COMPETITION IN HEALTH CARE AND CERTIFICATES OF NEED

Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform

September 15, 2008[1]

[1] This statement draws from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007; to the Committee on Health of the Alaska House of Representatives on January 31, 2008; and to the Florida Senate Committee on Health and Human Services Appropriations on March 25, 2008. It also draws from testimony delivered on behalf of the Federal Trade Commission to the Committee on Health of the Alaska House of Representatives on February 15, 2008 and to the Florida State Senate on April 2, 2008.

[2] This statement responds to an invitation from Illinois State Senator Susan Garrett, co-chair of the Illinois Task Force on Health Planning Reform, dated June 30, 2008.

[3] This extensive hearing record is largely available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

[4] FEDERAL TRADE COMMISSION AND THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July 2004), *available at* http://www.usdoj.gov/atr/public/health_care/204694.htm (hereinafter A DOSE OF COMPETITION).

create barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs. Together, we support the repeal of such laws, as well as steps that reduce their scope.

We have also examined historical and current arguments for CON laws, and conclude that such arguments provide inadequate economic justification for depriving health care consumers of the benefits of competition. To the extent that CONs are used to further non-n0(fitsC6)9(g3 -1.18 l4(x)0(a)ls, ca) To 0(s)y9(os3 -11(e)s)0(ubs3 -th ca)nt10(9(.8(a10(l)0(c)o0(l)0(e)9, ca)

[5] U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, at 3, *available at* http://www.usdoj.gov/atr/public/guidelines/1791.htm.

supported by the evidence or the law. Similar arguments made by engineers and lawyers – that competition fundamentally does not work and, in fact is harmful to public policy goals – have been rejected by the courts, and private restraints on competition have long been condemned. Beginning with the seminal 1943 decision in *American Medical Association*

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[6] *See, e.g., F.T.C. v. Superior Court Trial La*[illegible]*ers Ass n*, 493 U.S. 411 (1990); *National Societ of Professional Engineers v. U.S.*, 435 U.S. 679 (1978).

[7] 317 U.S. 519, 528, 536 (1943) (holding that a group of physicians and a medical association were not exempted by the Clayton Act and the Norris-LaGuardia Acts from the operation of the Sherman Act, although declining to reach the question whether a physician's practice of his or her profession constitutes "trade" under the meaning of Section 3 of the Sherman Act).

[8] A DOSE OF COMPETITION, Executive Summary, at 4.

[9] *Id.*; *see also id.*, Ch. 3, §VIII.

[10] Id., Ch. 3 at 25.

[11] MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY § 2F, at 140 (2003), *available at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[12] A DOSE OF COMPETITION, Ch. 3 at 24.

National Health Planning and Resources Development Act of 1974. And health plans and other purchasers now routinely bargain with health care providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[15]

CON laws also appear to have generally failed in their intended purpose of containing costs. Numerous studies have examined the effects of CON laws on health care costs,[16] and the best empirical evidence shows that "on balance . . . CON has no effect or actually increases both hospital spending per capita and total spending per capita."[17] A recent study conducted by the Lewin Group for the state of Illinois confirms this finding, concluding that "the evidence on cost containment is weak," and that using "the CON process to reduce overall expenditures is unrealistic."[18]

2. CON Laws Impose Additional Costs and May Facilitate Anti-Competitive Behavior

Not only have CON laws been generally unsuccessful at reducing health care costs, but they also impose additional costs of their own. First, like any barrier to entry, CON laws interfere with the entry of firms that could otherwise provide higher-quality services than

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[15] A DOSE OF COMPETITION, Ch. 8 at 1-6.

[16] A DOSE OF COMPETITION, Ch. 8 at 1-6; CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003); David S. Salkever, *Regulation of Prices and Investment in Hospital in the United States*, in 1B Handbook of Health Economics, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) ("there is little evidence that [1970's era] investment controls reduced the rate of cost growth."); Washington State Joint Legislative Audit and Review Committee (JLARC), Effects of Certificate of Need and Its Possible Repeal, *I* (Jan. 8, 1999) ("CON has not controlled overall health care spending or hospital costs."); DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale).

[17] *See* CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 15, at 30.

[18] The Lewin Group, *An Evaluation of Illinois Certificate of Need Program*, prepared for the Illinois Commission on Government Forecasting and Accountability (February 15, 2007), at 31 (hereinafter Lewin Group).

[19] A DOSE OF COMPETITION, Ch. 8 at 4 (citing *Hosp. Corp. of Am.*, 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry")).

[20] With regard to hospital markets, *see, e.g.*, UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE

Moreover, much of this conduct, even if exclusionary and anticompetitive, may be shielded from federal antitrust scrutiny, because it involves protected petitioning of the state government.[24] During our hearings, we gathered evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[25]

In addition, incumbent providers have sometimes entered into anticompetitive agreements that were facilitated by the CON process, if outside the CON laws themselves. For example:

- In 2006, the Antitrust Division alleged that a hospital in Charleston, West Virginia used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce another hospital seeking a CON for an open heart surgery program not to apply for it at a location that would have well served Charleston consumers.[26] The hospital eventually entered into a consent decree with the Antitrust Division (without a trial on the merits) which prohibited the hospital from taking actions that would restrict

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defendants also acted in bad faith to obstruct, delay, and prevent the hospital from obtaining a hearing and later a review of the adverse decision).

[24] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[25] A DOSE OF COMPETITION, Executive Summary at 22.

[26] *U.S. v. Charleston Area Med. Ctr., Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006), *available at* http://www.usdoj.gov/atr/cases/f214400/214477.htm.

[27] Justice Department Requires West Virginia Medical Center to End Illegal Agreement (Feb. 6, 2006), *available at* http://home.atrnet.gov/subdocs/214463.htm.

[28] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

[29] *See id.* at 2-3 (referring to the prohibited conduct).

decree with the Antitrust Division (without a trial on the merits) that prohibited the hospitals from enforcing the agreement between them.[30]

- In Vermont, two home health agencies entered into anticompetitive territorial market allocations, facilitated by the state regulatory program, to give each other exclusive geographic markets.[31] Without the state's CON laws, competitive entry into these markets normally might have disciplined such cartel behavior. The Antitrust Division found that as a result, Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.[32]

Finally, the CON process itself may sometimes be susceptible to corruption. For example, as the task force is probably aware, in 2004, a member of the Illinois Health Facilities Planning Board was convicted for using his position on the Board to secure the approval of a CON application for Mercy Hospital. In exchange for his help, the Board member agreed to accept a kickback from the owner of the construction company that had been hired to work on the new hospital.[33]

3. Protecting Revenues of Incumbents Does Not Justify CON Laws

Incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. Under this rationale, CON laws should impede the entry of new health care providers that consumers might enjoy (such as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, and single- or multi-specialty physician-owned hospitals) for the express purpose of preserving the market power of incumbent providers. The providers argue that without CON laws, they would be deprived of revenue that otherwise could be put to charitable use.[34]

We fully appreciate the laudatory public-policy goal of providing sufficient funding for the provision of important health care services – at community hospitals and elsewhere

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[30] *Id.*

[31] Department of Justice Statement on the Closing of the Vermont Home Health Investigation (Nov. 23, 2005), *available at* http://www.usdoj.gov/atr/public/press_releases/2005/213248.htm.

[32] *Id.*

[33] Plea Agreement at 20-23, *U.S. v. Levine* (D. Ill. 2005) (No. 05-691).

[34] There is an ironic element to this argument: What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

viability of rival community hospitals.[38] One substantial reason for this was that specialty hospitals generally locate in areas that have above-average population growth. Thus, they are competing for a new and growing patient population, not just siphoning off the existing customer base of the community hospitals. This is consistent with the Lewin Group study showing that safety-net hospitals in non-CON states actually had higher profit margins than safety-net hospitals in CON states.[39]

III. Conclusion

The Agencies believe that CON laws impose substantial costs on consumers and health care markets and that their costs as well as their purported benefits ought to be considered with care. CON laws were adopted in most states under particular market and regulatory conditions substantially different from those that predominate today. They were intended to help contain health care spending, but the best available research does not support the conclusion that CON laws reduce such expenditures. As the Agencies have said, "[O]n balance, CON programs are not successful in containing health care costs, and . . . they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[40] CON laws tend to create barriers to entry for health care providers who may otherwise contribute to competition and provide consumers with important choices in the market, but they do not, on balance, tend to suppress health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets. For these reasons, the Agencies encourage the task force to seriously consider whether Illinois's CON law does more harm than good.

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[38] MEDPAC, *supra* note 19, at 23-24; *see also* MedPAC, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS REVISITED, at 21-25 (August 2006), *available at* http://www.medpac.gov/documents/Aug06_specialtyhospital_mandated_report.pdf.

[39] Lewin Group, at 28.

[40] A DOSE OF COMPETITION, Executive Summary at 22.