PREPARED STATEMENT OF
THE FEDERAL TRADE COMMISSION

Before the

Florida State Senate

on

Committee Substitute for Senate Bill 2326, which would amend, e.g., s. 408.036, F.S., removing certain hospitals from required certificate of need review, and s. 408.043, F.S., removing osteopathic acute care hospitals from required certificate of need review.

April 2, 2008

I. Introduction

The Federal Trade Commission (FTC) is pleased to have the opportunity to discuss health care competition, Florida's certificate of need (CON) laws, and the Committee Substitute for Florida Senate Bill 2326 (S.B. 2326 or the Bill), which would repeal certain of Florida's CON laws. In particular, and subject to certain exceptions, the Bill would eliminate CON requirements for the establishment of hospitals generally, as well as special CON requirements regarding acute care hospitals in "low growth" counties and osteopathic hospitals.[1] At the same time, the Bill would leave general licensing requirements for hospitals and other health care facilities in place and would impose certain new licensing requirements.[2] The Commission believes that CON laws such as Florida's can be a barrier to entry to the detriment of health care competition and health care consumers. Therefore, the Commission generally supports the repeal of such laws as well as steps, such as those taken in S.B. 2326, to reduce significantly the scope of CON laws.

The Commission's conclusion is based on the joint FTC/Department of Justice (DOJ) report, *Improving Health Care: A Dose of Competition* (Report or FTC/DOJ

[1] Hospital facilities generally – but not, e.g., long-term care hospitals, skilled nursing facilities, or hospices – would be exempted from CON requirements under proposed Fla. Stat. § 408.036(1)(b); existing special CON requirements for acute care facilities in low growth counties under § 408.036 would be repealed, as would existing CON requirements for Osteopathic Acute Care Hospitals under § 408.043.

[2] *See, e.g.*, Section 1 of the Bill, which would add new subsections 11-19 to Fla. Stat. § 395.003 (regarding Licensure; denial, suspension, and revocation). Licensing requirements for hospital facilities are found throughout the United States, including those states that have eliminated all CON requirements for hospitals and other health care facilities. *See, e.g.*, 35 P.S. § 448.801a et seq. (2007) (licensing of health care facilities in Pennsylvania). Although various licensing requirements can raise competition issues, the Commission is not here presenting an analysis of extant or proposed Florida licensing requirements.

Report),[3] its underlying research, and recent work by FTC staff and the staffs of our sister agencies, such as DOJ and the Centers for Medicare & Medicaid Services (CMS) of the Department of Health and Human Services. As noted in the FTC/DOJ Report, "[t]he 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."[4]

Congress has charged the Commission with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[5] Pursuant to its statutory mandate, the FTC seeks to identify business practices and regulations that impede competition without offering countervailing benefits to consumers. For several decades, the FTC and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[6] Included in that general body of health care competition work have been hearings, studies, and reports addressing issues raised by CON laws.

Specifically, the FTC/DOJ Report discusses critically the role of CON laws in health care competition, both as a distinct policy issue and as an important component of other health care competition issues, such as entry problems in hospital markets. The Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of

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[3] FEDERAL TRADE COMMISSION & THE DEPARTMENT OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July, 2004) [hereinafter "IMPROVING HEALTH CARE"].

[4] *Id.* at Executive Summary, p. 22.

[5] Federal Trade Commission Act, 15 U.S.C. § 45.

[6] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products* (Oct. 2003), *available at* http://www.ftc.gov/bc/hcupdate031024.pdf.

Americans for high-quality, cost-effective health care. The Report was based on, among other things, joint FTC/DOJ hearings that took place over 27 days from February through October 2003, following a Commission-sponsored workshop on health care issues in September 2002. The FTC and DOJ heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the hearings and workshop elicited written submissions from interested parties. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the Commission website, www.ftc.gov. In addition, FTC and DOJ staffs undertook independent research for the Report.

In this testimony, the Commission focuses specifically on a few of the issues discussed in the Report that address CON laws and new entry into competition among health care facilities. Three main points require attention:

- First, vigorous competition among healthcare providers, such as hospitals, clinics, and nursing homes, usually benefits consumers through better and more varied services and, in some cases, lower prices. CON laws were designed to create barriers to entry for new healthcare facilities or providers to contain the costs of healthcare services. CON laws, however, have not been particularly effective in controlling healthcare costs, while posing significant risks to competition. In particular, CON laws can retard the provision of higher quality services or the setting of lower prices by entrants relative to

incumbents, depress consumer choice between qualitatively different treatment options or settings, or reduce the pressure on incumbents to improve qualitative aspects of their own offerings. Policymakers would be wise to consider reviewing all of the actual costs, benefits, and consequences – intended and unintended – of a regulatory system when assessing that system's future.

- Second, the CON regulatory system creates both the incentive and means by which an incumbent healthcare provider can use the regulatory system itself to delay effective competition, independent of the demand for additional healthcare services. This additional loss of competition is another regulatory cost that must be weighed in the balance when assessing the public interest.
- Third, Florida's CON requirements are among the broadest remaining in the United States. The Bill's elimination of CON requirements for many hospital facilities would thus reduce barriers to entry for a wide and important range of health care facilities, while leaving intact Florida's general licensing requirements for hospital facilities.

These points are addressed more fully below.

II. Discussion

A. Provider Competition Generally: Competition has important benefits in health care services markets, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals and other entities to lower costs, improve quality, and

compete more efficiently. In particular, competitive pressure may spur new types of competition. In some hospital markets, new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.[7] Elsewhere, health care services once delivered only in large hospitals – and requiring overnight stays – may be performed more conveniently and less invasively, at lower cost, in outpatient settings. In addition, both traditional providers and new entities have explored new means to expand access to basic health care by, for example, establishing limited service clinics that can provide more convenient and lower cost care and bring more consumers into contact with the larger health care system.[8]

Although new strategies for lowering costs and enhancing quality are emerging, competition is not as effective as possible in most health care markets, because the prerequisites for competitive markets are not fully satisfied. Of particular concern for today's purpose is the extent to which state regulations can create barriers to entry in health care markets, without conferring countervailing benefits in quality of care or cost containment.[9]

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[7] *See generally Prepared Statement of the Federal Trade Commission, Before the S. Subcomm. On Federal Financial Management, Gov't Information and Int. Security of the S. Comm. on Homeland Security and Governmental Affairs, on New Entry Into Hospital Competition* (May 24, 2005) (regarding new specialty hospital entry), *available at* http://www.ftc.gov/os/2005/05/052405newentryintohospitalcomp.pdf; *see also* UNITED STATES DEPT. OF HEALTH AND HUMAN SERVICES, FINAL REPORT TO THE CONGRESS AND STRATEGIC IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (2006) [hereinafter "HHS FINAL REPORT"], *available at http://www.cms.hhs.gov/PhysicianSelfReferral/06a_DRA_Reports.asp*.

[8] *See, e.g.*, FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 1-2 (Oct. 2007).

[9] In discussing competition concerns raised by CON requirements, the Commission does not mean to suggest that state CON regulations are the only regulatory impediments to competitive forces in health care markets.

At the same time, the empirical evidence generally does not indicate that CON laws control health care costs.[10] Recent broad studies analyzing both national and state data reveal "little evidence that CON results in a reduction in costs and some evidence to suggest the opposite."[11] Studies also fail to show any consistent increase or surge in health care spending when states remove or modify their CON requirements.[12]

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[10] IMPROVING HEALTH CARE, *supra* note 3, at C. 8, at pp. 1-6. Although the larger body of CON literature – including anecdotal reports and small, uncontrolled studies – presents somewhat mixed conclusions on cost savings, the conclusions of the FTC/DOJ Report and staff research have substantially been borne out by more recent, sophisticated large-scale data analyses and literature reviews: "[O]n balance, the most methodologically sound studies have found that CON has no effect or actually increases both hospital spending per capita and total spending per capita." CHRISTOPHER J. CONOVER & FRANK A. SLOAN, EVALUATION OF CERTIFICATE OF NEED IN MICHIGAN, CENTER FOR HEALTH POLICY, LAW AND MANAGEMENT, TERRY SANFORD INSTITUTE OF PUBLIC POLICY, DUKE UNIVERSITY, A REPORT TO THE MICHIGAN DEPT. OF COMMUNITY HEALTH, 30 (May 2003) (reviewing literature and discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws) (hereinafter "CONOVER & SLOAN, REPORT TO MICHIGAN"); WASHINGTON STATE JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE (JLARC), EFFECTS OF CERTIFICATE OF NEED AND ITS POSSIBLE REPEAL, 1 (Jan. 8, 1999) ("The study found that CON has not controlled overall health care spending or hospital costs. The study generally found either conflicting or limited evidence about the effects of CON on the cost of non-hospital services, and on the quality and availability of the various health care services.") DANIEL SHERMAN, FEDERAL TRADE COMMISSION, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS, iv, 58-60 (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, FEDERAL TRADE COMMISSION, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMMISSION, 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). *But c.f.*, COMMONWEALTH OF VIRGINIA, REPORT OF THE JOINT COMMISSION ON HEALTH CARE, HOUSE DOC. NO. 82, STUDY OF VIRGINIA'S CERTIFICATE OF PUBLIC NEED (COPN) PROGRAM PURSUANT TO HB 1302 OF 1996 *(*1997), ("There is little evidence of significant COPN impact on aggregate health expenditures, but there is evidence of savings for specific services covered by COPN"). *Id.* at 1, *available at* http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD821997/$file/HD82_1997.pdf?bcsi_scan_129F6A3CDB83467E=xLesgwMDZ3sPV18TFUnlHEQAAAD+Q30W&bcsi_scan_filename=HD82_1997.pdf (last checked 1/31/08).

[11] CONOVER & SLOAN, REPORT TO MICHIGAN, *supra* note 10 at vii (discussing national and Michigan-specific material regarding acute care [hospitals, MRI services, cardiac services] CON laws); *id.* at 30-31.

[12] CONOVER AND SLOAN also report that, "[i]n most states that lifted CON, per capita spending on hospital and physician services (relative to the US) has remained below the U.S. average following removal of CON.") *Id.* at 50; *see also* Christopher J. Conover and Frank A. Sloan. *Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?*, 23 J. HEALTH POL'Y & LAW 455 (1998) ("no evidence of a surge in acquisition of facilities or in costs following removal of a CON.") 458.

Barriers to entry can affect qualitative competition as well. As the Report noted, state CON laws can retard the entry of firms that could provide higher quality services than those offered by incumbents.[13] That may tend to depress consumer choice between qualitatively different treatment options or settings,[14] or it may reduce the pressure on incumbents to improve qualitative aspects of their own offerings.[15]

B. Incumbent Lobbying and Petitioning Protections: When new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such conduct may violate the antitrust laws.[16] Certain anticompetitive conduct may, however, be shielded from antitrust scrutiny. The *Noerr-Pennington* doctrine immunizes from antitrust liability conduct that represents petitioning the government, even when such

[13] IMPROVING HEALTH CARE, *supra* note 3, at C. 8, p. 4 (citing Hosp. Corp. of Am., 106 F.T.C. 361, 495 (1985) (Opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

[14] With regard to hospital markets, *see, e.g.*, HHS FINAL REPORT, *supra* note 7, at 10 (reporting "quality of care at least as good as, and in some cases better than, care provided at local competitor hospitals" for cardiac care, as well as "very high" patient satisfaction in cardiac hospitals and orthopedic specialty hospitals) (citations omitted). In addition, specialty hospitals appear to offer shorter lengths of stay, per procedure, than peer hospitals. *See* MEDICARE PAYMENT ADVISORY COMMISSION, REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS, 15-17 (Mar. 2005) (hereinafter MEDPAC REPORT). MedPAC was directed to report to Congress on certain issues regarding specialty hospitals under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. *Id.* at vii.

[15] *See, e.g.*, MEDPAC REPORT at 10-11 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations").

[16] *See* IMPROVING HEALTH CARE, *supra* note 3, at 15-16, ch.1, at 31-33, ch.3, at 22-27.

petitioning is done "to restrain competition or gain advantage over competitors."[17] Moreover, the state action doctrine shields from antitrust scrutiny many of a state's own activities when a state government is acting in its sovereign, legislative capacity.[18]

In the context of health care competition, the combination of these two doctrines can offer antitrust immunity to providers that wish to lobby state officials to impede the entry of potential competitors, by denying or delaying the CONs required for operation. State CON programs generally prevent firms from entering certain areas of the health care market unless they can demonstrate to state authorities an unmet need for their services. Because that demonstration can be time-consuming and costly, it may delay or, at the margin, prevent the introduction of certain needed facilities and services.[19] Indeed, limiting competitor entry and raising competitors' costs may both be incentives for incumbents to seek to abuse the regulatory process. The FTC/DOJ Report concluded that "incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."[20] To the extent they are successful in doing so, incumbents may

[17] Andrx Pharm. V. Biovail, 256 F.3d 799, 817 (D.C. Cir. 2001), *cert. denied*, 122 S. Ct. 1305 (2002). The doctrine is named for the seminal cases that treated it: Eastern R.R. Presidents Conference v. Noerr, 365 U.S. 127 (1961), and United Mine Workers v. Pennington, 381 U.S. 657 (1965).

[18] Parker v. Brown, 317 U.S. 341, 351 (1943). The state action doctrine also immunizes from antitrust scrutiny the actions of other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state. *See, e.g.*, California Retail Liquor Dealers Assn. v. Midcal Aluminum, 445 U.S. 97, 105 (1980).

[19] *See, e.g.*, IMPROVING HEALTH CARE, *supra* note 3, at C. 4, p. 25 (noting that approval of a CON "can take anywhere from 18 months to several years," and that regulatory delays from CON approval are in addition to those imposed by, for example, traditional licensing requirements).

[20] *Id. at* Exec. Summ., at 22.

preserve their market shares and revenue streams without enhancing their own operating efficiency or providing health care savings to the state or its consumers.[21]

C. The Scope of Florida CON Law: Florida's current CON law – as it deals with health care facilities generally – appears to be among the broadest of such laws in the United States.[22] Many CON programs trace their origin to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974,[23] which offered states powerful incentives to enact laws implementing CON programs.[24] By 1980, all states except Louisiana had done so.[25] Congress repealed the federal law in 1986, however, and many states have repealed or revised their CON laws in the years since. Fourteen states have eliminated their CON requirements altogether[26] and, although a substantial number of states continue to maintain CON programs,[27] they do so

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[21] *See, e.g.*, MEDPAC REPORT at 10-11 ("Some community hospital administrators admit that competition with specialty hospitals has had some positive effects on community hospitals' operations").

[22] *See generally*, Fla. Stat. § 408.031 et seq. (requiring CON for health care projects generally, subject to certain exceptions).

[23] Pub. L. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. 99-660, § 701, 100 Stat. 3799 (1986).

[24] *See* JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES & PRACTICE § 16:1, at 16-2 (2003) (noting that the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services.")

[25] *See, e.g., On Certificate of Need Regulation: Hearing on H.B. 332 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director).

[26] *See, e.g.*, National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs* (updated Nov. 2007) (CON laws repealed or not in effect in CA, AZ, NM, TX, KS, CO, UT, WY, ID, SD, ND, MN, IN, and PA), *available at* http://www.ncsl.org/programs/health/cert-need.htm (last checked 01/25/08).

[27] MILES, *supra* note 24, § 16:2, at 16-9 (stating that "CON laws remain in many states and the District of Columbia"). Quite recently, Florida exempted from CON requirements new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill SJ 01740 (effective July 1, 2004), *amending* FLA STAT. ch. 408.036, .0361 (2003).

"often in a loosened form compared to their predecessors."[28] Remaining CON laws may address only specific types of health care facilities – such as hospitals or nursing homes,[29] – exempt certain types of health care facilities,[30] or apply broadly to health care facilities improvements, but only those of a substantial magnitude.[31] In addition, certain CON laws may be pending repeal according to a sunset provision.[32]

Subject to certain exceptions, Florida law requires a CON for the establishment of health care facilities generally, the establishment of tertiary health services, and any increase in acute care beds in any hospital in a "low growth county."[33] In so doing, it places significant regulatory burdens on the development or improvement of a very broad class of health care facilities, which might otherwise develop dynamically in response to market needs. The scope of current Florida law thus stands in contrast not only to the laws of those states that have eliminated their CON requirements altogether, but the laws of the many states that have more limited CON requirements. The fact that many such

[28] MILES, *supra* note 24, § 16:1, at 16-2 to 16-3. *See also* Len M . Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs "eroded through the 1990s").

[29] *See, e.g.*, OAC Ann. 3701-12-05 (2007) (regarding only certain activities by "long-term care" facilities in Ohio); R.R.S. Neb. § 71.5829.03 (2007) (CON covers only certain activities related to long-term care and rehab beds in Nebraska); ORS § 442.315(1) (2005) (regarding "any new hospital or new skilled nursing or intermediate care service or facility" in Oregon, subject to certain exclusions).

[30] For example, Connecticut law exempts critical access hospital beds and related equipment from the State's CON laws. *See* Conn. Gen. Stat. § 19a-487a (2007); *see also* Fla. Stat. § 408.0361 (2007) (regarding cardiovascular services and burn unit licensing), Fla. Stat. § 408.036 (2007).

[31] For example, Connecticut health care facilities must obtain a CON prior to developing, expanding or closing certain services and expending more than $3 million on a capital project. Conn. Gen. Stat. § 19a-638(a)(4) (2007); Delaware requires a CON for the establishment of a new facility, but only for capital expenditures by existing facilities in excess of $5.8 million (or a higher amount based on inflation adjustments to the $5.8 million baseline). *See* 16 Del. C. § 9304 (2007).

[32] *See, e.g.* 16 Del. C. § 9311 (2007) (sunset provision).

[33] *See, e.g.*, Fla. Stat. § 408.036(b), (c), (f), and (g) (requiring CONs for new construction or establishment of health care facilities, conversion of one type of health care facility to another, tertiary care services, and acute care beds in low growth counties, respectively).

CON requirements are imposed independent of any particular financial threshold itself may be a special burden to the State's health care spending, as low CON thresholds have been observed to increase costs – relative to higher thresholds – rather than decrease them.[34]

Because the Bill would eliminate current CON requirements for a broad range of hospital facilities,[35] it could enable Florida consumers to enjoy the benefits of much needed competition in hospital markets throughout the State. These benefits could include qualitatively different options in underserved areas, qualitative improvements at existing hospital facilities, and reduced pressure to substitute less desirable facilities and treatments.

A degree of controversy may remain about particular issues addressed by certain CON laws. These include, for example, efficiency and possible conflicts of interest concerns about certain categories of physician-owned specialty hospitals and access issues for rural or other underserved areas.[36] However, the sweep of Florida's CON law

[34] *See* SHERMAN, *supra* note 10, at 58-60 (1.4 percent decline in costs associated with doubling of all thresholds).

[35] Hospital facilities generally – but not, for example, long-term care hospitals, skilled nursing facilities, or hospices – would be exempted from CON requirements under proposed Fla. Stat. § 408.036(1)(b); the special CON requirements for acute care facilities in low growth counties would be struck from proposed § 408.036; and the CON requirements for Osteopathic Acute Care Hospitals under § 408.043 would also be eliminated.

[36] *See, e.g., Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the H. Comm. on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care,"* (May 12, 2005), *available at* http://www.hhs.gov/asl/testify/t050512.html; *see also Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, on Physician-Owned Specialty Hospitals Before the S. Finance Comm.* (May 17, 2006), *available at http://www.hhs.gov/asl/testify/t060517b.html.* (regarding CMS studies of physician-owned specialty hospitals, implementation and termination of limited moratorium on new specialty hospitals). The Commission does not here intend to analyze the details of ongoing regulatory reform at CMS designed to address special concerns about certain limited types of specialty hospitals (and related physician self-referral issues) or the various bodies of research on which those reforms are based. The FTC notes, simply, that most of the actual and potential health care entities

is much broader than required to address any of those more narrow and complex issues and is likely to be detrimental to Florida's health care consumers. The Commission recommends that Florida carefully consider the evidentiary basis of these issues as they may relate to Florida health care consumers. If the evidence and public policy considerations warrant some legislative action, the Commission recommends that Florida consider regulation that is narrowly tailored to achieve focused health policy goals instead of broad regulation of entry into the market for health care facilities.

III. Conclusion

CON laws were adopted throughout most states under particular market and regulatory conditions substantially different from those that predominate today and were intended to help contain health care spending. The best available research does not support the conclusion that CON laws actually reduce such expenditures. As the FTC and DOJ have said, "on balance, CON programs are not successful in containing health care costs, and … they pose serious anticompetitive risks that usually outweigh their purported economic benefits."[37] CON laws tend to create barriers to entry for health care service providers who may contribute to qualitative competition and provide consumers with important choices in the market, but CON laws do not, on balance, tend to suppress health care costs or aggregate health care spending. Moreover, CON laws may be especially subject to abuse by incumbent providers, who can seek to exploit a state's CON process to forestall the entry of competitors in their markets.

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subject to Florida CON law are not such specialty hospitals and appear to fall outside the concerns driving those studies and reforms.

[37] IMPROVING HEALTH CARE, *supra* note 3, at Executive Summary, p. 22.

Florida's current CON requirements – which the Bill seeks to curtail – appear to be among the broadest of such laws in the United States. As a consequence, Florida CON law creates a barrier to entry for a very wide range of health care facilities, including almost all hospital facilities. The Commission believes that both the breadth of Florida's CON law and its lack of a financial threshold are of special concern, as they may work to the detriment of Florida health care consumers. Accordingly, the Commission supports steps, such as those taken in S.B. 2326, that reduce significantly the application of CON laws, as well as the ultimate repeal of such laws. In the event that adequate evidence develops to support more narrow policy priorities, the Commission believes that Florida should consider regulations narrowly tailored to meet those priorities, while minimizing the general costs to Florida health care consumers.