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]

The Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission appreciate the opportunity to share our views on the impact of Certificate-of-Need ("CON") laws on health care markets.[2]

The Antitrust Division and the FTC (together, the Agencies) have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals, and other health care goods and services. In addition to this enforcement, we have conducted hearings and undertaken research on various issues in health care competition. For example, in 2003, we conducted 27 days of hearings on competition and policy concerns in the health care industry, hearing from approximately 250 panelists, eliciting 62 written submissions, and generating almost 6,000 pages of transcripts.[3] As a result of that effort, the Agencies jointly published an extensive report in July 2004 entitled, *Improving Health Care: A Dose of Competition*.[4] We regularly issue informal advisory letters on the application of the antitrust laws to health care markets, and periodically issue reports and general guidance to the health care community. Through this work, we have developed a substantial understanding of the competitive forces that drive innovation, costs, and prices in health care.

The Agencies' experience and expertise has taught us that Certificate-of-Need laws impede the efficient performance of health care markets. By their very nature, CON laws

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[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-economic goals, they impose substantial costs, and such goals can likely be more efficiently achieved through other mechanisms. We hope you will carefully consider the substantial costs that CON laws may impose on consumers as you consider eliminating or otherwise amending Illinois's CON requirements.

I. Scope of Remarks

Although we do not intend to focus on specific aspects of the CON program in Illinois, we are generally familiar with the issues before you and recognize them as issues that CON laws present in other states and markets. Also, please note that it is not the intent of the Agencies to "favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, [our] goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices . . ."[5] Our mission is to preserve and promote consumer access to the benefits of competition, rather than any particular marketplace rival or group of rivals.

II. Importance of Competition and the Harm Caused by Regulatory Barriers to Entry

A. The Benefits of Competition in Health Care

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces tend to improve the quality and lower the costs of health care goods and services. They drive innovation and ultimately lead to the delivery of better health care. In contrast, over-restrictive government intervention can undermine market forces to the detriment of health care consumers and may facilitate anticompetitive private behavior.

In our antitrust investigations we often hear the argument that health care is "different" and that competition principles do not apply to the provision of health care services. However, the proposition that competition cannot work in health care is not

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[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.[6] Beginning with the seminal 1943 decision in *American Medical Association v. United States*, the Supreme Court has come to recognize the importance of competition and the application of antitrust principles to health care.[7] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that barriers to that competition do not arise.

During our extensive health care hearings in 2003, we obtained substantial evidence about the role of competition in our health care delivery system and reached the conclusion that vigorous competition among health care providers "promotes the delivery of high-quality, cost-effective health care."[8] Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[9]

Competition has also brought consumers important innovations in health care delivery. For example, health plan demand for lower costs and "'patient demand for a non-institutional, friendly, convenient setting for their surgical care'" drove the growth of Ambulatory Surgery Centers.[10] Ambulatory Surgery Centers offered patients more convenient locations, shorter wait times, and lower coinsurance than hospital departments.[11] Technological innovations, such as endoscopic surgery and advanced anesthetic agents, were a central factor in this success.[12] Many traditional acute care hospitals have responded to these market innovations by improving the quality, variety, and value of their own surgical services, often developing on- or off-site ambulatory surgery centers of their own.

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[6] *See, e.g., F.T.C. v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411 (1990); *National Society 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.

This type of competitive success story has occurred often in health care in the areas of pharmaceuticals, urgent care centers, limited service or "retail" clinics, and the development of elective surgeries such as LASIK, to name just a few. Without private or governmental impediments to their performance, we can expect health care markets to continue to deliver such benefits.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a regulatory barrier to entry, which, by their nature, are an impediment to health care competition. Accordingly, in *A Dose of Competition*, we urged states to rethink their CON laws.[13]

1. Original Cost-Control Reasons For CON Laws No Longer Apply

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At that time, the federal government and private insurance reimbursed health care charges predominantly on a "cost-plus" basis, which provided incentives for over-investment. There was concern that, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest-quality services, allegedly driving up health care costs.[14] The hope was that CON laws would provide a counterweight against that skewed incentive.

Thus, it is important to note that:

- CON laws were not adopted as a means of cross-subsidizing care;
- CON laws were not adopted to have centralized planning of health care markets as an end in itself;
- CON laws were not adopted to supplant or augment state-law licensing regulations designed to protect the health and safety of the population from poor-quality health care.

Since the 1970s, the reimbursement methodologies that may in theory have justified CON laws initially have significantly changed. The federal government, as well as private third-party payors, no longer reimburse on a cost-plus basis. In 1986, Congress repealed the

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

[14] *See* A DOSE OF COMPETITION, Ch. 8 at 1-2.

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).

those offered by incumbents.[19] This may tend to depress consumer choice between different types of treatment options or settings,[20] and it may reduce the pressure on incumbents to improve their own offerings.[21]

Second, CON laws can be subject to various types of abuse, creating additional barriers to entry, as well as opportunities for anticompetitive behavior by private parties. In some instances, existing competitors have exploited the CON process to thwart or delay new competition to protect their own supra-competitive revenues. Such behavior, commonly called "rent seeking," is a well-recognized consequence of certain regulatory interventions in the market.[22] For example, incumbent providers may use the hearing and appeals process to cause substantial delays in the development of new health care services and facilities. Such delays can lead both the incumbent providers and potential competitors to divert substantial funds from investments in such facilities and services to legal, consulting, and lobbying expenditures; and such expenditures, in turn, have the potential to raise costs, delay, or – in some instances – prevent the establishment of new facilities and programs.[23]

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[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 CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006), *available at* http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp (reporting at specialty hospitals a "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for 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 also* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, vii (Mar. 2005), *available at* http://www.medpac.gov/documents/Mar05_SpecHospitals.pdf (hereinafter MEDPAC).

[21] *See, e.g.*, MEDPAC, *supra* note 19, at 10 (observing both administrative improvements – "Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations" – and other qualitative improvements – "We heard several examples of constructive improvements sparked by the entrance of a specialty hospital into a market, including extending service hours, improving operating room scheduling, standardizing the supplies in the operating room, and upgrading equipment.").

[22] Paul Joskow and Nancy Rose, *The Effects of Economic Regulation*, *in* 2 HANDBOOK OF INDUSTRIAL ORGANIZATION (Schmalensee and Willig, eds., 1989).

[23] *See, e.g., Armstrong Surgical Ctr., Inc. v. Armstrong County Mem'l Hosp.*, 185 F.3d 154, 158 (3rd Cir. 1999) (an ambulatory surgery center alleged that a competing hospital had conspired with nineteen of its physicians to make factual misrepresentations as well as boycott threats to the state board, allegedly causing the board to deny the center its CON); *St. Joseph's Hosp., Inc. v. Hosp. Corp. of America*, 795 F.2d 948 (11th Cir. 1986) (a new hospital applying for a CON alleged that an existing competitor submitted false information to the CON board; that the board relied on that information in denying the CON; and that 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 other health care facilities from developing cardiac surgery services.[27]

- In another case from West Virginia, the Antitrust Division alleged that two closely competing hospitals agreed to allocate certain health care services among themselves.[28] The informal urging of state CON officials led the hospitals to agree that just one of the hospitals would seek approval for an open heart surgery program, while the other would seek approval to provide cancer treatment services.[29] These hospitals also entered into a consent

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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.

– to those who cannot afford them, and for whom government payments are either unavailable or too low to cover the cost of care. But at the same time, we want to be clear that the imposition of regulatory barriers to entry as an indirect means of funding indigent care may impose significant costs on all health care consumers – consumers who might otherwise benefit from additional competition in health care markets.

First, as noted above, CON laws stifle new competition that might otherwise encourage community hospitals to improve their performance. For example, in studying the effects of new single-specialty hospitals, the Medicare Payment Advisory Committee (MedPAC) found that certain community hospitals responded to competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[35] In addition to administrative and operational efficiencies, the MedPAC Report identified several examples of improvements sparked by the entrance of a specialty hospital into a market, including extended service hours, improved operating room scheduling, standardized supplies in the operating room, and upgraded equipment.[36]

Second, we note that general CON requirements such as those imposed under Illinois law sweep very broadly, instead of targeting specific, documented social needs (such as indigent care). Although the Agencies do not suggest to Illinois policy makers any particular mechanism for funding indigent care, we note that solutions more narrowly tailored to the state's recognized policy goals may be substantially less costly to Illinois consumers than the current CON regime, and that the Lewin Group report commissioned by the state identifies various alternatives that may be more efficient in advancing such goals.[37]

Third, it is possible that CON laws do not actually advance the goal of maintaining indigent care at general community hospitals. Recently the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. That study found that, for several reasons, specialty hospitals did not undercut the financial

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[35] *See, e.g.*, MEDPAC, *supra* note 19, at 10 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations"). Other studies have found that the presence of for-profit competitors leads to increased efficiency at nonprofit hospitals. Kessler, D. and McClellan M., "The Effects of Hospital Ownership on Medical Productivity," RAND Journal of Economics 33 (3), 488-506 (2002).

[36] MEDPAC, *supra* note 19, at 10; *see also* Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117; Stensland J. and Winter A., "Do Physician-Owned Cardiac Hospitals Increase Utilization?" *Health Affairs* 25, no. 1 (2006): 128 (some community hospitals have responded to the presence of specialty hospitals by recruiting physicians and adding new cardiac catheterization labs).

[37] *See* Lewin Group, at 29 (discussing various financing options for charity care in Illinois).

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] DOSE OF COMPETITION, Executive Summary at 22.