Concurring 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 to the Virginia Certificate of Public Need Work Group

October 23, 2015

The Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice submitted a joint statement ("Joint Statement") today to the Virginia Certificate of Public Need Work Group ("Virginia COPN Work Group") advocating for the repeal or retrenchment of Virginia's COPN laws. The Virginia COPN Work Group is charged with reviewing Virginia's COPN program and its impact on access to health care, as well as the need for changes to the current COPN process.[1] 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 that suffer from a lack of robust competition.

I agree it is appropriate that we, as an antitrust agency, explain the considerable benefits that come from competitive markets and how regulations may adversely affect competition. There is ample evidence that competition can work effectively in health care markets. Indeed, consolidation and coordination among health care providers can increase the risk of higher prices without offsetting quality improvements.[2] On this issue, the Joint Statement appropriately describes to the Virginia COPN Work Group how 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 this agency possesses sufficient current information to opine on non-competition-related public policy goals in this area. The

[1] 2015 Va. Acts Chapter 665, Item 278.D.

[2] *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).

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."[3] 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.

Our experience is broad but it does not extend to every issue: the FTC should advise public bodies like the Virginia COPN Work Group based on our area of expertise—competition—and not overstep our collective knowledge. Empirical evidence on the success or failure of COPN to obtain their numerous objectives—in Virginia or beyond—is limited, and we lack evidence on the broader impact of COPN repeal.[4] Certainly, neither the FTC nor the DOJ has done a close, state-wide analysis of the effect of Virginia's COPN laws in particular and whether they have met such policy goals.

Certain conclusions in the Joint Statement 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 COPN laws. But it cites just one study relating to the financial viability of safety-net hospitals for this proposition; and, like many other cited studies, it has meaningful limitations.[5] Moreover, this study, by the Lewin Group, expresses caution about its results, noting that it may be too soon (when the study was written in 2007) after repeal of COPN laws to observe the long-run impact, and possible detrimental effect, on safety-net hospitals. Another limitation is that the study did not analyze the effect of repealing COPN within a state—it merely conducted cross-state comparisons. This information, while relevant, may not reliably predict the effect of COPN repeal on safety-net hospitals in Virginia in particular. And importantly, the Lewin Group specifically did *not* recommend repeal of Illinois' COPN

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

[4] For example, Ho and Ku-Goto describe a positive relationship between cost containment and repealing COPN laws, but its focus is narrow—limited to coronary surgeries—and not necessarily generalizable to all types of health care covered by COPN laws. Vivian Ho & Meei-Hsiang Ku-Goto, *State Deregulation and Medicare Costs for Acute Cardiac Care*, 70 MED. CARE RESEARCH & REVIEW 185, 202 (2012). And while Rivers et al. deals with a broader measure of cost, the results are more nuanced: this study does not find a significant difference in cost between COPN and non-COPN states, but rather that states with more stringent COPN laws see higher costs than states with less stringent laws. In this way, the study is more directly supportive of retrenchment than repeal of COPN laws. Patrick A. Rivers et al., *The Effects of Certificate of Need Regulation on Hospital Costs*, 36 J. HEALTH CARE FIN. 1, 11 (2010).

[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.

laws, and instead called on Illinois policy makers to study the issue further.[6] Similarly, the Virginia COPN Work Group should conduct further studies and specifically consider whether COPN repeal could squeeze safety-net hospitals with lower margins, making it plausible that repeal could compromise access to care.[7]

In addition, there are other important public health goals beyond what the Joint Statement outlines. Indeed, objectives of a COPN 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 outlined above, these are public policies where we, as competition authorities, are not experts.

For these reasons, I encourage the Virginia COPN Work Group to continue examining whether its COPN laws are measurably meeting identifiable policy objectives. I commend Virginia's Secretary of Health and Human Resources William Hazel and the Virginia COPN Work Group for working to answer the questions: What is the public good? Is COPN working? If not, what needs to be fixed? How do we define the public good if COPN is kept?[8] In evaluating these issues, the Virginia COPN Work Group does well to weigh any of COPN laws' accomplishments with risks to competition that COPN laws may present. Thank you for consideration of these issues.

[6] *Id*. 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] The Joint Statement has no alternative policy to COPN laws on this issue.
[8] Virginia Secretary of Health and Human Resources William A. Hazel, Jr., M.D., Initial Remarks and Charge to the Workgroup (July 1, 2015), http://www.vdh.state.va.us/Administration/COPN.htm.