**Statement of the Federal Trade Commission**
**to the Alaska Senate Committee on Labor & Commerce**
**on Certificate-of-Need Laws and SB 62**
**February 6, 2018**

Chairman Costello, Senator Wilson, and Members of the Committee, my name is Daniel Gilman, an Attorney Advisor in the Federal Trade Commission's Office of Policy Planning. With me today is David Schmidt, Assistant Director of the FTC's Bureau of Economics. Thank you for this opportunity to present the views of the FTC on Certificate-of-Need laws, often called "CON laws" for short. Our prepared remarks review recent statements on the effects of CON laws issued jointly by the two federal competition authorities, the FTC and the Antitrust Division of the U.S. Department of Justice. In particular, in April 2017, the Agencies specifically commented on SB 62.[1] These prior statements reflect the Agencies' extensive experience with health care competition – including several decades of law enforcement, research, and policy experience regarding the effects of provider concentration generally and CON laws in particular.[2] Any additional comments we might make, including responses to clarifying questions, are our own, and do not necessarily reflect the views of the FTC, any individual Commissioner, or the Department of Justice.

CON laws,[3] when first enacted, had the laudable goals of reducing health care costs and improving access to care.[4] However, after considerable

experience, it has become apparent that CON laws do not provide the benefits they originally promised. Worse, in operation, CON laws can undermine some of the very policy goals they were originally intended to advance.

Over the years, there have been many efforts to study CON laws empirically, to determine whether their claimed benefits have materialized. The empirical literature does not generally suggest that CON laws have succeeded in controlling costs, improving quality, or increasing access.

We have identified at least three serious problems with CON laws. First, CON laws create barriers to entry and expansion, which can increase prices, limit consumer choice, and stifle innovation. Second, incumbent firms can use CON laws to thwart or delay otherwise beneficial market entry or expansion by new or existing competitors. Third, as illustrated by the FTC's experience in the *Phoebe Putney* case, CON laws can deny consumers the benefit of an effective remedy following the consummation of an anticompetitive merger.

For these reasons, last April we respectfully suggested that Alaska repeal its CON laws, and we are here today to reiterate that suggestion.

## I. CON Laws Create Barriers to Entry and Expansion, Potentially Depriving Consumers of the Benefits of Health Care Competition.

CON laws, such as Alaska's, require new entrants and incumbent providers to obtain state-issued approval before constructing new facilities or offering certain health care services. By interfering with the market forces that normally determine the supply of facilities and services, CON laws can suppress increases in supply and misallocate resources. They also shield

incumbent health care providers from competition from new entrants and innovations in health care delivery, which means consumers lose these benefits.[5]

We urge you to consider all of these ways that CON laws may harm health care consumers. We also urge you to consider how consumers – including patients and both public and private payers – might benefit if new facilities and services could enter the market more easily. Entry and expansion – and often even just the credible threat of entry or expansion – typically restrains health care prices, improves the quality of care, incentivizes innovation, and improves access to care.

Entry restrictions, on the other hand, tend to raise costs and prices. They also limit opportunities for providers to compete not just on price, but also on non-price aspects – like quality and convenience – that may be particularly important to patients. Impeding new entry into health care markets can be especially harmful in rural or other underserved areas. CON laws may delay or block the development of facilities and services where they are needed most and, potentially, reinforce market power that incumbent providers may enjoy in already-concentrated areas.

## II. Incumbent Providers May Exacerbate the Competitive Harm From These Entry Barriers by Taking Advantage of the CON *Process* – and not Merely its Outcome – to Protect Their Revenues.[6]

The strategic use of the CON process by competitors can cause more than delay.[7] It can divert scarce resources away from health care innovation and delivery, as potential entrants incur legal, consulting, and lobbying expenses responding to competitor challenges, and as incumbents incur

expenses in mounting such challenges.[8] Moreover, as the FTC's recent experience in *FTC v. Phoebe Putney* shows,[9] CON laws can entrench anticompetitive mergers by limiting the ability of antitrust enforcers to implement effective structural remedies to consummated transactions.

## III. The Evidence Does Not Show that CON Laws Have Achieved Their Goals

States originally adopted CON programs over 40 years ago as a way to control health care costs and mitigate the incentives created by a cost-plus based health care reimbursement system.[10] Although this type of reimbursement system has mostly gone away, CON laws remain in force in a number of states, and CON proponents continue to raise cost control as a justification. Proponents also argue that CON laws improve health care quality while increasing access. The evidence suggests otherwise:

- Empirical evidence on competition in health care markets generally has demonstrated that more competition leads to lower prices.[11] FTC scrutiny of hospital mergers has been particularly useful in understanding concentrated provider markets; and retrospective studies of provider consolidation by FTC staff and independent scholars consistently indicate that "increases in hospital market concentration lead to increases in the price of hospital care."[12]
- The best empirical evidence also suggests that greater competition incentivizes providers to become more efficient.[13] Recent work shows that hospitals faced with a more competitive environment have better management practices,[14] and that repealing or narrowing CON laws can reduce the per-patient cost of health care.[15]

- We have found no empirical evidence that CON laws have successfully restricted so-called "over-investment."[16] CON laws can, however, limit investments that would lower costs in the long run.
- Several studies directly analyze the impact of changes in CON laws on health outcomes, and the weight of this research has found that repealing or narrowing CON laws is unlikely to lower quality – it may, in fact, improve the quality of certain types of care.[17]
- CON proponents concede that CON laws allow incumbent providers to earn greater profits than they would in a competitive environment. They argue that, in theory, incumbents can then use those extra profits to cross-subsidize charity care. We appreciate the importance of providing charity care, but we urge you to consider whether there are less costly and more effective ways to do it.
    - Keep in mind that the charity-care rationale is at odds with the cost-control rationale. If the idea is that CON-protected incumbents will use their market power and profits to cross-subsidize charity care, that implies providers will charge *supra*-competitive prices for non-charity care. Such *supra*-competitive pricing might harm many Alaska health care consumers, including low-income or under-insured patients who are ineligible for charity care.
    - Also, because CON programs impede entry and expansion, they can impede access to care for all patients, including the indigent and other low-income patients.
    - Although advocates of CON laws might seek to promote charity care, the evidence does not show that CON laws advance that goal. In fact, there is some research suggesting that safety net hospitals

are no stronger financially in CON states than in non-CON states;[18] and there is some empirical evidence contradicting the notion that dominant providers use their market power to cross-subsidize charity care.[19]

**In Conclusion:** The FTC recognizes that states must weigh a variety of policy objectives when considering health care legislation. But CON laws raise considerable competitive concerns and generally do not appear to have achieved their intended benefits for health care consumers. In brief, CON laws have failed to demonstrate success at delivering on their policy goals over the course of 40-plus years. We respectfully suggest that the legislature consider whether Alaska's citizens are well served by its CON laws and, if not, whether they would benefit from the repeal of those laws.

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[1] Joint Statement of the Antitrust Div. of the U.S. Dep't Justice and the Fed. Trade Comm'n on Certificate-of-Need Laws and Alaska Senate Bill 62 (2017) [hereinafter, "Joint Statement"], https://www.ftc.gov/news-events/press-releases/2017/04/ftc-doj-support-reform-alaska-laws-limit-competition-health-care.

[2] For a brief summary of FTC and DOJ research, enforcement, and policy analysis regarding health care competition, including provider concentration and CON laws, see id. at 1-3.

[3] Generally speaking, CON laws prevent firms from entering certain areas of the health care market (e.g., building a new hospital) unless they can demonstrate to a state regulator that there is an unmet need for the services. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 8 at 1 (2004) [hereinafter A DOSE OF COMPETITION], https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

[4] Most CON programs trace their origins to the National Health Planning and Resources Development Act of 1974. Under provisions of that Act, repealed in 1986, states were required to adopt CON legislation to avoid losing certain federal funding. *See* CHRISTINE L. WHITE ET AL., ANTITRUST AND HEALTHCARE: A COMPREHENSIVE GUIDE 527 (2013).

[5] *See* A DOSE OF COMPETITION, *supra* note 3, at ch. 8 at 4 (discussing examples of how CON programs limited access to new cancer treatments and shielded incumbents from competition from innovative newcomers).

[6] A DOSE OF COMPETITION, *supra* note 3, Exec. Summ. at 22; *see also* Tracy Yee et al., Health Care Certificate-of-Need Laws: Policy or Politics? 2, 4 (Research Br. No. 4, Nat'l Institute for Health Care Reform May 2011) [hereinafter, Policy or Politics?] (interviewees stated that CON programs "tend to be influenced heavily by political relationships, such as a provider's clout, organizational size, or overall wealth and resources, rather than policy objectives," that, in Georgia, "large hospitals, which often have ample financial resources and political clout, have kept smaller hospitals out of a market by tying them up in CON litigation for years," that the CON process "often takes several years before a final decision," and that providers "use the process to protect existing market share – either geographic or by service line – and block competitors"). This can cause more than delay. Policy or Politics?, at 5 ("CONs for new technology may take upward of 18 months, delaying facilities from offering the most-advanced equipment to patients and staff."). It can divert scarce resources away from health care delivery and innovation, as potential entrants incur legal, consulting, and lobbying expenses responding to competitor challenges. [DUPLICATED BELOW IN FN 8]

[7] *See, e.g.*, Policy or Politics?, *supra* note 6, at 5 ("CONs for new technology may take upward of 18 months, delaying facilities from offering the most-advanced equipment to patients and staff.").

[8] What makes this conduct more concerning is the fact that, even if exclusionary and anticompetitive, it is shielded from federal antitrust scrutiny to the extent it involves protected petitioning of the state government. *See* Fed. Trade Comm'n and U.S. Dep't Justice, Written Testimony Before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws, 6-7 (2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-and-department-justice-written-testimony-illinois-task-force-health-planning-reform-concerning/v080018illconlaws.pdf; Prepared Statement of the Fed. Trade Comm'n Before the Florida State Senate, 8-9 (2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-prepared-statement-florida-senate-concerning-florida-certificate-need-laws/v080009florida.pdf.

[9] https://www.ftc.gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf

[10] *See* A DOSE OF COMPETITION, *supra* note 3, ch. 8 at 2; CHRISTINE L. WHITE ET AL., ANTITRUST AND HEALTHCARE: A COMPREHENSIVE GUIDE, 527 (2013).

[11] *See, e.g.*, Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update*, ROBERT WOOD JOHNSON FOUNDATION: THE SYNTHESIS PROJECT (2012) [hereinafter *Impact of Hospital Consolidation*] (synthesizing research on the impact of hospital mergers on prices, cost, and quality and finding that hospital consolidation generally results in higher prices, hospital competition improves quality of care, and physician-hospital consolidation has not led to either improved quality or reduced costs); Martin Gaynor & Robert J. Town, *Competition in Health Care Markets*, 2 HANDBOOK OF HEALTH ECONOMICS. 499, 637 (2012). Martin Gaynor et al., *The Industrial Organization of Health-Care Markets*, 53 J. ECON.2 LITERATURE 235, 284 (2015) (critical review of empirical and theoretical literature regarding markets in health care services and insurance).

[12] Gaynor & Town, *Impact of Hospital Consolidation*, *supra* note 11, at 1 (citing, e.g., Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 IN. J. ECON. BUS. 17, 30 (2011) (post-merger review of Agency methods applied to two hospital mergers; data "strongly suggests" that large price increases in challenged merger be attributed to increased market power and bargaining leverage); Leemore Dafny, *Estimation and Identification of Merger Effects: An*

*Application to Hospital Mergers*, 52 J. L. & ECON. 523, 544 (2009) ("hospitals increase price by roughly 40 percent following the merger of nearby rivals"); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175, 179 (2004) ("Overall, our results do not support the argument that efficiencies from consolidations among competing hospitals lead to lower prices. Instead, they are broadly consistent with the opposing view that consolidations among competing hospitals lead to higher prices.")); *see also, e.g.*, Joseph Farrell et al., *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals*, 35 REV. INDUS. ORG. 369 (2009) (mergers between not-for-profit hospitals can result in substantial anticompetitive price increases).

[13] Recent marketplace developments may undermine further the case for CON laws. Proponents of CON programs generally assume that providers are incentivized to provide a higher volume of services. But this assumption may be undermined as policy reforms and market developments encourage a move toward value-based payments and away from volume-based payment structures.

[14] *See, e.g.*, Nicholas Bloom et al., *The Impact of Competition on Management Quality: Evidence from Public Hospitals*, 82 REV. ECON. STUDIES 457, 457 (2015) ("We find that higher competition results in higher management quality.").

[15] *See, e.g.*, Vivian Ho & Meei-Hsiang Ku-Goto, *State Deregulation and Medicare Costs for Acute Cardiac Care*, 70 MED. CARE RES. & REV. 185, 202 (2012) (finding an association between the lifting of CON laws and a reduction in mean patient costs for coronary artery bypass graft surgery, and finding that these cost savings slightly exceed the fixed costs of new entrants); Patrick A. Rivers et al., *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 J. HEALTH CARE FIN. 1, 11 (2010) (finding a positive relationship between the stringency of CON laws and health care costs per adjusted admission and concluding that the "results, as well as those of several previous studies, indicate that [CON] programs do not only fail to contain [hospital costs], but may actually *increase* costs as well" (emphasis in original)). While other studies evaluate the impact of repealing CON laws (with varying results), many of these studies are less persuasive because they do not account for preexisting cost differences between the states. *Compare* Michael D. Rosko & Ryan L. Mutter, *The Association of Hospital Cost-Inefficiency with Certificate-of-Need Regulation*, 71 MED. CARE RES. & REV. 1, 15 (2014) (finding "a plausible association between CON regulation and greater hospital cost-efficiency"), *with* Gerald Granderson, *The Impacts of Hospital Alliance Membership, Alliance Size, and Repealing Certificate of Need Regulation on Cost Efficiency of Non-profit Hospitals*, 32 MANAGE. DECIS. ECON. 159, 167-68 (2011) ("[R]epealing state CON programs contributed to an improvement in hospital cost efficiency.").

[16] Some papers find that CON laws are associated with lower utilization of hospital beds. These studies, however, do not address the critical question of whether the lower bed utilization in states with CON laws is a result of preventing over-investment or restricting beneficial investment. *See, e.g.*, Paul L. Delamater et al., *Do More Hospital Beds Lead to Higher Hospitalization Rates? A Spatial Examination of Roemer's Law*, 8 PLOS ONE e54900, 13-14 (2013) (finding "a positive, significant association between hospital bed availability and hospital utilization rates"); Fred J. Hellinger, *The Effect of Certificate-of-Need Laws on Hospitals Beds and Healthcare Expenditures: An Empirical Analysis*, 15 AM. J. MANG. CARE 737 (2009) (finding that CON laws "have reduced the number of hospital beds by about 10%").

[17] *See* Suhui Li & Avi Dor, *How Do Hospitals Respond to Market Entry? Evidence from a Deregulated Market for Cardiac Revascularization*, 24 HEALTH ECON. 990, 1006 (2015) (finding that repeal of Pennsylvania's CON program improved "the match between underlying medical risk and treatment intensity"); Ho & Ku-Goto, *supra*, note 14, at 199 (finding association between lifting of CON laws and shorter lengths of stay and fewer strokes during admission for coronary artery bypass patients, finding no significant association between lifting CON laws and three other complications during admission for coronary artery bypass graft patients, and finding no significant associations between lifting of CON laws and length of stay or need for coronary artery bypass graft surgery for percutaneous coronary intervention patients); David M. Cutler et al., *Input Constraints and the Efficiency of Entry: Lesson from Cardiac Surgery* 2:1 AM. ECON. J.: ECON. POLICY 51, 52 (2010) (finding that new entry after repeal of Pennsylvania's CON program "had a salutary effect on the market for cardiac surgery by directing more volume to better doctors and increasing access to treatment"). Additional empirical evidence suggests that,

"[a]t least for some procedures, hospital concentration reduces quality." Gaynor & Town, *Impact of Hospital Consolidation*, *supra* note 11, at 3; *see also* Patrick S. Romano & David J. Balan, A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare (Fed. Trade Comm'n Bureau of Econ., Working Paper No. 307, 2010), https://www.ftc.gov/reports/retrospective-analysis-clinical-quality-effects-acquisition-highland-park-hospital-evanston.

[18] Cutler, *supra* note 17, at 63 (finding that, following repeal of Pennsylvania's CON program, incumbent hospitals "were not put in a precarious position by the elimination of CON"); THE LEWIN GROUP, AN EVALUATION OF ILLINOIS' CERTIFICATE OF NEED PROGRAM: PREPARED FOR THE STATE OF ILLINOIS COMMISSION ON GOVERNMENT FORECASTING AND ACCOUNTABILITY ii, 27-28 (2007), http://cgfa.ilga.gov/Upload/LewinGroupEvalCertOfNeed.pdf ("Through our research and analysis we could find no evidence that safety-net hospitals are financially stronger in CON states than other states.").

[19] Christopher Garmon, *Hospital Competition and Charity Care*, 12 FORUM FOR HEALTH ECON. & POL'Y 1, 13 (2009).