 2014), https://med.stanford.edu/news/all-news/2014/10/competition-keeps-health-care-costs-low—researchers-find.html [https://perma.cc/2MAZ-WF4T] (observing that "the top 10 percent of areas with the least competition had prices ranging from $5.85 to $11.67 higher for 'intermediate' office visits than those of the 10 percent of markets with the highest levels of competition. Studying a measure that averaged prices across multiple types of office visits, in their most conservative model, being in the top 10 percent of areas with the least competition was associated with 3.5 to 5.4 percent higher mean price. The researchers point out that in 2011, private insurers in the United States spent nearly $250 billion on physician services. In that context, these small percentage increases could translate to tens of billions of dollars in extra spending."); *see also* Leemore S. Dafny & Thomas H. Lee, *Health Care Needs Real Competition*, HARV. BUS. REV., Dec. 2016, at 76, 78 (stating that "health care needs more competition. In other sectors of the economy, competition improves quality and efficiency, spurs innovation, and drives down costs. Health care should be no exception.").

[169] *See* David Wessel, *Is Lack of Competition Strangling the U.S. Economy?*, HARV. BUS. REV., Mar.–Apr. 2018, at 106, 108.

[170] REFORMING AMERICA'S HEALTHCARE SYSTEM, *supra* note 30, at 53; *see also* Sherman, *supra* note 29, at 58 (stating that "[t]he regression results do not support the hypothesis that subjecting more of a hospital's expenditures to CON review by establishing lower thresholds helps to contain hospital costs."); Mitchell, *supra* note 20, at 5 (finding that "[s]even studies find that CON regulation increases healthcare spending, two find no statistically significant effect, and two find that CON regulation increases some expenditures while reducing others. To date, only one study finds that CON regulation is associated with less healthcare spending. In this case, however, the connection is tenuous."); Patrick McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System*, 23 FLA. ST. U. L. REV. 141, 143 (1995)

Between 2014 and 2018, despite New York's CON law being in effect, the cumulative growth in healthcare spending per person in New York (keep in mind that New York has the strictest CON law in the nation[171]) increased 28.4 percent—10 percent higher than the national increase of 18.4 percent.[172] In fact, as of 2019, 52 percent of New Yorkers experienced some kind of "healthcare affordability burden[.]"[173] What is more, 51 percent of all uninsured New Yorkers said that they did not have insurance because insurance premiums were too high.[174] Out of the 45 percent of all New Yorkers that experienced an affordability barrier, every single person noted that their respective healthcare barriers were due to cost.[175] In fact, of the 45 percent that encountered cost barriers, 31 percent "[d]elayed going to the doctor or having a procedure done,"[176] 26 percent avoided having a procedure or visiting their doctor all together,[177] 23 percent cut recommended doses of medication in half as a means of rationing medication that they could not afford,[178] and 17 percent struggled to access mental healthcare services.[179] Certainly in the half-century that New York has used its CON law, one would expect to find some trace that New York's healthcare delivery "systems are . . . *cost-effective*."[180] However, little evidence exists to show that CON laws make healthcare more affordable.[181]

(noting that "Congress required all states to pass CON laws in 1974, but quickly repealed that requirement after finding it ineffective for controlling health care costs").

171 *See* CAVANAUGH ET AL., *supra* note 11, at 136–38.

172 *2018 Health Care Cost and Utilization Report*, *supra* note 5.

173 Altarum, *supra* note 121, at 1.

174 *Id.*

175 *Id.*

176 *Id.*

177 *Id.*

178 *Id.*

179 *Id.*

180 Pub. Health & Health Plan. Council, *A Mission and Vision for Certificate of Need*, *supra* note 71, at 1 (emphasis added).

181 REFORMING AMERICA'S HEALTHCARE SYSTEM, *supra* note 30, at 53; *see also* Sherman, *supra* note 29, at 58 (stating that "[t]he regression results do not support the hypothesis that subjecting more of a hospital's expenditures to CON review by establishing lower thresholds helps to contain hospital costs"); Mitchell, *supra* note 20, at 5 (finding that "[s]even studies find that CON regulation increases healthcare spending, two find no statistically significant effect, and two find that CON regulation increases some expenditures while reducing others. To date, only one study finds that CON regulation is associated with less healthcare spending. In this case, however, the connection is tenuous."); McGinley, *supra* note 170, at 143 (noting that "Congress required all states to pass CON laws in 1974, but quickly repealed that requirement after finding it ineffective for controlling health care costs").

III. ANTITRUST LAW: THE PROPER FRAMEWORK TO APPLY TO NEW YORK'S CON LAW

This Part will show that antitrust law is the proper framework to address New York's CON law. Though, before explaining why antitrust law is the proper framework, it may be helpful to explain why alternative frameworks are insufficient.

A. Why is Antitrust Law the Proper Framework over Alternative Frameworks?

There are two alternative frameworks to analyze New York's CON law that both fall short: the commerce clause framework and the due process framework. To use a commerce clause framework to analyze New York's CON law would analyze only half the issue. Using a commerce clause framework would require a showing that New York's CON law either facially discriminates against interstate commerce, in which case the law would be subject to strict scrutiny, or that the objectives of the law could be served by reasonable nondiscriminatory means.[182] Under such a limited analytical framework, the price-lowering, access-limiting, innovation-choking effects of New York's CON law would not be addressed.

Using a due process framework to challenge New York's CON law would require a showing that the law not have a rational relation to a legitimate government interest.[183] However, when conducting a due process analysis of a state regulation, the state government's desire to legislate for social and economic reasons is almost always upheld under a rational relation test.[184] This test is extremely deferential, and absent a showing that the state regulation violates a specific federal constitutional provision or other federal law, the state's regulation will almost always be upheld.[185] Accordingly, using a due process framework to analyze the issue would be ineffective.

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[182] Tinajero, *supra* note 38.

[183] *See* Ferguson v. Skrupa, 372 U.S. 726, 729–30 (1963) (holding that acts of a state legislature are to be granted deference, ultimately leaving the issue of unreasonableness to the state legislators).

[184] *See id.*

[185] *See id.* at 730–31 (holding that the Court will not interfere with state legislation so long as the legislation does "not run afoul of some specific federal constitutional prohibition, or of some valid federal law"); *e.g.*, *In re* Certificate of Need Granted to the Harborage, 693 A.2d 133, 145 (N.J. Super. Ct. App. Div. 1997) (explaining that "substantive due process does not protect against all governmental actions that infringe on an individual's liberty interests or injure property rights." Rather, substantive due process only protects against "the most egregious governmental abuses, . . . abuses that 'shock the conscience or otherwise offend . . . judicial notions of fairness." Moreover,

In contrast, because antitrust law is designed to analyze the effects of ones conduct on the price and output of goods and services by ensuring that there is "vigorous competition among sellers in an open marketplace,"[186] it is better equipped to deal with the issues that CON laws present than, say, a commerce clause or due process analysis. Indeed, CON laws present issues related to the competitive effects of explicit or tacit agreements to insulate incumbent healthcare providers from competitive market forces.[187] Using any other legal framework to analyze CON laws would ultimately leave issues unaddressed, such as the anticompetitive effects of the behavior, the harm to consumers, and the pros and cons of such behavior. Moreover, antitrust law has ready-made mechanisms of analysis that would permit the government a certain level of deference when regulating, yet subject those same regulations to a weighing of their pros and cons.

Antitrust laws are designed to "protect economic freedom and opportunity by promoting free and fair competition in the marketplace."[188] The Supreme Court reiterated this sentiment when they stated the following:

> The purpose of the [Sherman] Act is not to protect businesses from the working of the market; it is to protect the public from the failure of the market. The law directs itself not against conduct which is competitive, even severely so, but against conduct which unfairly tends to destroy competition itself. It does so not out of solicitude for private concerns but out of concern for the public interest.[189]

Indeed, the premise undergirding the antitrust laws of the United States serves a more significant cause than merely ensuring that actors within the marketplace do not improperly exclude or harm other actors within the marketplace. Antitrust laws also serve a broader, deeper purpose of preserving the type of marketplace that has been deemed by many economists and governments alike to be the most beneficial: a competitive one.[190]

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the court noted that attached to every "regulation which is within the authority delegated to the promulgating agency, as well as to statutes" (citation omitted) is a presumption of validity, with the "heavy" burden to prove that such a presumption must be rebutted.).

[186] DOJ & FTC JOINT STATEMENT, *supra* note 28, at 2.

[187] U.S. DEP'T OF JUST. & FED. TRADE COMM'N, 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 1–2, 4 (2008), https://www.justice.gov/sites/default/files/atr/legacy/2008/09/19/237351.pdf [https://perma.cc/33SE-JKC9].

[188] *Mission: Antitrust Laws*, *supra* note 35.

[189] Spectrum Sports v. McQuillan, 506 U.S. 447, 458 (1993).

[190] *Benefits of Competition and Indicators of Market Power*, COUNCIL ECON. ADVISERS ISSUE BRIEF, May 2016, at 1, 1–4 (noting that "a long line of economic literature argues that" a competitive marketplace benefits consumers via lower prices,

The antitrust laws of the United States stem from the Sherman Act of 1890, which forbids "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations."[191] However, in *Standard Oil Company of New Jersey v. United States*, the Supreme Court held that Section 1 of the Sherman Act did not forbid all restraints of trade, but only restraints of trade that were unreasonable.[192] Hence, the focus of antitrust law is much narrower than its language would suggest, because it only protects businesses from unreasonable restraints on trade.[193]

In theory, antitrust laws are designed to maintain a competitive marketplace because a competitive marketplace encourages the efficient use of a nation's resources.[194] Moreover, antitrust laws are supposed to shield the competitive forces of the market by incentivizing businesses "to operate efficiently, keep prices down, and keep quality up."[195] Yet CON laws have the opposite effect because they, by their very nature, suppress competition.[196]

B. Overview of Antitrust Laws

There are two types of antitrust analyses relevant for this note: a Sherman Act Section 1 analysis, and a Sherman Act Section 2 analysis. Section 1 is used to analyze concerted actions involving contracts, combinations, or conspiracies[197] made between two or more actors that unreasonably restrains trade.[198] In the absence of evidence of an explicit agreement to restrain trade between actors, a court normally looks at indirect evidence to find a tacit agreement.[199] A Sherman Act Section 2 analysis is concerned with abuses of monopoly power. A monopoly is "[t]he control of a market for goods

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"greater product variety, higher product quality, and greater innovation, which drives productivity growth and helps lift living standards").

191 15 U.S.C. § 1.

192 *See* Standard Oil Co. of N.J. v. United States, 221 U.S. 1, 59–60 (1911). Indeed, if the Act's language were read literally, every business would be guilty of some kind of impermissible restraint of trade. Accordingly, businesses that have patents—patents that grant them a monopoly for a certain period of time—would be guilty of restraining trade.

193 *See id.*

194 GODFREY, *supra* note 36.

195 *The Antitrust Laws*, FED. TRADE COMM'N (OCT. 23, 2020), https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws [https://perma.cc/G35N-GL5X].

196 DOJ & FTC JOINT STATEMENT, *supra* note 28, at 5.

197 15 U.S.C. § 1.

198 ARMSTRONG ET AL., *supra* note 41.

199 *See, e.g.*, Kovacic et al., *supra* note 42, at 414–15, 426–30 (asserting that factors such as relative market shares, price variations, level and pattern of profits, and exclusionary practices, among other things, cuts toward a finding of anticompetitive conduct).

or services by a single supplier or owner,"[200] and "abuse[s] of monopoly power . . . [exist where there are] illegally attained monopolies, attempts to monopolize [and]–conspiracies to monopolize."[201] Sherman Act Section 1 and Sherman Act Section 2 analyses are very similar because both inherently require a definition of the relevant market, a calculation of market power, a showing that the conduct had an effect on interstate or foreign commerce, and a rule of reason burden-shifting inquiry.

The "rule of reason"[202] weighs the procompetitive benefits of an actor's conduct with the conduct's anticompetitive effects.[203] This type of analysis naturally permits the court to view the restraint of trade within the economic realities surrounding the restraint. The rule of reason analysis only applies to restraints deemed "unreasonable."[204] A restraint is only "unreasonable" when it harms consumers.[205]

Harm to consumers is the natural outgrowth of anticompetitive conduct perpetrated by actors that use their "market power"[206] to restrain competition insomuch that such restraints have a negative effect on the competitive nature of the market.[207] Ultimately, an actor with no market power cannot harm consumers, and antitrust law is therefore not concerned about their actions.[208] "Market power" is "the ability of a firm (or a group of firms, acting jointly) to raise price[s] above the competitive level without losing so many sales so rapidly that the price increase is unprofitable."[209] However, a determination of market power requires a definition of the relevant market.[210]

In *Ohio v. American Express*, the Supreme Court noted that the relevant product market is the area of competition in which there can be a substitution between products.[211] Substitution between products refers to one's ability to, in the absence of one product, use another in its place with relative ease.[212] The relevant geographic market is generally the physical expanse in which a

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[200] *See Monopoly*, *supra* note 43.

[201] Floyd, *supra* note 43 (emphasis omitted).

[202] Hovenkamp, *supra* note 44, at 85.

[203] Stuhlsatz, *supra* note 45, at 243–44.

[204] Hovenkamp, *supra* note 44, at 85.

[205] Ohio v. Am. Express Co., 138 S. Ct. 2274, 2284 (2018).

[206] *Am. Express*, 138 S. Ct. at 2284; *see also* SCFC ILC, Inc. v. Visa USA, Inc., 36 F.3d 958, 965 (10th Cir. 1994); William M. Landes & Richard Posner, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937, 955 (1981).

[207] *Am. Express*, 138 S. Ct. at 2284.

[208] Landes & Posner, *supra* note 206, at 955 (1981).

[209] *Id.* at 937.

[210] Fed. Trade Comm'n v. Qualcomm Inc., 969 F.3d 974, 992 (9th Cir. 2020).

[211] *Am. Express*, 138 S. Ct. at 2285.

[212] *See Markets*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers/markets [https://perma.cc/Q33D-GN9N].

producer is able to distribute their product or service based on consumer demand.[213] Using these definitions, market power is determined by taking the actor's share of the relevant market and then determining whether that share is large enough to raise prices to supracompetitive levels, or above the marginal cost.[214]

Once the court has defined the relevant markets and determined market power, the court can then employ the rule of reason burden shifting framework. The burden shifting framework largely consists of three steps: (1) the plaintiff must show that the challenged restraint has a substantial anticompetitive effect that "harms consumers in the relevant market";[215] (2) if the plaintiff demonstrates a substantial anticompetitive effect, the burden shifts to the defendant to show a procompetitive justification for the conduct; and (3) if the defendant can make this showing, the burden shifts back to the plaintiff to prove that there were less restrictive means available to accomplish the procompetitive benefits.[216]

IV. WITHOUT *PARKER* IMMUNITY, NEW YORK'S CON LAW WOULD VIOLATE ANTITRUST LAW

This Part will demonstrate why *Parker* should be overturned and the *Parker* immunity doctrine eliminated. To do this, this Part will first walk through an antitrust analysis of New York's CON law. Second, this Part will address the issues that *Parker* immunity raises when applying this analysis. Finally, this Part will discuss the paradox that exists between the power of the government and the underlying principles of antitrust law.

A. Market Definition and Power

Because the relevant market is succinctly defined as "the area of effective competition,"[217] the relevant market here would be the healthcare market of New York. Sweeping in other states' healthcare markets would take the analysis outside the area of effective competition given that most insurance providers limit coverage areas to the state in which the insured person resides (with an exception given for emergencies in most cases).[218]

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[213] Brown Shoe Co. v. United States, 370 U.S. 294, 328 (1962).

[214] Landes & Posner, *supra* note 206, at 939.

[215] *Am. Express*, 138 S. Ct. at 2284.

[216] Michael A. Carrier, *The Four-Step Rule of Reason*, 33 ANTITRUST 50, 53 (2019).

[217] *Am. Express*, 138 S. Ct. at 2285.

[218] Ryan Kennelly, *Can I Use My Health Insurance Plan Outside of My State?*, IHEALTHAGENTS (Dec. 19, 2020), https://help.ihealthagents.com/hc/en-us/articles/224360547-Can-I-Use-My-Health-Insurance-Plan-Outside-of-My-State- [https://perma.cc/H4QA-35B9].

Moreover, incorporating other states into the relevant market would remove the act or conduct that is to be analyzed in the first place: New York's CON law. Likewise, a narrower definition, say the healthcare market of New York City, would be equally insufficient because it would exclude areas where New York's CON law has an effect, thus providing an incomplete picture.

Therefore, within this market, this note proposes that one entity, above all others, has monopoly power: the government. The decision to approve construction of a new facility, the adoption of a new technology, the addition of hospital beds, or the renovation of existing facilities is ultimately left to the state, which is represented by the Commissioner of Health.[219] Entrance into the market is wholly dependent on the approval of a CON application.[220] Approval of that application rests on determinations[221] that are not only very subjective, but which arguably favor personal insights over data.

The "Community Need" schedule that must be submitted with a CON application demonstrates this point.[222] This schedule requires the applicant to "[i]ndicate the current and projected demand for the service [they] propose to provide,"[223] to "[d]escribe how [the] project is responsive to and reflective of the needs of the residents in the community [they] propose to serve,"[224] and to "describe the consequences to the population to be served if [the] project is not implemented."[225] Such questions seem to be based more on the subjective opinions or the ideas of the governmental authorities in charge of the applications approval than they are on data or findings of market need. Indeed, phrases such as "public need"[226] demonstrate the highly subjective nature of the CON application process, but these determinations are not only subjective, but vital. The New York Administrative Code notes that an application may be denied solely because the prospective market entrant failed to demonstrate sufficient public need to the satisfaction of the committee.[227]

Moreover, not only are the questions, upon which approval of a CON application hinges, subjective, but approval

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[219] *Certificate of Need (CON) Overview*, RSCH. & PLAN. CONSULTANTS, LP (Jan. 2019), https://www.rpcconsulting.com/certificate-of-need/new-york/ [https://perma.cc/53NU-S766].

[220] *See supra* Section I.B.

[221] N.Y. COMP. CODES R. & REGS. tit. 10, § 670.1(d)(1) (2020).

[222] *See Schedule 3, Certificate of Need Application*, *supra* note 94.

[223] *Id.*

[224] *Id.*

[225] *Id.*

[226] *Certificate of Need Review Criteria*, *supra* note 94.

[227] N.Y. COMP. CODES R. & REGS. tit. 10, § 670.1(d)(1) (2020).

is ultimately left to the Commissioner of Health.[228] Though an appeals process is provided, that process does nothing more than punt the question of appropriateness back to the Commissioner of Health who denied the CON application in the first place.[229] Thus, ultimate power to grant access to the walled off sector that is New York's healthcare market rests solely with the state and their use of highly subjective approval criteria.

B. Application of a Rule of Reason Analysis

In our case, the rule of reason analysis requires that an antitrust plaintiff show that the actions of the state by means of the CON law harms consumers.[230] This, above every other factor, may be the easiest to prove. New York's CON law directly led to longer ambulance wait times, diminished bed capacity, and precipitated a lack of essential supplies and medical equipment, likely leading to a larger death toll.[231] Thus, if the relevant consumer is defined as the patients of New York's healthcare facilities, then it follows that they were absolutely harmed by the anticompetitive effect of New York's CON law during the COVID-19 pandemic. Moreover, CON laws have (with surprising consistency) decreased access to healthcare services[232] and stifled innovation by making the healthcare industry too inflexible to adequately innovate and adapt to changing circumstances, thus increasing costs and reducing the quality of service.[233] Furthermore, there are almost no procompetitive justifications for CON laws, which is perhaps the most perplexing thing about CON laws. A quick internet search or more thorough examination of academic journals results in a near complete absence of arguments that CON laws are beneficial.

Still, with enough digging one can find a few examples of supportive literature for CON laws. But, even such literature tends to note that while "certificates of need have contributed to some cost efficiency[,] [t]he issue is whether they have done that much."[234] While some cost saving is good, harm to consumers is not and advocates have yet to cite a study that effectively

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228 *Certificate of Need (CON) Overview*, *supra* note 219.

229 N.Y. COMP. CODES R. & REGS. tit. 10, § 708.3(k) (2020).

230 *See* Ohio v. Am. Express Co., 138 S. Ct. 2274, 2284 (2018).

231 *See supra* Section I.A.

232 Stratmann & Baker, *supra* note 115, at 5, 6, 11.

233 REFORMING AMERICA'S HEALTHCARE SYSTEM, *supra* note 30, at 50–55.

234 Veronica Brezina, *Health Care Expert: Why Certificates of Need Are Important in Central Florida*, ORLANDO BUS. J. (Dec. 25, 2017, 10:33 AM), https://www.bizjournals.com/orlando/news/2017/12/25/health-care-expert-why-certificates-of-need-are.html [https://perma.cc/5FEG-2CXE].

demonstrates that CON laws have not harmed consumers.[235] In fact, the opposite seems to be true; CON laws have harmed consumers.[236] Admittedly, advocates note that studies showing the beneficial effects of CON laws are "scant."[237] CON law advocates also acknowledge that while "the certificate-of-need process is imperfect, most believe[] that CON requirements should be maintained in their state," some observing that the CON laws in place are "better than nothing."[238] Surely, this is not a good enough reason to continue to implement a program that has been shown by the vast majority of scientific data[239] to be harmful to competition and to consumers.[240] Without more than merely stating that CON laws are "better than nothing,"[241] there are no procompetitive justifications that would place the supposed procompetitive benefits above the anticompetitive effects. Thus, CON laws would fail to satisfy even the most basic balancing test of the rule of reason analysis.

C. How Parker *Immunity Gets in the Way*

Given that, at first blush, CON laws would fail a rule of reason analysis because their procompetitive benefits do not outweigh their anticompetitive effects, it would appear that CON laws are ripe for annulment under antitrust law. However, the *Parker* immunity doctrine effectively precludes this result.

In *Parker v. Brown*, the Supreme Court held that the Sherman Act is not applicable to the regulatory actions of state governments.[242] The Court in *Parker* went so far as to say that the state-run program would violate the Sherman Act "if it were organized and made effective solely by virtue of a contract, combination or conspiracy of private persons, individual or corporate."[243] The Court has further stated that "[t]he Parker state-action exemption reflects Congress' intention to embody in the Sherman Act the federalism principle

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235 *See supra* Section I.C.

236 *See supra* Part II.

237 *See* Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics?*, NAT'L INST. FOR HEALTH CARE REFORM RSCH. BRIEF, May 2011, at 5, 6.

238 *Id.* at 7.

239 *See supra* Section III.A.

240 *See supra* Part II.

241 Yee et al., *supra* note 237, at 7.

242 *See* Parker v. Brown, 317 U.S. 341, 350–51 (1943) (holding that "[w]e find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature. In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress.").

243 *Id.* at 350.

that the States possess a significant measure of sovereignty under our Constitution."[244]

The Supreme Court has since clarified that, while state-action immunity is the law of the land, "state-action immunity is disfavored,"[245] and only applicable "when it is clear that the challenged anticompetitive conduct is undertaken pursuant to a regulatory scheme that 'is the State's own.'"[246] Moreover, the Court has noted that "where the action complained . . . was that of the State itself, the action is exempt from antitrust liability regardless of the State's motives . . . ."[247]

Accordingly, the Supreme Court has provided distinct categories that determine whether the state-action is in fact immune. First, when a state legislative body passes a law or regulation, that action is seen as an action of the state and is therefore exempt from antitrust scrutiny.[248] Similarly, decisions of the state supreme court are *ipso facto* exempt from antitrust scrutiny when the court acts "legislatively rather than judicially."[249]

Thus, the *Parker* immunity doctrine presents a problem in challenging New York's CON law on antitrust grounds because CON laws are state actions that were passed by a legislative body decades ago. What is more, the *Parker* doctrine is a very deferential standard, and such deference attaches to extremely subjective decisions. Yet, if the purposes of antitrust laws of the United States include "protect[ing] economic freedom and opportunity by promoting free and fair competition in the marketplace,"[250] then excluding the entities that are perhaps best positioned to create and maintain harmful monopolies—state governments—directly undermines that goal.

It is not as though this cognitive dissonance is a secret. In *Lafayette v. Louisiana Power & Light Company*, a group of cities that owned their own municipal electric utility companies petitioned the district court, claiming that a rival, privately held electric utility company had violated the antitrust laws and thereby injured the petitioners.[251] The respondent counterclaimed, asserting that the cities had, through their ownership of their respective municipal electric utility companies, violated several antitrust provisions and harmed the

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[244] Cmty. Commc'n Co., Inc. v. City of Boulder, 455 U.S. 40, 53 (1982).

[245] Fed. Trade Comm'n v. Ticor Title Ins. Co., 504 U.S. 621, 636 (1992).

[246] Fed. Trade Comm'n v. Phoebe Putney Health Sys., Inc., 568 U.S. 216, 225 (2013) (quoting *Ticor Title Ins.*, 504 U.S. at 635).

[247] Hoover v. Ronwin, 466 U.S. 558, 579–80 (1984).

[248] *See id.* at 567–68.

[249] *Id.* at 568.

[250] *Mission: Antitrust Laws*, *supra* note 35.

[251] Lafayette v. La. Power & Light Co., 435 U.S. 389, 391–92 (1978).

respondent's business.[252] The petitioners moved to dismiss on the grounds that they were immune from antitrust law pursuant to the *Parker* immunity doctrine.[253]

Chief Justice Burger wrote the following regarding the paradox of antitrust law and *Parker* immunity:

> It [is] somewhat remarkable to suggest that the same Congress which "meant to deal comprehensively and effectively with the evils resulting from contracts, combinations and conspiracies in restraint of trade" would have allowed these petitioners [municipalities in this case] to complain of such economic damage while baldly asserting that any similar harms they might unleash upon competitors or the economy are absolutely beyond the purview of federal law.[254]

It is therefore troubling that municipalities and states can restrain trade, restrict economic freedom, and harm consumers,[255] yet claim immunity from adjudicative accountability based almost solely on their status as a state or municipal governmental entity.[256]

V. SOLUTION: OVERTURN *PARKER* AND APPLY RULE OF REASON TO REGULATIONS

New York's CON law has not only failed to achieve its stated goals, but it has arguably weakened the healthcare market within New York. The law has created significant barriers to entry,[257] stifled innovation,[258] led to higher costs,[259] and, in relation to COVID-19, caused more deaths than were otherwise necessary.[260] While constituents can petition their respective governmental representatives to push for a repeal of New York's CON law, such calls for a repeal have occurred for decades with no result.

Yet, even if a repeal were to happen, the root problem—the government's immunity from antitrust law—would not be solved. The fact that the government of New York can restrict trade through regulations that are subject to highly subjective regulatory criteria, and then claim immunity from antitrust

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[252] *Id.* at 392.

[253] *Id.*

[254] *Id.* at 419 (Burger, J., concurring) (citation omitted) (quoting Atl. Cleaner & Dyers, Inc. v. United States, 286 U.S. 427, 435 (1932)).

[255] *See supra* Section III.A.

[256] Recall that in *Parker v. Brown* the Supreme Court noted that the state-run program would violate the Sherman Act "if it were organized and made effective solely by virtue of a contract, combination or conspiracy of private persons, individual or corporate." Parker v. Brown, 317 U.S. 341, 350 (1943).

[257] *See supra* Section II.C.

[258] *See supra* Section II.B.

[259] *See supra* Section II.A.1.

[260] *See supra* Section II.A.2.

scrutiny, undermines the entire purpose of antitrust law in the United States: to "protect economic freedom and opportunity by promoting free and fair competition in the marketplace."[261]

To protect consumers both physically and financially, *Parker* should be overturned, and the *Parker* immunity doctrine should be done away with. In the *Parker* doctrine's place, a rule of reason framework should be implemented, thereby permitting government deference while still subjecting government regulations to some degree of accountability for their laws and regulations. Such an approach would ensure that governments, which are perhaps the best poised to create and maintain market monopolies to the detriment of consumers, are subjected to the same laws that private actors are beholden to. This approach would ensure that market regulations are, in fact, laws that will benefit consumers.

In subjecting government regulations to antitrust scrutiny, the burden-shifting approach mentioned above could be applied to the regulation at issue. Under the burden-shifting framework, a plaintiff challenging a regulation would have to prove that the regulation has had a substantial anticompetitive effect that actually harms consumers. Accordingly, regulations that negatively affect the market but not to a substantial degree would survive antitrust scrutiny. This would still preserve the government's regulatory authority, while simultaneously curtailing regulations that go too far.

Though, even if the plaintiff were able to demonstrate a substantial anticompetitive effect that harms consumers, the defendant could rebut this showing by demonstrating that the regulation has procompetitive benefits that outweigh those effects. This would provide yet another layer of protection for government regulation. But the protection provided would be conditioned upon the law providing procompetitive benefits rather than being immunized based solely on its status as a government regulation.

Finally, if the defendant were to succeed in showing that the procompetitive benefits outweigh the anticompetitive effects, the plaintiff could show that there were less restrictive means available to accomplish what the regulation had been intended to do. This burden-shifting process would ensure that regulations avoid causing substantial harm to consumers. In turn, this would strengthen the foundational principle of antitrust law within the United States: to promote vigorous competition.

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[261] *Mission: Antitrust Laws*, *supra* note 35.

CONCLUSION

To promote a market that works for the consumer, rather than against them, *Parker* should be overturned, and the blanket immunity that it provides to the government should be replaced with the rule of reason analytical framework. In turn, this new framework would allow government regulations just enough deference to be effective, while still subjecting those regulations to some form of scrutiny as dictated by the social and economic realities in which those laws exist. While we cannot predict when the next pandemic-level event will occur, it is a near certainty that there will be another at some point in the future. If we do not learn from the lessons that COVID-19 taught, then continued blind acceptance of and adherence to government regulation will undoubtedly come back to haunt us.

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