U.S. Department of Justice

Antitrust Division

Competition in Healthcare and Certificates of Need
Statement of the Antitrust Division, US Department of Justice
Before the Florida Senate Committee on Health and Human Services Appropriations

JOSEPH M. MILLER
Assistant Chief, Litigation I Section

March 25, 2008[1]

I appreciate the invitation to the Antitrust Division of the U.S. Department of Justice to share our views on the impact of Certificate of Need ("CON") laws on healthcare markets. My name is Joseph Miller. I am the Assistant Chief of the Litigation I Section of the Antitrust Division. The Litigation I Section enforces the antitrust laws in a wide variety of industries, including healthcare markets. Our attorneys confer closely with a large team of economists holding doctorates in the study of markets and their performance, including a number who specialize in the performance of healthcare markets. We also confer closely with the attorneys and economists at the Federal Trade Commission (FTC), who have dedicated time to the study of healthcare markets.

The Antitrust Division and the FTC have investigated and litigated antitrust cases in markets across the country involving hospitals, physicians, ambulatory surgery centers, stand-alone radiology programs, medical equipment, pharmaceuticals and other healthcare products. Through that work we have developed a substantial understanding of the competitive forces that drive innovation in and contain the costs of healthcare. We regularly issue informal advisory letters on the application of the antitrust laws to healthcare markets, and periodically issue reports and general guidance to the healthcare community. For example, 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]

---

[1] This paper draws significantly from testimony delivered on behalf of the Antitrust Division to the General Assembly and Senate of the State of Georgia on February 23, 2007 and testimony delivered to the Committee on Health of the Alaska House of Representatives on January 31, 2008.

[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*").

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 efficient performance of healthcare markets. By their very nature, CON laws create barriers to entry and expansion and thus restrict free and open competition. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation.

We have examined historical and current arguments for CON laws, and conclude that these arguments provide no economic justification for depriving consumers of the benefits of free markets. To the extent that CONs are used to further non-economic goals, those goals can be more efficiently achieved through other means that do not impose the substantial (perhaps unintended) costs on consumers that restrictive CON laws impose. We hope you will carefully consider those significant costs as you evaluate whether to eliminate those laws in Florida.

I do not offer these comments today to discuss the details of the legislation you are considering. 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.

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 economic 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

Our concerns about the harm from CON laws are informed by one fundamental principle: market forces improve the quality and lower the costs of healthcare services. They drive innovation and ultimately lead to the delivery of better healthcare. Government intervention can undermine market forces to the detriment of healthcare consumers.

In our antitrust investigations we often hear the argument that healthcare is "different" and that competition principles do not apply to the provision of healthcare services. The proposition that competition cannot work in healthcare is simply not true. Similar arguments

---

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

made by engineers and lawyers that competition fundamentally does not work and, is in fact harmful to public policy goals, have been rejected by the courts 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.[6] The Antitrust Division and the Federal Trade Commission have worked diligently to make sure that private barriers to that competition do not arise.

During our extensive healthcare hearings in 2003, we obtained substantial evidence generally 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." Specifically, competition results in lower prices and broader access to health care and health insurance, while non-price competition can promote higher quality.[7]

This finding is not new. 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 caused 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 more affordable and available health insurance.

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 (ASCs).[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

---

[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 Commitions (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.

agents.[10] Competition harnessed this new technology and brought it to consumers in the lower cost, more convenient setting of ambulatory surgery centers. Also important to the success of innovative forms of healthcare delivery has been the ability for hospitals and other healthcare facilities to provide specialized services, reaping the benefits of specialization and economies of scale, without being encumbered by unnecessary regulatory requirements that these facilities provide the full spectrum of services available at general hospitals. The impact of innovation by competitors 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.

B. CON Laws Create Barriers to Beneficial Competition

CON laws are a classic government-erected barrier to entry, and by their nature are an impediment to the proper functioning of the market process. Accordingly, in *A Dose of Competition*, the Federal Trade Commission and we urged the states to rethink their CON laws.[11]

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

We made that recommendation in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At the time, the federal government and private insurance reimbursed healthcare charges predominantly on a "cost-plus" basis, which provided incentives for over-investment. The hope was that CON laws would provide a counterweight against that skewed incentive.

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

* CON laws were not adopted 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

---

[10] *A Dose of Competition*, at ch. 3 at 24.

[11] *A Dose of Competition*, Executive Summary at 22.

* 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, because patients are usually not price-sensitive, providers engaged in a "medical arms race" by unnecessarily expanding their services to offer the perceived highest quality services.[12]

CON laws appear to have failed in their intended purpose of containing costs. Several studies have 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.[13]

In addition, the reimbursement methodologies that in theory may have justified the adoption of CON laws in the 1970s have changed significantly. 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. And, health plans and other purchasers routinely bargain with healthcare providers over prices. In sum, changed government regulation has eliminated the original justification for CON programs, leaving us with CON laws that now only serve to impede competition we rely on to spur innovation and contain costs.[14]

2. Protecting Revenues of Incumbents Does Not Justify CON Laws and Other Regulations

In lobbying for CON laws, incumbent hospitals often argue that they should be protected against additional competition so that they can continue to cross-subsidize care provided to uninsured or under-insured patients. In essence, they argue that they cannot provide care to needy patients unless they can continue to charge high prices to patients more able to pay without fear of losing them to more attractive healthcare alternatives. In other words, those patients from whom the higher prices are obtained need to be kept "captive" through the lack of alternative healthcare choices. [15]

---

[12] *A Dose of Competition*, Ch. 8, pg. 1-2.

[13] 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.")

[14] *A Dose of Competition* at pg. 1-6.

[15] Note the irony of this argument: What started as laws intended to control costs have become laws intended to inflate costs. Proponents of CON laws now would use these barriers to

As discussed below, however, the premise of the argument is false: a recent study shows that competition does not undercut the ability of community hospitals to fulfill their charitable mission. In addition, CON laws actually do more harm than good by restricting the output of healthcare services, keeping prices high, and reducing innovation, quality and choice. The government pays more for less care delivered to those in need while consumers more able to pay also pay too much for less.

While we wholeheartedly appreciate the laudatory goal of providing healthcare services to those who cannot afford them, we want to make clear our belief that limiting competition in order to achieve this goal is the wrong way to go. CON laws unnecessarily impose significant costs on all healthcare consumers, including the needy, by restricting the output of healthcare services and diminishing incentives to pursue innovation and cost containment. There are more efficient ways to accomplish the goal of providing healthcare to the uninsured citizens of Florida that will better ensure that an optimal amount of healthcare is actually delivered to those persons in need – without impeding the proper functioning of health care markets. Put more starkly, by protecting incumbent hospitals from competition, CON laws allows dominant hospitals 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 consumers who would have chosen lower priced, higher quality, or more convenient sources of care if they were permitted the choice. This includes all consumers, including the uninsured.

Second, CON laws impose that cost without any clear evidence that other desired social goals are advanced. The evidence to date indicates that new competition does *not* undercut community hospitals' ability to fulfill their charitable mission. In 2006 the Medicare Payment Advisory Commission (MedPAC) studied just this issue in connection with the emergence of single-specialty hospitals around the country. The MedPAC study found that, for several reasons, specialty hospitals did not undercut the financial viability of rival community hospitals.[16] One 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.

Third, new competition can force community hospitals to improve their performance. In studying the effect of single-specialty hospitals, MedPAC found that the community hospitals

---

entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high.

[16] Report to the Congress: Physician-Owned Specialty Hospitals Revisited, pg. 21-25 (August 2006), available at http://www.medpac.gov/publications/congressional_reports/Aug06_specialtyhospital_mandated_report.pdf. ("MedPAC 2006 Report")

responded to the competition by improving efficiency, adjusting their pricing, and expanding profitable lines of business.[17] Community hospitals encouraged physicians to perform procedures on the hospital campus by developing centers of excellence and building physician offices on campus.[18]

Overall, community hospitals affected by specialty hospital entry maintained profit margins in line with national averages. Rather than undercutting community hospitals, new entry drives them to do a better job. Thus, in addition to the harm to the consumers who would have chosen the new healthcare provider, CON laws harm society in general by depriving it of the increased efficiency that competition would have brought to the health care market. We accordingly urge you to consider going further in the reform of your law by eliminating CON requirements that currently apply to all healthcare facilities, which will directly benefit Florida's healthcare consumers, and also provide incentives to general hospitals to improve quality and lower costs.[19]

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.[20] 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

---

[17] 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).

[18] 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).

[19] While we lack sufficient information to comment on the details of the legislation before the Committee, we note that requirements for all hospitals to provide an indeterminate amount of charity care and 24 hour emergency rooms may have the same effect of a CON requirement by discouraging new entry through the imposition of substantial costs.

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

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.[21] 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."[22]

We have found that existing competitors, at times with the encouragement or acquiescence of state officials, 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.[23] 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 Virginia case, two closely competing hospitals decided to allocate healthcare services between themselves.[24] The informal urging of state CON officials led them to agree 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

---

[21] *Eastern Rail. Pres. Conf. v. Noerr Motor Frgt., Inc.*, 365 U.S. 127 (1961).

[22] *A Dose of Competition*, Executive Summary at 22.

[23] *U.S. 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).

[24] *U.S. v. Bluefield Regional Medical Center, Inc.*, 2005-2 Trade Cases ¶ 74,916 (S.D. W.Va. 2005).