JANUARY 2

FEDERAL TRADE COMMISSION
Washington, DC 20580

DEPARTMENT OF JUSTICE
Washington, DC 20530

The Honorable Nikki R. Haley, Governor
Office of the Governor
1205 Pendleton Street
Columbia, SC 29201

January 11, 2016

Dear Governor Haley:

In response to your request, dated November 13, 2015, we submit the enclosed Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250. We hope that the statement is helpful to you and the South Carolina General Assembly in your deliberations. Thank you for your time and consideration.

Marina Lao

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cc: Holly G. Pisarik, Chief Legal Counsel, Office of the Governor

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Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250

The Federal Trade Commission (the "FTC" or the "Commission") and the Antitrust Division of the U.S. Department of Justice (the "Division") (together, the "Agencies") welcome the opportunity to share our views on certificate-of-need ("CON") laws and South Carolina House Bill 3250 (the "Bill"), which would narrow the application of and ultimately repeal South Carolina's CON laws.[1]

CON laws, when first enacted, had the laudable goals of reducing health care costs and improving access to care.[2] However, after considerable experience, it is now apparent that CON laws can prevent the efficient functioning of health care markets in several ways that may undermine those goals. First, CON laws create barriers to entry and expansion, limit consumer choice, and stifle innovation. Second, incumbent firms seeking to thwart or delay entry or expansion by new or existing competitors may use CON laws to achieve that end. Third, as illustrated by the FTC's recent experience in the *Phoebe Putney* case, CON laws can deny consumers the benefit of an effective remedy following the consummation of an anticompetitive merger. Finally, the evidence to date does not suggest that CON laws have generally succeeded in controlling costs or improving quality. For these reasons, explained more fully below, the Agencies historically have suggested that states consider repeal or retrenchment of their CON laws, and, in this case, respectfully suggest that South Carolina repeal its CON laws.

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[1] Letter from Governor Nikki R. Haley to Marina Lao, Director, Office of Policy Planning, Fed. Trade Comm'n (Nov. 13, 2015).

[2] CON programs originated under the National Health Planning and Resources Development Act of 1974. States were required to pass CON legislation to avoid losing certain federal funding. *See* CHRISTINE L. WHITE ET AL., ANTITRUST AND HEALTHCARE: A COMPREHENSIVE GUIDE 527 (2013).

I. The Agencies' Interest and Experience in Health Care Competition

Competition is the core organizing principle of America's economy,[3] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.[4] The Agencies work to promote competition through enforcement of the antitrust laws, which prohibit certain transactions and business practices that harm competition and consumers, and through competition advocacy, whereby the Agencies advance outcomes that benefit competition and consumers via comments on legislation, discussions with regulators, and court filings, among other means.

Because of the importance of health care competition to the economy and consumer welfare, this sector has long been a priority for the Agencies.[5] The Agencies have extensive experience investigating the competitive effects of mergers and business practices by hospitals, insurers, pharmaceutical companies, physicians, and other providers of health care goods and services. The Agencies also have provided guidance to the health care community on the antitrust laws, and have devoted significant resources to examining the health care industry by sponsoring various workshops and studies.

In particular, the Agencies have examined the competitive impact of CON laws for several decades. For example, staff from the FTC's Bureau of Economics conducted several studies of CON laws in the late 1980s, both before and after repeal of the federal law that had encouraged the adoption of CON laws across the United States.[6] In addition, the Agencies jointly conducted 27 days of

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[3] *See, e.g.*, N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1109 (2014) ("Federal antitrust law is a central safeguard for the Nation's free market structures."); Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy has long been faith in the value of competition.").

[4] *See, e.g.*, Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978) (noting that the antitrust laws reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[5] A description of, and links to, the FTC's various health care-related activities can be found at https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care. An overview of the Division's health care-related activities is available at http://www.justice.gov/atr/health-care.

[6] DANIEL SHERMAN, FED. TRADE COMM'N, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data on 3,708 hospitals, that strong CON

hearings on health care competition matters in 2003, receiving testimony about CON laws and market entry, as well as testimony on many other aspects of health care competition pertinent to CON policy, such as the effects of concentration in hospital markets.[7] In 2004, based on those hearings, independent research, and a public workshop, the Agencies released a substantial report on health care competition issues, including those related to CON laws.[8] Finally, through their competition advocacy programs, the Agencies for many years have reviewed particular CON laws and encouraged states to consider the competitive impact of those laws.[9]

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programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FED. TRADE COMM'N, COMPETITION AMONG HOSPITALS (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FED. TRADE COMM'N, 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).

[7] *Health Care and Competition Law and Policy Hearings*, FED. TRADE COMM'N, https://www.ftc.gov/news-events/events-calendar/2003/02/health-care-competition-law-policy-hearings (last visited Dec. 2, 2015).

[8] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION Exec. Summ. at 22, ch. 8 at 1-6 (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.

[9] *See, e.g.*, Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice to the Virginia Certificate of Public Need Work Group (Oct. 26, 2015), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-virginia-certificate-public-need-work-group/151026ftc-dojstmtva_copn1.pdf; Letter from Marina Lao, Dir., Office of Policy Planning, Fed. Trade Comm'n, et al., to The Honorable Marilyn W. Avila, N.C. House of Representatives (July 10, 2015), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-concurring-comment-commissioner-wright-regarding-north-carolina-house-bill-200/150113ncconadv.pdf; Prepared Statement of the Federal Trade Commission Before the Florida State Senate (Apr. 2, 2008) [hereinafter FTC Florida Statement], *available at* https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-prepared-statement-florida-senate-concerning-florida-certificate-need-laws/v080009florida.pdf; Statement of the Antitrust Division, U.S. Department of Justice, Before the Florida Senate Committee on Health & Human Services (Mar. 25, 2008), *available at* http://www.justice.gov/atr/comments-competition-healthcare-and-certificates-need; Prepared Statement of the Federal Trade Commission Before the Standing Committee on Health, Education, & Social Services of the Alaska House of Representatives (Feb. 15, 2008) [hereinafter FTC Alaska Statement], *available at* https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-written-testimony-alaska-house-representatives-concerning-alaska-certificate-need-laws/v080007alaska.pdf; Statement of the Antitrust Division, U.S. Department of Justice, Before a Joint Session of the Health and Human Services Committee of the State Senate and the CON Special Committee of the State House of Representatives of the General Assembly of the State of Georgia (Feb. 23, 2007), *available at* http://www.justice.gov/atr/competition-healthcare-and-certificates-need.

II. South Carolina's CON Program and House Bill 3250

South Carolina established its CON program in 1971 "to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which will best serve public needs, and ensure that high quality services are provided in health facilities in this State."[10] The program requires providers to obtain a CON from the Department of Health and Environmental Control (the "Department") before initiating a wide range of projects. Covered projects include the construction or expansion of acute care hospitals, psychiatric hospitals, alcohol and substance abuse hospitals, nursing homes, ambulatory surgery facilities, hospice facilities, radiation therapy facilities, rehabilitation facilities, residential treatment facilities for children and adolescents, intermediate care facilities for persons with intellectual disability, and narcotic treatment programs.[11] Additionally, facilities must obtain a CON before adding certain services, acquiring certain medical equipment, and making certain capital expenditures.[12] In reviewing an application for a CON, the Department considers, among other factors, the need for the project, the financial feasibility of the project, the suitability of the proposed site, the availability of physicians and other required staff, and any adverse effects on other facilities.[13]

South Carolina's CON process can be time-consuming and costly, potentially involving multiple layers of review and spanning many months or years. A party seeking a CON must publish a notification in a newspaper 20 days prior to filing its application.[14] After receiving an application,[15] the Department has 30 days to request additional information.[16] The review period commences once the application is complete and the Department has notified "affected persons,"[17] including competitors of the proposed project.[18]

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[10] S.C. Code Ann. § 44-7-120 (2015).

[11] S.C. Code Ann. §§ 44-7-130(10), 44-7-160 (2015).

[12] S.C. Code Ann. § 44-7-160 (2015).

[13] S.C. Code Ann. § 44-7-190 (2015); S.C. Code Ann. Regs. 61-15 §§ 801-802 (2015).

[14] S.C. Code Ann. § 44-7-200(B) (2015).

[15] The requirements for the application span some 7 pages. BUREAU OF HEALTH FACILITIES & SERVICES DEVELOPMENT, SOUTH CAROLINA DEPARTMENT OF HEALTH & ENVIRONMENTAL CONTROL, REGULATION NO. 61-15: CERTIFICATE OF NEED FOR HEALTH FACILITIES AND SERVICES 9-16 (May 25, 2012), *available at* http://www.scdhec.gov/Agency/docs/health-regs/61-15.pdf.

[16] S.C. Code Ann. § 44-7-200(D) (2015).

[17] S.C. Code Ann. § 44-7-210(A) (2015).

Department staff then have 120 days to reach a decision, unless an affected person requests a public hearing, in which case the deadline is 150 days.[19] The staff decision becomes the final agency decision, unless an affected person requests a final review by the Department within 15 days.[20] The Department must hold any final review conference within 60 days of the request, and must issue a written decision within 30 days of the conference.[21] An affected party may appeal the Department's final decision to the Administrative Law Court, which has 18 months from the date of that appeal to file its final decision.[22] An aggrieved party may then seek judicial review of the Administrative Law Court's decision.[23] Therefore, even before any appeal to the judiciary, the CON process can delay entry or expansion by approximately two years.[24] Court challenges can add additional months or years to the process,[25] even in cases where, ultimately, a CON is granted.

House Bill 3250 would narrow the application of, and ultimately repeal, South Carolina's CON program. The Bill, if passed, immediately would amend the procedures for obtaining a CON (for example, placing additional limits on discovery in an Administrative Law Court proceeding and providing for attorney's fees if a party challenging the issuance of a CON at the Administrative Law Court does not prevail)[26] and revise the scope of the CON program (for

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[18] S.C. Code Ann. § 44-7-130(1) (2015) (defining affected person to include "persons located in the health service area in which the project is located and who provide similar services to the proposed project").

[19] S.C. Code Ann. § 44-7-210(A) (2015).

[20] S.C. Code Ann. §§ 44-1-60(E), 44-7-210(C) (2015).

[21] S.C. Code Ann. § 44-1-60(F) (2015).

[22] S.C. Code Ann. § 44-7-210(E)-(G) (2015).

[23] S.C. Code Ann. § 44-7-220(A) (2015). A party challenging the approval of a CON request must post a bond in the amount of the larger of five percent of the cost of the project or $100,000, and, if its appeal fails, the court awards the bond to the applicant and may award the applicant reasonable attorney's fees as well. S.C. Code Ann. § 44-7-220(B) (2015).

[24] *See, e.g.*, Final Order & Decision, Grand Strand Reg'l Med. Ctr., LLC v. S.C. Dep't of Health & Envtl. Control, No. 2012-ALK-07-0091-CC (Mar. 19, 2014) (application for a CON filed July 19, 2011, and Administration Law Court decision reversing the Department's denial of the application issued March 10, 2014).

[25] *See, e.g.*, Trident Med. Ctr., LLC v. S.C. Dep't of Health & Envtl. Control, 412 S.C. 341, 772 S.E.2d 177 (Ct. App. 2015) (application for CON filed on December 10, 2008, and Court of Appeals issued its decision affirming the Department's approval of the application on February 18, 2015, over six years later).

[26] H. 3250, 121st Gen. Assemb. §§ 4, 11-12 (S.C. 2015).

example, setting the threshold for CON coverage of capital expenditures at $5 million).[27] The Bill would repeal the CON program, effective January 1, 2018.[28]

III. Analysis of the Likely Competitive Effects of South Carolina's CON Laws

Competition in health care markets can benefit consumers by containing costs, improving quality, and encouraging innovation.[29] Indeed, price competition generally results in lower prices for, and thus, broader access to, health care products and services, while non-price competition can promote higher quality care and encourage innovation. CON laws may suppress these substantial benefits of competition by limiting the availability of new or expanded health care services. For these reasons, the Agencies historically have suggested that states with CON laws repeal or narrow those laws, [30] and now respectfully suggest that South Carolina repeal its CON program.

A. CON Laws Create Barriers to Entry and Expansion, Which May Suppress More Cost-Effective, Innovative, and Higher Quality Health Care Options

CON laws, such as South Carolina'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 supply, misallocate resources, and shield incumbent health care providers from competition from new entrants.[31] Specifically, CON laws can tend to do the following:

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[27] *Id.* §§ 7-8. The current threshold is $2 million. S.C. Code Ann. Regs. 61-15 § 102(1)(c) (2015).

[28] H. 3250, 121st Gen. Assemb. §§ 16(E)-(G) (S.C. 2015).

[29] A DOSE OF COMPETITION, *supra* note 8, at Exec. Summ. at 4.

[30] *See id.* at ch. 8 at 6; 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 2 (Sept. 15, 2008) [hereinafter DOJ-FTC Illinois Testimony], *available at* 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.

[31] *See* A DOSE OF COMPETITION, *supra* note 8, 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).

- raise the cost of entry and expansion – by adding time, uncertainty, and the cost of the approval process itself – for firms that have the potential to offer new, lower cost, more convenient, or higher quality services;

- remove, reduce, or delay the competitive pressures that typically incentivize incumbent firms to innovate, improve existing services, introduce new ones, or moderate prices;[32] and

- prohibit entry or expansion outright, in the event that a CON is denied by regulators or the courts.

We urge South Carolina to consider that its CON law may have these results, to the detriment of health care consumers, and to consider the benefit to both patients and third-party payors if new facilities and services could enter the market more easily. This new entry and expansion – and the threat of entry or expansion – could restrain the price of health care, improve the quality of care, incentivize innovation in the delivery of care, and improve access to care.[33]

B. The CON Process May Be Exploited by Competitors Seeking to Protect Their Revenues and May Facilitate Anticompetitive Agreements

Incumbents 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. For instance, an incumbent firm may file challenges or comments to a potential competitor's CON application to thwart or delay competition. As noted in an FTC-DOJ report, existing firms can use the CON

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[32] *See id.*; DOJ-FTC Illinois Testimony, *supra* note 30, at 6.

[33] One of the criteria used by the Department in reviewing CON applications is any "Adverse Effect on Other Facilities," including whether the proposed facility could be staffed "without unnecessarily depleting the staff of existing facilities or services or causing an excessive rise in staffing costs due to increased competition." S.C. Code Ann. Regs. 61-15 § 802(23)(b) (2015). Reducing competition among buyers – here, competition among hospitals for nurses and other medical professionals – not only can harm sellers – here, nurses and other medical professionals who may receive lower wages or reduced benefits – but also may harm downstream consumers – here, the loss of competition due to the CON regime may be reducing the quantity or degrading the quality of medical services. *See, e.g.*, Competitive Impact Statement at 8, United States v. UnitedHealth Group, Inc., No. 05-2436 (D.D.C. Mar. 3, 2006), *available at* http://www.justice.gov/atr/case-document/competitive-impact-statement-214 (explaining that a merger of two health insurers would have given the merged insurer the ability to unduly depress physician reimbursement rates, likely leading to a reduction in quantity or degradation in the quality of physician services).

process "to forestall competitors from entering an incumbent's market."[34] This use of the CON process by competitors can cause more than delay;[35] it can divert scarce resources away from health care innovation as potential entrants incur legal, consulting, and lobbying expenses responding to competitor challenges (and as incumbents incur expenses in mounting such challenges).[36] Repeal or retrenchment of South Carolina's CON law would eliminate or mitigate the opportunity for this type of exploitation of the CON process.

CON programs also have facilitated anticompetitive agreements among competitors. For example, in 2006, a hospital in Charleston, West Virginia, used the threat of objection during the CON process to induce another hospital to refrain from seeking a CON for a location where it would have competed to a greater extent with the existing hospital's program.[37] In a separate but similar case, informal suggestions by state CON officials led a pair of closely competing West Virginia hospitals to agree that one hospital would seek a CON for open heart surgery, while the other would seek a CON for cancer treatment.[38] While the Division secured consent decrees prohibiting these agreements between competitors to allocate services and territories,[39] such conduct indicates that CON laws can provide the opportunity for anticompetitive agreements.

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[34] A DOSE OF COMPETITION, *supra* note 8, 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").

[35] *See* text accompanying notes 14 - 23, *supra*; *see also* Yee et al., *supra* note 34, at 5 ("CONs for new technology may take upward of 18 months, delaying facilities from offering the most-advanced equipment to patients and staff.").

[36] 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* DOJ-FTC Joint Illinois Testimony, *supra* note 30, at 6-7; FTC Florida Statement, *supra* note 9, at 8-9; FTC Alaska Statement, *supra* note 9, at 8-9.

[37] United States v. Charleston Area Med. Ctr., Inc., No. 2:06-0091 (S.D. W.Va. 2006).

[38] United States v. Bluefield Reg'l Med. Ctr., Inc., No. 1:05-0234 (S.D. W.Va. 2005).

[39] *See also* Press Release, U.S. Dep't of Justice, Department of Justice Statement on the Closing of the Vermont Home Health Investigation (Nov. 23, 2005), *available at* http://www.justice.gov/archive/opa/pr/2005/November/05_at_629.html (home health agencies entered into territorial market allocations, which were facilitated by the state regulatory program, to give each other exclusive geographic markets; without the state's CON laws, competitive entry might have disciplined this cartel behavior).

C. CON Laws Can Impede Effective Antitrust Remedies

As the FTC's recent experience in *FTC v. Phoebe Putney* demonstrates, CON laws can entrench anticompetitive mergers by limiting the government's ability to implement effective structural remedies to consummated transactions. *Phoebe Putney* involved a challenge to the merger of two hospitals in Albany, Georgia.[40] Seeking a preliminary injunction in federal court, the FTC alleged that the merger would create a monopoly in the provision of inpatient general acute care hospital services sold to commercial health plans in Albany and its surrounding areas. The district court dismissed the suit, finding that the merger was protected from antitrust scrutiny by the "state action doctrine."[41] The U.S. Court of Appeals for the Eleventh Circuit affirmed the district court's dismissal on state action grounds, although finding that "the joint operation of [the two hospitals] would substantially lessen competition or tend to create, if not create, a monopoly."[42] The Supreme Court reversed, holding that "state action immunity" did not apply.[43] However, the merger was consummated while appeals were pending, and Georgia's CON regime precluded structural relief for the anticompetitive merger.[44] As the Commission explained, "[w]hile [divestiture] would have been the most appropriate and effective remedy to restore the lost competition in Albany and the surrounding six-county area from this merger to monopoly, Georgia's [CON] laws and regulations unfortunately render a divestiture in this case virtually impossible."[45]

The Commission concluded that the case "illustrates how state CON laws, despite their original and laudable goal of reducing health care facility costs, often act as a barrier to entry to the detriment of competition and healthcare

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[40] *See generally* In re Phoebe Putney Health Sys., Inc., Dkt. No. 9348, *available at* https://www.ftc.gov/enforcement/cases-proceedings/111-0067/phoebe-putney-health-system-inc-phoebe-putney-memorial.

[41] FTC v. Phoebe Putney Health Sys., 793 F. Supp. 2d 1356, 1361-62 (M.D. Ga. 2011).

[42] FTC v. Phoebe Putney Health Sys., 663 F.3d 1369 (11th Cir. 2011).

[43] FTC v. Phoebe Putney Health Sys., 133 S. Ct. 1003, 1007 (2013).

[44] The Eleventh Circuit affirmed the district court's dismissal of the case on state-action grounds and dissolved the stay that had prevented the parties from consummating the merger. With the stay dissolved, the parties had consummated their merger before the state-action question was resolved by the federal courts. *See* FTC v. Phoebe Putney Health Sys. Inc., 133 S. Ct. at 1011 (2013).

[45] Statement of the Federal Trade Commission at 1, In re Phoebe Putney Health Sys., Inc., Dkt. No. 9348, (Mar. 31, 2015), https://www.ftc.gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf.

consumers."[46] That is, because CON laws can limit the supply of competitors, and not just the supply of health care facilities and services, they can foster or preserve provider market power. Thus, South Carolina should consider whether its CON laws could prevent divestiture as an effective tool to remedy anticompetitive mergers in appropriate cases.

D. Interim Provisions in H.B. 3250 Discriminate Against New Entrants

This statement focuses on the impact of CON laws generally because House Bill 3250 would repeal South Carolina's entire CON program, effective January 2018. This statement does not attempt to evaluate the Bill's various interim provisions, but one such provision deserves comment. Reducing the scope of CON laws can, in many cases, lower barriers to entry and enhance competition; for that reason, the Agencies generally have advocated for CON's retrenchment as well as its repeal. However, the Agencies are concerned about the likely competitive effects of the Bill's proposal to exempt certain facilities expansions or capital expenditures by incumbent providers from CON review, if undertaken prior to 2018, while requiring CON review and approval for similar expansions and expenditures proposed by new entrants.[47] This proposal, on its face, discriminates against the type of entry that would tend to reduce provider concentration. Lowering entry costs for incumbent providers might help them make more efficient investment decisions in the near term. At the same time, to remove CON requirements *only* for incumbent providers – while their potential competitors cannot enter – could facilitate the type of strategic investment that may harm competition going forward.[48] As such, the Agencies are concerned that it would preserve or exacerbate extant provider market power. Thus, this particular form of retrenchment might be anticompetitive on balance, and its anticompetitive effects could persist well past the repeal of the CON program in 2018.

IV. Evidence on the Impact of CON Laws

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-based

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[46] *Id.* at 3.

[47] H. 3250, 121st Gen. Assemb. § 8 (S.C. 2015).

[48] *See, e.g.,* Leemore S. Dafny, *Games Hospitals Play: Entry Deterrence in Hospital Procedure Markets* 14.3 J. ECON. & MGT. STRATEGY 513, 536-37 (2005) (finding "evidence of investment for the purpose of entry deterrence" by U.S. hospitals in response to a change in Medicare reimbursement).

health care reimbursement system.[49] Although that reimbursement system has changed significantly, CON laws remain in force in many states, and CON proponents continue to raise cost control as a justification for CON programs. CON proponents also argue that CON laws positively affect the quality of health care services and that CON programs have enabled states to assure access to health care services. As described below, however, the evidence on balance suggests that CON laws have failed to produce cost savings or higher quality health care.

A. CON Laws Appear to Have Failed to Control Costs

Proponents of CON programs contend that CON laws contain health care costs by preventing "overinvestment" in capital-intensive facilities, services, and equipment. They claim that normal market forces do not discipline investment in the health care sector given, in many cases, the disconnect between the party selecting a provider (the patient) and the party paying all or most of the bill (the insurer), and the information asymmetries among provider, patient, and insurer. They therefore call for a regulatory regime requiring preapproval for health care investments.[50]

However, CON laws are likely to increase, rather than constrain, health care costs. First, as noted above, South Carolina's CON process is costly, due, in part, to its length and complexity.[51] For a wide range of facilities and diverse capital investments,[52] there are the legal and regulatory costs of preparing an application and, then, seeing that application through the approval process and potential third-party challenges. Such costs represent investments in an administrative process – they do not directly contribute to the construction of health care facilities or the delivery of health care services. They are, moreover, investments made at risk, to the extent that the result of a CON application is uncertain during the months or years that the application, or a challenge to it, is pending. The costs of the CON process – the investment, the time, and the risk – are among the costs of new, expanded, or improved health care facilities.

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[49] *See* A DOSE OF COMPETITION, *supra* note 8, ch. 8 at 2; WHITE, *supra* note 2, at 527.

[50] *See CON Background*, AM. HEALTH PLANNING ASS'N, http://www.ahpanet.org/copnahpa.html ("The rationale for imposing market entry controls is that regulations, grounded in community-based planning, will result in more appropriate allocation and distribution of health care resources and, thereby, help assure access to care, maintain or improve quality, and help control health care capital spending.").

[51] *See* text accompanying notes 14-23, *supra*.

[52] *See* text accompanying notes 11-12, *supra*.

Second, those regulatory costs also can work as a barrier to entry, tending to discourage some would-be providers from entering certain health care markets, and tending to discourage some incumbent providers from expanding or innovating in ways that would make business sense, but for the costs imposed by the CON system. Further, even for providers willing to incur those regulatory costs, CON requirements stand as a hard barrier to entry in the event that a CON application is denied. Hence, CON laws can diminish the supply of health care facilities and services, denying consumers options for treatment and raising the prices charged for health care.

Empirical evidence on competition in health care markets generally has demonstrated that consumers benefit from lower prices when provider markets are more competitive.[53] Agency scrutiny of hospital mergers has been particularly useful in understanding concentrated provider markets, and retrospective studies of the effects of provider consolidation by Agency staff and independent scholars suggest that "increases in hospital market concentration lead to increases in the price of hospital care."[54] Furthermore, both the FTC and the Division have engaged in significant enforcement efforts to prevent anticompetitive behavior in health care provider markets because the evidence

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[53] *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 (Nat'l Bureau of Econ. Research, Working Paper 17208, 2011) (critical review of empirical and theoretical literature regarding markets in health care services and insurance).

[54] *Impact of Hospital Consolidation, supra* note 53, 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 and 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).

suggests that consumers benefit from competition.[55] The Agencies strongly believe that competition can work in health care markets.[56]

The best empirical evidence suggests that greater competition incentivizes providers to become more efficient.[57] Recent work shows that hospitals faced with a more competitive environment have better management practices.[58] Consistent with this, there is evidence suggesting that repealing or narrowing CON laws can reduce the per-patient cost of health care.[59]

Finally, the Agencies have found no empirical evidence that CON laws have successfully restricted "over-investment."[60] CON laws can, however,

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[55] *Supra* note 5.

[56] Indeed, similar arguments made by engineers and lawyers in defense of anticompetitive agreements on price – that competition fundamentally does not work in certain markets, and in fact is harmful to public policy goals – have been rejected by the courts, and private restraints on competition have been condemned. *See, e.g.*, FTC v. Superior Court Trial Lawyers Ass'n, 493 U.S. 411, 424 (1990); Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978).

[57] Furthermore, 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.

[58] *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.").

[59] *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.").

[60] 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

restrict investments that would benefit consumers and lower costs in the long run. Because CON laws raise the cost of investment for all firms, they make it less likely that beneficial investment will occur. The CON application process directly adds to the cost of investment for both incumbents and potential entrants. In addition, CON laws shield incumbents from competitive incentives to invest.

B. Quality of Care Arguments Should Not Preclude CON Reform

Proponents also have argued that CON laws improve the quality of health care services. Specifically, they contend that providers performing higher volumes of procedures have better patient outcomes, particularly for more complex procedures.[61] Hence, by concentrating services at a limited number of locations, CON laws could increase the number of procedures performed by particular providers and reduce the frequency of adverse outcomes.

Such arguments do not fully consider the relevant literature or the effect of competition on clinical quality. First, the most pronounced effect of volume on quality outcomes may be limited to certain relatively complicated procedures.[62] Second, even for services where certain studies have shown a volume/outcome relationship, such as coronary artery bypass graft surgery,[63] evidence suggests that these volume effects may not offset the other effects of

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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%").

[61] This relationship between the volume of surgical procedures and quality has been studied in numerous settings, and is often supported by the evidence. *See, e.g.*, Martin Gaynor et al., *The Volume-Outcome Effect, Scale Economies, and Learning-by-Doing*, 95:2 AM. ECON. REV. 243, 245 (2005) ("Like the prior literature, we find a large volume-outcome effect.").

[62] *See* Ethan A. Halm et al., *Is Volume Related to Outcome in Health Care? A Systematic Review and Methodological Critique of the Literature*, 137.6 ANNALS INTERNAL MED. 511, 514 (2002) ("We found the most consistent and striking differences in mortality rates between high- and low-volume providers for several high-risk procedures and conditions, including pancreatic cancer, esophageal cancer, abdominal aortic aneurysms, pediatric cardiac problems, and treatment of AIDS. The magnitude of volume-outcome relationships for more common procedures, such as [coronary artery bypass graft surgery], coronary angioplasty, and carotid endarterectomy, for which selective referral and regionalization policies have been proposed, was much more modest.").

[63] *See* Gaynor et al., *supra*, note 61, at 244.

CON programs on quality.[64] The volume/outcome relationship is just one mechanism by which quality of health care can be affected by CON laws, so this literature only provides a partial picture of the impact of CON. A more complete picture is obtained by studies that directly analyze the impact of changes in CON laws on health outcomes. The weight of this research has found that repealing or narrowing CON laws is generally unlikely to lower quality, and may, in fact, improve the quality of certain types of care.[65] Moreover, additional empirical evidence suggests that, "[a]t least for some procedures, hospital concentration reduces quality."[66]

Finally, although the Agencies defer to the State of South Carolina to implement its health and safety priorities, we note that the states commonly have other, more direct means of regulating the quality of health care providers. For example, South Carolina already provides for the regulation of hospitals and other health care facilities,[67] and provides for the regulation of physicians, nurses, and other health care professionals.[68]

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[64] *See, e.g.*, Vivian Ho et al., *Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON*, 44:2 HEALTH SERVS. RES. 483, 483 (2009) ("States that dropped CON experienced lower [coronary artery bypass graft surgery] mortality rates relative to states that kept CON, although the differential is not permanent.").

[65] *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 59, 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").

[66] *Impact of Hospital Consolidation*, *supra* note 53, 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), *available at* https://www.ftc.gov/reports/retrospective-analysis-clinical-quality-effects-acquisition-highland-park-hospital-evanston.

[67] *See, e.g.*, S.C. Code Ann. § 44-7-250 (2015) (requiring the Department to "establish and enforce basic standards for the licensure, maintenance, and operation of health facilities and services to ensure the safe and adequate treatment of persons served in this State"); S.C. Code Ann. § 44-7-260 (2015) (barring hospitals and other facilities from operating in South Carolina without a license).

[68] *See, e.g.*, S.C. Code Ann. § 40-33-30 (2015) (requiring a license for the practice of nursing in South Carolina); S.C. Code Ann. § 40-47-30 (2015) (requiring a license for the practice of medicine

C. More Targeted Policies May Be More Effective at Ensuring Access to Care and Would Not Inflict Anticompetitive Costs

Another argument advanced by proponents of CON programs is that the programs enable states to increase access to care for their indigent residents and in medically underserved areas. The general argument is that, by limiting competition, CON laws allow incumbent health care providers to earn greater profits – through the charging of higher prices and the preservation of their volume of lucrative procedures – than they would earn in a competitive environment. According to this argument, these incumbents can then use those extra profits to cross-subsidize their provision of care to the indigent. Additionally, proponents maintain that regulators can use CON laws to restrict entry into well-served areas and encourage it in medically underserved areas.

Although the Agencies appreciate the importance of ensuring access to health care for the indigent and in medically underserved areas, we urge South Carolina lawmakers to consider whether there are more effective or narrowly tailored ways in which to accomplish this public policy goal. We note, first, that the charity-care rationale is at odds with the cost-control rationale. That is, the notion that CON-protected incumbents will use their market power and profits to cross-subsidize charity care supposes that those providers will charge *supra*-competitive prices for non-charity care. Such *supra*-competitive pricing might harm many South Carolina health care consumers, including low-income or under-insured patients who are ineligible for charity care.

Moreover, as described in Section III.A., above, 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 indigent 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.[69] In addition, there is some empirical evidence contrary to the notion that

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in South Carolina); S.C. Code Ann. §§ 44-7-3410-3470 (2015) (Lewis Blackman Hospital Safety Act).

[69] Cutler, *supra* note 65, 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), *available at* 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.").

dominant providers use their market power to cross-subsidize charity care. For example, one empirical study of the relationship between competition and charity care found a "complete lack of support for the 'cross-subsidization hypothesis': that hospitals use increased market power to fund more charity care or, stated in the negative, that increased competition will harm patients who rely on charity care."[70]

Finally, CON programs are a blunt tool for accomplishing the specific goal of providing care to the indigent and in medically underserved areas. They tend to sweep broadly, limiting competition for a wide variety of health care services. Although the Agencies do not endorse any particular mechanism for funding indigent care, we note that solutions more narrowly tailored to a state's recognized policy goals may be substantially less costly to consumers, and ultimately more effective at achieving the desired social goals, than a CON regime.[71]

V. Conclusion

The Agencies recognize that states must weigh a variety of policy objectives when considering health care legislation. But, as described above, CON laws raise considerable competitive concerns and generally do not appear to have achieved their intended benefits for health care consumers. For these reasons, the Agencies historically have suggested that states consider repeal or retrenchment of their CON laws. We respectfully suggest that South Carolina repeal its CON laws.

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

[71] *See, e.g.*, LEWIN GROUP, *supra* note 69, at 29 (discussing various financing options for charity care in Illinois); DOJ-FTC Illinois Testimony, *supra* note 30, at 9; Joint Comm'n on Health Care, A Plan to Eliminate the Certificate of Public Need Program Pursuant to Senate Bill 337 22 (2000), *available at* http://www.vdh.state.va.us/Administration/documents/COPN/Prior%20Virginia%20Studies/JCHC%20COPN%20Deregulation%20Plan%20SB337%20of%20%202000.pdf (plan to eliminate Virginia's COPN program included "several provisions to help cushion hospitals and the AHCs from the impact of being less able to cost-shift and subsidize indigent care, low revenue-generating services, and undergraduate medical education").