

**CERTIFICATE OF NEED IN SOUTH CAROLINA: SOMETHING ROTTEN IN
THE STATE OF HEALTHCARE**

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I. INTRODUCTION.....	602
II. BACKGROUND.....	603
III. ANALYSIS.....	606
A. <i>CON's Evolution from Grassroots Planning to Federal Regulation</i>	606
B. <i>CON in South Carolina</i>	608
1. <i>CON Adoption in the Context of the Nationwide Health Planning Movement</i>	608
a. <i>Pitfalls of Abandoning a Holistic CON Model</i>	609
2. <i>CON Administration in South Carolina</i>	610
3. <i>The Legislative Audit Council's 2022 Report</i>	612
C. <i>The Facts Precluding CON Success</i>	617
1. <i>CON Is an Ineffective Cost-Reduction Mechanism Because It Is Ideologically Stalled Behind Decades of Economic and Legislative Healthcare Developments</i>	617
2. <i>CON Is a Redundant-at-Best Strategy Given Earlier Legislation and More Recent Insurance Developments</i>	619
3. <i>CON Is Subversive to New Development in the State Healthcare Landscape</i>	622
D. <i>Legislative CON Repeal Is Necessary to Foster Healthcare Improvement in South Carolina</i>	626
1. <i>Failed Commerce Clause Analyses</i>	626
2. <i>Failed Economic Substantive Due Process Analyses</i>	628
3. <i>Failed Antitrust Analyses</i>	630
4. <i>Failure of the South Carolina Executive Branch to Repeal CON</i>	632
IV. CONCLUSION.....	634

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I. INTRODUCTION

Certificate of Need (CON) laws have maintained a stubborn presence in the American healthcare landscape since the 1970s as a last-ditch plug against unnecessary expenditures.¹ Generally, CON programs require healthcare systems to apply (and necessarily compete) for certificates of need based on existing supply, population, and other factors, seeking to limit supply variables in the healthcare economy so as to prevent overspending of state and federal funding.² In South Carolina, CON goals work towards that end through a four-part mission: to “promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State.”³

Most CON programs in the United States operate to these ends in much the same way: the state agency responsible for healthcare planning issues guidelines, including quotas for resources per population, prerequisites for construction and expansion, and development priorities meant to inform new projects.⁴ In accordance with such factors, healthcare organizations submit CON applications to the agency for permission to undertake new construction, expansions, or the purchase of select resources all above a threshold cost.⁵ State statutes require these projects to be approved via the CON application process so that the agency may choose the most priority-conforming project from amongst multiple applicants and screen for any projects deemed redundant given existing facilities or resources.⁶ By enforcing these prescriptive centralized planning measures, CON programs have historically aimed to cut healthcare costs incurred by providers and simultaneously force a degree of competition amongst providers to encourage increases in quality and accessibility of care for patients.⁷ However, this Note will demonstrate

1. Laretta Higgins Wolfson, *State Regulation of Health Facility Planning: The Economic Theory and Political Realities of Certificates of Need*, 4 DEPAUL J. HEALTH CARE L. 261, 266 (2001).

2. *See generally id.*

3. S.C. CODE ANN. § 44-7-120 (2018).

4. *See generally Certificate of Need (CON) State Laws*, NAT'L CONF. OF STATE LEGISLATURES [hereinafter *CON State Laws*], <https://www.ncsl.org/research/health/certificate-of-need-state-laws.aspx#:~:text=Currently%2C%2035%20states%20and%20Washington,state%20as%20of%20December%202021> [<https://perma.cc/LK6V-ACTY>].

5. *See id.*

6. *See id.*

7. *See id.*

that CON programs are no longer a valid instrument to achieve these goals given decades of change in both legislative and economic policy.

II. BACKGROUND

Though now mandated by state governments, CON laws were originally informed by the model of local community efforts organizing hospital expansion in response to a nationwide healthcare crisis in the twentieth century.⁸ By the late 1940s, the Great Depression and the Second World War had diverted investment in national healthcare infrastructure such that healthcare facilities lacked both equipment and capacity to handle the needs of U.S. troops returning from Europe and the Pacific or the resulting baby boom.⁹ At that time, local planning became an essential mechanism in addressing not only the scarcity of accessible hospitals but also the lack of modern equipment and technology available within existing hospitals.¹⁰ Recognizing this, Congress passed the 1946 Hill-Burton Hospital Survey and Construction Act—the first piece of federal healthcare legislation—which incentivized local planning for hospital construction and modernization projects with federal funding.¹¹ The Hill-Burton Act’s planning incentivization method then evolved into the funding mechanism of the National Health Planning and Resources Development Act (NHPRA) in 1974, which instead made federal funding for healthcare expansion projects fully conditional upon states’ implementation of CON laws designed to limit and regulate hospital expansions to prevent unnecessary costs.¹²

However, it quickly became apparent that CON laws did not achieve their economic objective.¹³ Congress repealed the NHPRA in 1986, as national hospital costs alone had continued to skyrocket from \$52.4 billion annually in 1974 to slightly over \$230 billion annually by 1989, despite every state but Louisiana having implemented a CON program by 1980.¹⁴ The forty-nine

8. Patrick John McGinley, Comment, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a “Managed Competition” System*, 23 FLA. ST. U. L. REV. 141, 145 (1995).

9. Carol Brayshaw Longwell & James T. Steele, Jr., *The Rise and Fall of Certificate of Need in Pennsylvania: An Experiment in Health Care Planning and the Role of the Commonwealth Court*, 21 WIDENER L.J. 185, 186 (2011).

10. See McGinley, *supra* note 8, at 145.

11. Emily Whelan Parento, *Certificate of Need in the Post-Affordable Care Act Era*, 105 KY. L. J. 201, 210 (2017).

12. *Id.* at 211.

13. See McGinley, *supra* note 8, at 148.

14. Lowell M. Zeta, Note, *Fundamental First Steps Along the Road to Health Care Reform: Eliminating the Bureaucratic Burdens of Certificate of Need Programs and Embracing Market Competition to Improve State Health Care Systems*, 41 CREIGHTON L. REV. 727, 728, 732 (2008).

CON states, though, were resistant to abandoning their programs when the option arose—today, thirty-five states and Washington, D.C. still maintain CON independent of a federal mandate.¹⁵

CON programs continue to pose issues because they remain implemented despite both experience and studies indicating that, at best, CON has no effect on rising healthcare costs, and, at worst, CON itself contributes to rising costs.¹⁶ In addition to their inefficiency in working as a cost-cutting regime, CON laws have also posed a hindrance to improvements in the American healthcare system in two other ways: CON programs have a tendency to be manipulated as a method of judicial obstruction amongst competing providers,¹⁷ and they do not reflect decades of evolution in economic strategy and federal healthcare legislation.¹⁸ South Carolina's healthcare landscape embodies the combined effects of all three of these CON-sprung problems, especially as these issues manifest in a largely rural state.¹⁹

In 2015, the South Carolina House of Representatives introduced a bill which included several reforms to ease CON restrictions, including a provision to fully repeal the CON program by 2018.²⁰ However, after the state senate removed that provision in the 2016 session, it took no further action to pass repeal or reform legislation.²¹ After the Covid-19 pandemic, however, CON reform gained momentum: a new effort to pass a repeal bill was launched in 2021 but did not clear the South Carolina House Ways and Means

15. See *CON State Laws*, *supra* note 4.

16. See Zeta, *supra* note 14, at 738.

17. See Jamie Cavanaugh et al., *Conning the Competition: A Nationwide Survey of Certificate of Need Laws*, INST. FOR JUST. (Aug. 19, 2020), <https://ij.org/report/conning-the-competition/> [<https://perma.cc/DHA3-6QFJ>].

18. See generally McGinley, *supra* note 8, at 145–74.

19. See Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250 (Jan. 11, 2016) [hereinafter *Joint Statement on S.C. CON*], https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf [<https://perma.cc/GQD7-M9XU>] (stating “the Agencies have found no empirical evidence that CON laws have successfully restricted ‘over-investment’” and describing anticompetitive effects of CON programs); McGinley, *supra* note 8, at 169–70 (describing CON redundancy in a managed competition system); Parento, *supra* note 11, at 238–39 (describing ACA mandates that expand Medicaid access with the effect of drastically reducing need for safety-net hospitals to rely on CON protection from lost expenditures incurred treating low-income patients).

20. H. 3250, 2015–2016 Gen. Assemb., 121st Sess. (S.C. 2015); *ANALYSIS: Abolishing Certificate of Need Laws*, S.C. POL’Y COUNCIL (Jan. 21, 2016), <https://scpolicycouncil.org/commentary/amending-con-laws> [<https://perma.cc/46AQ-T69N>].

21. See *ANALYSIS: Abolishing Certificate of Need Laws*, *supra* note 20.

Committee, with the committee voting to end debate in May 2022.²² CON repeal did not completely fall off the table, as Senate Majority Leader Gary Simrill indicated that CON reform would likely be a subject of discussion during the 2023 session.²³ This prediction proved accurate, with both the house and senate approving a spring 2023 bill that would repeal CON regulation for hospitals by 2027.²⁴ However, the bill does not remove CON governance over development of long-term care facilities.²⁵

It is essential and long overdue that the South Carolina state legislature repeals the CON program to remedy its failure to reduce healthcare expenses, its incompatibility with current national healthcare strategy, and its predisposition to manipulation that prevents service delivery to patients. That so many of the aims and justifications of the CON program are focused on cost reduction, yet states with CON programs often instead see costs increase post-implementation, indicates baffling reliance on CON as a disproven economic strategy.²⁶ Efforts to address increasingly multidimensional issues surrounding CON cost-reduction and quality of care strategies are hamstrung by CON's failure to adapt to a remodeled national healthcare landscape.²⁷ And, arguably most critically for South Carolina, that the CON program is so readily wielded to decrease provider competition rather than increase service delivery reveals its nearsightedness in focusing on cost containment rather than strategic investment. In sum, the CON program overwhelmingly acts to the detriment of state residents it purports to benefit.²⁸

22. S. 290, 2021–2022 Gen. Assemb., 124th Sess. (S.C. 2021); *see also* Jon Styf, *South Carolina House Committee Fails to Repeal Certificate of Need*, HEARTLAND DAILY NEWS (May 11, 2022), <https://heartlanddailynews.com/2022/05/south-carolina-house-committee-fails-to-repeal-certificate-of-need/> [<https://perma.cc/K8LU-SV77>].

23. *See* Styf, *supra* note 22.

24. *See* S. 164, 2023–2024 Gen. Assemb., 125th Sess. (S.C. 2023); *see also* Jason Raven, “SC House Approves ‘Certificate of Need’ Repeal Bill,” WSPA 7 NEWS (May 3, 2023, 3:48 PM), <https://www.wspa.com/news/state-news/sc-house-approves-certificate-of-need-repeal-bill/> [<https://perma.cc/RN4M-Z5YP>].

25. *See* S.C. S. 164.

26. *See generally* LEGIS. AUDIT COUNCIL, S.C. GEN. ASSEMBLY, A REVIEW OF THE S.C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL CERTIFICATE OF NEED PROGRAM (2022) [hereinafter LAC], <https://lac.sc.gov/sites/lac/files/Documents/Legislative%20Audit%20Council/Reports/A-K/DHEC-CON-2022.pdf> [<https://perma.cc/CCM3-EGY9>]; *see* McGinley, *supra* note 8, at 149.

27. *See* Parento, *supra* note 11, at 212–15.

28. *See* MATTHEW D. MITCHELL, SOUTH CAROLINA’S CERTIFICATE OF NEED PROGRAM: A COMPREHENSIVE REVIEW OF THE LITERATURE 24 (2022); Mark D. Fenwick et al., *Regulation Tomorrow: What Happens When Technology Is Faster than the Law?*, 6 AM. U. BUS. L. REV., 561, 563 (2017).

III. ANALYSIS

A. *CON's Evolution from Grassroots Planning to Federal Regulation*

CON was not a lost cause from the beginning; rather, the social and economic conditions surrounding its conception made CON a natural and practical solution to widespread hospital inaccessibility in the mid-twentieth century.²⁹ In the 1940s, scarcity and a lack of current equipment prompted local communities to organize hospital expansion themselves—a move that became especially effective when Congress urged communities to articulate their needs through local planning, in turn rewarding localities with federal subsidies for hospital development under the Hill-Burton Act.³⁰ In response, some states centralized their planning in order to keep momentum, while states that continued to rely on local planning tended to see their efforts stall.³¹ In 1966, the first state CON program was implemented in New York, requiring expansion approval directly from the state rather than independent planning agencies.³² Twenty other states implemented their own CON programs in the next six years, and when the NHRPA was passed in 1974, Congress made hospital funding previously available through Hill-Burton-style local planning subject to states' adoption of their own CON laws.³³

CON mandates made sense as a solution to rising healthcare costs during this period due to the mechanisms of the fee-for-service (FFS) insurance system and the prevalence of the Roemer theory of demand.³⁴ At the time Medicare was first enacted, healthcare providers were able to dictate costs to insurers (public and private), allowing providers leeway to inflate the cost of services to earn higher profits.³⁵ FFS was intended to curb this inflation practice.³⁶ In an FFS insurance system, providers receive payment for each individual service rendered to a patient.³⁷ However, insurers negotiate with providers to determine what is “customary, prevailing, and reasonable” in terms of pricing, allowing insurers to rein in costs.³⁸ Providers have been able

29. See McGinley, *supra* note 8, at 145–46.

30. *Id.* at 145.

31. *Id.* at 145–46.

32. Parento, *supra* note 11, at 211.

33. See McGinley, *supra* note 8, at 147–48.

34. *Id.* at 150–56. The Roemer theory posits that induced demand allows healthcare providers to unilaterally increase demand for services by increasing supply of services (most prevalently, hospital bed availability). See generally Milton Roemer, *Bed Supply and Hospital Utilization: A Natural Experiment*, 35 HOSPITALS 36–42 (1961).

35. See McGinley, *supra* note 8, at 151–53.

36. See Robert A. Berenson & Eugene C. Rich, *US Approaches to Physician Payment: The Deconstruction of Primary Care*, 25 J. OF GEN. INTERNAL MED., 613, 613 (2010).

37. *Id.* at 614.

38. *Id.* at 613.

to stretch these criteria, often by overestimating the value of evaluation and management services associated with visits and also adjusting to compensate for overhead business costs.³⁹

At the same time, economic thinking around healthcare was predominately dictated by a single economic theory—the Roemer theory of demand. The Roemer theory posits that, in a healthcare setting, market forces work so that supply creates demand.⁴⁰ For example, demand for a particular type of cancer treatment in a certain area would exist because of the presence of the technology for administering the treatment; whereas outside the healthcare context, the amount of supply would generally be accepted as driven by the amount of demand. This thinking makes it logical for healthcare systems to expand services and investments over the level of demand because they expect that such over-investment will be matched by demand they create in doing so, leading to more profits.⁴¹

When Congress integrated CON with the NHRPA, their intent was for the program to regulate necessary further expansion by cutting profit-driven investment to contain and channel growth where it was objectively needed.⁴² At the same time, in theory, insurance costs would be eased as these restrictions allowed providers less ability to render tangential or optional supplementary services to patients seeking acute or specific care for the sake of profit.⁴³ However, further changes in insurance structures and the expansion of federal healthcare legislation made CON itself redundant and ineffective at furthering these ends, and it became a vehicle for larger healthcare corporations to protect their profits at the expense of public access to care and long-term sustainability of rural healthcare centers.⁴⁴ This dynamic will be explored in Section C, but it is important to first outline the economic context in which South Carolina initially implemented CON.

39. *Id.*

40. *See generally* Roemer, *supra* note 34, at 36–42. *Contra* Wolfson, *supra* note 1, at 264 (“[T]his general premise of supply creating demand, thereby contributing to needless and escalating health costs is not supported by conclusive studies.”).

41. *See* McGinley, *supra* note 8, at 153–56.

42. *Id.* at 149–50.

43. *Id.*

44. *Id.* at 159–60.

B. *CON in South Carolina*

1. *CON Adoption in the Context of the Nationwide Health Planning Movement*

The healthcare sector defies the norms of generally accepted market principles.⁴⁵ This is why, even in the emphatic free market culture of the mid-twentieth century, government intervention in the healthcare economy was justified as a means of achieving predictability in an irregular yet vital market.⁴⁶ In the late 1970s, healthcare scholars James Blumstein and Frank Sloan identified two particular “dysfunctions” which necessitated that the government initiate healthcare planning to bring the healthcare market in closer alignment with classical market behavior: first, in a regular market, we assume that consumers are equipped to make educated choices about “what, when, where, and why to buy.”⁴⁷ In the healthcare setting, however, that is not true. Patients must rely on physicians to make decisions about what treatments are necessary, when treatment should be administered, and why any specific treatment is best to serve patient needs.⁴⁸ In this sense, physicians, rather than consumer-patients, dictate demand for services.⁴⁹ As suppliers, though, this leaves physicians on the controlling end of a power imbalance, enabling them to influence their own profit margins, overcoming the output restriction achieved through traditional dynamics of supply and demand.⁵⁰

Second, Blumstein points to the fact that nonprofit suppliers have a far greater presence in a healthcare market than in a traditional market.⁵¹ There is a long history of faith-based and other charitable enterprises establishing hospitals and other treatment facilities throughout the United States, which are well-established players in regional healthcare that benefit from major philanthropic donations.⁵² Because they receive such hefty and consistent funding, nonprofit suppliers are not subject to competitive market pressure to lower prices, increase their efficiency, or adjust their output in order to

45. See generally James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3 (1978).

46. *Id.* at 3–4.

47. *Id.* at 4.

48. *Id.*

49. See *id.*

50. See *id.*

51. *Id.* 4–5.

52. See Rachel Wimpee & Barbara Shubinski, *Timeline: American Foundations and the History of Public Health*, ROCKEFELLER ARCHIVE CTR. (Dec. 11, 2020), <https://resource.rockarch.org/story/timeline-american-foundations-and-the-history-of-public-health/> [https://perma.cc/45EB-PJAM].

maintain a profit margin.⁵³ On top of this, during the period of national CON implementation in the 1970s, the system of “nearly complete third-party payment” insurance further enabled providers to disregard efficiency concerns and place higher costs on consumers shielded by insurance coverage.⁵⁴

In addition to advocating for economic planning as a response to the lack of consumer knowledge and high nonprofit presence necessitating government intervention in the healthcare sector, economists also recognize planning as a “merit good” in situations where it helps achieve specific government policy goals.⁵⁵ Congress outlined exactly such policy goals for its CON requirement in the NHPRA, which laid the cornerstones of South Carolina’s CON statute: to curb healthcare costs, prevent unnecessary duplication of health resources, and achieve equal access to care at reasonable cost.⁵⁶ All these factors considered, the healthcare landscape of the 1970s was an appropriate setting for government intervention via CON.

a. Pitfalls of Abandoning a Holistic CON Model

As McGinley notes, however, Congress’s three policy goals for CON boiled down to one: “to reduce the aggregate cost of the nation’s health care” any positive side effects of such an endeavor welcome.⁵⁷ In contrast, from the perspective of pro-CON economists at the time of nationwide CON implementation, “the goal of achieving greater equity in access to medical care [was] perhaps the major energizing force underlying the health planning movement.”⁵⁸ South Carolina’s statutory CON adaptation illustrates this discrepancy between focus on access and focus on cost-cutting. Where the third prong of CON’s mission, as per the NHPRA, aspires (in print, at least) to ensure equal healthcare access at reasonable cost, the third and fourth prongs of South Carolina’s CON mission reorient that goal towards the interest of streamlining: to “guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality

53. Blumstein & Sloan, *supra* note 45, at 4.

54. *Id.* at 4–5 (footnote omitted).

55. *Id.* at 3–4.

56. McGinley, *supra* note 8, at 149.

57. *Id.* McGinley argues that Congress’s three CON goals—cost restraint, prevention of unnecessary duplication of healthcare resources, and equal healthcare access at reasonable cost—are all really in service of the first. That is, because 20th century insurance frameworks and the Roemer theory rewarded high expenditures, and equal access was really the objective of forthcoming Medicaid legislation and a never-realized national healthcare policy, congressional intent was solely for CON to cut expenditures. *Id.* at 155–56.

58. Blumstein & Sloan, *supra* note 45, at 6–7.

services are provided in health facilities in this State.”⁵⁹ In contrast to the NHPRA, South Carolina’s CON statute does not reference equal or equitable healthcare access.⁶⁰ Rather, the third prong seems to prioritize efficiency, with a fourth prong supplementing some kind of quality assurance in the process.⁶¹ Altogether, the statute presents more of a restrictive effort rather than an effort at recalibration of service delivery.⁶² The statute’s sacrifice of emphasis on quality and accessibility in favor of cost-cutting results in an imbalance of overall priorities, severely limiting any positive impacts that could otherwise be achieved through a CON program in South Carolina. The rest of this Section demonstrates the self-defeating results of South Carolina’s further deviation from a more holistic—and already outdated—CON model.

2. *CON Administration in South Carolina*

The following is a concise overview of the South Carolina CON administration procedure. An individual or a healthcare system must apply for a Certificate of Need in six scenarios covering expansion of facilities, services, and capital expenditures.⁶³ Most frequent among those six, since 2018, are the construction or establishment of a new healthcare facility, a capital expenditure by or on behalf of a healthcare facility in excess of \$5,000,000,⁶⁴ the acquisition of medical equipment to be used for diagnosis or treatment if the total project cost is over \$1,500,000,⁶⁵ and the offering of a health service (1) by or on behalf of a health care facility which has not

59. S.C. CODE ANN. § 44-7-120 (2018). In later pages, this Note will address the problem underlying this goal: the assumption is that enforced competition through CON application will necessitate higher-quality projects and care, but this projection is unrealistic because CON inherently and steadfastly protects incumbent providers.

60. *See id.*

61. *See id.*

62. *See id.*

63. *Id.* § 44-7-160. These circumstances are as follows: “(1) the construction or other establishment of a new health care facility; (2) a change in the existing bed complement of a health care facility . . . (3) an expenditure by or on behalf of a health care facility in excess of an amount to be prescribed by regulation . . . (4) a capital expenditure by or on behalf of a health care facility which is associated with the addition or substantial expansion of a health service for which specific standards or criteria are prescribed in the South Carolina Health Plan; (5) the offering of a health service by or on behalf of a health care facility which has not been offered by the facility in the preceding twelve months and for which specific standards or criteria are prescribed in the South Carolina Health Plan; (6) the acquisition of medical equipment which is to be used for diagnosis or treatment if the total project cost is in excess of that prescribed by regulation.” *Id.*

64. S.C. CODE ANN. REGS. R. 61-15.A.1.102(1) (2022).

65. *Id.*

offered the service for at least one year and (2) for which specific criteria are prescribed in the South Carolina Health Plan.⁶⁶

The State Health Plan (SHP) is prepared and released at least every two years⁶⁷ by DHEC alongside the state health planning committee, containing: inventory of healthcare facilities and resources; projections of further need based on that inventory; a standard for distribution of healthcare facilities, services, and equipment; and a general statement of review criteria for CON applications.⁶⁸ Applicants must announce their intent to obtain a CON to the community in their prospective location via a newspaper advertisement which must run for three consecutive days and then must submit proof of the three-day advertisement, applicable fees,⁶⁹ and their proposal to DHEC.⁷⁰ The proposal must address specific DHEC project review criteria as well as the standards and requirements in the current SHP.⁷¹

Applications undergo review by DHEC staff, currently including a senior consultant, project administrator, and an administrative coordinator.⁷² DHEC must notify “affected persons” (including the applicant, healthcare providers that provide similar services in the area of the proposed service, residents of the area to be served, and people who have formally declared that they also intend to provide similar services in the future)⁷³ in order to begin the review.⁷⁴ Individual proposals are evaluated based on their accordancy with the SHP and DHEC Project Review Criteria, and competing proposals are narrowed to the one that most closely aligns with the applicable criteria.⁷⁵

Applicants may appeal adverse decisions to the Administrative Law Court (ALC).⁷⁶ The average length of time to complete the review process from receipt of an application to the final agency decision for all types of applicants is 168 days, with a range from an average of 124 days (for narcotics treatment program applications) to an average of 223 days (for rehab facility applications).⁷⁷ When decisions are appealed to the ALC, the overall average extends to 405 days, ranging from an average of 309 days (for diagnostic imaging applications) to 675 days (for emergency department applications).⁷⁸

66. See LAC, *supra* note 26, at 66.

67. S.C. CODE ANN. § 44-7-180(C) (2018).

68. *Id.* § 44-7-180(B).

69. Applicable fees include a \$500 filing fee and an application fee equal to 0.5% of the total project cost (not to exceed \$7,000). S.C. CODE ANN. REGS. R. 61-15.A.1.103 (2022).

70. S.C. CODE ANN. § 44-7-200(B) (2022).

71. *Id.* § 44-7-200(A).

72. LAC, *supra* note 26, at 8.

73. S.C. CODE ANN. §§ 44-7-210(A), -130(1) (2018).

74. § 44-7-210(A).

75. *Id.* § 44-7-210(B).

76. See *id.*; see also *id.* § 44-7-210(C)–(G).

77. LAC, *supra* note 26, at 47.

78. *Id.* at 49.

3. *The Legislative Audit Council's 2022 Report*

In February 2022, at the request of the South Carolina General Assembly, the Legislative Audit Council (LAC) released a review of the state CON program.⁷⁹ The review focused on the CON application review process, DHEC staff's execution of their roles, the role of incumbent providers in the application process, and consideration of reform measures.⁸⁰ Additionally, CON operation in tandem with Covid-19 measures amidst the pandemic was scrutinized.⁸¹ Overall, few clear benefits of continued CON regulations were presented.⁸² Taken together, access to routine and emergent healthcare are on par with average rates nationally, but this reflected the midpoint between highly rated routine care access and below-average emergent care access in South Carolina.⁸³ The impact of CON laws on healthcare in the state is inconclusive at best—where certain outcomes may be improved by CON measures, others suffer detriment due to CON restrictions.⁸⁴ Overall, the data reported by the LAC seems to paint CON as lost-in-translation as adopted by South Carolina. A skewed legislative emphasis on expenditure efficiency over access efficiency, rather than a holistic approach more aligned with the original Congressional goals for CON, has resulted in the CON framework's inability to achieve the intended balance between patient need and provider development.⁸⁵

The LAC breaks down its analysis of general CON efficacy according to its understanding of “access” as an umbrella term, alluding to Penchansky and Thomas's definition of access as “the degree of ‘fit’ between the clients and the system. . . . [T]he general concept . . . summarizes a set of more specific areas of fit . . .” comprised of availability, accessibility (in geographic terms), accommodation, affordability, and acceptability.⁸⁶ In turn, the LAC evaluates likely effects of CON on healthcare access according to the criteria of health expenditures (cost), competition, quality, number and geographic and

79. *See id.* at 1.

80. *See id.*

81. *Id.*

82. *See generally* LAC, *supra* note 26.

83. LEGIS. AUDIT COUNCIL, S.C. GEN. ASSEMBLY, SUMMARY: A REVIEW OF THE S.C. DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL CERTIFICATE OF NEED PROGRAM (2022), <https://lac.sc.gov/sites/lac/files/Documents/Legislative%20Audit%20Council/Reports/A-K/DHEC-CON-Summary-2022.pdf> [<https://perma.cc/8BK9-6YG2>].

84. *Id.*

85. *See generally* LAC, *supra* note 26.

86. Roy Penchansky & J. William Thomas, *The Concept of Access: Definition and Relationship to Consumer Satisfaction*, 19 MED. CARE 127, 128 (1981); *see* LAC, *supra* note 26, at 11 (defining access as a “fit between characteristics and expectations of the providers and clients”). In practice, CON administrators situate cost and access as two interrelated but distinct interests.

demographic distribution of facilities, and financial viability of safety-net hospitals.⁸⁷ Due to an apparent lack of South Carolina data, the LAC performed these evaluations as part of a literature review of nineteen CON studies (published through 2010) assessing CON's impact in various locations and healthcare disciplines nationally.⁸⁸ Considering the selected studies with regard to the aforementioned criteria, the LAC determined that, overall, "conclusions often conflict or find little effect in any direction. Furthermore, the scope and rigor varies, limiting [the literature's] usefulness in determining what specific measures will best improve access to healthcare in South Carolina."⁸⁹

A follow-up report prepared by Matthew D. Mitchell on behalf of the Palmetto Promise Institute (a libertarian South Carolina think tank) disagrees with the LAC's assessment of the literature.⁹⁰ Mitchell argues that, while the LAC report provides important data about CON effects in South Carolina, it is limited in the scope of literature from which it draws conclusions about CON efficacy.⁹¹ Mitchell presents ninety-three studies divided into three categories: papers assessing the effect of CON on healthcare costs, on access to care, and on the quality of care.⁹² In the cost category, 52% of papers find that CON raises costs, 43% find that CON has mixed, insignificant, or statistically negligible effects on costs, and 5% find that CON lowers costs.⁹³ Regarding access, 73% find that CON reduces access, 22% find that CON has mixed, insignificant, or statistically negligible effects on access, and 5% find that CON improves access.⁹⁴ Regarding quality, 47% find that CON reduces quality, 40% find that CON has mixed, insignificant, or statistically negligible effects on quality, and 13% find that CON improves quality.⁹⁵ These broader findings do not lend themselves to the LAC's "mixed interpretation" of data from the literature concerning CON efficacy; rather, they suggest decisive inefficacy.⁹⁶

The LAC report nevertheless offers insight into discrepancies between the state CON program's goals and some of its policies—namely, over-inclusivity in project regulation and continued restriction of services for which

87. See LAC, *supra* note 26, at 16–19.

88. MITCHELL, *supra* note 28; see LAC, *supra* note 26, at 12.

89. LAC, *supra* note 26, at 14.

90. See generally MITCHELL, *supra* note 28.

91. See *id.* at 7.

92. MITCHELL, *supra* note 28, at 8–10.

93. *Id.* at 8.

94. *Id.* at 9.

95. *Id.* at 10.

96. *Id.* at 7.

there is documented, urgent need.⁹⁷ First, despite CON's preoccupation with discouraging over-investment mainly on the part of hospitals and other large spenders, South Carolina's CON program also governs a high volume of lower-cost entities, including home health organizations.⁹⁸ Including such entities within CON's scope directly opposes its purpose, as they do not involve expenditures of the scale CON is intended to restrict. Of 390 CON applications accepted between January 1, 2018 and September 30, 2021, 198 were home health project applications.⁹⁹ However, the average cost of home health initiatives (\$27,000) is less than one percent of the total average of all other types of initiatives (\$6.5 million).¹⁰⁰ The LAC noted, "[b]ecause of the sheer volume of home health agency applications that account for such a low average project cost, when removed, the average cost of applicant projects would be \$13.3 million, which is a 103% increase."¹⁰¹ This number would better reflect the expense of higher-cost, high-incidence applications for projects including hospitals (over \$15.9 million on average), ambulatory surgery facilities (over \$9.7 million on average), and nursing homes (over \$18.2 million on average).¹⁰² Excluding home health project costs from the total average would therefore clarify the true cost of the most expensive projects, making it easier for CON administrators to discern which projects need greater cost supervision. Removal of the CON barrier for home health organizations would also greatly relieve the burden of high application volume, which a DHEC official cited as "the biggest challenge to the CON program meeting its goals."¹⁰³

Most importantly, the LAC reported:

Multiple officials stated that there is a need for more home health agencies in South Carolina. According to the SHP, the benefit of improved accessibility outweighs the adverse effects caused by the service duplication of any existing home health services. A DHEC official stated that the adverse effects of duplication are less for services like home health agencies and there is a need for home health agencies across the state. A representative from a major healthcare

97. See LAC, *supra* note 26, at 7–10 (describing the effect of CON on low-cost facilities and services, unreasonable thresholds for equipment and capital expenditures, manipulable CON application criteria, and incumbent obstruction of the CON review process).

98. S.C. CODE ANN. § 44-69-75 (2018), S.C. CODE ANN. § 44-7-130(10) (2018).

99. LAC, *supra* note 26, at 21. Home health agencies must apply for a certificate of need before even acquiring licensure. § 44-69-75.

100. LAC, *supra* note 26, at 21.

101. *Id.*

102. *Id.* at 22.

103. *Id.* at 21.

system in South Carolina is quoted saying “everyone agrees we need more home health services.”¹⁰⁴

This need is confirmed by U.S. Census Bureau and CMS data that shows South Carolina places forty-second nationwide in terms of the rate of home health agencies per 100,000 people.¹⁰⁵ Additionally, the LAC posits that, while home health quality is above average in South Carolina, CON laws may be inhibiting further improvement by blocking competition which would serve as an incentive.¹⁰⁶ The LAC suggests such competition might readily enter the market if not for the deterrent posed by CON, as evidenced by a sharp increase in home health licensure applications after Governor Nikki Haley’s attempted line-item budget veto of the CON program in 2013.¹⁰⁷ CON may also be redundant as a mechanism for quality enforcement, as regulations already exist which grant DHEC broad authority to monitor home health agencies through inspections, investigations, and consultations, and provide wide berth to penalize agencies who violate specific regulations.¹⁰⁸

Second, CON also governs substance abuse treatment facilities.¹⁰⁹ Of the five types of such facilities in South Carolina, inpatient treatment services and opioid treatment programs are the two that require a CON.¹¹⁰ Inpatient treatment facilities are “licensed either as a specialized hospital or as part of a hospital,”¹¹¹ and opioid treatment programs “provide medications for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug.”¹¹² Regarding these treatment options, “[a] DHEC official explained that these types of services are low-cost, hugely effective, and require everyday access to treatment.”¹¹³ The SHP notes that, regardless of existing CON review criteria for opioid treatment programs, “due to the increasing number of opioid deaths in South Carolina, additional facilities are needed for the services to be accessible within 30 minutes’ travel

104. *Id.* at 24.

105. *See id.* at 20.

106. *See id.* at 23.

107. *Id.* at 25; *see infra* note 246 and accompanying text.

108. *See* LAC, *supra* note 26, at 24.; S.C. CODE ANN. REGS. § 61-77.

109. S.C. CODE ANN. § 44-7-130(10) (2018).

110. DEP’T OF HEALTH AND ENV’T CONTROL, 2020 SOUTH CAROLINA HEALTH PLAN 52–55 (2020) [hereinafter SHP]. The other treatment programs available are outpatient facilities, social detoxification programs, and residential treatment program facilities. *Id.* at 51. The 2020 SHP is the most recent plan published.

111. *Id.* at 52.

112. *Id.* at 54. A methadone clinic is an example of an opioid treatment program. *See id.*

113. LAC, *supra* note 26, at 26 (“Furthermore, the official mentioned that the types of patients using these services usually have unreliable transportation, and the patients need to receive the services daily.”).

time for the majority of state residents.”¹¹⁴ The benefits of improved accessibility¹¹⁵ “will outweigh the adverse effects of the duplication of this existing service.”¹¹⁶ Though the SHP calls for at least one opioid treatment program per county, with areas able to apply for additional expansion where need is greater,¹¹⁷ only thirteen of forty-six counties in South Carolina currently offer opioid treatment programs.¹¹⁸ Meanwhile, the LAC cites a De Gruyter study indicating that CON laws cause a reduction in the number of available substance abuse treatment facilities,¹¹⁹ even though inpatient treatment centers and opioid treatment facilities are the lowest-cost projects aside from home health in South Carolina.¹²⁰ Eliminating the CON requirement for these facilities would help to mend the rift between the SHP’s treatment recommendations and CON’s cost-focused restriction of recommended services. Removal of regulatory obstacles posed by CON would allow development of more facilities to increase access and thereby necessitate competitive prices. And, excluding treatment facilities from the CON requirement would also subtract further from the burden of time-consuming applications on CON program administrators.¹²¹

Discrepancies between local need and CON-imposed supply limitations in South Carolina, as described by the LAC report, arguably illustrate problems caused by lopsided adoption of CON principles as envisioned by Blumstein and other economists. Heavy legislative emphasis favoring the cost-cutting tenet of CON is detrimental to CON’s ability to improve healthcare access and quality—prioritization of efficient cost reduction places blinders on program administrators who inevitably act to ration instead of redistribute healthcare services, and in doing so prohibit the very competition that alone would serve both cost-reduction and goals related to access and quality. This nearsighted implementation of CON strategies is even more self-defeating outside the FFS setting it was designed to impact.

114. SHP, *supra* note 110, at 55. Opioid treatment patients are recommended to receive treatment six days per week. LAC, *supra* note 26, at 26.

115. Accessibility of this treatment is further complicated by the fact that “Regulation 61-93 states that a narcotic (opioid) treatment program shall not operate within 500 feet of: the property line of a church, the property line of a public or private elementary or secondary school, a boundary of any residential district, a public park adjacent to any residential district, or the property line of a lot devoted to residential use.” SHP, *supra* note 110, at 54.

116. *Id.* at 55.

117. *Id.* at 54.

118. See *Local Treatment Providers*, S.C. DEP’T OF ALCOHOL AND OTHER DRUG ABUSE SERVS., <https://www.daodas.sc.gov/services/treatment/local-providers/?category=opioid-treatment-program&county=all> [https://perma.cc/RA5V-QUD4].

119. LAC, *supra* note 26, at 26.

120. *Id.*

121. See *id.*

C. *The Facts Precluding CON Success*

Since CON's nationwide implementation under the NHPRA, the U.S. healthcare landscape has shifted in terms of insurance structure and payment strategy so that the high-cost problem CON was designed to solve no longer correlates as strongly with overinvestment on the part of providers.¹²² Furthermore, regulation strategies highly similar to CON's were already in place per Social Security Act provisions, with questionable efficacy in their own right.¹²³

1. *CON Is an Ineffective Cost-Reduction Mechanism Because It Is Ideologically Stalled Behind Decades of Economic and Legislative Healthcare Developments*

When the NHPRA was passed, CON support was founded on Congress's belief that the FFS system was responsible for wild inflation of healthcare costs due to its strong incentives for provision of unnecessary resources, following from the Roemer theory of demand.¹²⁴ In addition to the Roemer effect, McGinley points to three other reasons behind Congress's entrenched view that healthcare organizations were bound to over-invest: "externalization of purchase costs, the non-price competition among providers, [and] physicians' effect on supply"¹²⁵

Congress believed that the FFS reimbursement system allowed healthcare entities to offset investment costs to consumers, avoiding consequences of over-investment.¹²⁶ Because providers negotiated payment with insurers post-service delivery, providers had the leeway to inflate the cost of services to help cover the facility's cost of daily operations and investments.¹²⁷ This was Congress's fear: as Parento states, "when combined with the availability of third-party reimbursement, oversupply of resources will create its own demand for excessive use," overcoming any cost-shyness for providers.¹²⁸ Congress still viewed those costs as landing on consumers, either through higher taxes for Medicare and Medicaid or higher premiums for private insurance, and therefore it sought to curb healthcare entities' ability to shrug these expenses through CON regulation.¹²⁹

122. See generally McGinley, *supra* note 8.

123. *Id.* at 151–52.

124. *Id.* at 149.

125. *Id.* at 150.

126. *Id.* at 151.

127. See *id.*

128. Parento, *supra* note 11, at 210–11.

129. *Id.*

Additionally, Congress believed that providers' competition via quality instead of price fueled overinvestment.¹³⁰ Patients want the best services available regardless of their needs, and providers must provide the most up-to-date technology and the best-equipped physicians in order to maintain the best services.¹³¹ Therefore, providers must be willing to spend enough to keep up with advances in technology and to attract the most capable, well-regarded physicians, adding further urgency to investment.¹³²

Finally, Congress noted that while the Roemer theory broadly usurped traditional supply and demand in the healthcare realm so that provider organizations could create demand for services, physicians themselves were in a unique position to dictate demand on a smaller scale.¹³³ The number of surgeons, for example, located at a particular facility in itself played a large role in determining how many procedures can be performed—per Roemer, more surgeons supplied equals more patients requiring procedures, increasing revenue.¹³⁴ Even in the case of general practitioners, the physician makes the judgement call about when and how often a particular patient should return for follow-up or check-in appointments.¹³⁵ Therefore, physicians' impact on supply added another layer of incentive for investment in physicians.¹³⁶ Overall, Congress observed a profit vortex taking hold under the FFS system that inevitably drove healthcare overinvestments, leading to an uncontrolled increase in national healthcare expenditures.¹³⁷

A regulatory program intended to curb this perceived wild overspending based on objective local need would seem a logical solution, particularly given the warped supply and demand dynamics recognized in the healthcare sphere.¹³⁸ There are certainly parallels between the classic output restriction and market division goals of a cartel and goals set by CON—in each scenario, the aim is to avoid the demands a competitive market places upon suppliers and sanction suppliers who do not conform to central planning.¹³⁹ However, “in some instances compelling state interests may trump or limit free market competition” without running afoul of prohibitions on anticompetitive trade.¹⁴⁰ The Congressional CON initiative passed to states under the NHPRA

130. See McGinley, *supra* note 8, at 153.

131. See *id.*

132. See *id.* at 153–54.

133. *Id.* at 155.

134. *Id.* at 155–56.

135. See *id.* at 155.

136. See *id.*

137. *Id.* at 156.

138. See generally Blumstein & Sloan, *supra* note 45.

139. See McGinley, *supra* note 8, at 146–47.

140. FED. TRADE COMM'N & DEP'T OF JUST., IMPROVING HEALTH CARE: A DOSE OF COMPETITION 29 (2004), <https://www.ftc.gov/sites/default/files/documents/reports/improving->

is exactly such an instance.¹⁴¹ But, as justified as CON may have been at the time, its redundance alongside Social Security Act provisions and its tailoring for the FFS payment system cripples whatever impact it might achieve in the current healthcare market.¹⁴²

2. *CON is a Redundant-at-Best Strategy Given Earlier Legislation and More Recent Insurance Developments*

First, CON was predated by a similar supply-monitoring mechanism in the form of Section 1122's provisions under the Social Security Act Amendments of 1972.¹⁴³ Section 1122 provides a framework for healthcare expenditure review very similar to CON, in which states elect to make an agreement with the federal government to review certain healthcare expenditures (generally non-overhead) in excess of \$600,000.¹⁴⁴ If a review finds that a healthcare entity has made such an expenditure without approval from the state health planning agency, then the federal government will withhold Medicaid and Medicare funding reimbursement for that expenditure.¹⁴⁵ In essence, Section 1122 reviews and CON use the same methods to the same end.¹⁴⁶ However, it was apparent that Section 1122 did not work to effectively reduce healthcare expenses as costs continued to rise. Congress was aware of this increase as CON requirements were being debated but nonetheless chose not to exempt states who still implemented Section 1122 reviews when inserting the CON requirement into the NHPRA.¹⁴⁷ Neither, clearly, did Section 1122's failure as a cost-reduction measure raise sincere questions about the potential of CON's highly similar requirements.¹⁴⁸

Second, perhaps most important in terms of cost strategy, the FFS system Congress identified as the root of the overspending problem CON was meant to address has given way to a much less provider-biased insurance structure.¹⁴⁹ In the 1990s, the managed care system began to gain serious traction in the national healthcare economy and is now the predominant health insurance structure.¹⁵⁰ As opposed to an FFS system, in which providers dictate the cost of different services, a managed care system allows insurers

health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723
healthcarerept.pdf [https://perma.cc/X6E2-W5ZY].

141. *See id.* at 22.

142. *See* Parento, *supra* note 11, at 221; McGinley, *supra* note 8, at 152.

143. McGinley, *supra* note 8, at 151.

144. *See* 42 U.S.C. § 1320a-1(g).

145. *See* 42 U.S.C. § 1320a-7b(a).

146. McGinley, *supra* note 8, at 152.

147. *Id.*

148. *Id.*

149. *See id.* at 151.

150. Parento, *supra* note 11, at 221.

to contract with a finite network of providers for healthcare services rendered to plan members at a lower rate of cost.¹⁵¹ Insurers band together to negotiate these prices for a selection of health plans determined by legislation and thereby counter the provider price inflation enabled under FFS.¹⁵² In this way, the managed care system seeks to supervise both care and its cost, aligning with CON's spending and resource allocation goals.¹⁵³ Additionally, the managed competition system essentially draws borders by designating network zones, and in this way it acts to divide markets on its own but allow competition within those boundaries.¹⁵⁴ This pseudo-zoning process also helps to define areas in which local need can be more clearly identified, complementing the process of CON administration.¹⁵⁵ But, as McGinley points out, "[t]he critical factor of managed competition is that market forces, and not regulatory forces, determine the cost of health care," which means the managed care system is working to the same end as CON without resorting to thinly veiled anticompetitive principles.¹⁵⁶ However, CON undermines this achievement by overriding provider networks and insurers to restrict new providers from entering a market.¹⁵⁷ And, of course, healthcare costs continue to increase while CON remains fixed in state legislation despite achieving negatable, if not regressive, results over almost fifty years.¹⁵⁸ Considering this dynamic, it may well be more effective in terms of cost control to remove CON in the interest of allowing the managed care system to encourage price competition within provider networks.¹⁵⁹

Furthermore, the implementation of the Affordable Care Act (ACA) in 2010 helped to undermine arguments for maintaining CON laws for the purpose of ensuring indigent care provision.¹⁶⁰ Many CON proponents in South Carolina and the broader U.S. support their view by arguing CON protects the financial security of "safety-net" hospitals that are mandated to treat indigent, uninsured patients, with no expectation of reimbursement for that treatment.¹⁶¹ In theory, CON increases the overall number of patients that seek treatment at these hospitals by restricting competition, inevitably causing

151. *What is Managed Care?*, CIGNA, <https://www.cigna.com/knowledge-center/what-is-managed-care> [<https://perma.cc/4W3P-DZWZ>].

152. See McGinley, *supra* note 8, at 162.

153. See Parento, *supra* note 11, at 221.

154. See *What is Managed Care?*, *supra* note 151.

155. FED. TRADE COMM'N & DEP'T OF JUST., *supra* note 140, at 11.

156. McGinley, *supra* note 8 at 163.

157. See LAC, *supra* note 26, at 53 (noting that critics argue that CON shields incumbent health providers from more competition).

158. Parento, *supra* note 11, at 224.

159. See generally McGinley, *supra* note 8; Parento, *supra* note 11.

160. Parento, *supra* note 11, at 238–39.

161. Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, ANTITRUST, Fall 2015, at 50, 52; LAC, *supra* note 26, at 19.

more insured patients to come through the door and ensuring that these hospitals also provide higher-profit services in order to cross-subsidize the “profitless” treatment of the indigent.¹⁶² The 2022 LAC report stated:

The South Carolina Hospital Association and multiple regional medical systems in South Carolina assert that they depend on cross-subsidization effects from CON to continue to provide care, especially in rural and underserved areas. One medical system that operates across seven counties estimated that it would provide over \$40 million in charity care in 2021.¹⁶³

However, the ACA includes several provisions which have drastically reduced the number of uninsured Americans, including expansion of Medicaid to include “all adults with income less than 138% of the FPL,” prohibiting insurers from discriminating on the basis of pre-existing conditions, and requiring all adults without access to an affordable employment-based insurance plan to purchase private insurance with help from federal subsidies.¹⁶⁴ Since the new provisions took effect in 2014, an estimated twenty million Americans have gained Medicaid coverage (which reimburses providers), substantially dulling the argument that CON is necessary as a measure to sustain safety-net hospitals.¹⁶⁵ It is also uncertain whether CON does in fact increase indigent care.¹⁶⁶ Furthermore, there exists no data tracking to ascertain how much CON windfall is dedicated to indigent care or even how much it really costs providers to comply with indigent care mandates where they exist.¹⁶⁷ The redundancy of CON as a cost-reduction mechanism given Section 1122 review, CON’s low compatibility with the managed care system, and its dubious effect on indigent care all demonstrate that it is a belated and increasingly irrelevant mechanism for achieving either lower healthcare costs or improved healthcare access.

162. *See id.*

163. *Id.*

164. Parento, *supra* note 11, at 237.

165. *Id.* at 238–39; *see also* 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, 601 (2017) (“A higher number of insured individuals will lead to more demand for health care services, which may be burdened by the strict approval requirements of CON laws.”).

166. *See generally* Thomas Stratmann & Jacob W. Russ, *Do Certificate-of-Need Laws Increase Indigent Care?* 3 (Geo. Mason U.: Mercatus Ctr., Working Paper No. 13-20, 2014), <https://www.mercatus.org/system/files/Stratmann-Certificate-of-Need.pdf> [<https://perma.cc/MG9G-9T2A>] (“We do not find evidence associating CON programs with an increase of indigent care.”).

167. Ohlhausen, *supra* note 161, at 53.

3. *CON Is Subversive to New Development in the State Healthcare Landscape*

CON has in fact proven indisputably effective as a means of bureaucratic obstruction and procedural manipulation.¹⁶⁸ Studies of state CON administration, joint studies and statements by the Antitrust Division of the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC), and South Carolina's case history demonstrate that CON is perhaps most effective as a thin veil to cover the substitution of policy aims for political ones or as means for incumbent providers to shield themselves from the threat of prospective competition.¹⁶⁹

In South Carolina, these issues begin at the level of CON evaluation criteria established in the SHP. The LAC report indicated that “quality standards in state regulation and the SHP are nearly all qualitative in nature, which can result in subjectivity in the evaluation process.”¹⁷⁰ Subjectivity in the evaluation process is a concern for two reasons: first, because subjective evaluation of criteria means CON has failed as a blanket regulatory mechanism before review even begins; and second, because this subjectivity is doubly manipulable—both by applicants and by agencies or individuals subject to political influence.¹⁷¹

The South Carolina Code of Regulations lists thirty-three CON project review criteria which fall under five general categories: Need for the Proposed Project, Economic Consideration, Health System Resources, Site Suitability, and Special Consideration.¹⁷² DHEC officials “generally [do] not use

168. *See id.* at 52.

169. *See generally* *Competition in Healthcare and Certificates of Need: Hearing Before the Health and Human Services Comm. of the State S. and The CON Spec. Comm. of the State H.R. of the Gen. Assemb. of the State of Ga.*, 149th Gen. Assemb., Reg. Sess. (Ga. 2007) (statement of Mark J. Botti, Litigation I Section Chief, U.S. Dep’t of Justice, Antitrust Division) [hereinafter *Botti Statement*]; Ohlhausen, *supra* note 161; FED. TRADE COMM’N & DEP’T OF JUST., *COMPETITION IN HEALTHCARE AND CERTIFICATES OF NEED* (2008); *Joint Statement on S.C. CON*, *supra* note 19; *Amisub of S.C., Inc. v. S.C. Dep’t of Health & Env’t Control*, 424 S.C. 80, 817 S.E.2d 633 (2018); *Amisub of S.C., Inc. v. S.C. Dep’t of Health & Env’t Control*, 403 S.C. 576, 743 S.E.2d 786 (2013); Yee et al., *infra* note 171.

170. LAC, *supra* note 26, at 31.

171. *See* Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics?*, NAT’L INST. HEALTH CARE REFORM, No. 4, May 2011, at 1, 2; LAC, *supra* note 26, at 36 (demonstrating the means and impact of application data manipulation). Regarding inconsistency in data evaluated, “[f]or example, one applicant provided the revenue per case for the proposed service, while other applicants provided the per day charge for an inpatient bed or bassinets at a hospital. Another applicant provided its chargemaster sheets, and others provided the average gross charges for each type of service.” LAC, *supra* note 26, at 36.

172. S.C. CODE ANN. REGS. 61-15 § 802. “Special Consideration” is given to medically underserved groups, other entities (competitors or potential competitors), and elimination of safety hazards. *Id.* § 802.31–.33.

quantitative metrics” to evaluate the quality of proposed projects.¹⁷³ This omission runs counter to the fact that quantitative data benefits the review process when there are multiple entities applying for one CON, and applicants are required to “provide documentation of policies and procedures to assure the quality of healthcare services by addressing patient safety and quality indicators” to begin with.¹⁷⁴ Additionally, the definition of “reasonable” cost within CON evaluation is subjective, with no sliding scale or other reference applied.¹⁷⁵ Meanwhile, there is a lack of continuity in costs for projects of the same kind, sometimes amounting to tens of millions in difference, and twelve of the forty-nine projects completed since 2018 exceeded the total cost declared on their applications.¹⁷⁶ Based on this data, it is clear that CON review procedures impede and directly undermine policy goals of cost containment and quality standards.

What follows from the inadequacy of review standards is that state health agencies themselves play a role in mismanaging CON evaluations. As part of a study of six CON states including South Carolina, Tracy Yee et al. distributed a survey inquiring about the overall effectiveness of CON regulations.¹⁷⁷ South Carolina was among the majority of respondents who replied that “CON authorities often interpret regulations or standards quite broadly.”¹⁷⁸ In DHEC’s case, CON interpretation has also been decidedly invalid. Until the ALC ruled on a contested CON in 2019, DHEC was operating under the assumption that it was entitled to be selective in what SHP review criteria they applied to a given project under evaluation despite clear statutory guidance.¹⁷⁹ In another instance, the South Carolina Court of Appeals found that the DHEC Board substantially overstepped its authority in reviewing an ALC decision by applying a *de novo* standard of review of the entire CON application at issue rather than applying a “substantial evidence” standard regarding the ALC’s decision.¹⁸⁰ Additionally, the South Carolina Supreme Court found that, when an applicant sought formal acknowledgement of project costs under the CON threshold, DHEC impermissibly arrived at a calculation below the threshold by treating six purchases within the scope of the expansion as six separate projects and

173. LAC, *supra* note 26, at 31.

174. *Id.* at 33 (The referenced documentation is required “as applicable,” leaving further discretion to applicants in choosing to provide it).

175. *See id.* at 34.

176. *Id.* at 35–36.

177. *See* Yee et al., *supra* note 171, at 7.

178. *Id.* at 2.

179. LAC, *supra* note 26, at 38.

180. *Marlboro Park Hosp. v. S.C. Dep’t of Health & Env’t Control*, 358 S.C. 573, 577, 595 S.E.2d 851, 854 (Ct. App. 2004) (noting “that the DHEC Board’s brazen attitude and utter disregard for the proper standard of review created the procedural chaos that followed”).

assigning them equal shares of the total cost.¹⁸¹ Regarding the same CON evaluation, the court also found that the both DHEC and the ALC had improperly relied on an unreasonable appraisal of the expansion property.¹⁸² Even from a perspective sympathetic to the demands of overwhelming applications on DHEC staff, these procedural failures raise concern about CON's ability to provide genuinely objective regulation, particularly as several appeals were necessary to correct each error.

Such inconsistency raises further questions about CON's legitimacy, given that it does not operate in a vacuum. CON programs are subject to the influences of public opinion, applicants' public relations efforts, political interests, and other factors which inevitably weigh on decision-making.¹⁸³ Yee et al. found that a powerful tool for healthcare entities is the ability to win public opinion in favor of a proposed project, as members of the public can urge government officials to voice support for a proposal to the agency administering CON review.¹⁸⁴ This dynamic exists despite the fact that public opinion has no bearing within review criteria.¹⁸⁵ Also, South Carolina was among the five states in the Yee study that reported political relationships often usurp policy objectives in CON evaluations, adding to the high subjectivity in the review process.¹⁸⁶ Given the malleability of review criteria, it is not difficult to imagine the possibility for political interests to overwhelm any objective foundations of review.

What is certainly costly for CON is its appropriation by incumbent providers to block new competition.¹⁸⁷ The DOJ's Antitrust Division and the FTC have identified widespread behavior termed "rent-seeking," which describes the actions of incumbents using the deference granted them during CON review to seriously delay projects that have already been approved.¹⁸⁸ An affected person (including incumbents) may file for review within fifteen days of an initial CON decision in order to have an approval reversed.¹⁸⁹ This practice alone causes a high increase in overall expenditures due to additional legal expenses and schedule delays, especially when appeals reach the ALC.¹⁹⁰ In South Carolina, the majority of appeals come from incumbent providers seeking to have approvals for new entrants reversed, sometimes

181. MRI at Belfair, LLC v. S.C. Dep't of Health & Env't Control, 392 S.C. 314, 317, 709 S.E.2d 626, 627–28 (2011).

182. *Id.* at 323–35, 709 S.E.2d at 631–32.

183. *See* Yee et al., *supra* note 171, at 2, 5.

184. *See id.*

185. *Id.*

186. *Id.* at 1.

187. *See* Ohlhausen, *supra* note 161, at 51.

188. FED. TRADE COMM'N & DEP'T OF JUST., *supra* note 169, at 6.

189. LAC, *supra* note 26, at 48. The appellant must also pay a filing fee. *Id.*

190. *See Joint Statement on S.C. CON*, *supra* note 19.

regardless of cost.¹⁹¹ As of the LAC report's release, one hospital system had "recently exceeded its monthly budget for legal services by over \$300,000 due to its ongoing litigation before the Administrative Law Court," arguing to reverse a CON granted to a competitor.¹⁹² DHEC itself averaged \$172,952 in CON litigation expenses per fiscal year between 2018–2019 and 2020–2021.¹⁹³ However, perhaps the most devastating cost is the severe delay or total prevention of patient care brought about by relentless litigation:

In one case, providers contesting the construction of an acute care hospital in Fort Mill exhausted their appeals in February 2019—nearly 13 years after DHEC issued a decision on the CON applications in 2006. During that time, the populations of Fort Mill and nearby Tega Cay increased by 105%. The hospital is expected to open in September 2022.¹⁹⁴

In many instances, though, applicants are not equipped to withstand a decade-plus of legal obstruction. In South Carolina, the threat of challenges from incumbent providers and the associated expenses of litigation has been directly responsible for: cancer centers in Pee Dee and the Midlands deciding against obtaining new MRI machines and developing a new radiation center; a Midlands cardiology practice abandoning judicial review due to the expense of anticipated challenges; an Upstate ENT practice deciding not to seek diagnostic equipment or an ambulatory surgery center; and a Pee Dee gastroenterology center's decision not to apply to open an endoscopy center.¹⁹⁵

That incumbent providers enjoy such firm footing in the CON system demonstrates Maureen Ohlhausen's observation that CON is "regulation that squelches the beneficial effects of competition in health care markets without delivering valuable public benefits in return."¹⁹⁶ Insulated so well by CON programs, incumbents are not at all motivated to pursue the higher quality of care envisioned by the CON statute and its proponents, leaving the public with

191. LAC, *supra* note 26, at 53.

192. *Id.* at 52.

193. *Id.*

194. *Id.* Piedmont Medical Center at Fort Mill did open on September 7, 2022. See WBTV Web Staff, *New Hospital Opens to Patients in Fort Mill, S.C.*, WBTV NEWS (Sept. 7, 2022), <https://www.wbtv.com/2022/09/07/new-hospital-opens-patients-fort-mill-sc/> [https://perma.cc/TE9A-6743].

195. LAC, *supra* note 26, at 60. The LAC notes that the full extent of CON deterrence has not been quantified. *Id.*

196. Ohlhausen, *supra* note 161, at 50.

restricted access to services which otherwise may be both more accessible and more attuned to their needs.¹⁹⁷

D. Legislative CON Repeal Is Necessary to Foster Healthcare Improvement in South Carolina

Almost from its initial federal implementation, CON has been subject to legal challenges.¹⁹⁸ However, despite a variety of judicial attacks and direct executive action in South Carolina, all efforts to strike the program have so far nearly always failed, leaving it to the legislature to repeal CON and make way for healthcare improvements.¹⁹⁹

1. Failed Commerce Clause Analyses

While the broader Commerce Clause governs disputes between states to protect the flow of nationwide commerce, the Dormant Commerce Clause more specifically restricts individual states from putting strain on interstate commerce.²⁰⁰ The Supreme Court included state-contained policies under the authority of the Commerce Clause as early as *Gibbons v. Ogden*, clarifying that even when a regulation or activity exists only in one state, it may still be subject to federal control if it affects interstate commerce.²⁰¹ Constitutional challenges under the Commerce Clause fall in two categories: challenges to facially discriminatory laws, reviewed under strict scrutiny; and challenges to facially neutral laws (CON included), reviewed under modified rational basis, weighing local benefits against burdens on interstate commerce—the *Pike* test.²⁰²

There is a split between the First, Ninth, and Fourth Circuits regarding the constitutionality of CON laws under Dormant Commerce Clause analysis.²⁰³ In the First Circuit, the court of appeals applied the *Pike* test to a facially neutral CON law and rejected Puerto Rico’s argument that benefits of “encouraging pharmacies to locate in all parts of Puerto Rico” outweighed the burden placed on interstate commerce by the prohibition of new competitors

197. See FED. TRADE COMM’N & DEP’T OF JUST., *supra* note 169, at 5–6; see generally Botti Statement, *supra* note 169, at 3–4.

198. See Botti Statement, *supra* note 169, at 2.

199. See generally *Amisub of S.C., Inc. v. S.C. Dep’t of Health & Env’t Control*, 407 S.C. 583, 757 S.E.2d 408 (2014).

200. Tinajero, *supra* note 165, at 602.

201. See generally *Gibbons v. Ogden*, 22 U.S. 1 (1824).

202. See *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970).

203. Tinajero, *supra* note 165, at 598–99.

entering the market, ultimately finding the CON program unconstitutional.²⁰⁴ In his article *The Need to Repeal Certificate of Need Laws to Improve America's Healthcare System*, Joshua Tinajero highlights that this case is essential to Dormant Commerce Clause challenges against CON because it demonstrates the likelihood of CON administration to develop a “tendency to discriminate” against providers entering a market from outside a state.²⁰⁵

However, the Ninth and Fourth Circuits have both upheld the constitutionality of CON programs under the Dormant Commerce Clause. In *Yakima Valley Memorial Hospital v. Washington State Department of Health*, the Ninth Circuit Court of Appeals recognized that CON had “burden[ed] the free flow of commerce to Memorial’s financial detriment” but stopped short of finding that this harm reflected an excessive burden on interstate commerce under the *Pike* test.²⁰⁶ In the Fourth Circuit, which governs South Carolina, Dormant Commerce Clause challenges face more significant hurdles posed by the appellate court’s ruling in *Colon Health Centers of America, LLC v. Hazel*.²⁰⁷ Here, the court affirmed the district court’s ruling that the CON program withstood a rational basis test based on the state interests of preventing excess market capacity, ensuring “proper” geographic distribution of facilities, protecting the financial viability of incumbents, and promoting cost-efficient services.²⁰⁸ But, more importantly, the court declared the *Pike* test “too soggy” to prevent the judiciary from overstepping its bounds and crossing over into policymaking that should be determined by the legislature.²⁰⁹ Instead, it directed the district court to apply the discriminatory effects test on remand to determine whether CON discriminated facially, effectually, or purposefully against out-of-state providers.²¹⁰

From the holding in *Colon Health Centers of America, LLC*, it is evident that the Fourth Circuit disregards the *Pike* test as a judicial mechanism, and therefore South Carolina’s CON program need only withstand rational basis review or a (likely subjective) discriminatory effects test.²¹¹ The fact that CON’s track record in South Carolina indicates that it is ineffective at achieving its purported ends does not factor into either of these analyses,

204. *Walgreen Co. v. Rullan*, 405 F.3d 50, 60 (1st Cir. 2005) (acknowledging “the denial of a certificate request is likely to lead a pharmacy to seek to open in another potentially profitable (and therefore probably already-served) area or to withdraw from the Puerto Rico market entirely”).

205. Tinajero, *supra* note 165, at 604.

206. *Yakima Valley Mem’l Hosp. v. Wash. State Dep’t of Health*, 654 F.3d 919, 935 (9th Cir. 2011).

207. *See generally* *Colon Health Ctrs. of America, LLC v. Hazel*, 733 F.3d 535 (4th Cir. 2013).

208. *Id.* at 540, 549.

209. *Id.* at 546–47.

210. *Id.* at 542–43, 546.

211. *See id.*

making it theoretically very simple for the state to argue for CON legitimacy based on rational purposes of cost-cutting, ensuring quality of care, etc.—despite the fact that the program does not necessarily serve those purposes.²¹² Because the Fourth Circuit considers the balancing of local benefit against strain on interstate commerce as a policy issue rather than a legal one, it is far more within the scope of the South Carolina legislature to extinguish the CON program.²¹³

2. *Failed Economic Substantive Due Process Analyses*

Another potential challenge to CON programs is rooted in economic substantive due process. This doctrine is an extension of the Fourteenth Amendment which protects social policies including contract and property rights against interference from government regulation.²¹⁴ During the *Lochner* era, economic substantive due process challenges were governed by a means-ends test that evaluated the efficacy of a policy or regulation, but this standard slipped to rational basis review when the Great Depression became a powerful influence on judicial policy analyses.²¹⁵

Robert M. Anderson has described this shift in analysis as an imperative for legislative action to repeal CON programs.²¹⁶ The Supreme Court's decision in *Lochner v. New York* stated that state police power (including regulatory power) was limited by a means-ends criterion of legitimacy that demanded "direct relation" between a policy and an appropriate end.²¹⁷ The Court further constrained state regulatory power in *Munn v. Illinois*, determining that private businesses and property could only be subject to state regulation when they were "affected with the public interest."²¹⁸ In response, Anderson identifies an argument that, because healthcare involves private businesses—arguably not "affected with the public interest,"—CON regulations may violate the Constitution according to *Lochner* and *Munn*.²¹⁹ However, as of *United States v. Carolene Products Company*, the Court determined the means-ends test no longer applied to economic substantive due

212. See Botti Statement, *supra* note 169, at 5.

213. See *Colon Health Ctrs. of America, LLC*, 733 F.3d at 45–47.

214. See generally *Overview of Economic Substantive Due Process*, U.S. CONG.: CONST. ANNOTATED, https://constitution.congress.gov/browse/essay/amdt14-S1-6-2-1/ALDE_00013703/ [<https://perma.cc/JUF2-E4QN>].

215. See *id.*; Robert M. Anderson, Note, *The Judiciary's Inability to Strike Down Healthcare Service Certificate of Need Laws Through Economic Substantive Due Process: A Call for Legislative Action*, 2 CHARLESTON L. REV. 703, 713–15 (2008).

216. See generally Anderson, *supra* note 215.

217. *Id.* at 710; *Lochner v. New York*, 198 U.S. 45, 58–59 (1905).

218. *Munn v. Illinois*, 94 U.S. 113, 126 (1877).

219. Anderson, *supra* note 215, at 712 (citing *In re Certificate of Need for Aston Park Hosp., Inc.*, 193 S.E.2d 729, 735–36 (N.C. 1973)).

process claims, instead deeming rational basis review the appropriate standard.²²⁰

The fact that many states were slow to adopt the Supreme Court's new rational basis standard in this context was temporarily helpful to CON challenges, with many retaining heightened standards more aligned with the means-ends test.²²¹ Anderson notes in his survey of major economic substantive due process cases involving CON that this fact brought about the result in *In re: Aston Park Hospital Inc.* in North Carolina: applying a means-ends test, the North Carolina Supreme Court struck down a CON program in 1973 upon finding that the law was not a sufficient means to the ends of lowering costs and preventing overinvestment and that Aston Park was not a business affected enough in the realm of public interest to warrant regulation.²²² However, this case was decided a year before the NHPRA mandated CON.²²³ The CON program was soon reenacted, and North Carolina has since adopted rational basis review to examine economic substantive due process claims, meaning that the court's decision here may be overturned at any time.²²⁴

What's more, Anderson demonstrates that, even under a *Lochner* means-ends standard, CON may still be upheld.²²⁵ This was the result in *Mount Royal Towers, Inc. v. Alabama Board of Health*, where the Alabama Supreme Court leaned on *Munn*'s eligibility standards for state regulation in upholding a CON program by characterizing the healthcare industry at large as affecting the public interest.²²⁶ For Anderson, this case shows the "arbitrary nature" of *Munn*'s "affected with the public interest" qualifying standard.²²⁷ Where the means-ends test has fully given way to rational basis review in economic substantive due process cases, it is even likelier for CON laws to survive challenges, as states may simply cite the purpose of CON statutes to reduce healthcare costs and create economic stability in order to satisfy the test.²²⁸

220. *United States v. Carolene Prods. Co.*, 304 U.S. 144, 154 (1938) (upholding a federal ban on filled milk by establishing a presumption of factual support for legislative judgment regarding commercial regulations unless the regulation fails rational basis review).

221. Anderson, *supra* note 215, at 717.

222. *Id.* at 720–21 (citing *In re Certificate of Need for Aston Park Hosp.*, 193 S.E.2d at 730–35).

223. *See id.* at 721.

224. *Id.* at 721–22.

225. *See id.* at 722.

226. *Id.* (citing *Mount Royal Towers, Inc. v. Ala. Bd. of Health*, 388 So. 2d 1209 (Ala. 1980)).

227. *Id.* at 724.

228. *Id.* at 725–28 (first citing *Madarang v. Bermudes*, 889 F.2d 251 (9th Cir. 1989); and then citing *In re Certificate of Need Granted to the Harborage*, 693 A.2d 133 (N.J. Super. Ct. App. Div. 1997)).

Again, legislative repeal is therefore the better and most expedient option for overturning CON laws.

3. *Failed Antitrust Analyses*

Perhaps the most obvious legal challenge to CON programs is one rooted in antitrust law. The FTC identifies three “core federal antitrust laws” that govern the sort of anti-competitive behavior CON programs enable.²²⁹ First, the Sherman Act, which prohibits agreement to restrain trade, along with attempted and successful monopolization.²³⁰ Second, the FTC Act, which broadly bans “unfair” competition and “unfair or deceptive acts or practices.”²³¹ Third, the Clayton Act, which fills in gaps in the Sherman Act including prohibition on “certain discriminatory prices, services, and allowances in dealings between merchants.”²³² The FTC has worked jointly with the DOJ’s Antitrust Division to investigate, litigate, and research antitrust issues in healthcare markets nationwide for decades.²³³ Consistently, they have found that CON laws “impede the efficient performance of health care markets” because they “undercut consumer choice, stifle innovation, and weaken markets’ ability to contain health care costs.”²³⁴

Upon request of Governor Haley in 2016, the FTC and DOJ Antitrust Division delivered both a joint statement regarding South Carolina’s CON laws and a proposed repeal bill.²³⁵ The agencies found that the bill’s CON exemption for projects undertaken by incumbents within a certain window before final repeal would facially discriminate against market entry, while “facilitat[ing] the type of strategic investment that may harm competition going forward.”²³⁶ Adding that CON laws are more likely to increase than decrease costs, that CON is not an effective mechanism to increase or maintain quality of care, and that subsidizing indigent care is better achieved through direct policies rather than anticipated CON windfall, the agencies recommended that South Carolina fully repeal its CON program.²³⁷ Regardless, the legislature failed to pass the repeal.

229. *The Antitrust Laws*, FED. TRADE COMM’N, <https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/antitrust-laws> [https://perma.cc/2EHR-VP78].

230. *Id.*

231. *Id.*

232. *Id.*

233. See FED. TRADE COMM’N & DEP’T OF JUST., *supra* note 169, at 1–2.

234. *Id.* at 2, 4.

235. *Joint Statement on S.C. CON*, *supra* note 19.

236. *Id.*

237. *Id.*

However, the doctrine of state action immunity from antitrust law makes it even more essential from an antitrust perspective that state legislation takes initiative to repeal CON.²³⁸ In *Parker v. Brown*, the Supreme Court determined that federal antitrust laws do not apply, under some circumstances, to private parties acting under the authority of a state.²³⁹ Dean M. Harris has described the “catch-22” repeal efforts have faced as state action immunity has been applied to CON laws: to qualify for state action immunity, private hospitals must show (1) that the state has adopted a “clearly articulated and affirmatively expressed” policy to replace competition with regulations, and (2) that the state “actively supervises” the hospital’s conduct.²⁴⁰ To satisfy the first criteria, the Supreme Court has clarified that the anticompetitive conduct must be shown as a “foreseeable result” of the state’s grant of power to a private party.²⁴¹ “Thus,” Harris writes, “foreseeability is a surrogate for intent, which in turn is a surrogate for the adoption of a clearly articulated policy to displace competition.”²⁴² The Fourth Circuit uses a subjective foreseeability test in evaluating legislative thinking, which has proven exceedingly deferential to anticompetitive outcomes of regulation.²⁴³ This judicial attempt at clairvoyance is especially problematic when statutory authority may be misconstrued or regulatory authority may be misplaced in a certain entity.²⁴⁴ Given the Fourth Circuit’s low standard, hospitals in South Carolina need only cite the statutory purpose of CON to cut costs, prevent unnecessary duplication of facilities and services, and balance supply against need to provide a basis for CON’s anticompetitive effects as a foreseeable result of hospitals’ ability to box out competitors.²⁴⁵ Again under this analysis, it makes no difference that CON has proven unable to achieve those purposes, leaving it to the legislature to remove inept regulation.

238. See generally Dean M. Harris, *State Action Immunity from Antitrust Law for Public Hospitals: The Hidden Time Bomb for Health Care Reform*, 44 U. KAN. L. REV. 459 (1996).

239. See *Parker v. Brown*, 317 U.S. 341, 350–52 (1943).

240. Harris, *supra* note 238, at 477 (quoting *Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 435 U.S. 97, 105 (1980)). Public hospitals must only show the first criteria to qualify for state action immunity. See *id.* at 482.

241. *Id.* at 486 (quoting *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 41–43, (1985)).

242. *Id.*

243. *Id.* at 491–92 (discussing *Coastal Neuro-Psychiatric Assocs., P.A. v. Onslow Mem’l Hosp. Inc.*, 795 F.2d 340 (4th Cir. 1986) (upholding state action immunity for a hospital based on a statute that allowed hospitals to deny physicians privileges for reasons beyond the scope of qualifications and determining that the state legislature must have foreseen the anticompetitive outcome of the statute and decided regulatory benefit was the superior interest)).

244. *Id.* at 492–93 (discussing *Cent. Fla. Clinic v. Citrus Cnty. Hosp. Bd.*, 738 F. Supp. 459 (M.D. Fla. 1989) (finding monopolization was a foreseeable consequence of granted authority when a hospital was authorized to provide services but not authorized to engage in otherwise prohibited anticompetitive conduct)).

245. See S.C. CODE ANN. § 44-7-120 (2018).

4. *Failure of the South Carolina Executive Branch to Repeal CON*

In 2013, Governor Haley vetoed the portion of the legislative budget for 2013–2014 designated to support the CON program, attempting to use executive power to effectively repeal it in a move eventually declared void by the South Carolina Supreme Court.²⁴⁶ State statute names DHEC as the “sole state agency for control and administration of the granting of Certificates of Need,” broadly entrusting it to ensure CON operations.²⁴⁷ For the 2013–2014 fiscal year, DHEC requested a sum of \$1,759,915 be allocated to CON administration in the state budget, and the general assembly appropriated the requested amount.²⁴⁸ However, Governor Haley vetoed the budget line item for CON, citing bureaucratic obstruction of medical services, and the house sustained the veto, passing the budget without any allocations for the CON program.²⁴⁹ In response, DHEC suspended the CON program as of July 1, 2013 with thirty-nine applications and requests still pending.²⁵⁰ A group of medical providers in turn sought a declaration from the South Carolina Supreme Court that the budget veto did not relieve DHEC of statutory responsibility to administer the CON program and that DHEC was obliged to find alternative funding for the program.²⁵¹

In the resulting case, *Amisub of South Carolina, Inc. v. South Carolina Department of Health and Environmental Control*, the court evaluated both claims. Regarding DHEC’s statutory duty, the court clarified a previous decision to hold that “a Governor’s line item veto destroys only the funding provided for in that line item,” and that consequently, the line item veto does not allow the governor “to negate the effect of a long-standing permanent law.”²⁵² As such, whether DHEC was still responsible for CON administration came down to whether the house sustaining the veto could be interpreted as legislative intent for DHEC’s administrative CON duties to be suspended for 2013–14.²⁵³

Precedent had established that “only provisions of a permanent statute that conflict with the current budget provisos are suspended” when the two do

246. Dan Brown, *Governor’s CON Veto Puts Hospitals’ Future in Limbo*, GAZETTE (July 16, 2013), https://www.postandcourier.com/our-gazette/news/governors-con-veto-puts-hospitals-future-in-limbo/article_466b473a-bf9b-5a21-a4d0-7b049f69c61d.html [<https://perma.cc/3ZVZ-YUM2>].

247. S.C. CODE ANN. § 44-7-140 (2018).

248. *Amisub of S.C., Inc. v. S.C. Dep’t of Health & Env’t Control*, 407 S.C. 583, 588–89, 757 S.E.2d 408, 411 (2014).

249. *Id.* at 589, 757 S.E.2d at 411–12.

250. *Id.* at 590, 757 S.E.2d at 412.

251. *See generally id.*

252. *Id.* at 595, 757 S.E.2d at 414–15. The Court offered no comment on the potential impact of a line-item veto on laws that are not “long-standing permanent” ones. *See id.*

253. *Id.* at 596, 757 S.E.2d at 415.

not align.²⁵⁴ The court evaluated the impact of the line item veto on the entirety of the CON statute and found it unlikely that the legislature intended to repeal an entire regulatory system without taking action itself to do so.²⁵⁵ Even if that was its intention, the court deemed it would be improper to find repeal was the intent of the entire general assembly despite the fact that the house alone sustained the veto.²⁵⁶ As such, DHEC still bore responsibility for administering CON.²⁵⁷

Regarding whether DHEC was obligated to seek alternative funding, the court determined DHEC's argument that a lack of state funding precluded CON administration was a "smoke screen," pointing to two statutes which specifically authorized DHEC to obtain special funding.²⁵⁸ First, the court cited § 44-7-150(5) which allows DHEC to "charge and collect fees to cover the cost of operating the [CON] program, including application fees, filing fees, issuance fees, and nonapplicability/exemption determination fees."²⁵⁹ Second, the appropriations act for 2013-2014 permitted agencies to transfer funds within themselves, providing an opportunity for DHEC to re-allocate some of their own existing operating budget towards CON.²⁶⁰ As such, the budget veto did not preclude DHEC from funding the program, so it was obligated to obtain funding elsewhere.²⁶¹ Therefore, DHEC remained responsible for both administering and funding CON despite Governor Haley's refusal to include it in the state budget.²⁶²

The court's insistence on continued CON administration in the face of either dramatically increased cost or detriment to other programs, however legally sound, is emblematic of the CON paradox overall—the program is kept for the sake of lowering hospital expenditures at any and all cost, no matter how expensive the program itself may be in terms of either direct administration or collateral losses.²⁶³ In its argument, DHEC raised that, even if it drew emergency revenue through application fees under § 44-7-150(5), the statute also required that the first \$750,000 obtained be deposited in the state's general fund before DHEC could use the remainder for CON administration.²⁶⁴ This would stand despite the fact that DHEC had collected less than that amount in CON fees each year since 2010; however, the court

254. *Id.* at 598, 757 S.E.2d at 416. There must be "irreconcilable conflict" between the two for any part of a statute to be suspended. *Id.*

255. *Id.* at 599, 757 S.E.2d at 417.

256. *Id.* at 599–600, 757 S.E.2d at 417.

257. *Id.* at 600, 757 S.E.2d at 417.

258. *Id.* at 601, 757 S.E.2d at 418.

259. *Id.* (quoting S.C. CODE ANN. § 44-7-150(5) (2010)).

260. *Id.* at 602, 757 S.E.2d at 418.

261. *Id.*

262. *Id.* at 602–03, 757 S.E.2d at 418–19.

263. *See id.*

264. *Id.* at 601–02, 757 S.E.2d at 418.

responded that DHEC should simply increase application fees in order to collect a remainder.²⁶⁵ Surely if CON proponents would not characterize such a brazenly counterproductive imperative as causing “unnecessary healthcare expenditure,” then nothing could be defined as such.

Given the inadequacy of legal attacks on CON from a Commerce Clause standpoint, an economic substantive due process perspective, and an antitrust law perspective, combined with executive inability to repeal legislation, the state legislature is the sole body equipped to remove the program. The legislature is uniquely situated to do so at will; it needs only to develop the initiative based on a recognition of CON’s failure to achieve its policy objectives and its detriment to modernized healthcare progress.

IV. CONCLUSION

Time and effort have exhausted the traditional benefit of the doubt extended to CON programs, and it is time to put more faith in the modern healthcare market by removing CON. Allowing market forces to work alongside current insurance structures is the natural next step in managing the unique fluctuations of the healthcare market alongside the need for cost efficiency, quality, and accessibility in healthcare. Repealing CON regulation of hospitals is an important landmark in addressing these concerns, but it does not diminish CON’s barrier to accessing healthcare provided by other entities. As such, it is essential for the South Carolina General Assembly to continue monitoring the effects of lingering CON regulations, so that South Carolina residents can see increased access to facilities and new strategies for easing the burden of healthcare costs can be evaluated to fit the current healthcare landscape.

265. *See id.*