THE ROLE OF COMPETITION IN DELIVERING AFFORDABLE CARE

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Eleven years ago, the Federal Trade Commission and Department of Justice issued a comprehensive report describing the benefits the agencies believed more competition in health care would deliver. The report, "*Improving Health Care: A Dose of Competition*,"[1] also catalogued many obstacles to increasing reliance on competition to bring about a more efficient health care system. A decade later the report remains relevant and interesting reading. If anything, with the passage of the President's signature health care reform bill in 2010,[2] the report's message—competition in health care is critical to consumers—is more important now than it was then. As FTC Commissioner Julie Brill declared recently, the Affordable Care Act "is structured to operate within … underlying competitive markets."[3] Two of the central components of the ACA, the health care financing provisions and the Medicare Shared Savings Program, both "depend in large part on well-functioning competitive markets in order to provide the intended benefits to consumers."[4]

But impediments to increased reliance on competition in health care remain. This paper examines three issues. The first is the notion that the ACA is inconsistent with the antitrust laws and that enforcers and courts should pull back from insisting on competition in the health care field if the ACA is to work. The second is the concern consumers and others have expressed in the wake of the ACA that health plans are employing narrow networks of providers and that this somehow will harm consumer welfare. The third is the ongoing damage to a competitive health care marketplace caused by state certificate of need laws.

Many other impediments to competition could be examined as well. These include overly restrictive state licensing laws; turf battles among professionals that result in fewer than all qualified professionals rendering certain services; inadequate information for buyers and health care consumers on prices and quality (and this in turn is a reflection of the more general problem of information asymmetry in health care); the tax deductible treatment accorded to employer-based insurance, which encourages overconsumption of health care; the separation between purchaser and consumer in health care, which deadens the consumer's response to price signals (and the related efforts made to increase the consumer's "skin in the game" by increasing co-insurance and deductibles, sometimes to the point of potentially threatening health outcomes); the oft-criticized fee-for-service system with its well documented incentive to provide too much care (though the use of capitated methods of payment may no better align provider and end user, as these methods may encourage delivery of too little care[5]); and state-imposed insurance mandates which, as *Dose of Competition* pointed out, unless carefully considered, "are likely to

[1] Available at www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.
[2] The Patient Protection and Affordable Care Act, 124 Stat. 119 (colloquially referred to as "Obamacare").
[3] Julie Brill, *Competition in Health Care Markets* (June 9, 2014) at 7, available at www.ftc.gov/system/files/documents/public_statements/314861/140609halwhite.pdf
[4] *Id.* at 8.
[5] *See, e.g.*, Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic, 65 F.3d (7th Cir. 1995) ("From a short-term financial standpoint—which we do not suggest is the only standpoint that an HMO is likely to have—the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible.").

reduce competition, restrict consumer choice, raise the cost of health insurance, and increase the number of uninsured Americans."[6]

A. The ACA is Not Inconsistent with Increased Reliance on Competition to Deliver Better Care at More Affordable Prices

Many providers and others long have been deeply skeptical of the notion that competition will allocate health care resources in a societally beneficial way. Ten years ago, the authors of the *Dose of Competition* acknowledged this, writing:

> The proper role of competition in health care markets has long been debated. For much of our history, federal and state regulators, judges, and academic commentators saw health care as a "special" good to which normal economic forces did not apply. Skepticism about the role of competition in health care continues in controlling health care costs.[7]

Ten years on, despite a decade of successful enforcement actions in health care, and advocacy efforts by the federal antitrust enforcement agencies, this skepticism remains.[8] In fact, with passage of the ACA it may have grown worse. Many inside and outside the health care industry argue that the goals of the ACA are at odds with the policies of the nation's antitrust laws, which provide the rules of the road for a competitive, market based system. For example, Bruce Vladeck, a former Clinton-era administrator of CMS (then known as the Health Care Financing Administration), wrote earlier this year, "there appears to be a contradiction between efforts to contain health care prices and the fact that aggressive policies aimed at reducing provider concentration might be ineffective and could even have the unintended effect of stunting positive developments."[9] Two researchers writing last year in the New England Journal of Medicine sounded a similar note:

> There is … often—though not always—a trade-off between coordination and competition. Well-integrated provider networks may promote coordinated care that improves the allocation of health care resources, but they are likely to undermine competitive pressures to keep prices down while maintaining high quality.

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[6] *Dose of Competition*, Executive Summary at 24.

[7] *Id.*, Executive Summary, at 1.

[8] It is not difficult to find criticisms of market based solutions and the idea that competition has a constructive role to play in health care among a wide spectrum of academics and others who believe strongly in making health care more affordable and available. *See, e.g.*, Diane Archer, Health Affairs Blog, *No Competition: The Price of a Highly Concentrated Health Care Market* (March 6, 2013) available at http://healthaffairs.org/blog/2013/03/06/no-competition-the-price-of-a-highly-concentrated-health-care-market/; (the ACA "will for the first time guarantee the overwhelming majority of Americans access to good coverage, a huge step forward. But it expands coverage mostly by relying on the dysfunctional private insurance market. There is no evidence that the newly created exchanges will exert any downward pressure on prices, given the experience of private plans to date"); Amitai Etzioni, "Why health care competition won't work," CNN Opinion (Jan. 4, 2012) available at www.cnn.com/2011/12/27/opinion/etzioni-health-care-competition/ ("In short, calling for more competition in health care may gain a presidential candidate some votes, but it cannot be relied upon to make for a higher quality and lower cost health care system").

[9] Bruce C. Vladeck, "*Paradigm Lost: Provider Concentration And The Failure Of Market Theory*," Health Affairs (May 2014) available at http://content.healthaffairs.org/content/early/2014/05/20/hlthaff.2014.0336.full.html.

> Coordinated systems may thus deliver the right care to the right patient at the right time, but at the wrong price. Competitive markets may do a better job of keeping prices low, but with the well-documented drawbacks of fragmentation.[10]

Newspaper columnists sympathetic to the reform law have suggested that the goals of the ACA and antitrust are in conflict.[11] Even some individuals closely connected with the Obama administration's health care reform efforts have suggested that there is a tension between the ACA, on the one hand, and increased reliance on competition and antitrust on the other. *Modern HealthCare* reported in 2012:

> [A] well-known healthcare thinker who supported the reform law, Massachusetts Institute of Technology economics professor Jonathan Gruber, disagreed with [then CMS-director Donald] Berwick on the question of whether the Affordable Care Act encourages consolidation of providers. 'I think it probably does, in the sense that the idea of the law is to move toward more integrated care and more bundled care, and that happens more naturally in consolidated entities,' said Gruber."[12]

Kathleen Sibelius, then the Secretary of the Department of Health and Human Services, told an audience at the Harvard School of Public Health, as reported in various media at the time, that "provisions of the Affordable Care Act are in 'constant tension' with antitrust laws."[13] Not unreasonably, the Secretary's comments were interpreted by some in the hospital industry as an acknowledgement that there is "a real abiding tension between what the antitrust laws allow and where the ACA is really pushing hospitals" to go.[14]

The FTC, realizing the danger this outlook presents to maintaining, let alone increasing, the role of competition in health care, has responded strongly to these criticisms. Commissioner Brill observed, in the same speech quoted earlier,

> Some providers have pointed to the [accountable care organization] program [in the ACA] as a justification for potentially problematic mergers, complaining that the federal government is "speaking out of both sides of its mouth," with the Medicare program encouraging providers to come together and

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[10] Katherine Baicker, and Helen Levy, *Coordination versus Competition in Health Care Reform*, N. Engl. J. Med. 789-79 (August 29, 2013).
[11] *See, e.g.*, Eduardo Porter, *New York Times*, "Health Law Goals Face Antitrust Hurdles," (Feb. 4, 2014) available at www.nytimes.com/2014/02/05/business/economy/health-law-goals-face-antitrust-hurdles.html?_r=0.
[12] Modern HealthCare (Dec. 15, 2012) available at www.modernhealthcare.com/article/20121215/MAGAZINE/312159986.
[13] EHR Intelligence (April 9, 2013) available at http://ehrintelligence.com/2013/04/09/sebelius-care-coordination-can-easily-turn-into-a-monopoly/.
[14] *Id.* (comments of Melinda Hatton, General Counsel for the American Hospital Association).

> create organizations that will enable greater collaboration, while the antitrust agencies challenge them.[15]

The commissioner rejected the proposition, calling it "misguided."[16] Nothing in the ACA, she said, "express[es] a preference for consolidation among competing entities." To the contrary, "far from being a barrier to procompetitive collaboration envisioned in the ACA, antitrust aligns naturally with the goals of ACOs."[17]

The FTC Chairwoman has delivered the same message.[18] So too Deborah Feinstein, the Director of the FTC's Bureau of Competition, who spoke at an ACO summit last summer and asserted, "there is no tension between rigorous antitrust enforcement and bona fide efforts to coordinate care."[19] As a result, she said, the ACA "has not altered the antitrust standard that would apply to similar collaborations designed to reduce costs and improve the quality of health care."[20] The assistant director at the Bureau of Competition in charge of health care, Markus Meier, delivered the same message in particularly blunt language during an interview with *Modern HealthCare*. When asked what he thought "of the criticism from hospital leaders that the FTC is discouraging them from entering mergers and partnerships, which conflicts with reform's goal to create networks that coordinate care," he answered:

> That contention is wrong. It reflects misunderstandings about the Affordable Care Act, accountable care organizations and the antitrust laws. The goals of the ACA and the antitrust laws are actually very well-aligned in promoting the development of pro-competitive accountable care organizations. ACOs are intended to promote greater efficiency for patients by coordinating care to achieve higher quality at lower cost. Antitrust has the same goal, protecting competition that benefits consumers and promotes efficiencies.[21]

Meier concluded, "Antitrust is not a barrier to the formation of pro-competitive ACOs."

The FTC's view is consistent with straightforward antitrust law. Going back to Judge Taft's decision in *Addyston Pipe*,[22] eight years after passage of the Sherman Act, it has been clearly understood that efficiency-enhancing collaborations among competitors do not violate antitrust law, so long as these collaborations encompass only those agreements reasonably necessary to accomplish the legitimate goals of the collaboration and do not aggregate so much market power

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[15] *Competition in Health Care Markets* at 9.
[16] *Id.*
[17] *Id.*
[18] Remarks of Chairwoman Edith Ramirez on The FTC and Evolving Health Care Provider Markets at AHLA and ABA Antitrust in Health Care Conference (May 13, 2014).
[19] Deborah L. Feinstein, "Antitrust Enforcement in Health Care: Proscription, not Prescription," Fifth National Accountable Care Organization Summit – Washington, D.C. (June 19, 2014) at 1-2, available at http://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf.
[20] *Id.*
[21] Modern HealthCare, "*Antitrust laws exist to protect consumers, not providers*," (April 14, 2014) available at www.modernhealthcare.com/article/20140419/MAGAZINE/304199951/1248.
[22] United States v. Addyston Pipe & Steel Co., 85 F. 271 (6th Cir. 1898), *modified and aff'd*, 175 U.S. 211 (1899).

that the benefits of the collaboration are swamped by anticompetitive effects.[23] These principles were explained in detail, complete with helpful examples, in the "Statements of Antitrust Enforcement Policy in Health Care," issued by FTC and DOJ in 1996.[24]

As the FTC's Feinstein put it in her speech at the ACO summit, "The antitrust laws treat collaborations among health care providers that are bona fide efforts to create legitimate, efficiency-enhancing joint ventures differently from the way they treat price fixing schemes." Such joint ventures "are evaluated under the rule of reason … if the providers are financially or clinically integrated and the agreement is reasonably necessary to accomplish the procompetitive benefits of the integration."[25] And under the rule of reason, legitimate joint ventures pass muster "so long as those efforts do not result in the accumulation of market power."[26]

B. Narrow Networks and Competition

It has been widely reported that insurers seeking to provide more affordable products on the state and federal exchanges have offered many panels that contain fewer than all—sometimes substantially fewer than all—providers. The reasons insurers offer "narrow networks" are straightforward: by selecting some, but not all, providers, an insurer can induce providers to compete for a place on its provider panel. Insurers also can exclude particularly high cost providers, or those who are inefficient, or those who deliver poor care. At the same time, because a narrow panel will contain some but not all providers, the value to the provider of being on the panel increases, inducing even more competition for a spot on the panel.[27]

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[23] A concise statement of this view is found in the "Antitrust Guidelines for Collaborations Among Competitors" (April 2000), issued by the FTC and U.S. Department of Justice's Antitrust Division: "If, however, participants in an efficiency-enhancing integration of economic activity enter into an agreement that is reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits, the Agencies analyze the agreement under the rule of reason, even if it is of a type that might otherwise be considered per se illegal." Section 3.2 available at www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf. The agencies also have made clear that in assessing whether an agreement among competitors is "reasonably necessary" to deliver the procompetitive benefits, "the Agencies consider whether practical, significantly less restrictive means were reasonably available when the agreement was entered into, but do not search for a theoretically less restrictive alternative that was not practical given the business realities." *Id.* Recently some have questioned whether the agencies have followed this approach, *see, e.g.*, David Balto, "An Open Letter to the FTC on Hospitals and Providers," The Health Care Blog, available at http://thehealthcareblog.com/blog/2014/10/08/an-open-letter-to-the-ftc-on-hospitals-and-providers/ (suggesting that the FTC in the St. Luke's case in Idaho insisted on affiliations short of an acquisition by the St. Luke's health system of the Saltzer Medical Group and employment of its physicians when, in practical effect, such affiliations would not deliver the same efficiencies as the parties claimed would flow from the acquisition).

[24] In particular, see Statements 7 and 8, available at www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf. The FTC's more recent "Enforcement Policy Statement Regarding Accountable Care Organizations Participating In the Medicare Shared Savings Program," (Oct. 28, 2011) available at www.ftc.gov/policy/federal-register-notices/ftc-doj-enforcement-policy-statement-regarding-accountable-care employs the same structured analysis. *See also* Douglas Ross and Charles Wright, "Antitrust Enforcement Agencies Issue Final Guidance on ACOs," (Nov. 2, 2011) available at www.lexology.com/library/detail.aspx?g=19665858-9e61-42ae-9891-36c1a4d12f6d (explaining ACO statement).

[25] *Competition in Health Care Markets* at 4.

[26] *Id*. at 1-2.

[27] For more discussion on these points, see Matthew S. Lewis and Kevin E. Pflum, "Diagnosing Hospital System Bargaining Power in Managed Care Networks," working paper, forthcoming, in *American Economic Journal: Economic Policy*, www.kevinpflum.com/wp-content/uploads/hospital-systems.pdf.

Narrow networks have become very popular with health plans. Earlier this year McKinsey reported that narrow networks "make up about half (48 percent) of all exchange networks across the U.S. and 60 percent of the networks in the largest city in each state."[28] Permitting insurers to offer narrow networks is critically important to the success of the exchanges and so to the ability of the ACA to make good on its promise of affordable health care.

But several significant threats to the ability of plans to offer narrow network products exist.

The first is consumer backlash. In the 1980s and 1990s, HMOs and other managed care organizations employed a similar tactic to control health care costs. These managed care organizations selectively contracted with providers to obtain discounts in return for a place on a provider panel. Though there is evidence selective contracting was effective in controlling health care costs,[29] the tactic was not popular with consumers. A similar backlash now could severely jeopardize the ability of insurers to provide affordable products on the health care exchanges. As one writer in the *Washington Post* put it, "Obamacare's narrow networks are going to make people furious—but they might control costs."

Preliminary indications suggest that many consumers may not be reacting as adversely to the narrowing of panels as feared. A study by the Robert Wood Johnson Foundation and the Urban Institute on the implementation of the ACA in six states (Colorado, Maryland, New York, Oregon, Rhode Island, and Virginia) reported:

> The significant network changes have triggered widespread media coverage and concern among providers, policymakers and consumer advocates about policyholders' ability to access timely, appropriate care. However, insurers and regulators in our six study states report receiving few complaints from consumers. One insurer told us that "it's been pretty silent" when asked about network adequacy complaints from consumers. Every insurer we spoke with reported a similar lack of reported problems.[30]

One reason for the lack of consumer indignation so far may be because, as McKinsey reports, "[b]road networks are available to close to 90 percent of the addressable population." As a result, the vast majority of consumers on health care exchanges can choose between a broad or a narrow network and those choosing the latter, at least in theory, have made a knowing decision to accept less choice in return for lower premiums.

A second risk to the narrow network experiment lies with state insurance regulators including state legislatures. States, usually through their insurance commissioners, typically have the

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[28] McKinsey & Co., "Hospital networks: Updated national view of configurations on the exchanges," (June 2014) available at http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges.
[29] David Dranove, Mark Shanley, and William D. White, "Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition," 36 Journal of Law and Economics 179 (April 1993).
[30] *See* Robert Wood Johnson Foundation and the Urban Institute, "Implementation of the Affordable Care Act: Cross-Cutting Issues, Six-State Case Study on Network Adequacy," at 7 (September 2014). The report cautions, however, that it still is too early to draw definitive conclusions on consumer reactions.

ability to regulate health plan networks to assure these networks are adequate for consumers.[31] If regulators tighten adequacy rules, they could preclude plans from inducing providers to compete for a place on a panel and so frustrate the cost containment goals of health care reform. There are concerns this may already be underway in some states.[32] Encouragingly, however, in at least one state studied by the Robert Wood Johnson Foundation and the Urban Institute (Rhode Island) regulators "encouraged insurers to offer narrower—rather than broader—networks in 2015 so that plans can offer lower premiums."[33]

So-called "any willing provider" laws pose a third risk to narrow networks. These are statutes that require insurers to include any licensed provider that wants to be included in the insurer's network. A variation is an "any willing category of provider" law, that may not require all providers of a given licensure be included, but forbids insurers from excluding entire categories of providers from their panels. The antitrust enforcement agencies warned against any willing provider laws in the *Dose of Competition* report; they have done so as well in advocacy before state legislatures.[34] These statutes eliminate the possibility of inducing provider competition to participate on a panel. Moreover, if every insurer must offer the services of every provider, insurers will be unable to exclude high cost or inefficient providers, they will not be able to focus on providers they perceive to be of the highest quality, or otherwise to decide for themselves how to design the products they offer to consumers. Every health plan, regardless of which insurer organized it, would look alike. Such an outcome, far from assuring that consumers have more choice, actually would "limit consumer choice, eliminate product diversity, … [and] raise the cost of health insurance." Such an outcome, the agencies have warned, would "increase the number of uninsured Americans."[35] This outcome is not theoretical: some studies confirm that an inability to contract selectively with providers raises health care costs.[36]

There are some indications that enactment of the ACA and insurers' increased use of narrow networks may be spurring adoption of new "any willing provider" laws. In the most recent election, for example, South Dakota voters adopted such a law.[37] If these laws remain on the books, or expand to additional states, they could seriously affect the ability of plans offered on

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[31] In the six states in which the Robert Wood Johnson Foundation and the Urban Institute studied implementation of the ACA, for example, five (Colorado, Maryland, New York, Rhode Island, and Virginia) had network adequacy rules. The sixth, Oregon, did not. *Id*.

[32] See "*Narrow-network controversy spurs tougher rules for California plans*," available at www.modernhealthcare.com/article/20140902/NEWS/309029816.

[33] *Id*.

[34] *See, e.g.*, Letter from FTC Staff to Patrick J. Lynch, Rhode Island Attorney General, and Hon. Juan M. Pichardo, Rhode Island State Senate, at 5-6 (April 8, 2004), available at www.ftc.gov/os/2004/04/ribills.pdf (noting "such laws appear to protect competitors, not competition or consumers").

[35] *Improving Health Care: A Dose of Competition* Ch. 6, at 32.

[36] *See* Michael G. Vita, "Regulatory Restrictions on Selective Contracting: An Empirical Analysis of 'Any-Willing-Provider' Regulations," 20 *Journal of Health Economics* 955 (2001); *see also* Yu-Chu Shen, Vivian Y. Wu, and Glenn Melnick, "Trends in Hospital Cost and Revenue, 1994–2005: How Are They Related to HMO Penetration, Concentration, and For-Profit Ownership?" 45 *Health Services Research* 42, (February 2010); David Dranove, Richard Lindrooth, William D. White, and Jack Zwanziger, "Is the Impact of Managed Care on Hospital Prices Decreasing?" 27 *Journal of Health Economics* 362 (2008).

[37] "*Voters nix California healthcare initiatives, approve measures in other states*," Modern HealthCare, at 10 (Nov. 10, 2014). And Modern HealthCare reported earlier in the year that several other states are considering such laws. "*Pressure Builds Over Narrow Networks*," Modern HealthCare (Feb. 8, 2014), available at www.modernhealthcare.com/article/20140208/MAGAZINE/302089963.

the exchanges to lower the cost of health care for consumers—and, in the case of those consumers whose insurance is subsidized—at the expense of taxpayers.

Finally, health care providers who are excluded from narrow networks could frustrate the goals of health care reform if they were to sue under the antitrust laws and prevail.[38] Such claims are common. Many providers, when excluded from a panel, react by alleging that their exclusion is anticompetitive. Some, schooled in the knowledge that the antitrust laws are a consumer welfare prescription,[39] will dress their claim in consumer garb, asserting that an insured who subscribes to a narrow panel has his choice of physicians limited—and allege, because the antitrust laws are all about consumer choice, this is some species of an antitrust violation. Except in the rarest cases, it is not. As already noted, if every provider had a right to be on every panel, all panels would look the same, no narrow panels would be permitted, and consumer choice actually would be limited because anyone wanting to purchase a narrow (and presumably less expensive) network would be unable to do so. Moreover, if providers could use the antitrust laws to force their way onto panels then these laws would have the same unfortunate consequences that any willing provider laws have, of eliminating the incentive for providers to compete to secure a place on a limited panel by lowering their prices and improving quality.

The courts have recognized that exclusion of providers from a network generally has no anticompetitive effects and may even be procompetitive. The case law in this area dates back at least a quarter of a century. In *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc.*,[40] for example, a district court wrote that "[o]ne of the essential features of an HMO is that it selects preferred physicians and excludes others thereby creating competition among the providers of health care services." In *Hassan v. Independent Practice Associates, P.C.*,[41] another district court recognized it was procompetitive for a network to terminate two allergists from its physician panel on grounds that they overutilized costly allergy tests and disagreed with the network's allergy testing policy. Other efforts by excluded providers to force their way onto provider panels have been almost uniformly unsuccessful, regardless of the antitrust theories selected.[42]

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[38] Clearly, some lawsuits brought against narrow networks may raise legitimate concerns. If exclusion of a specialized provider will threaten public health, for example, public policy might be better served if that provider were included on the network. Similarly, some lawsuits have been filed alleging that some networks misled consumers into thinking they were broad networks on which certain providers would be found when, in fact, they were narrow networks that excluded those providers. *See, e.g.*, *Brown et al. v. Blue Cross of California*, Case BC554949 (Superior Court, County of Los Angeles) available at www.law360.com/health/articles/569164?nl_pk=66f0890c-4a0f-4b0e-abb7-a0572a7d546&utm_source=newsletter&utm_medium=email&utm_campaign=health.

[39] Reiter v. Sonotone Corp., 442 U.S. 330, 343 (1979).

[40] 725 F. Supp. 669, 673 (N.D.N.Y. 1989), *aff'd*, 996 F.2d 537 (2nd Cir. 1993).

[41] 698 F. Supp. 679, 694 (E.D. Mich. 1988).

[42] *See, e.g.*, East Portland Imaging Center, P.C. v. Providence Health Plan, 280 Fed.Appx. 584 (9th Cir. 2008); Abraham v. Intermountain Health Care, Inc., 461 F.3d 1249 (10th Cir. 2006); Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of Rhode Island,, 373 F.3d 57 (1st Cir. 2004); Surgical Care Ctr. of Hammond v. Hosp. Serv. Dist. No. 1, 309 F.3d 836 (5th Cir. 2002); Park Avenue Radiology Assocs., P.C. v. Methodist Health Sys., Inc., No. 98-5668, 1999 WL 1045098 (6th Cir. 1999); All Care Nursing Servs., Inc. v. High Tech Staffing Servs., 135 F.3d 740 (11th Cir. 1998); Doctor's Hosp. of Jefferson, Inc. v. Southeast Med. Alliance, Inc., 123 F.3d 301 (5th Cir. 1997); Levine v. Central Florida Med. Affiliates, Inc., 72 F.3d 1538 (11th Cir. 1996); Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325 (7th Cir. 1986); Klamath-Lake v. Klamath Medical Serv. Bureau, 701 F.2d

The antitrust enforcement agencies have long made clear that the exclusion of particular providers from a network is unlikely to be an antitrust problem and, more likely, may be procompetitive. In the agencies' 1996 Statements of Antitrust Enforcement Policy in Health Care, the FTC and DOJ stated that "selective contracting may be a method through which networks limit their provider panels in an effort to achieve quality and cost-containment goals, and thus enhance their ability to compete against other networks."[43] Consequently, a "rule of reason analysis usually is applied in judging the legality of a multiprovider network's exclusion of providers or classes of providers from the network, or its policies on referring enrollees to network providers." The policies reflected in the Statements were in evidence at the agencies even before those Statements were adopted.[44]

C. Certificate of Need Laws and Competition

Most states still have certificate of need regulatory systems which, by restricting entry, drive health care costs higher than they otherwise would be. The National Conference of State Legislatures reports that as of December 2013, about 36 states had CON regulation.[45]

The agencies have long warned that CON laws serve little purpose other than to restrict entry and so these laws thereby contribute to higher health care costs. A succinct statement of the agencies' historic position was set out ten years ago in the *Dose of Competition* report:

> The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market.[46]

The Federal Trade Commission and Department of Justice have repeated their opposition to certificate of need laws in various forums. For example, in joint comments provided to a task force in Illinois considering health care reform in 2008, the agencies asserted CON laws "impede the efficient performance of health care markets. By their very nature, CON laws create barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care

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1276 (9th Cir. 1983); Drug Emporium v. Blue Cross of Western New York, 104 F. Supp. 2d 184 (W.D.N.Y. 2000); J. Allen Ramey M.D., Inc. v. Pacific Found. for Health Care, 999 F. Supp. 1355 (S.D. Cal. 1998); Capital Imaging Assoc., P.C. v. Mohawk Valley Med. Assocs., Inc., 725 F. Supp. 669 (N.D.N.Y. 1989); *but see* St. Bernard General Hosp. v. Hosp. Serv. Assoc. of New Orleans, 712 F.2d 978 (5th Cir. 1983) (reversing dismissal of per se claims excluded hospital brought against health plan controlled by rivals).

[43] Statement 9, available at www.justice.gov/atr/public/guidelines/0000.htm.

[44] *See, e.g.*, Robert Bloch, Chief of the Professions and Intellectual Properties Section, Antitrust Division, Department of Justice (Comments November 15, 1991, before the Practicing Law Institute) (noting exclusion of providers is not likely to be anticompetitive).

[45] National Conf. of State Legislatures, Certificate of Need: State Laws, available at www.ncsl.org/IssuesResearch/Health/CONCertificateofNeedStateLaws/tabid/14373/Default.aspx.

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

costs."[47] In a press release issued along with the statement the agencies charged that "the CON process itself may be susceptible to corruption."

The joint statement noted that CON laws were adopted decades ago, when providers were reimbursed on the basis of their costs. Under that system, multiplying facilities and increasing costs could lead to more reimbursement. Policymakers believed controls were necessary to restrict the ability of providers to build new facilities and initiate expensive new treatments.[48] State efforts to limit the profusion of hospitals were predicated on the idea that supplying a health care service induced demand for that service. As "Roemer's Law" put it, "a hospital bed built is a bed filled."[49] But as the era of cost-based reimbursement ended long ago, the need for CON laws has disappeared as well. The available research, while perhaps not conclusive, suggests strongly that CON laws have failed to deliver on their goal of constraining health care costs.[50]

As a result, the argument in favor of continuing these laws has changed. Hospitals that provide a wide array of services to their communities, including indigent care, sometimes argue that they need protection against competition from hospitals that specialize in one or two profitable services or do not subsidize indigent care.[51] "Under this rationale," the agencies wrote in their Illinois comments,

> CON laws should impede the entry of new health care providers that consumers might enjoy (such as independent ambulatory surgery centers, freestanding radiology or radiation-therapy providers, and single- or multi-specialty physician owned hospitals) for the express purpose of preserving the market power of incumbent providers. The providers argue that without CON laws, they would be deprived of revenue that otherwise could be put to charitable use.[52]

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[47] 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 (Sept. 15, 2008) available at www.ftc.gov/os/2008/09/V080018illconlaws.pdf ; press release available at www.usdoj.gov/atr/public/press_releases/2008/237153.htm.

[48] *See generally* National Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross of Kansas, 452 U.S. 378, 386 (1981) (Congress was concerned "that marketplace forces in [the healthcare] industry failed to produce efficient investment in facilities and to minimize the costs of health care").

[49] David Dranove & William D. White, *Recent Theory and Evidence on Competition in Hospital Markets*, J. ECON. & MGMT. STRATEGY, Spring 1994, 169, at 177.

[50] *Dose of Competition*, Chpt. 8 at 4 ("empirical studies indicate that CON programs generally fail to control costs and can actually lead to increased prices").

[51] The argument is not a new one. More than 20 years ago, two researchers observed that because CON policies were ineffectual in accomplishing their "explicit purpose[s] … to prevent hospitals from duplicating services and investing in costly excess capacity," defenders had moved to arguing that such laws permitted hospitals to cross-subsidize needed services and should be kept for that reason. Ellen S. Campbell and Gary M. Fournier, "*Certificate-of-Need Deregulation and Indigent Hospital Care*," Journal of Health Politics, Policy and Law, Vol. 18, No. 4 (Winter 1993).

[52] 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.

While acknowledging the importance of providing care to the indigent, the report notes the "ironic element to 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 entry to stifle competition, protect incumbent market power, frustrate consumer choice, and keep prices and profits high."[53] According to the agencies, "the imposition of regulatory barriers to entry as an indirect means of funding indigent care may impose significant costs on all health care consumers—consumers who might otherwise benefit from additional competition in health care markets."[54] The agencies similarly have urged other states not to adopt or expand their CON laws.[55]

In the last several months, the Federal Trade Commission has again strongly opposed relying on CON regulation to control health care costs. When North Carolina's legislature considered narrowing the scope of that state's existing CON laws, the FTC staff wrote to encourage the legislature do so. "CON laws raise considerable competitive concerns and generally do not appear to achieve their alleged benefits for health care consumers," according to the FTC. The agency repeated its position that CON laws restrict entry and expansion, limit consumer choice, and stifle innovation. "Additionally," the FTC wrote in its news release, "the CON process can be exploited by firms to thwart or delay entry by new competitors and can obstruct efforts to restore competition that has been lost to an anticompetitive merger."[56] In late October, the FTC and Department of Justice's Antitrust Division jointly submitted comments to a CON work group in Virginia that is studying the future of that state's certificate of public need law. The agencies repeat their long-standing opposition to CON laws and note, "the evidence to date does not suggest that CON laws have generally succeeded in controlling costs or improving quality."[57]

While some states did repeal their CON laws once cost-based reimbursement and centralized health planning gave way to DRGs and a more market oriented approach, few if any have done so recently and there is no particular impetus in the states to cut back or do away with these laws now. And yet, given the expansion of health care coverage that the ACA has brought about (and without regard to the ongoing debate of whether that expansion is smaller than originally promised) financial pressures on hospitals appear to be easing.[58] As a result, if cross-

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[53] *Id.*
[54] *Id.*
[55] *See, e.g.*, Letter from Joseph Miller to Senator Michael D. Bishop (June 6, 2008) available at www.usdoj.gov/atr/public/comments/234407.htm; Prepared Statement of the Federal Trade Commission before Florida State Senate On Committee Substitute for Senate Bill 2326, which would amend, e.g., s. 408.036 (April 2, 2008) available at http://www.ftc.gov/os/2008/04/V080009florida.pdf; Prepared Statement of the Federal Trade Commission before the Standing Committee on Health, Education and Social Services of the Alaska House of Representatives (Feb. 19, 2008) available at www.ftc.gov/os/2008/02/V080007alaska.pdf.
[56] *See* FTC Staff Comment, and Concurring Comment of Commissioner Wright, Regarding North Carolina House Bill 200, Which Would Exempt Diagnostic Centers, Ambulatory Surgical Facilities and Psychiatric Hospitals From Certificate of Need Regulation (July 10, 2015) available at https://www.ftc.gov/policy/policy-actions/advocacy-filings/2015/07/ftc-staff-comment-concurring-comment-commissioner.
[57] *See* 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 (October 26, 2015) available at https://www.ftc.gov/policy/policy-actions/advocacy-filings/2015/10/joint-statement-federal-trade-commission-antitrust.
[58] The Advisory Board, "*Hospitals see boost in revenues with new Obamacare patients*," available at www.advisory.com/daily-briefing/2014/08/06/hospitals-see-boost-in-revenues-with-new-obamacare-patients.

subsidization ever was a legitimate argument to preserve CON laws, it is far less so now. Yet continuation of these laws keeps health care costs high, insulates a wide variety of providers from competition, and so acts at cross-purposes with the goals of the Affordable Care Act.

D. Conclusion

Continued—and perhaps even increasing—skepticism of the value of competition in health care, and of its necessary corollary, strong enforcement of the antitrust laws, is worrisome. Evidence that competition delivers better care and value is abundant. Unless competitive forces are given freer rein in the U.S. health care system, the ability of the Patient Protection and Affordable Care Act to deliver on the twin promises implicit in its title—good health care at affordable prices—will be severely compromised.