UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF
COMMISSIONER BRILL

January 8, 2016

The Honorable Senator Harvey S. Peeler, Jr.
Chairman, Senate Medical Affairs Committee
213 Gressette Bldg.
Columbia, S.C. 29201

Dear Senator Peeler Jr.,

Please find attached my dissenting statement to the Federal Trade Commission and Antitrust Division of the U.S. Department of Justice's Statement on Certificate-of-Need Laws and South Carolina House Bill 3250, issued today. That statement and my dissent are in response to Governor Haley's November 13, 2015 request that the Federal Trade Commission submit its views on the Certificate-of-Need Laws and South Carolina House Bill 3250.

I hope that this is helpful to you and the South Carolina legislature. Please don't hesitate to contact me if you have any questions or would like to discuss my dissenting statement. I can be reached at 202-326-2626. Thanks very much.

Sincerely,

Julie Brill

Julie Brill
Commissioner
U.S. Federal Trade Commission

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

January 8, 2016

The Federal Trade Commission (the "FTC") and the Antitrust Division (the "Division") of the U.S. Department of Justice (together, the "Agencies") submitted a joint statement today regarding South Carolina House Bill 3250 (the "Bill"). The Bill, which is currently under consideration by the South Carolina Senate, would narrow the application of and ultimately repeal South Carolina's CON laws.[1] The Agencies' statement advocates for the repeal of South Carolina's CON laws. I write separately to explain my position on this issue.

Before serving as a Commissioner at the FTC, I spent over 20 years as a state antitrust and consumer protection regulator, including as Assistant Attorney General for Consumer Protection and Antitrust in Vermont and Senior Deputy Attorney General and Chief of Consumer Protection and Antitrust in North Carolina. Through these years of experience, I have gained a deep understanding of the multifaceted concerns states face with respect to the provision of health care services, particularly in rural and underserved areas.

I agree it is appropriate that the FTC, as an antitrust agency, explain to South Carolina policymakers the considerable benefits that come from competitive markets, and how regulations may adversely affect competition. The FTC's mission statement outlines the important role that we play "[t]o prevent business practices that are anticompetitive" and "to enhance ... public understanding of the competitive process."[2] Indeed, the FTC has extensive experience not only investigating and enforcing potential violations of the antitrust laws, but also conducting authoritative studies on the benefits of competition across many industries. In health care markets, there is ample evidence that competition can work effectively. Consolidation and coordination among health care providers can increase the risk of higher prices without offsetting quality improvements.[3] On this issue, the Joint Statement appropriately describes how

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[1] H. 3250, 121st Gen. Assemb. (S.C. 2015).

[2] FTC Mission Statement, https://www.ftc.gov/about-ftc.

[3] *See, e.g.*, Martin Gaynor, Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze, 33 HEALTH AFF. 1088 (June 2014); Martin Gaynor & Robert Town, The Impact of Hospital Consolidation – Update (Robert Wood Johnson Found., Synthesis Project Report, June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Steven Tenn, The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction, INT'L J.L. ECON. OF BUS., 65-82 (2011).

competition can spur providers to reduce prices, increase efficiency, or improve clinical quality. Such guidance is consistent with the FTC's mission to enhance the public understanding of the competitive process.

My concern is I do not believe the Agencies possess sufficient relevant information to opine on *non-competition*-related public policy goals of the CON laws. Our experience is broad but it does not extend to every issue. The FTC should advise South Carolina policy makers based on our area of expertise—competition—and not overstep our collective knowledge. Health care policy makers at the state level are faced with difficult issues separate and apart from the strong benefits competition brings to health care markets. These include the critically important issue of preserving access to care for the needy, and doing so in a complex market, involving informational asymmetries among patients, providers, and payors. In this context, it is important to understand that competition will not move resources from those that can afford health care to those that cannot. As the Agencies stated in 2004:

> ". . . competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payors. Competition also will not shift resources to those who do not have them."[4]

Moreover, empirical evidence on the success or failure of CON laws to obtain their numerous objectives—in South Carolina or elsewhere—is limited, and we lack evidence on the broader impact of CON law repeal. In particular, the Agencies have not done or cited an analysis of the effect of South Carolina's CON laws and whether they fail to meet such policy goals.

Certain conclusions by the Agencies appear unsupported by a solid empirical foundation. For example, the Joint Statement suggests that preserving access to care is not a persuasive reason to maintain CON laws. But it cites just one study by the Lewin Group on the financial viability of safety-net hospitals in CON states as compared to

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[4] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION Exec. Summ. at 4 (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

non-CON states for this proposition.[5] Like many other studies cited by the Agencies, it has meaningful limitations. Importantly, the Lewin Group study expresses caution about its results, noting that it may have been conducted too soon after repeal of the CON laws it studied to observe the long-run impact, and possible detrimental effect, on safety-net hospitals. The Lewin Group also did not analyze the effect of repealing CON within a state—it merely conducted cross-state comparisons. As a result, the Lewin Group study may not reliably predict the effect of CON repeal on safety-net hospitals in South Carolina in particular. Finally, the Lewin Group specifically did *not* recommend repeal of CON laws in Illinois, which commissioned the group's work; instead, the Lewin Group called on Illinois policy makers to study the issue further.[6] I've attached an Appendix to my Statement to outline my critique of some the other studies discussed by the Agencies in their statement.

In addition, there are other reports which are *not* cited by the Agencies that urge caution in considering the repeal of CON laws. For example, last year, a health care consulting firm known as Ascendient issued a report in conjunction with North Carolina's review of its CON laws, concluding that until other means of cost control, such as new payment methods, are widespread and universally adopted, and the care for the uninsured addressed, the reduction or elimination of North Carolina's CON program would be premature. While not a rigorous empirical study and specific only to North Carolina, Ascendient analyzed the market conditions in North Carolina and concluded that already vulnerable hospitals in North Carolina would be put at much greater risk because new entrants would pick off their best patients without taking up the burden of indigent care.[7]

Another study not cited by the Agencies contains evidence tending to show that CON laws may improve access to care. A 2006 report to the Georgia Commission on the Efficacy of the CON Program compared data on self-pay hospital admissions across 11 states and found that markets with CON laws had more self-pay admissions per

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[5] The Lewin Group, An Evaluation of Illinois' Certificate of Need Program: Prepared for the State of Illinois Commission on Government Forecasting and Accountability (Feb. 2007), http://cgfa.ilga.gov/Upload/LewinGroupEvalCertOfNeed.pdf [hereinafter Lewin Group Report].

[6] Lewin Group Report, supra n. 5,. at 32 ("[G]iven the potential for harm to specific critical elements of the health care system, we would advise the Illinois Legislature to move forward with an abundance of caution. Nontraditional arguments for maintaining CON deserve consideration, until the evidence on the impact that specialty hospitals and ambulatory surgery centers may have on safety-net providers can be better quantified.") (emphasis in original).

[7] *See* First, Do No Harm, Analyzing the Certificate of Need Debate in North Carolina, report by Ascendient, July 2015, http://ascendient.com/new2015/wp-content/uploads/2015/07/NC-CON-FINAL-0722151.pdf.

1,000 uninsured people than markets with similar incomes in states without CON laws.[8] This evidence that uninsured patients are admitted to hospitals more frequently in CON law states, controlling for ability to pay, suggests that CON laws allow the uninsured greater access to inpatient care.

I do not contend that the Ascendient and Georgia studies are dispositive on the issues before the South Carolina Legislature; like other studies on the impact of CON laws on non-competition-related policy matters, there are limitations to what can be taken from their results. Instead, I point out these additional studies in order to demonstrate that there are, in fact, widely varying results and differing interpretations of the existing recent studies on this critically important issue. Before deciding whether or not to repeal South Carolina's CON laws, I urge the South Carolina Legislature to examine the state of all of the evidence before it, and specifically consider whether repeal of the CON laws could squeeze safety-net hospitals with lower margins, making it plausible that repeal could compromise access to care.[9]

Moreover, there are other important public health goals beyond those outlined by the Agencies in their statement. Indeed, objectives of a CON process can include providing charity care, establishing standards for providing services, preventing unqualified entities from providing certain services, and assessing quality by monitoring outcomes. As with access to care, these too are public policies in which the competition authorities are not experts.

For all of these reasons, I encourage the South Carolina Legislature to continue examining whether its CON laws are measurably meeting identifiable policy objectives. I respectfully suggest that the relevant questions should include: What are all the public policy goals of the South Carolina CON laws? Are South Carolina's CON laws working to achieve these goals? If not, what needs to be fixed? In evaluating these issues, the South Carolina Legislature would do well to weigh any of the South Carolina CON laws' accomplishments against the risks to competition that the CON laws may present. Rather than outright repeal, the South Carolina Legislature should also consider less drastic means to modify the CON laws so that they operate in less restrictive ways. In that manner, South Carolina may be able to improve the competitive landscape that may be currently affected by the CON laws, and at the same

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[8] *See* William S. Custer et al, Georgia State University, Report of Data Analyses to the Georgia Commission on the Efficicacy of the CON Program, Amended November, 2006, http://www.issuelab.org/resource/report_of_data_analysis_to_the_georgia_commission_on_the_efficacy_con_program.

[9] The Joint Statement does not address this issue.

time continue to achieve some of the other policy goals that the CON laws are designed to achieve.

Thank you for consideration of my views.

Appendix

A critique of certain studies cited by the Agencies

1. Vivian Ho & Meei-Hsiang Ku-Goto, State Deregulation and Medicare Costs for Acute Cardiac Care, 70 MED. CARE RESEARCH & REVIEW 185, 202 (2012).

The Agencies cite this study by Ho and Ku-Goto as support for the point that repealing or narrowing CON laws can reduce the per-patient cost of health care. The study describes a positive relationship between cost containment and repealing CON laws, but its focus is narrow—it is limited solely to coronary surgeries. Therefore the results of this study are not necessarily generalizable to all types of health care covered by CON laws.

2. Patrick A. Rivers et al., The Effects of Certificate of Need Regulation on Hospital Costs, 36 J. HEALTH CARE FIN. 1, 11 (2010).

The Agencies cite this study by Rivers *et al.* for the same point they cite the Ho and Ku-Goto study. However, the Rivers *et al.* study deals with a broader measure of cost, and thus the results are more nuanced: the study does not find a significant difference in cost between CON and non-CON states, but rather that states with more stringent CON laws see higher costs than states with less stringent laws. In this way, the study is more directly supportive of retrenchment than repeal of CON laws.

3. 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).

The Agencies cite this study by Cutler *et al* (2010) as support for the point that Pennsylvania's 1996 CON repeal did not threaten the viability of incumbent hospitals. However, the basis for this conclusion was that incumbent hospitals returned to profitability in 2002 after several years of negative margins in the late 1990's following CON repeal. If incumbent hospitals in other states experience a similar period of unprofitability following CON repeal, it is unclear whether they would achieve the same long-run outcome as was observed in Pennsylvania in this study. Furthermore, like other research in this area, this study only examines data from one type of procedure — coronary surgeries — so it is unclear whether its conclusions would hold more generally.

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

The Agencies cite this study by Garmon as evidence showing that dominant providers do not use their market power to cross-subsidize charity care. While Garmon's study finds a lack of evidence that changes in hospital market concentration affect the provision of charity care among *private* hospitals, public hospitals were excluded from the data analyzed in the study. Thus, the study does not address the relationship between competition and the viability of public hospitals' important role as safety-net providers.

5. Daniel Sherman, FED. TRADE COMM'N, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS (1988);

6. Monica Noether, FED. TRADE COMM'N, COMPETITION AMONG HOSPITALS (1987);

7. 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).

The Agencies cite these three FTC economic studies from the 1980s in discussing the FTC's expertise in examining the competitive impact of CON laws. The Agencies rightly do not place any evidentiary weight on these studies, which are quite outdated now, especially given how much health care markets and the regulatory landscape have changed in the last 30-40 years. Each of the studies evaluate the effects of CON regulation on various aspects of hospital costs, pricing, and expenses, and find no evidence that CON programs led to the savings they were designed to promote. However, the data analyzed in these studies is actually older than the studies themselves: Sherman (1988) looked at 1984 hospital survey data, Anderson and Kass (1986) looked at 1981 Medicare cost reports, and Noether (1987) looked at 1977-78 Medicare and American Hospital Association survey data. Thus, the conclusions drawn in these studies are not very relevant insofar as predicting what will happen in South Carolina in 2016 and future years if it repeals its CON laws.

Not only are these studies extremely outdated, there are other reasons to question whether their conclusions are at all predictive of the effect of changing CON regulations in South Carolina. For example, because they examine data collected roughly within the decade following the establishment of CON laws in the 1970s, the differences in cost between CON and non-CON states that these studies observe might be due to reverse causality. That is, when they observe higher costs in CON states than in non-CON states, this might not be due to a cost-increasing effect of CON laws, but

instead due to states that historically had higher costs being more likely to implement CON laws in the 1970's as a cost control measure. In addition, like some of the more recent studies already cited, none of these studies examine the effect of enacting, repealing or changing CON laws within the same state, or for that matter, any other changes in cost occurring over time due to policy changes. Also, the Anderson and Kass (1986) study, which studied costs for home healthcare providers in CON vs. non-CON states, actually found mixed results: compared to states without CON laws, Anderson and Kass find evidence of higher costs in states with CON laws for non-profit firms, but lower costs for government providers, and no significant difference for for-profit providers. Finally, none of the studies include measures of quality of care aside from cost, so any observed differences in cost may be due to differences in quality, rather than differences in efficiency between CON and non-CON states.