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Competition in Healthcare and Certificates of Need

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The CON Special Committee of the State House of Representatives
of the General Assembly of the State of Georgia

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Good afternoon. I want to thank Chairman Thomas and Chairman Cooper for their invitation to the Antitrust Division of the U.S. Department of Justice to appear before you today and to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets.

My name is Mark Botti. I am the Chief of the Litigation I Section of the Antitrust Division. My group has approximately 30 attorneys and additional staff dedicated to enforcement of the antitrust laws and advocacy of the importance of competition in a number of sectors of the nation's economy. In particular, we focus to a substantial degree on healthcare markets. In doing that work, we confer closely with a large team of Antitrust Division economists holding doctorates in the study of markets and their performance, including a number with specialization in the performance of healthcare markets. We also confer closely with the attorneys and economists at the Federal Trade Commission, who also have dedicated time to the study of healthcare markets.

My remarks today are built on the work of these professionals and the Antitrust Division's decades long focus on healthcare markets. Over those years, we have brought many antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals and other healthcare products. Through that work we understand the competitive forces that drive innovation in and contain the costs of healthcare. We consult regularly with federal and state agencies responsible for the delivery of healthcare services and the setting of healthcare policy. Our attorneys and economists study the latest academic and policy works in healthcare on an ongoing basis. We

have on many occasions met informally and formally with experts in the field. For example, in the first half of the 1990s, the Federal Trade Commission and the Antitrust Division committed substantial resources to the study of competitive markets, out of which effort we prepared a series of nine antitrust enforcement principles that guide industry behavior today.[1] I worked on those enforcement statements and am directly responsible for their application. More recently, in 2003, we conducted 27 days of hearings on competition and policy concerns in the healthcare industry, heard from approximately 250 panelists, elicited 62 written submissions, and generated almost 6,000 pages of transcripts.[2] As a result of that effort, we published an extensive report, entitled *Improving Health Care: A Dose of Competition*, in July 2004.[3] I oversaw the Antitrust Division's work on those hearings and that report and am the designated point of contact at the Division regarding the report.

I. Scope of Remarks

The Antitrust Division's experience and expertise has taught us that Certificate of Need laws pose a substantial threat to the proper performance of healthcare markets. Indeed, by their very nature, CON laws create barriers to entry and expansion and thus are anathema to free markets. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation. We have examined historical and current arguments for CON laws. They do not provide an economic justification for depriving consumers of the benefits of free markets. To the extent non-economic goals are pursued, the use of CON laws to help pursue them imposes substantial costs. Those goals can be better achieved through other mechanisms. I will explain our reasoning in more detail in just a moment; but first allow me to respectfully suggest to you our bottom line -- we hope you will carefully consider the substantial costs that CON laws impose on consumers as you evaluate whether to reform those laws in your state.

I have not come here today to discuss the details of any particular proposal before you for the reform of Georgia's CON laws. I am, however, generally familiar with the issues before you and recognize them as issues that CON laws present in other states and other markets. My remarks, accordingly, will focus on the impact of and justifications for CON laws generally. For your convenience, I am leaving with you the written text of these remarks with citations to relevant sources included.

In offering these remarks, please understand that it is not the Antitrust Division's intent 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 . . . ."[4] Our overall mission is to preserve and promote competition, rather than to preserve 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 Healthcare

Let me set the stage for explaining our concerns about the harm from CON laws by talking for a moment about competition in healthcare generally. No doubt there are aspects of the delivery of healthcare services that make healthcare different from other sectors of the economy. The health

of any individual is a sensitive and very important matter. But in our concern over the health and well-being of our fellow citizens, we as government officials should not lose sight of a basic truth -- market forces improve the quality and lower the costs of healthcare services. Increased competition in healthcare markets does not require us to choose between obtaining the benefits of competition or the delivery of high-quality healthcare. Competition drives innovation and ultimately leads to the delivery of better healthcare. Government intervention can undermine the ability of markets to deliver that benefit.

The proposition that competition cannot work in healthcare is simply not true. Similar arguments, made by engineers and later by lawyers, that competition fundamentally does not work in their industries and is harmful to public policy goals, have been soundly rejected and private restraints on competition have long been condemned.[5] Indeed, at least since the Supreme Court's seminal 1943 decision in a case brought by the Department of Justice against the American Medical Association, competition has played a critical role in shaping the delivery of healthcare in this country. The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.[6]

During our extensive healthcare hearings in 2003, we obtained substantial evidence about the role of competition in our healthcare delivery system and reached the conclusion that vigorous competition among healthcare providers "promotes the delivery of high-quality, cost-effective healthcare." Competition results in lower prices and broader access to health care and health insurance, and in particular non-price competition can promote higher quality.[7]

This finding is not surprising. We saw in the 1990s the growth of managed care and the impact it had on the cost and availability of insurance. Competition among and between hospitals and physicians intensified with the development of managed care organizations. In addition to putting pressure on costs, managed care plans have pressured providers to use shorter hospital stays and to offer alternative outpatient treatments. This evolution in health care purchasing led to lower costs and increased choice without sacrificing quality. Moreover, lower costs and improved efficiency made health insurance more affordable and available.

Competition also helped bring to consumers important innovations in healthcare technology. 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.[8] Ambulatory surgery centers offered patients more "convenient locations, shorter wait time, and lower coinsurance than a hospital department."[9] Important to the success of these competitive forces in improving the delivery of care to consumers was the availability of technological advances, such as endoscopic surgery and advanced anesthetic agents.[10] Thus, competition harnessed this new technology and brought it to consumers in the lower cost, more convenient setting of ambulatory surgery centers. The impact on traditional general acute care hospitals led to those hospitals responding to the competition by delivering more care, in a better manner, in an outpatient setting, both at their own campuses and at ambulatory surgery centers in which they invested.

This type of competitive success story has occurred again and again in healthcare in the area of pharmaceuticals, urgent care centers, and elective surgeries such as Lasik procedures, to name

just a few. Without private or governmental impediments to their performance, we can expect healthcare markets to continue to deliver these benefits.

For example, we are on the cusp of a potentially significant advance in how competition empowers consumer choice, thus delivering more quality and containing costs. In an August 22, 2006 Executive Order, the President ordered executive agencies to take steps to promote transparency in healthcare quality measures and pricing and to facilitate the development of health information technology.[11] In implementing that directive, the Department of Health and Human Services (HHS), has launched a transparency initiative for value-driven health care that aims to facilitate the delivery of better care at lower costs. Similarly, private health plans have developed products that give consumers greater choice and more information, with an eye toward improving quality while controlling costs. And new companies are entering the market seeking to provide more information and empower consumer choice in healthcare markets.[12] Capturing the promise of these initiatives, HHS has observed that "[c]onsumer choice creates incentives at all levels, and motivates the entire system to provide better care for less money."[13]

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry. As such, they are anathema to competitive markets. Accordingly, in *A Dose of Competition*, the Department of Justice and the Federal Trade Commission urged the states to rethink their CON laws.[14]

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 origins 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 the time, the federal government and private insurance reimbursed healthcare expenses predominantly on a "cost-plus basis." This is a very important point. The original reason for CON laws was not, as some have argued, that competition inherently does not work in healthcare or that market forces promote over-investment. Instead, CON laws were desired because the reimbursement mechanism, i.e., cost-plus reimbursement, incentivized over-investment. The hope was that CON laws would compensate for that skewed incentive.

In considering this historical justification for CON laws, we need to keep clear that a number of other arguments made in support of CON laws were not part of the rationale for their original adoption:

- CON laws were not adopted around the country as a means of cross-subsidizing care;
- CON laws were not adopted in order to have centralized planning of the location and nature of healthcare facilities; and,
- CON laws were not adopted to protect the health and safety of the population from poor quality medicine.

Instead, CON laws were adopted because excessive capital investments, spurred by the then-current cost-plus method of reimbursement, were driving up healthcare costs. There was concern

that, since patients were not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[15]

CON laws appear not to have served well even their intended purpose of containing costs. Several studies examined the effectiveness of CONs in controlling costs. The empirical evidence on the economic effects of CON programs demonstrated near-universal agreement among health economists that CON laws were unsuccessful in containing healthcare costs.[16]

In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis. In 1986, Congress repealed the National Health Planning and Resources Development Act of 1974. Health plans and other purchasers routinely bargain with healthcare providers over prices. Essentially, government regulations have changed in a way that eliminates the original justification for CON programs.[17]

2. Protecting Revenues of Incumbents Does Not Justify CON Laws

I want to address directly one of the most prominent rationales advanced for keeping CON laws, namely, that incumbent hospitals should be protected against additional competition so that they can use their profits to cross-subsidize care for uninsured or under-insured patients.[18] Under this rationale, CON laws would impede the entry of such healthcare providers as independent ambulatory surgery centers, free-standing radiology or radiation-therapy providers, single- or multi-specialty physician-owned hospitals, because if these new competitors were to enter the marketplace, community hospitals could not continue to exploit their existing market power over consumers. Put another way, without CON laws, we would see new, higher-quality, low cost providers in the marketplace, which would put competitive pressure on incumbent providers.

The cross-subsidization rationale essentially turns these laws on their head. What started as laws intended to control costs have become laws intended to inflate prices. Ironically, proponents of CON laws now would use these barriers to entry to accomplish precisely what economic theory would predict barriers to entry usually accomplish -- stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

Please do not misunderstand my point here. We are not accusing community hospital proponents of CON laws of seeking these barriers to entry for some improper purpose. We fully appreciate the laudatory goal of trying to make sure that community hospitals have sufficient funding so that they can provide healthcare services to those who cannot afford them and for whom government payments are either unavailable or too little to cover the cost of care. But we also want to make clear that the use of government barriers to entry to fund this laudatory purpose has costs. Importantly, to the extent legislatures choose to help cover health care costs for the indigent, there are more efficient ways to accomplish this goal, without incurring the costs of impeding the proper functioning of health care markets. Essentially, by protecting incumbent hospitals from competition, CON laws allow them to tax consumers through the exercise of market power in order to pursue the charitable goal of providing care to other, less fortunate consumers. In using that funding mechanism, however, the CON laws may do more harm than good.

First, CON laws harm the consumers who would have chosen alternative, lower priced, higher quality, or more convenient sources of care.

Second, CON laws impose that cost without any clear evidence that other desired social goals are advanced. Put another way, the evidence to date indicates that new competition does not undercut community hospitals' ability to fulfill their charitable mission. Last year, the federal government studied just this issue in connection with the emergence of single-specialty hospitals around the country. The study found that, for several reasons, specialty hospitals did not undercut the financial viability of rival community hospitals.[19] 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.

A third reason why CONs may do more harm than good results from the beneficial effect that new competition has on community hospitals. In studying the effect of single-specialty hospitals, MedPAC found that the community hospitals responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[20] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[21] Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting community hospitals, we have seen that new entry drives them to do a better job. Thus, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market.[22]

3. CON Laws Impose Other Costs and May Facilitate Anti-Competitive Behavior

CON laws appear to raise a particularly substantial barrier to entry and expansion of competitors because they create an opportunity for existing competitors to exploit procedural opportunities to thwart or delay new competition. Such behavior, commonly called "rent seeking" conduct, is a well-recognized consequence of regulatory intervention in the market.[23] Essentially, an existing competitor uses the hearing and appeals process to cause substantial delays, leading both the existing competitor and the new entrant to divert significant funds away from delivering healthcare and to spend them on legal fees, consulting fees, and lobbying efforts. Moreover, much of this conduct, even if exclusionary and anticompetitive, is unlikely to be subject to legal challenge as a violation of the antitrust laws because it involves petitioning of the state government by the existing competitor.[24] Indeed, during our hearings, we received evidence of the widespread recognition that existing competitors use the CON process "to forestall competitors from entering an incumbent's market."[25]

We have found that existing competitors at times go further and enter into agreements not required by the CON laws but nonetheless facilitated by them. Two examples arise from West Virginia, and a third comes from Vermont.

In the first West Virginia case, we found that a Charleston, West Virginia hospital used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce a hospital seeking a certificate of need for an open heart surgery program not to apply for it at the

location that would have well served Charleston consumers and provided greater competition for their business.[26] Instead, the Charleston hospital successfully prevented the possibility of this competing open heart program. The state authorities never had the opportunity to decide whether under the CON laws that second program would have been approved because of the unlawful agreement among the hospitals.

In the second West Virgina case, two closely competing hospitals decided to use the CON process to allocate healthcare services between themselves.[27] The hospitals agreed unlawfully that only the one hospital would apply for an open heart program and only the other would apply to provide cancer services. Again, the state took no official action and consumers were deprived of the potential competition between these hospitals.

A third example comes from the State of Vermont. There, home health agencies entered into territorial market allocations, again under cover of the state regulatory program, to give each other exclusive geographic markets.[28] That state's CON laws prevented competitive entry, which normally might have disciplined such cartel behavior. We found that Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.

We have learned from these matters and others that CON laws have the potential to impede competition in ways well beyond what is intended by their supporters.

4. CON Laws Lead To Less Competition and Higher Prices

It is not surprising, given that the prevalent justification for CON laws is to protect the exercise of market power by existing hospitals, that studies show that the removal of CON regulation does not consistently lead to a surge in medical expenditures.[29] Indeed, as one would expect, several studies have concluded that the presence of CON regulations may be responsible for increases in healthcare costs.[30] These findings were supported by the recent study by Georgia State University conducted as part of your state's review. That study showed that rigorous CON regulation is associated with less competitive markets and higher prices for private inpatient care.[31]

III. Framework for Evaluation of CON Laws

My remarks are intended to convey to you our belief that CON laws impose substantial costs on consumers and healthcare markets. In light of these costs, the Antitrust Division believes that Georgia should carefully consider whether, and if yes, to what degree, its CON laws continue to serve the citizens of this state. We offer the following framework for your consideration:

First, we suggest that the enactment or continuation of CON laws should have a significant, clearly articulated justification, because they are government intervention in the marketplace that create barriers to entry into healthcare markets. That substantial justification should have a basis in serious and persuasive market studies that demonstrate that the market has failed in some significant way.

Second, any evaluation of a proposed CON law should consider not only the justification for the law but also identify and weigh the harm to consumers that is likely to result from creating the barrier to entry. The consideration of these potential harms should include the ways in which the regulations could distort the market, affect incentives, or diminish competition. A state should enact or maintain a CON law only if it finds that the justification does more good than harm.

Third, in cases where the evidence does show a greater benefit than harm from a CON law, we urge you to consider whether you can address the problem in an alternative fashion that preserves competition, or at least is narrowly tailored to remedy only the demonstrated need and preserve as much competition as is possible. A state should only use CON laws to address some problem if that problem cannot be addressed without government intervention in the form of a barrier to entry. If a state must erect a barrier to entry, select the approach that accomplishes the objective with the least disruptive effect on competition.

Let me close by encouraging you not to accept without careful scrutiny claims that elimination of CON laws will visit significant harm on your state. We are unaware of evidence that those states which have eliminated CON laws have suffered such harm. The studies, cited above, in fact suggest that elimination of CON laws leads to improved markets. Accordingly, we encourage you to consider carefully whether the maintenance of those laws or the enactment of new ones best serves your citizens.

Thank you again for the opportunity to discuss our views on how CON laws affect competition and consumers in healthcare. I would be happy to take your questions.

FOOTNOTES

1. Statements of Antitrust Enforcement Policy in Health Care, August 1996, Introduction, pg. 3 (available at http://www.usdoj.gov/atr/public/guidelines/1791.htm) ("1996 Statements").

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

3. *Improving Health Care: A Dose of Competition* (July 2004) available at http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf. ("*A Dose of Competition*").

4. *See* 1996 Statements, pg. 3.

5. *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).

6. *American Medical Association v. U.S.*, 317 U.S. 519, 529 (1943).

7. *A Dose of Competition*, ch. 3 § VIII and Executive Summary at 4.

8. *Id.*, Ch. 3 at 25.

9. Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy § 2F, at 140 (2003), available at http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

10. A Dose of Competition, Ch. 3 at 24.

11. http://www.whitehouse.gov/news/releases/2006/08/20060822-2.html.

12. See http://www.revolutionhealth.com.

13. See http://www.dhhs.gov/transparency.

14. *A Dose of Competition*, Executive Summary at 22.

15. *A Dose of Competition*, Ch. 8 at 1-2.

16. 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").

17. *A Dose of Competition* at 1-6.

18. *Id.*, Ch. 3 at 36-40.

19. *See* MedPAC 2006 Report.

20. 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).

21. Greenwald, L. et al., "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits," *Health Affairs* 25, no. 1 (2006): 116-117. *See also* 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).

22. For similar reasons, we have not found persuasive other arguments, such as community planning or quality of care as reasons for erecting barriers to entry through CON laws.

23. Joskow, Paul and Rose, Nancy, "The Effects of Economic Regulation." *Handbook of Industrial Organization*, vol. 2, Schmalensee and Willig, eds., Amsterdam: North-Holland, 1989.

24. The *Noerr-Pennington* doctrine of antitrust law holds that under the First Amendment, it cannot be a violation of the federal antitrust laws for competitors to lobby the government to change the law in a way that would reduce competition. *See Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961) ("no violation of the [Sherman] Act can be predicated upon mere attempts to influence the passage or enforcement of laws");

United Mine Workers v. Pennington, 381 U.S. 657 (1965) ("joint efforts to influence public officials do not violate the antitrust laws even though intended to eliminate competition").

25. *A Dose of Competition*, Executive Summary at 22.

26. *United States v. Charleston Area Medical Center, Inc.*, Civil Action 2:06 -0091 (S.D.W.Va. 2006) (available at: http://www.usdoj.gov/atr/cases/f214400/214477.htm).

27. *United States v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).

28. 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).

29. Christopher Connover and Frank Sloan, Evaluation of Certificate of Need in Michigan (2003) (available at http://www.michigan.gov/mdch/0,1607,7-132-2945_5106-83771--,00.html).

30. Daniel Sherman, Federal Trade Commission, "The Effect of State Certificate-Of-Need Laws On Hospital Costs: An Economic Policy Analysis" (1988) (strong CON programs may increase costs); Christopher Connover and Frank Sloan, Evaluation of Certificate of Need in Michigan (2003) (available at http://www.michigan.gov/mdch/ 0,1607,7-132-2945_5106-83771--,00.html) (CON in some instances may have raised costs).

31. The Effect of Certificate of Need Laws on Cost, Quality, and Access (Georgia State University, Oct. 2006); Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program, at 9 (Nov. 2006).