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IN THE SUPREME COURT
OF THE STATE OF WASHINGTON

WASHINGTON STATE HOSPITAL ASSOCIATION,

Respondent,

v.

WASHINGTON STATE DEPARTMENT OF HEALTH,

Appellant.

**RESPONSE OF WASHINGTON STATE HOSPITAL
ASSOCIATION TO AMICI (1) NORTHWEST HEALTH LAW
ADVOCATES, NORTHWEST JUSTICE PROJECT, PUGET
SOUND ADVOCATES FOR RETIREMENT ACTION, AND
WASHINGTON COMMUNITY ACTION NETWORK; (2)
WASHINGTON STATE NURSES ASSOCIATION, UFCW 21, AND
SEIU HEALTHCARE 1199; AND (3) THE ACLU OF
WASHINGTON, LEGAL VOICE, MERGERWATCH, AND
PLANNED PARENTHOOD VOTES NORTHWEST**

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I. INTRODUCTION

This case presents a straightforward legal issue. The court below found the Department of Health exceeded its statutory authority when it promulgated a rule requiring a certificate of need (CN) be obtained for all transactions in which “control, either directly or indirectly,” of part or all of a hospital changes. The statute on which the Department relied, however, RCW 70.38.105(4)(b), requires a CN only for a “sale, purchase, or lease” of a hospital. If this Court agrees the Department exceeded its authority when it issued the rule, or acted arbitrarily and capriciously, the Court should affirm the lower court’s judgment that the rule is invalid.

The three briefs amici have filed in support of the Department largely ignore this legal issue.¹ Instead of focusing on *whether* the Department had authority to issue a rule expanding the scope of the statute, or whether it did so arbitrarily and capriciously, the Department’s amici argue *why* they believe such an expansion would be good policy.

It is the job of the legislature, however, not the Department, to amend the statute if a policy change is needed. While it is a complete answer to amici’s arguments to observe that amici should address them to

¹ The three briefs are filed by: (1) Northwest Health Law Advocates, Northwest Justice Project, Puget Sound Advocates for Retirement Action, and Washington Community Action Network (“NoHLA Br.”); (2) Washington State Nurses Association, UFCW 21, and SEIU Healthcare 1199 (“Union Br.”); and (3) the ACLU of Washington, on behalf of itself, Legal Voice, Mergerwatch, and Planned Parenthood Votes Northwest (the “ACLU Br.”). We refer to all as “the Department’s amici.”

the legislature, not this Court, nonetheless the Washington State Hospital Association (WSHA) shows below that amici's policy arguments do not support expanding the CN law.

II. ARGUMENT

A. Amici Do Not Address the Legal Issue Before this Court

The legislature amended the CN law in 1984 to require review for the “sale, purchase, or lease of part or all of any existing hospital.”² For the next 30 years, the Department interpreted this statute as written to require parties selling, purchasing, or leasing part or all of a hospital facility to first obtain a CN. In more than a dozen written determinations, the Department repeatedly concluded that transactions involving a change of control *without* the “sale, purchase, or lease” of a hospital facility—such as mergers, affiliations, substitutions of membership interests in nonprofit corporations, reorganizations, and stock transactions between non-hospital entities—were *not* sales, purchases or leases of hospitals under RCW 70.38.105(4)(b) and so did *not* require a CN.³

In 2013, the Department reversed course. It adopted a rule, WAC 246-310-010(54) (the “New Control Rule”), that redefines the statutory words “sale, purchase, or lease of part or all of any existing hospital” to include not just sales, purchases, and leases of hospital facilities, but also

² RCW 70.38.105(4)(b); Laws 1984, ch. 288 § 21 (1984).

³ WSHA Answering Br. (filed Nov. 3, 2014) at 7-9, 28-29, 37-39.

“any transaction in which the control, either directly or indirectly, of part or all of any existing hospital changes to a different person.” By this stroke of the regulatory pen, the Department—not the legislature—expanded the statute to capture transactions that the legislature did not regulate under the CN statute and that the Department, consistently over three decades, had recognized were *not* within the statute. Moreover, contrary to the assertions of some amici, this expansion is not limited to “major transactions.”⁴ The New Control Rule reaches minor transactions, including those in which “control” of only a small part of a hospital changes “indirectly”: this represents a dramatic expansion of CN regulation. For instance, the New Control Rule would require prior CN review whenever a hospital decided to contract with a physician group to run its emergency department, or with a children’s hospital or pediatric group to operate its neonatal ICU.

The Thurston County Superior Court invalidated the New Control Rule as exceeding the Department’s statutory authority. Judge Carol Murphy gave the words “sale, purchase, or lease” of a “hospital” their plain and ordinary meaning. She held the language does not reach transfers of control that occur through transactions other than sales, purchases, or leases of hospitals. Consistent with that ruling, whenever

⁴ Union Br. at 18.

the legislature has wanted in Title 70 to regulate *all* transactions in which a “change of ownership or control” occurs, it has done so explicitly.⁵

The NoHLA and ACLU briefs do not address the legal issue this Court must decide. The Union brief mentions the legal issue in passing, but makes no new arguments. Instead, the Department’s amici argue it would be good policy to regulate *all* changes of control of hospital facilities through the CN program. But the statute does not reach all changes in control. Because the Department expanded its regulatory reach without statutory authority it has acted unlawfully and usurped the legislature’s role.⁶

B. None of the Policy Arguments Amici Make Provides a Legal Basis for the Department’s New Control Rule

Amici argue subjecting every change of control of part or all of a hospital facility to the CN process is good policy because: (1) since 2009, hospitals allegedly have applied different “labels” to change-of-control transactions, so transactions that previously were subject to CN review now “escape” it; (2) expanding CN review to transactions other than sales, purchases, and leases would further the goals of transparency and public participation; (3) expanding CN review would ensure access to important reproductive and end-of-life services; and (4) expanding CN review would

⁵ WSHA Answering Br. at 23-26.

⁶ See also Brief of Amici Wash. State Medical Assoc. *et al.*, (“Physicians’ Br.”) at 16-19.

check market power that hospitals may acquire through consolidation.

None of these arguments supports the New Control Rule.

1. Hospitals Are Not Applying New “Labels” to Transactions to “Escape” CN Review

Several of the Department’s amici claim (as has the Department) that from 1984, when the CN statute was amended to require a CN for the sale, purchase, or lease of a hospital, until 2009, transactions changing control of a hospital proceeded as sales or purchases and thus, were subject to CN review. In 2009, according to the NoHLA brief, hospitals began to apply new “nonspecific label[s]” to their deals “to escape CN scrutiny.”⁷ The unions make the same argument: “hospitals began to label their consolidations as affiliation[s] or mergers or anything *other than* the three words used in the statute triggering certificate of need review.”⁸ Amici argue this alleged change in practice justifies the Department’s effort to expand the CN law by issuing the New Control Rule.

Amici have their history wrong. *Many* transactions changing control of hospitals before 2009 employed a variety of transactional forms other than sales, purchases, or leases—and the Department found *none*

⁷ NoHLA Br. at 8, 3.

⁸ Union Br. at 18 (italicized emphasis in original; bolded emphasis added); *see also id.* at 12. No evidence is provided in any brief to support the accusation.

required CN review.⁹ In its very first determination of nonreviewability, issued the year after the statute was amended, the Department examined a transaction between two nonprofit hospital systems in Spokane. In 1985, Deaconess Medical Center and St. Luke’s Memorial Hospital created a new nonprofit entity, Empire Health Services, to hold the membership interests of the previously separate systems.¹⁰ The Department concluded the transaction, which it labeled a “reorganization,” did “not constitute the sale, purchase or lease of an existing hospital (RCW 70.38.105(4)(b)).”¹¹ Between 1985 and 2008, there were at least eight more transactions in which a hospital changed control through mechanisms other than a “sale, purchase, or lease.”¹² (A chart showing these transactions is attached as an appendix.) These nine transactions show there is nothing new—let alone nothing that started in 2009—about hospitals reorganizing, restructuring, substituting membership interests in nonprofits, merging, affiliating, or otherwise transferring control without a “sale, purchase, or lease” of a “hospital.”¹³

⁹ WSHA Answering Br. at 37-40 & App.; WSHA Answer & Opp. to Mot. to Stay (Aug. 12, 2014) at 6-7; WSHA Response to Amici, App.

¹⁰ CP 327-331.

¹¹ CP 323.

¹² CP 171-84, 90-95, 198-202, 83-88, 186-96, 160-69, 152-58; CP 178 & 191 (discussing 1989 “reorganization” involving American Healthcare Management and Puget Sound Hospital).

¹³ No records exist showing how transactions were structured before 1984, when the legislature amended RCW 70.38.105. There is no reason to suppose, however, that all changes of control before 1984 were structured as sales, purchases, or leases. Since at

Even if amici's version of history were correct, and newfangled transactions to transfer control were invented in 2009, it would not follow that the Department, by rule, could rewrite the statute to capture these transactions. If amici wish to subject every change of control to CN regulation, they should urge the legislature enact a more expansive statute.

2. Transparency and Public Participation Do Not Justify Amending the Statute by Rule

Amici argue (as did the Department), that expanding the CN law through the New Control Rule would open private transactions to public review and afford the public an opportunity to comment. Amici assert a purpose of the CN law is to ensure the public has an opportunity to comment on "proposed health care facility transaction[s]."¹⁴ From this premise, amici jump to the conclusion that the statute's "sale, purchase, or lease" language should be read expansively to subject *all* change-of-control transactions to CN review. But that is at odds with the statute: it identifies *with specificity* the transactions subject to CN review, and omits many others that could have been subjected to review. For example:

least 1967, nonprofit corporations could transfer control of assets through membership substitutions. Laws 1967, ch. 235 (nonprofit corporations act). And mergers long have been a common method of consolidating corporations. Laws 1933, ch. 1985 (enacting Private Business Corporations Act, Title 23 of the RCW); Laws 1965, ch. 53 (repealing Title 23 and replacing it with the Business Corporation Act, Title 23A); Laws 1989, ch. 1965 (repealing Title 23A and replacing it with RCW 23B.01 *et seq.*). Presumably the legislature was fully aware of these transactional forms when it chose to regulate only the "sale, purchase, or lease" of a hospital in 1984.

¹⁴ NoHLA Br. at 7.

- A CN is needed before a hospital may offer a “new tertiary health service,” *but not before it adds many other hospital services*.¹⁵ No CN is needed to *abandon any* service.
- No CN is required for the construction of a new children’s hospital that does not charge for its services.¹⁶
- A CN is needed for the construction of a new kidney dialysis center and before an existing center can be expanded.¹⁷ *But no CN is needed for the purchase or sale of an existing dialysis center.*
- A CN is needed for the construction of a new ambulatory surgical facility.¹⁸ *But no CN is needed for expansion or the purchase or sale of an existing facility.*¹⁹
- A CN is needed for the construction or development of a new nursing home.²⁰ *But no CN is needed for the purchase or sale of an existing nursing home.* Expansions of existing nursing homes may or may not be subject to review, depending on a complex set of requirements.²¹
- No CN is required to develop facilities that provide assisted living, adult residential treatment, freestanding radiation treatment, mammography, or proton treatment.

Continued analysis of the CN statute would yield many more examples of “proposed health care facility transaction[s]” that are not subject to CN review, but the examples here suffice: if increasing

¹⁵ RCW 70.38.105(4)(f).

¹⁶ See RCW 70.38.105(4)(a) & RCW 70.38.025(6). Shriners Hospitals for Children (one of which is in Spokane) historically did not charge for services.

¹⁷ See RCW 70.38.105(4)(a) (requiring a CN for a new “health care facility”); RCW 70.38.025(6) (defining “health care facility” to include “kidney disease treatment centers”); RCW 70.38.105(4)(h) (requiring a CN to expand any dialysis center).

¹⁸ See RCW 70.38.105(4)(a) (requiring a CN for a new “health care facility”); RCW 70.38.025(6) (defining “health care facility” to include “ambulatory surgical facilities”).

¹⁹ RCW 70.38.105(4)(a); RCW 70.38.025(6). See also Physicians’ Br. at 14 n.28.

²⁰ See RCW 70.38.105(4)(a) (requiring a CN for a new “health care facility”); RCW 70.38.025(6) (defining “health care facility” to include “nursing homes”).

²¹ See RCW 70.38.105(4)(c), (d), (e), (g).

opportunities for public participation were to determine what is subject to CN review, all the distinctions above, drawn carefully by the legislature, would be obliterated. The Department's amici may believe all health care transactions should be subjected to CN review, "regardless of how ... labeled."²² But that is not the law. The Department cannot regulate transactions that the legislature has not subjected to CN review.

Finally, as WSHA observed in its answering brief, the legislature already has mandated public participation in a number of transactions in which control of a hospital changes. Ch. 70.45 RCW requires public hearings, an opinion from the Attorney General, and Department of Health approval before a for-profit company may take control of a nonprofit hospital.²³ (The Union amici complain about the increase in for-profit hospital ownership,²⁴ but do not acknowledge the extensive process and government approval required before such a change in control occurs.) Similarly, changes of control of hospitals owned by public hospital districts are subject to public scrutiny and approval by elected

²² NoHLA Br. at 5.

²³ RCW 70.45.030(1) provides a "person may not engage in the acquisition of a nonprofit hospital" without Departmental approval. "Acquisition" is broadly defined to include "acquisition ... of an interest ... whether by purchase, merger, lease, gift, joint venture, or otherwise, that results in a change of ownership or control of twenty percent or more of the assets of the hospital, or that results in the acquiring person holding or controlling fifty percent or more of the assets of the hospital." RCW 70.45.020(3). This does not reach nonprofit consolidations because "person" is defined to *exclude* nonprofit, tax-exempt hospitals and government entities. RCW 70.45.020(5).

²⁴ Union Br. at 13.

commissioners, regardless of the form used.²⁵ If the legislature wanted to ensure a public process before *every* change-of-control transaction, and in particular before any transaction not reached by the foregoing statutes, the enactment of Ch. 70.45 RCW in 1997 provided a perfect vehicle to do so. Instead, the legislature very carefully *excluded* transactions between nonprofit hospitals from the scope of that statute.

The Department cannot accomplish by rule a policy change the legislature has not yet adopted simply because some believe it desirable to subject additional transactions to public participation.

3. Access to Services Does Not Justify Expanding the CN Statute by Rule

Amici argue hospital consolidations between religiously affiliated and secular hospitals reduce access to reproductive and end-of-life services. They claim expanding CN review would avoid this result. Amici misdiagnose a problem and then prescribe a solution that is not tailored to solve the supposed problem.

The Governor issued a directive to the Department to adopt the New Control Rule in response to complaints from the ACLU and others that hospital affiliations involving religious systems threaten access to reproductive and end-of-life services.²⁶ On the same day, he acknowledged,

²⁵ See Amicus Brief of the Association of Washington Public Hospital Districts at 4-11.

²⁶ WSHA Answering Br. at 9-10.

“we have not identified any situations in which Washingtonians have been denied access as a result of these mergers and affiliations.”²⁷ He promised that the Office of Financial Management (OFM) would “initiate a review for specific access to care concerns.”²⁸ OFM completed its report before the final Rule was issued and found *no* evidence that communities with religiously affiliated hospitals have less access than others to tubal ligations, abortions, or death-with-dignity services.²⁹ The finding may appear counterintuitive to some but, as OFM explained when it transmitted the report to the Department, “much of what is prohibited by Catholic policy – Death with Dignity and abortions, for instance – are services that are typically provided outside the hospital inpatient setting.”³⁰

So amici misdiagnose the problem: hospital affiliations do not threaten access to these services. Amici compound their error by claiming expansion of the CN law is an effective way to combat this misdiagnosed problem. It is not, as WSHA commented during the rulemaking process.³¹ The Department makes two calculations that are central to the determination of “need” under the CN law: the volume of services demanded and the

²⁷ *Id.* at 13; CP 372.

²⁸ CP 373.

²⁹ CP 396, 398-417. The Report also found *no* instances of “discriminatory practices against LGBT patients or their families.” CP 400; *see also id.* at 417.

³⁰ CP 396; *see also* WSHA Comments AR 1238 (“by and large, not hospital services”). The Department reports in the first five years after passage of the Death With Dignity Act, lethal doses of medication were provided to 547 people; just one died in a hospital. *See* www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct.

³¹ *See* AR 1236-38 (WSHA Comments).

existing supply of that service. Only if demand exceeds supply is there a “need” justifying a CN.³² If the Department were to take “need” for reproductive and end-of-life services into account when granting a CN for a change-in-control transaction, it first would have to estimate demand. This would be a difficult and fraught calculation: it would require, for example, an estimate of the number of abortions and assisted suicides expected in an area. Then the Department would have to measure the existing supply of these services. Because most of the services in question are not performed in hospitals,³³ the Department has no reliable way to measure supply. Yet the Department cannot determine need without properly calculating supply and demand.

Finally, any effort by the Department to compel a particular provider to offer these services could run afoul of the conscience clauses included in each of the initiatives that expanded Washingtonians’ access to reproductive and end-of-life services, raising serious constitutional issues.³⁴

³² See RCW 70.38.115(2)(a) (“need”); WAC 246-310-210(1) (“the population served ... has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need”).

³³ See CP 396.

³⁴ See AR 1239 (WSHA Comments, discussing I-120 and I-1000). The Death With Dignity Act, for example, allows providers, including hospitals, to opt out, and many do (including secular hospitals). Using CN regulation to force a new owner of a hospital to provide these services would appear to violate this provision.

4. The Importance of Preserving Competition in Health Care Markets Does Not Justify Amending the Statute by Rule

Amici argue the New Control Rule is justified because subjecting all change-of-control transactions to CN review, in their view, will promote hospital competition and lead to lower prices.³⁵ Amici are vague as to how CN regulation could accomplish this result. Presumably, the Department would withhold a CN when, in its view, a hospital consolidation would reduce competition and lead to higher prices.

The argument suffers from two serious flaws. First, it is completely at odds with the premise of the CN statute, which holds that competition does not work in health care because, rather than lower prices, it *increases* prices. CN law addresses this perceived market failure by *limiting* providers of a given service and so reducing competition. If amici believe more competition is needed, then logically they should urge the CN law be scaled back, not expanded. Second, an entirely separate body of law—antitrust law—enforced by entirely different agencies, exists to promote competition. It would be unwise to ask the Department to use the CN law, a tool created to suppress competition, to promote competition when the antitrust agencies already do so, using antitrust law.

³⁵ NoHLA Br. at 10-12; Union Br. at 9-10.

a. **The CN Statute is Predicated on a Legislative Finding that Competition Drives Prices *Up* and Must Be Restrained**

The legislature enacted Washington's CN law in 1979. In *St. Joseph Hospital & Health Care Center v. Department of Health*, this Court noted the legislature "acted in response to" a federal statute that Congress had passed five years before to encourage states to rely on planning, not competition, for the delivery of health care services.³⁶ Congress enacted the federal statute because it "was concerned 'that marketplace forces in this industry failed to produce efficient investment in facilities and to minimize the costs of health care.'"³⁷ When the legislature adopted the state's CN law, it "clearly wanted to control health care costs."³⁸ But, this Court observed:

[E]qually clear is [the Legislature's] intention to accomplish that control by *limiting competition* within the health care industry. The U.S. Congress and *our Legislature made the judgment that competition had a tendency to drive health care costs up rather than down and government therefore needed to restrain marketplace forces.*³⁹

It makes no sense, therefore, for amici to urge the Department to use CN law to promote competition. CN regulation is the *antithesis* of

³⁶ 125 Wn.2d 733, 735-36, 887 P.2d 891 (1995).

³⁷ *Id.* (quoting *Nat'l Gerimed. Hosp. & Gerontology Ctr. v. Blue Cross of Kan. City*, 452 U.S. 378, 386 (1981)); see also Union Br. at 14 (quoting same).

³⁸ *St. Joseph*, 125 Wn.2d at 741.

³⁹ 125 Wn.2d at 741 (emphasis added); see also Union Br. at 5 (quoting same).

competition.

The two federal agencies charged with enforcing the nation's antitrust laws understand that, far from encouraging competition, CN regulation displaces competition. The Federal Trade Commission (FTC) and the Antitrust Division of the U.S. Department of Justice (DOJ) *oppose* CN regulation for exactly this reason. These agencies assert that by “creating barriers to entry in the health care market,” CN laws “prevent new health care entrants from competing.”⁴⁰ The agencies support the “repeal of such laws” and have urged state legislatures that wish to keep CN laws to at least take “steps that reduce their scope.”⁴¹

If amici wish to promote competition in health care, they should urge that CN regulation be rolled back, rather than support the New Control Rule, which seeks to *expand* CN regulation.

b. If Amici Wish to Inject Competition into Health Care they Should Rely on the Antitrust Laws and Enforcement Agencies, Not the CN Law and Department of Health

A very different body of law from CN regulation protects and

⁴⁰ U.S. Dep't of Justice & Fed. Trade Comm'n, *Improving Health Care: A Dose of Competition* (“*Dose of Competition*”), Ch. 8 at 3, 4 (July 2004), at: www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

⁴¹ FTC, *Competition in Health Care & Certificates of Need*, “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,” at 2 (Sept. 15, 2008) (“Joint Statement”), at: www.ftc.gov/os/2008/09/V080018illconlaws.pdf.

promotes competition: the federal and state antitrust laws. The antitrust laws are “a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade.”⁴² Unlike the CN law, the premise of antitrust law is that “the unrestrained interaction of competitive forces will yield the best allocation of our economic resources” and lead to “the lowest prices.”⁴³ The antitrust laws are “the Magna Carta of free enterprise.”⁴⁴

The antitrust enforcement agencies believe competition works in all industries, including health care. In late April, the FTC and DOJ wrote the New York State Department of Health that “in the health care industry, just like in other industries, consumers benefit from vigorous competition.”⁴⁵ These statements come as no surprise, given the agencies long have argued that “market forces tend to improve the quality and lower the costs of health care goods and services. They drive innovation and ultimately lead to the delivery of better health care.”⁴⁶

If amici believe a particular consolidation will lessen competition and lead to higher prices, they may urge the antitrust enforcement agencies

⁴² *N. Pac. Ry. v. United States*, 356 U.S. 1, 4 (1958).

⁴³ *Id.*; see also *Nat'l Soc. of Prof. Eng'rs v. United States*, 435 U.S. 679, 695 (1978) (“competition will produce not only lower prices, but also better goods and services”).

⁴⁴ *United States v. Topco Assocs.*, 405 U.S. 596, 610 (1972) (Marshall, J.).

⁴⁵ FTC Ltr. to N.Y. State Dep't of Health, at 4 (Apr. 22, 2015), at: https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf.

⁴⁶ Joint Statement, *supra* n.41, at 2.

to take action. There is no shortage of antitrust enforcers among which to choose: the FTC, which has an office in Seattle,⁴⁷ and DOJ both enforce the federal antitrust laws.⁴⁸ The Washington Attorney General's Office, through its Antitrust and Unfair Trade Practices Division, enforces both the federal and state antitrust laws.⁴⁹ Private plaintiffs may sue too, and are incentivized by the promise of treble damages and attorneys' fees.⁵⁰

The antitrust enforcement agencies are experts in enforcing the antitrust laws. They make judgments, informed by economics and experience, as to when a hospital consolidation may be anticompetitive and so warrant an enforcement action, and when that is not the case. When the antitrust agencies believe a transaction will lessen competition, they vigorously enforce the antitrust laws.⁵¹ Just as importantly, the

⁴⁷ See www.ftc.gov/about-ftc/bureaus-offices/regional-offices/northwest-region.

⁴⁸ The relevant federal antitrust law provisions are Section 7 of the Clayton Act, which prohibits anticompetitive mergers and acquisitions, 15 U.S.C. § 18, and Sections 1 and 2 of the Sherman Act, which prohibit other anticompetitive conduct, *id.* §§ 1, 2.

⁴⁹ Pertinent state antitrust provisions are found in the Consumer Protection Act at RCW 19.86.030, .040, and .060.

⁵⁰ 15 U.S.C. § 15(a); RCW 19.86.090.

⁵¹ See, e.g., Wash. Att'y Gen.'s Office, Past Cases, Investigation of Franciscan Health Acquisition of Enumclaw Hospital, at: www.atg.wa.gov/past-cases#Franciscan; Ronan P. Harty, ABA Section of Antitrust Law, *The Threshold: Newsletter of The Mergers & Acquisitions Committee*, "Interview with Chairwoman Edith Ramirez," at 3 (Spring 2014), at: www.ftc.gov/system/files/documents/public_statements/294181/140326thresholdspringisue_0.pdf ("[p]reventing anticompetitive provider consolidation is another healthcare priority that has deep roots at the Commission"); FTC Stats & Data 2014, at: www.ftc.gov/reports/annual-highlights-2014/stats-data-2014 (showing almost half of the FTC's enforcement actions involve health care); FTC Annual Highlights 2014, at: www.ftc.gov/reports/annual-highlights-2014/enforcement (prominently highlighting the FTC's litigation successes against anticompetitive health care mergers in Toledo, Ohio, and Nampa, Idaho). For a history of the enforcement actions by the federal agencies in

agencies understand, as perhaps amici do not, that the vast majority of hospital mergers are *not* anticompetitive. The agencies repeatedly have stated that “[m]ost hospital mergers and acquisitions do *not* present competitive concerns.”⁵² As a result, although the FTC has “been very concerned about certain collaborations, *the Commission challenges very few provider collaborations.*”⁵³ Over the last decade, in fact, the FTC “challenged less than 1% of hospital deals, and [it] brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition.”⁵⁴

The reason for this small number of challenges is simple: most hospital mergers are competitively neutral or benefit consumers. Martin Gaynor, the FTC’s Director of the Bureau of Economics and an economist who authored a number of the papers on which amici rely, made this point in a speech last year. While the FTC challenges hospital mergers that will increase costs, he said, such transactions constitute only a tiny fraction of

health care mergers, see Douglas Ross and Ryan Gist, “St. Luke’s Litigation,” ANTITRUST HEALTH CARE CHRONICLE (Mar. 2014) at 2, 4-6, *at*: www.weil.com/~media/files/pdfs/antitrust_healthcare_chronicle-march2014.pdf.

⁵² *Dose of Competition*, *supra* n. 40, at Ch. 4, p.1 (emphasis added); *see also* U.S. Dep’t of Justice & Fed. Trade Comm’n, *Statements of Antitrust Enforcement Policy in Health Care*, Stmt. at 8 (Aug. 1996) (same), *at*:

www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.

⁵³ Deborah Feinstein (Dir., Bureau of Competition, FTC), “Antitrust Enforcement in Health Care: Proscription, not Prescription,” Fifth Nat’l Accountable Care Org. Summit, at 9 (June 19, 2014) (emphasis added), *at*:

www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf.

⁵⁴ *Id.*

all mergers. He noted “[s]ome” mergers reduce competition but said others “may generate greater efficiency.”⁵⁵ The current FTC Chairwoman has made the same point: “hospital mergers can generate important efficiencies that benefit consumers.”⁵⁶

Ongoing research by a former head of the Centers for Medicare and Medicaid Services (CMS) and a prominent health care economist casts serious doubt on the notion that predicting which hospital mergers will have an impact on price is as simple as looking at the degree of hospital concentration in a market.⁵⁷ These researchers note they have reviewed the “oft-cited concentration-price literature” purporting to show a relationship between concentration and price (including virtually all of the papers on which amici rely) but found “*no systematic quantifiable*

⁵⁵ Martin Gaynor, “*Efficiencies Analysis: False Dichotomies, Modeling, and Applications to Health Care*,” at 5 (Aug. 2014), at: www.ftc.gov/system/files/documents/public_statements/574751/140619efficienciesanalysis.pdf.

⁵⁶ Harty, *supra* n. 51, at 3; *see also* Julie Brill, Comm’r, FTC, “Competition in Health Care Markets,” Keynote Address, at 10-11 (June 9, 2014), (“Antitrust law permits providers to engage in a wide array of legitimate collaborative activities ... as well as many mergers and consolidations, so long as the conduct is not likely to harm consumer welfare This is not a new concept....”), at: www.ftc.gov/public-statements/2014/06/competition-health-care-markets-keynote-address-julie-brill.

⁵⁷ *See* Margaret Guerin-Calvert, Jen Maki, Bruce Vladek, “Re-Aligning Prospective Hospital Merger guidance: Moving Beyond Concentration to More Meaningful Approaches,” (Apr. 10, 2015), at: papers.ssrn.com/sol3/papers.cfm?abstract_id=2593165; *see also* Bruce C. Vladek, HHN-Daily, “The Charge of the Uptight Brigade: Hospitals, Antitrust Theory and the Last War,” (Apr. 16, 2015), at: www.trusteemag.com/display/TRU-news-article.dhtml?dcrPath=/templatedata/HF_Common/NewsArticle/data/HHN/Daily/2015/April/hospital-consolidation-article-vladek.

relationship” between market concentration and price levels.⁵⁸ Instead, “*myriad market and firm specific factors account for price variation.*”⁵⁹

The Department’s personnel are not experts in the complex field of competition economics; the personnel at the FTC and DOJ are.⁶⁰ Even more to the point, the Department’s statute—the CN law—is the wrong tool for the job. If amici believe more competition is needed in health care, they should visit with the expert antitrust enforcement agencies. They should not ask that the Department be turned into yet another antitrust enforcement agency, armed with a statute founded on the idea that competition does not work in health care.

III. CONCLUSION

If amici believe sound policy supports expanding CN regulation, they should urge that the legislature amend the statute. Because the Department exceeded its authority when it issued the New Control Rule, the Superior Court properly held the rule unlawful. This Court should affirm.

⁵⁸ Guerin-Calvert, *supra* n. 57, at 1 (emphasis in original).

⁵⁹ *Id.* (emphasis in original).

⁶⁰ An audit of the CN Program revealed staff were not fully applying existing statutory review criteria, possibly because doing so “may require more expertise on health economics and planning than the [CN] staff currently have.” State of Wash., JLARC, Performance Audit of the Certificate of Need Program, Report 06-6, at 14, (June 26, 2006), at: <http://leg.wa.gov/jlarc/AuditAndStudyReports/Documents/06-6.pdf>.

RESPECTFULLY SUBMITTED this 12th day of May, 2015.

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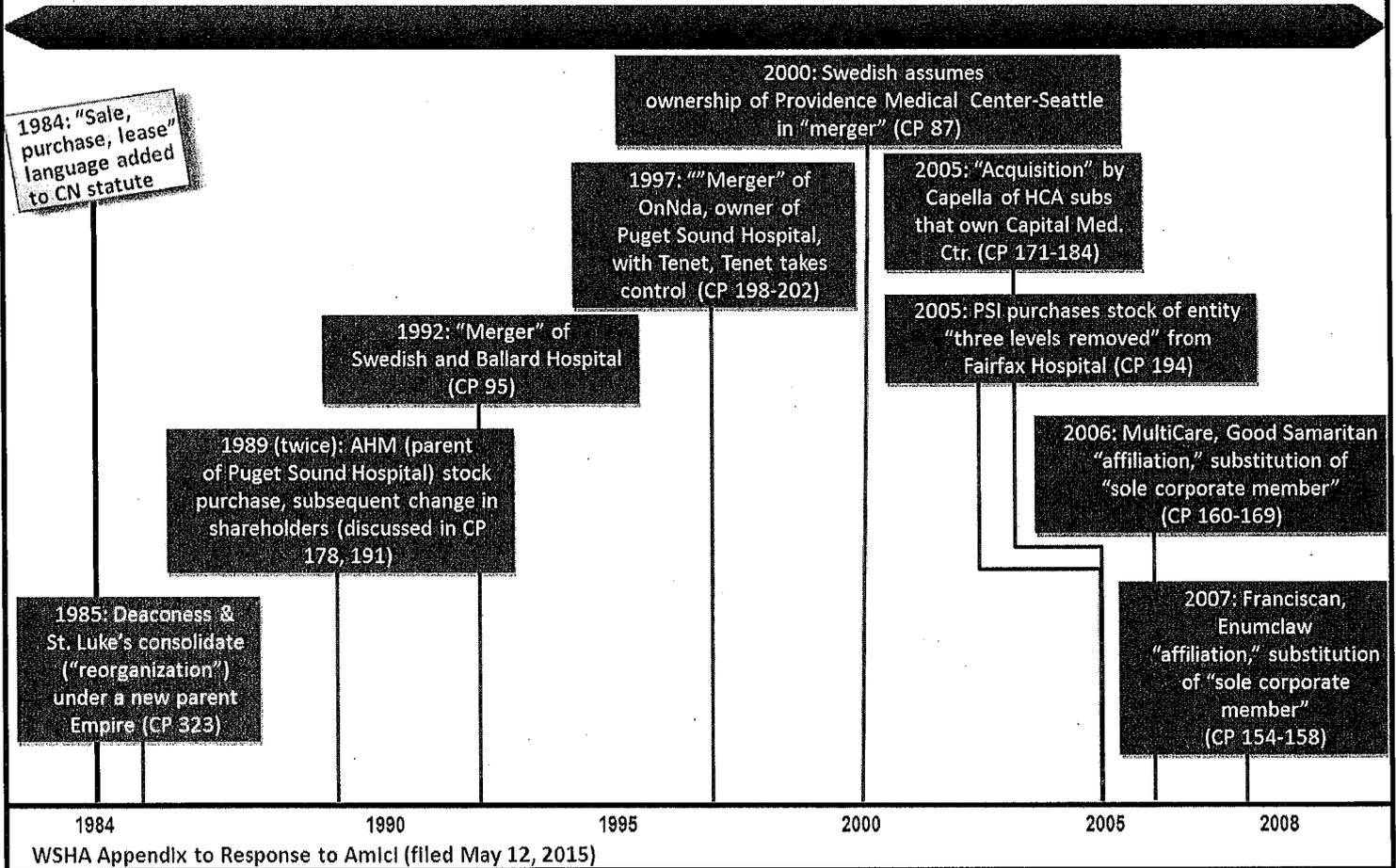
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APPENDIX

Determinations of Non-Reviewability between 1985 and 2008



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Subject: WSHA v. DOH - No. 90486-3: WSHA Response to Amici Briefs

Case Name: *Washington State Hospital Association v. Washington State Department of Health*
Case No.: 90486-3

Dear Clerk:

Please find attached for filing in the above-referenced matter the Response of Washington State Hospital Association to Amici (1) Northwest Health Law Advocates, Northwest Justice Project, Puget Sound Advocates for Retirement Action, and Washington Community Action Network; (2) Washington State Nurses Association, UFCW 21, and SEIU Healthcare 1199; and (3) the ACLU of Washington, Legal Voice, Mergerwatch, and Planned Parenthood Votes Northwest.

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cc: Counsel of Record (per service agreement of parties)

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