

DEPARTMENT OF JUSTICE
Washington, DC 20530



FEDERAL TRADE COMMISSION
Washington, DC 20580

Senator David Wilson
Alaska State Legislature
State Capitol, Room 115
Juneau, AK 99801-1182

April 7, 2017

Dear Senator Wilson,

In response to your request, dated March 16, 2017, we submit the enclosed Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission on Certificate-of-Need Laws and Alaska Senate Bill 62. We hope that the statement is helpful to you and the Alaska legislature in your deliberations. Thank you for your time and consideration.

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cc: Gary Zepp, Legislative Staff



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Joint Statement of the
Antitrust Division of the U.S. Department of Justice
and the Federal Trade Commission
on Certificate-of-Need Laws and Alaska Senate Bill 62

The Antitrust Division of the U.S. Department of Justice (the "Division") and the Federal Trade Commission (the "FTC" or the "Commission") (together, the "Agencies") welcome the opportunity to share our views on certificate-of-need ("CON") laws and Alaska Senate Bill 62 (the "Bill"), which would repeal Alaska's CON program.[1]

CON laws,[2] when first enacted, had the laudable goals of reducing health care costs and improving access to care.[3] 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 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

[1] S.B. 62, 30th Leg., 1st Sess. (Alaska 2017).

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

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 Under provisions of that Act, repealed in 1986, states were required to adopt CON legislation to avoid losing certain federal funding.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

costs or improving quality. For these reasons, the Agencies historically have suggested that states consider repeal or retrenchment of their CON laws, and, in this case, respectfully suggest that Alaska repeal its CON program.

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

Competition is the core organizing principle of America's economy,[4] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality, and greater access to goods and services, and innovation.[5] The Agencies work to promote competition through enforcement of the antitrust laws, which prohibit certain conduct that harms competition and consumers, and through competition advocacy (e.g., comments on legislation, discussions with regulators, and court filings).

Because of the importance of health care competition to consumers and the economy as whole, this sector has long been a priority for the Agencies.[6] 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

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[4] *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.").

[5] *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.").

[6] 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.

the United States.[7] In addition, the Agencies jointly conducted 27 days of 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.[8] 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.[9] 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.[10]

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[7] 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 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).

[8] *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.

[9] A DOSE OF COMPETITION, *supra* note 2, at Exec. Summ. at 22, ch. 8 at 1-6.

[10] *See, e.g.*, 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 Caroline House Bill 3250 (Jan. 11, 2016), https://www.justice.gov/atr/file/812606/download; 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), 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_copn-1.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), 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], 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), 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], https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-written-testimony-alaska-house-representatives-concerning-alaska-certificate-need-

II. Alaska's CON Program and Senate Bill 62

Alaska's CON program is intended to promote health care quality, access to health care, and cost containment, among other goals.[11] Under the program, a party must obtain a certificate of need before spending $1.5 million or more to construct a health care facility, alter the bed capacity of a health care facility, or add a category of health services provided by a health care facility.[12] Health care facilities include hospitals, independent diagnostic testing facilities, skilled nursing facilities, and ambulatory surgical facilities.[13] A certificate of need is granted "if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of citizens of [the] state."[14]

A party seeking a certificate of need must submit an application, along with an application fee ranging from $2,500 to $75,000, depending on the value of the project, to the Department of Health and Social Services (the "Department").[15] No later than 30 days after receipt, the Department will notify the party whether the application is complete.[16] The Department holds a public meeting and solicits written comments from the public concerning the application.[17] The Department must submit a recommendation to the Commissioner of Health and Social Services (the "Commissioner") within 60 days of notifying a party that its application is complete.[18] The Commissioner

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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), http://www.justice.gov/atr/competition-healthcare-and-certificates-need.

[11] *Certificate of Need (CON) Program Summary*, ALASKA DEP'T HEALTH & SOC. SERVS., http://dhss.alaska.gov/dhcs/Pages/CertificateOfNeed/default.aspx (last visited Mar. 16, 2017).

[12] Alaska Stat. § 18.07.031 (2016).

[13] Alaska Stat. § 18.07.111(8) (2016).

[14] Alaska Stat. § 18.07.041 (2016). A separate standard governs requests related to nursing homes and residential psychiatric treatment centers. Alaska Stat. § 18.07.43 (2016).

[15] Alaska Stat. § 18.07.035 (2016); Alaska Admin. Code tit. 7, §07.079 (2016).

[16] Alaska Admin. Code tit. 7, §07.050 (2016).

[17] Alaska Admin. Code tit. 7, §07.052 (2016).

[18] Alaska Stat. § 18.07.045(a)(2) (2016); Alaska Admin. Code tit. 7, §07.060 (2016). The Department may defer commencement of its review for a period not to exceed 60 days in order to receive competing applications. Alaska Stat. § 18.07.045(a)(1) (2016). Additionally, the period may be

then has 45 days to decide whether to grant or deny the certificate of need.[19] A member of the public substantially affected by activities authorized by a certificate of need may initiate an administrative proceeding concerning the Commissioner's decision and, ultimately, seek judicial review.[20]

The Bill would repeal Alaska's CON program effective July 1, 2019.[21]

III. Analysis of the Likely Competitive Effects of Alaska's CON Program

Competition in health care markets can benefit consumers by containing costs, reducing prices, improving quality, and encouraging innovation.[22] Indeed, 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.

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 Alaska's, require new entrants and incumbent providers to obtain state-issued approval before constructing new facilities or offering certain health care services. By interfering with the market forces that normally determine the supply of facilities and services, CON laws can suppress supply, misallocate resources, and shield incumbent health care providers from competition from new entrants.[23] Specifically, CON laws can tend to do the following:

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extended by 30 days in order to enable the Department to complete its recommendation. Alaska Stat. § 18.07.045(b) (2016).

[19] Alaska Admin. Code tit. 7, §07.070(c) (2016).

[20] Alaska Stat. § 18.07.081 (2016); Alaska Stat. § 44.62.560 (2016); Alaska Admin. Code tit. 7, §07.082 (2016); Alaska Admin. Code tit. 7, §07.072 (2016); *see also* Alaska Stat. § 18.07.091 (2016) (a member of the public substantially and adversely affected by a violation of CON statutes or regulations may seek injunctive relief from a court of competent jurisdiction).

[21] S.B. 62, 30th Leg., 1st Sess. (Alaska 2017).

[22] A DOSE OF COMPETITION, *supra* note 2, at Exec. Summ. at 4.

[23] *See id.* A DOSE OF COMPETITION, *supra* note 2, 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;[24] and

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

We urge Alaska to consider that its CON law may generate 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 health care prices, improve the quality of care, incentivize innovation in the delivery of care, and improve access to care.

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

Incumbents may exacerbate the potential competitive harm 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 process "to forestall competitors from entering an incumbent's market."[25] This use of the CON

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[24] *See id.*; 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 6 (Sept. 15, 2008) [hereinafter DOJ-FTC Illinois Testimony], 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.

[25] A DOSE OF COMPETITION, *supra* note 2, 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").

process by competitors can cause more than delay:[26] 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).[27] Repeal of Alaska's CON program would eliminate 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 through expansion it would have been able to compete to a greater extent with the existing hospital's program.[28] 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.[29] While the Division secured consent decrees prohibiting these agreements between competitors to allocate services and territories,[30] such conduct indicates that CON laws can provide the opportunity for anticompetitive agreements.

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,

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[26] *See, e.g.*, Policy or Politics, *supra* note 25, at 5 ("CONs for new technology may take upward of 18 months, delaying facilities from offering the most-advanced equipment to patients and staff.").

[27] 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 24, at 6-7; FTC Florida Statement, *supra* note 10, at 8-9; FTC Alaska Statement, *supra* note 10, at 8-9.

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

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

[30] *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), 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).

Georgia.[31] 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."[32] 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."[33] The Supreme Court reversed, holding that "state action immunity" did not apply.[34] However, the merging parties consummated the transaction while appeals were pending, and Georgia's CON regime precluded structural relief for the anticompetitive merger.[35] 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."[36]

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 consumers."[37] Moreover, 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, Alaska's CON laws could prevent divestiture as an effective tool to remedy anticompetitive mergers in appropriate cases.

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

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

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

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

[35] 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 id.* at 1011.

[36] 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.

[37] *Id*. at 3.

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 health care reimbursement system.[38] 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, higher quality health care, or greater access to care, whether for the indigent or in underserved areas.

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.[39]

However, CON laws are likely to increase, rather than constrain, health care costs. First, the CON regime imposes 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; not 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—add to the costs of new, expanded, or improved health care facilities.

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[38] *See* A DOSE OF COMPETITION, *supra* note 2, ch. 8 at 2; WHITE, *supra* note 3, at 527.

[39] *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.").

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.[40] 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."[41] Furthermore, both the FTC and the Division have engaged in significant enforcement efforts to prevent anticompetitive conduct in health care provider markets because the evidence

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

[41] Gaynor & Town, *Impact of Hospital Consolidation*, *supra* note 40, at 1 (citing, e.g., Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 IN. J. ECON. BUS. 17, 30 (2011) (post-merger review of Agency methods applied to two hospital mergers; data "strongly suggests" that large price increases in challenged merger be attributed to increased market power and bargaining leverage); Leemore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52 J. L. & ECON. 523, 544 (2009) ("hospitals increase price by roughly 40 percent following the merger of nearby rivals"); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175, 179 (2004) ("Overall, our results do not support the argument that efficiencies from consolidations among competing hospitals lead to lower prices. Instead, they are broadly consistent with the opposing view that consolidations among competing hospitals lead to higher prices.")); *see also, e.g.*, Joseph Farrell et al., *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals*, 35 REV. INDUS. ORG. 369 (2009) (mergers between not-for-profit hospitals can result in substantial anticompetitive price increases).

suggests that consumers benefit from competition.[42] The Agencies strongly believe that competition can work in health care markets.[43]

The best empirical evidence suggests that greater competition incentivizes providers to become more efficient.[44] Recent work shows that hospitals faced with a more competitive environment have better management practices.[45] Consistent with this, there is evidence suggesting that repealing or narrowing CON laws can reduce the per-patient cost of health care.[46]

Finally, the Agencies have found no empirical evidence that CON laws have successfully restricted "over-investment."[47] CON laws can, however,

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[42] *Supra* note 6.

[43] 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).

[44] 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.

[45] *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.").

[46] *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.").

[47] 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.[48] 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.[49] Second, even for services where certain studies have shown a volume/outcome relationship (e.g., coronary artery bypass graft surgery[50]), 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%").

[48] 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.").

[49] *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.").

[50] *See* Gaynor et al., *Volume-Outcome Effect*, *supra* note 48, at 244.

CON programs on quality.[51] The volume/outcome relationship is just one mechanism by which CON laws can affect health care quality, so this literature provides only a partial picture. Studies that directly analyze the impact of changes in CON laws on health outcomes provide a more complete picture. 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.[52] Moreover, additional empirical evidence suggests that, "[a]t least for some procedures, hospital concentration reduces quality."[53]

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.

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[51] *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.").

[52] *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 46, 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").

[53] Gaynor & Town, *Impact of Hospital Consolidation*, *supra* note 40, at 3; *see also* Patrick Romano & David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcareare*, 18 INT'L J. ECON. BUS. 45, 64 (2011).

Although the Agencies appreciate the importance of ensuring access to health care for the indigent and in medically underserved areas, we urge Alaska 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 Alaska 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.[54] In addition, some empirical evidence contradicts the notion that 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."[55]

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

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[54] Cutler, *supra* note 52, at 63 (finding that, following repeal of Pennsylvania's CON program, incumbent hospitals "were not put in a precarious position by the elimination of CON"); THE LEWIN GROUP, AN EVALUATION OF ILLINOIS' CERTIFICATE OF NEED PROGRAM: PREPARED FOR THE STATE OF ILLINOIS COMMISSION ON GOVERNMENT FORECASTING AND ACCOUNTABILITY ii, 27-28 (2007), http://cgfa.ilga.gov/Upload/LewinGroupEvalCertOfNeed.pdf ("Through our research and analysis we could find no evidence that safety-net hospitals are financially stronger in CON states than other states.").

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

ultimately more effective at achieving the desired social goals, than a CON regime.[56]

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 Alaska repeal its CON laws.

[56] *See, e.g.*, LEWIN GROUP, *supra* note 54, at 29 (discussing various financing options for charity care in Illinois); DOJ-FTC Illinois Testimony, *supra* note 24, 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), 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").