I. Introduction

The Federal Trade Commission (FTC) is pleased to have the opportunity to discuss health care competition, Alaska's ce

impede competition without offering countervailing benefits to consumers. For several decades, the FTC and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5]

In this testimony, the Commission focuses specifically on a few of the issues discussed in the Report that address CON laws and new entry into competition among health care facilities. Three main points require attention:

- First, vigorous competition among healthcare providers, such as hospitals, clinics, and nursing homes, usually benefits consumers through better and more varied services and, in some cases, lower prices. CON laws were designed to create barriers to entry for new healthcare facilities or providers to contain the costs of healthcare services. CON laws, however, have not been particularly effective in controlling healthcare costs, while posing significant risks to competition. In particular, CON laws can retard the entry of firms that could provide higher quality services or lower prices than those offered by incumbents, depress consumer choice between qualitatively different treatment options or settings, or reduce the pressure on incumbents to improve qualitative aspects of their own offerings. Policymakers would be wise to consider reviewing all of the actual costs, benefits, and consequences – intended and unintended – of a regulatory system when assessing that system's future.
- Second, the CON regulatory system creates both the incentive and means by which an incumbent healthcare provider can use the regulatory system itself to delay effective competition, independent of the demand for additional healthcare services. This additional loss of competition is another regulatory cost that must be weighed in the balance when assessing the public interest.

- Finally, Alaska currently has one of the most stringent CON laws in the United States. House Bill 337's proposed amendment of this law would eliminate or reduce barriers to entry for a broad range of healthcare service providers, including small entities that might then be able to thrive as never before.

These points are addressed more fully, below.

II. Discussion

A. Provider Competition Generally: Competition has important benefits in health care services markets, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals and other entities to lower costs, improve quality, and compete more efficiently. In particular, competitive pressure may spur new types of competition. In some hospital markets, new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.[6] Elsewhere, health care services once delivered only in large hospitals – and requiring overnight stays – may be performed more conveniently and less invasively, at

establishing limited service clinics that can provide more convenient and lower cost care and bring more consumers into contact with the larger health care system.[7]

Although new strategies for lowering costs and enhancing quality are emerging, competition is not as effective as possible in most health care markets, because the prerequisites for competitive markets are not fully satisfied. Of particular concern for today's purpose is the extent to which state regulations can create barriers to entry in health care markets, without conferring countervailing benefits in quality of care or cost containment.[8]

At the same time, the empirical evidence generally does not indicate that CON laws control health care costs.[9] Recent broad studies analyzing both national and state

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[7] *See, e.g.*, FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 1-2 (Oct. 2007).

[8] In discussing competition concerns raised by CON requirements, the Commission does not mean to suggest that state CON regulations are the only regulatory impediments to competitive forces in health care markets. For example, in testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, then Administrator of CMS, reported that CMS, following its own study of specialty hospitals pursuant to congressional direction, would analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals." *Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the H. Comm. on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care,"* (May 12, 2005), *available at* http://www.hhs.gov/asl/testify/t050512.html; *see also Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, on Physician-Owned S.2l-1.7(e)alr, Ctalh.3(rS. Fie, innand C9Comm*

data reveal "little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."[10] Studies also fail to show any consistent increase or surge in health care spending when states remove or modify their CON requirements.[11]

Barriers to entry can affect qualitative competition as well. As the Report noted, state CON laws can retard the entry of firms that could provide higher quality services than those offered by incumbents.[12] That may tend to depress consumer choice between qualitatively different treatment options or settings,[13] or it may reduce the pressure on incumbents to improve qualitative aspects of their own offerings.

The study generally found either conflicting or limited evidence about the effects of CON on the cost of non-hospital services, and on the quality and availability of the various health care services.") 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). *But c.f.*, COMMONWEALTH OF VIRGINIA, REPORT OF THE JOINT COMMISSION ON HEALTH CARE, HOUSE DOC. NO. 82, STUDY OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED (COPN) PROGRAM PURSUANT TO HB 1302 OF 1996 *(*1997), ("There is little evidence of significant COPN impact on aggregate health expenditures, but there is evidence of savings for specific services covered by COPN"). *Id.* at 1, *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD821997/$file/HD82_1997.pdf?bcsi_scan_129F6A3CDB83467E=xLesgwMDZ3sPV18TFUnlHEQAAAD+Q30W&bcsi_scan_filename=HD82_1997.pdf (last checked 1/31/08).

[10] CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 9 at vii (discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws); *id.* at 30-31.

[11] CONOVER AND SLOAN also report that, "[i]n most states that lifted CON, per capita spending on hospital and physician services (relative to the US) has remained below the U.S. average following removal of CON.") *Id.* at 50; *see also* Christopher J. Conover and Frank A. Sloan. *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL'Y & LAW 455 (1998) ("no evidence of a surge in acquisition of facilities or in costs following removal of a CON.") 458.

[12] IMPROVING HEALTH CARE, *supra* note 2, at C. 8, p. 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 omn) 2(od)-4.5((ng)0 Two9)5o9

B. Incumbent Lobbying and Petitioning Protections: When new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such conduct may violate the antitrust laws.[14] Certain anticompetitive conduct may, however, be shielded from antitrust scrutiny. The *Noerr-Pennington* doctrine immunizes from antitrust liability conduct that represents petitioning the government, even when such petitioning is done "to restrain competition or gain advantage over competitors."[15] Moreover, the state action doctrine shields from antitrust scrutiny many of a state's own activities when a state government is acting in its sovereign, legislative capacity.[16]

In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation. State CON programs generally prevent firms from entering certain areas of the health

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cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, 15-17 (Mar. 2005) (hereinafter MEDPAC REPORT). MedPAC was directed to report to Congress on certain issues regarding specialty hospitals under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *Id.* at vii.

[14] *See* IMPROVING HEALTH CARE, *supra* note 2, at 15-16, ch.1, at 31-33, ch.3, at 22-27.

[15] Andrx Pharm. V. Biovail, 256 F.3d 799, 817 (D.C. Cir. 2001), *cert. denied*, 122 S. Ct. 1305 (2002). The doctrine is named for the seminal cases that treated it: Eastern R.R. Presidents Conference v. Noerr, 365 U.S. 127 (1961), and United Mine Workers v. Pennington, 381 U.S. 657 (1965).

[16] Parker v. Brown, 317 U.S. 341, 351 (1943). The state action doctrine also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state. *See, e.g.*, California Retail Liquor Dealers Assn. v. Midcal Aluminum, 445 U.S. 97, 105 (1980).

Alaska law requires a CON for any type of health care facility construction or improvement of $1,000,000 or more, adjusted,[30] or the establishment of a nursing home facility independent of that cost threshold.[31] In so doing, it places significant regulatory burdens on the development or improvement of a very broad class of health care facilities – not just major hospital initiatives and expansions, which may be subject to long-term planning – but diverse outpatient clinic initiatives, which might otherwise develop dynamically in response to market needs. The scope of current Alaska law thus stands in contrast not only to the laws of those states that have eliminated their CON requirements altogether, but the laws of the many states that have more limited CON requirements. Alaska's low CON threshold itself may be a special burden to the State's health care spending, as low CON thresholds have been observed to increase costs – relative to higher thresholds – rather than decrease them.[32]

A degree of controversy may remain about particular issues addressed by certain CON laws. These include, for example, efficiency and possible conflicts of interest concerns about certain categories of physician-owned specialty hospitals and access issues for rural or other underserved areas.[33] However, the sweep of Alaska's CON law

[30] Alaska Stat. § 18.07.031(a) (2007). The statute contains an adjustment provision, whereby the $ 1 million dollar threshold may be increased by $50,000 per anum, between 2005 and 2014. *Id.* at § 18.07.031(d).

[31] *Id.* at § 18.07.031(b).

[32] *See* SHERMAN, *supra* note 9, at 58-60 (1.4 percent decline in costs associated with doubling of all thresholds).

[33] *See, e.g.*, Testimony of Mark B. McClellan, M.D., Ph.D. (2005), *supra* note 8; Testimony of Mark B. McClellan, M.D., Ph.D. (2006), *supra* note 8 (regarding CMS studies of physician-owned specialty

is much broader than required to address any of those more narrow and complex issues and is likely to be detrimental to Alaska's health care consumers. The Commission recommends that Alaska carefully consider the evidentiary basis of these issues as they may relate to Alaska health care consumers. If the evidence and public policy considerations warrant some legislative action, the Commission recommends that Alaska consider regulation that is narrowly tailored to achieve focused health policy goals instead of broad regulation of entry into the market for health care facilities.

III. Conclusion

CON laws were adopted throughout most states under particular market and regulatory conditions substantia

Alaska's current CON law – which House Bill 337 seeks to modify – is among the most stringent of such laws in the United States. As a consequence, Alaska CON law creates a barrier to entry for a very broad range of health care service providers, including small health care entities that may be ill-equipped to overcome it. The Commission believes that both the breadth of Alaska's CON law, and its low threshold, are of special concern, as they may work to the detriment of Alaska health care consumers. In the event that adequate evidence develops to support more narrow policy priorities, the Commission believes that Alaska should consider regulations narrowly tailored to meet those priorities, while minimizing the general costs to Alaska health care consumers.