

No. _____

TENTH DISTRICT

SUPREME COURT OF NORTH CAROLINA

JAY SINGLETON, D.O. and)
SINGLETON VISION CENTER, PA,)

Plaintiff-Appellants,)

v)

NORTH CAROLINA DEPARTMENT)
OF HEALTH AND HUMAN)
SERVICES; ROY COOPER, Governor of)
the State of North Carolina, in his)
official capacity; MANDY COHEN,)
North Carolina Secretary of Health and)
Human Services, in her official capacity;)
PHIL BERGER, President Pro Tempore)
of the North Carolina Senate, in his)
official capacity; and TIM MOORE,)
Speaker of the North Carolina House of)
Representatives, in his official capacity,)

Defendant-Appellees.)

From Wake County
No. COA21-558

MOTION BY TREASURER DALE R.
FOLWELL, CPA, FOR LEAVE TO FILE
A BRIEF AS AMICUS CURIAE

TO THE HONORABLE SUPREME COURT OF NORTH CAROLINA:

Treasurer Dale R. Folwell, CPA, respectfully seeks leave pursuant Rule 28(i) of the North Carolina Rules of Appellate Procedure to file an amicus curiae brief in support of Plaintiffs' Petition for Discretionary Review. The proposed amicus curiae brief is attached as Exhibit A.

NATURE OF APPLICANT'S INTEREST

As keeper of the public purse, Treasurer Folwell is also a fiduciary for the North Carolina State Health Plan for Teachers and State Employees (Plan) pursuant to N.C.G.S. § 135-48.2 (2021). Consisting of almost 750,000 members, including active and retired members, the Plan is one of the largest purchasers of healthcare in North Carolina. In the most recent fiscal year ending in June of 2022, the Plan had almost \$4 billion in expenditures, the vast majority of which are associated with medical and pharmacy claims. Thus, as a fiduciary, Treasurer Folwell is concerned for the continued solvency of the Plan, which is funded in part by taxpayers. In addition, as chairman of the Local Government Commission, Treasurer Folwell is often tasked with evaluating certain financing proposals for various healthcare entities.

WHY AN AMICUS CURIAE BRIEF IS DESIRABLE

In their complaint, Plaintiffs assert an as-applied challenge against the Certificate of Need (CON) law, N.C.G.S. § 131E-175, *et seq.* Such a challenge, by its nature, is limited to the factual circumstances of this case. The proposed brief provides a view of the significant public interest in this case from Treasurer Folwell's broader perspective.

ISSUES OF LAW TO BE ADDRESSED

The proposed brief would address the following issue:

(1) Whether the subject matter of this appeal has significant public interest such that discretionary review is appropriate under N.C.G.S. § 7A-31(c) (2021)?

POSITION OF AMICUS CURIAE

Treasurer Folwell holds the position that whether the CON law violates Article I, Sections 19, 32, and 34 of the North Carolina Constitution is an issue of significant public interest. CON laws create insurmountable barriers to entry that shield existing institutional healthcare providers from competition. In turn, the accessibility, quality, and affordability of healthcare decreases while profits dramatically increase, to the detriment of North Carolinians. This Court previously

recognized that the North Carolina Constitution protects North Carolinians against these harms. Whether it continues to do so is an issue of significant public interest.

CONCLUSION

Treasurer Folwell respectfully requests this motion for leave be allowed and the proposed amicus curiae brief attached hereto be accepted for consideration by the Supreme Court of North Carolina.

This, the 15th day of August, 2022.

DEPARTMENT OF THE STATE
TREASURER

/s/ J. Benjamin Garner

J. Benjamin Garner

N.C. State Bar No. 41257

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I certify that the attorneys listed
below have authorized me to list
their names on this brief as if
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BRIEF OF AMICUS CURIAE TREASURER
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BRIEF OF AMICUS CURIAE TREASURER
DALE R. FOLWELL, CPA

INTRODUCTION

The issue at the heart of this case—whether North Carolina’s Certificate of Need law violates Article I, Sections 19, 32, and 34 of the North Carolina Constitution—is of significant public interest due to the harmful effects that illegal healthcare monopolies enabled by this law inflict on North Carolinians. In theory, some argued, Certificate of Need laws would increase accessibility, quality, and affordability of healthcare services. In practice, however, Certificate of Need laws erect insurmountable regulatory barriers wielded by existing institutional healthcare entities to exclude others from entering the market.

Thus, Certificate of Need laws contribute to the creation of highly consolidated healthcare monopolies. In turn, these monopolies decrease the accessibility, quality, and affordability of healthcare while dramatically increasing their prices and excess revenues, all at the expense of North Carolinians. Determining whether the Certificate of Need law runs afoul of the North Carolina Constitution’s protections against these types of harmful monopolies and special privileges is an issue of significant public interest justifying this Court’s review.¹

¹ No person or entity other than amicus curiae or amicus curiae’s counsel wrote any part of this brief or contributed any money to support the briefs preparation. *See* N.C. R. App. P. 28(i)(2).

ARGUMENT

Under Section 7A-31(c), this Court may grant discretionary review when “[t]he subject matter of the appeal has significant public interest.” N.C.G.S. § 7A-31(c)(1) (2021). For the following reasons, the subject matter of this appeal is of significant interest to the public such that discretionary review is appropriate in this case.²

When Medicare and Medicaid were first implemented, the programs reimbursed medical providers for services based on actual cost, creating incentives for providers to increase healthcare costs. Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30 Antitrust 50, 51 (2015); R. at 17, ¶ 44–48.³ In an attempt to tamp down these costs, states started passing Certificate of Need (CON) laws, beginning with New York in 1964. Matthew D. Mitchell, *Certificate-of-Need Laws: Are They Achieving Their Goals?*, Mercatus Center 1 (April 2017). In 1971, North Carolina passed its own CON law, now codified at N.C.G.S. § 131E-175, *et seq.* See Act of July 27, 1971, ch. 1164, 1971 N.C.

² This brief argues that the Supreme Court’s review of this case is proper under N.C.G.S. § 7A-31(c)(1) (2021). This brief expresses no opinion, favorable or unfavorable, as to whether this Court should retain Plaintiffs’ notice of appeal based upon a substantial constitutional question or whether review is proper under N.C.G.S. § 7A-31(c)(2)–(3) (2021).

³ Because this case involves the trial court’s grant of Defendants’ motion to dismiss, this Court on review takes the allegations of Plaintiffs’ complaint as true. See *Cheryl Lloyd Humphrey Land Inv. Co., LLC v. Resco Prods., Inc.*, 377 N.C. 384, 2021-NCSC-56, ¶ 2.

Sess. L. 1715. Believing CON laws would help control public health expenditures, Congress enacted the National Health Planning and Resources Development Act (NHPRDA) of 1974 to mandate that states pass CON laws. Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed by* Pub. L. No. 99-660, § 701, 100 Stat. 3799 (1986). Apart from Louisiana, every state passed a CON law by the early 1980s. Mitchell, *supra*, at 1.

In 1984, however, “Congress restructured the Medicare and Medicaid reimbursement system to a fee-for-service model,” thus eliminating the key rationale for CON laws. R. at 10, ¶ 51. Congress then repealed the NHPRDA in 1986 because it “failed to reduce the nation’s aggregate health care costs, and it was beginning to produce detrimental effects in local communities.” Patrick John McGinley, *Reconsidering Certificate of Need Laws in a “Managed Competition” System*, 23 Fla. St. U. L. Rev. 141, 157 (1995). In 2008, the Federal Trade Commission and the United States Department of Justice stated that CON laws “undercut consumer choice, stifle innovation and weaken markets’ ability to contain health care costs.” Press Release, Federal Trade Commission and Department of Justice, *Fed. Trade Comm’n, Dep’t of Just. Issue Joint*

Statement on Certificate-of-Need Laws in Illinois (Sept. 12, 2008). Since the repeal of the NHPRDA, fifteen states have repealed their CON laws due to “higher healthcare prices and higher overall healthcare spending.” Matthew D. Mitchell and Christopher Koopman, *40 Years of Certificate-of-Need Laws Across America*, Mercatus Center (Sep. 27, 2016), <https://www.mercatus.org/publications/corporate-welfare/40-years-certificate-need-laws-across-america>.

Research shows that “by limiting supply and undermining competition, CON laws may undercut” the aims originally used by legislators to justify the laws. Matthew D. Mitchell, *Certificate-of-Need Laws: Are They Achieving Their Goals?*, Mercatus Center 1–2 (April 2017). Notably, “[t]he process for obtaining a CON can take years and tens or even hundreds of thousands of dollars.” *Id.* at 2. These high costs are generally a barrier to market entry, including for ambulatory surgical centers such as Plaintiff Singleton Vision Center (Center). *Id.* Because existing providers are shielded from competition, the availability of healthcare resources is restricted—states with CON laws “have about 99 fewer hospital beds per 100,000 people than states without these regulations.” Moreover, states with CON laws have “[thirty] percent

fewer *rural* hospitals per 100,000 residents compared with non-CON states.” *Id.* To maintain this barrier, existing healthcare institutions are willing to

inflict economic harm by spending heavily to sustain current monopoly barriers. . . . This is especially true for health care monopolists because so many are maintained with legal and regulatory barriers [such as] certificate of need laws Thus, health care monopolists are willing to spend heavily . . . on legal and political resources that impede competition. This contrasts starkly with the narrative in which we reward monopolies (with monopoly profits) for their investing in the ‘superior skill, foresight, and industry’ that creates social value.

Barak D. Richman, *Concentration in Health Care Markets: Chronic Problems and Better Solutions*, American Enter. Inst. 6 (June 2012) (footnote omitted).

Despite Congress’ repeal of the NHPRDA and these negative effects, North Carolina’s CON law remains in force to the detriment of North Carolinians. *See* N.C.G.S. § 131E-175, *et seq.* (2021). Our state’s lack of hospital capacity was a contributing factor to Governor Cooper’s decision to suspend the CON law during the COVID-19 pandemic. *See* Exec. Order. No. 130 (April 8, 2020). Moreover, the CON law is contributing to a rapid consolidation of our state’s major hospital

systems. See Steve Riley, *Dale Folwell Battles the Health Care ‘Cartel’*, The Assembly (Feb. 3, 2022), <https://www.theassemblync.com/long-form/dale-folwell-battles-the-health-care-cartel/> (“In the past decade in North Carolina, Atrium Health acquired Carolinas Medical Center and Wake Forest Baptist. Novant purchased New Hanover Regional Medical Center. And HCA bought Mission Hospital in Asheville.”).

While receiving tax breaks worth hundreds of millions of dollars, these consolidating entities are reaping incredible excess revenues. UNC Hospitals had \$516 million in excess revenue during the most recent fiscal year. Riley, *supra*. Duke University Health System had \$450 million in excess revenues in 2018 and \$430 million in 2019, both at a margin of greater than ten percent. *Id.* In 2020, Atrium Health, headquartered in Charlotte, had excess revenues of more than \$1 billion, *see id.*, while receiving \$617 million in federal COVID-19 relief funds, *see* Christopher Rowland, *The unintended consequences of the \$178 billion bailout to keep hospitals and doctors afloat*, Washington Post (June 22, 2022), <https://www.washingtonpost.com/business/2022/06/22/covid-hospital-relief-fund/>. North Carolina hospitals have been “more than three times more profitable than the national average.” N.C. State

Health Plan and Johns Hopkins Bloomberg Sch. of Pub. Health, *N.C. Hosps.: Charity Care Report* (Oct. 27, 2021).

While gaining these excess revenues, these consolidating entities are also able to engage in practices that harm North Carolinians. Despite their tax-exempt status, large reserves, and significant profits, many of our state’s institutional hospitals fail to provide sufficient levels of charity care. *Id.* at 3. Instead, these hospitals charge patients who qualify for charity care amounts they cannot afford. N.C. State Health Plan and Rice Univ. Baker Inst. for Pub. Pol’y, *N.C. Nonprofit Hosps. Bill the Poor* 1 (Jan. 26, 2022). In efforts to collect this money, institutional hospitals “have sued patients, garnished their tax returns, damaged their credit and encouraged them to open medical credit cards charging interest rates as high as 11.25% after the first year.” *Id.* at 3.

In addition, rising healthcare costs due in part to the CON law also impact state employees, along with taxpayers, through the North Carolina State Health Plan for Teachers and State Employees (Plan). Pursuant to statute, “[t]he State Treasurer . . . shall carry out [his] duties and responsibilities as [a] fiduciar[y] for the Plan.” N.C.G.S. § 135-48.2(a) (2021). The Plan consists of almost 750,000 members, including active

and retired teachers and state employees, along with their dependents. In the 2012–2013 fiscal year, the Plan’s expenditures were approximately \$2.7 billion dollars, the vast majority of which are associated with medical and pharmacy claims. In the most recent fiscal year, ending June 30, 2022, the Plan incurred almost \$4 billion in expenditures. Thus, over the past decade, the Plan’s annual expenditures have grown by approximately \$1.3 billion.

Rising healthcare costs thus pose a challenge to maintaining the solvency of the Plan and are a liability to taxpayers, who support the Plan through appropriations from the General Assembly. These appropriations grow at approximately four percent per year, but the Plan’s costs continue to grow at approximately seven percent per year. Moreover, the Plan faces a \$33.5 billion liability for retiree healthcare costs, with only \$2.6 billion set aside from the General Assembly to cover that liability. *See* Office of the State Controller, *State of North Carolina: Annual Comprehensive Financial Report* 235 (June 30, 2021). Thus, the healthcare monopolies maintained in part by the CON law are harming North Carolinians as consumers of healthcare and also as taxpayers.

Understanding that the CON law contributes to harmful monopolies, this Court previously held that the CON law violates the North Carolina Constitution. *See In re Certificate of Need for Aston Park Hosp., Inc.*, 282 N.C. 542, 551 (1973). In *Aston Park*, a private company was precluded from building a new hospital with “the sole reason for such prohibition being that, in the opinion of the [Medical Care] Commission, there are now in the area hospitals with bed capacity sufficient to meet the needs of the population.” *Id.* at 548. This Court found no “reasonable relation between the denial of the right of a person, association or corporation to construct and operate upon his or its own property, with his or its own funds, an adequately staffed and equipped hospital and the promotion of the public health.” *Id.* at 551.

Thus, this Court held that the CON law was “a deprivation of liberty without due process of law, in violation” of Article I, Section 19 of the North Carolina Constitution. *Id.* at 551. In addition, this Court held that “[s]uch requirement establishes a monopoly in the existing hospitals contrary to the provisions of Article I, [Section] 34 . . . and is a grant to them of exclusive privileges forbidden by Article I, [Section] 32.” *Id.* In so holding, the Court noted that the North Carolina Constitution does not

“permit the legislature to grant to the Medical Care Commission authority to exclude [the new hospital] from this field of service in order to protect existing hospitals from competition otherwise legitimate.” *Id.* at 552.

This Court’s concerns in *Aston Park* are evident in this case as well. Plaintiff Dr. Singleton desires to perform operations at the Center, which meets the licensure requirements to do so. R. at 12, ¶ 11; 15, ¶ 27–30. Under the current CON law, however, Dr. Singleton may only perform an “incidental” number of surgeries at the Center. R. at 12, ¶ 11; 15, ¶ 31. For example, Dr. Singleton charges \$1,800 to patients whose cataract surgeries are performed at the Center. R. at 14, ¶ 23. The remainder of Dr. Singleton’s surgeries must be performed at the nearby hospital, CarolinaEast, which charges \$6,000 for the facility fee alone. *Id.* Obtaining a CON allowing Dr. Singleton to perform surgeries at the Center may take years and cost him hundreds of thousands of dollars. R. at 22–23, ¶ 73–74; 24, ¶ 87. Adding to the difficulty, CarolinaEast, with its operating budget of more than \$1 billion, R. at 27, ¶ 101, has stated they will oppose Dr. Singleton’s request for a CON, R. at 30, ¶ 118. Thus, Dr. Singleton is precluded from performing surgeries at the Center, for

no reason other than the State has determined, through the CON regulatory scheme, that patients do not “need” those surgeries.

CONCLUSION

CON laws contribute to consolidated healthcare monopolies in North Carolina by distorting market power in favor of large institutional hospitals. This illegal distortion of market power then results in higher prices, lower quality, and less availability of healthcare services. In turn, large institutional hospitals create incredible excess revenue while failing to earn their tax-exempt status through the provision of charity care and engage in business practices harmful to North Carolinians. This Court has previously determined that the North Carolina Constitution protects North Carolinians against these harms. Whether the North Carolina Constitution continues to do so is a matter of significant public interest. Accordingly, discretionary review is proper in this case under Section 7A-31(c) and this Court should grant Plaintiffs’ petition.

DEPARTMENT OF THE STATE
TREASURER

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