

# Deregulating Health Care in a Pandemic— and Beyond

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**F**OR DECADES, THE FEDERAL TRADE Commission has engaged in an array of competition advocacy initiatives. Its advocacy program augments its enforcement efforts, and stems from the recognition that while private action can distort market forces, so too can government action.<sup>1</sup> Of course, government actors seek to protect a variety of interests, including public health, safety, and security.<sup>2</sup> The FTC does not expect competition inevitably to trump these other goals. Instead, it provides input on legislative and regulatory proposals so that policymakers can weigh the desirability of a given proposal in light of all benefits and harms, including the potential for higher prices and a decrease in the quality and availability of goods and services.

Given both the importance of health care in the daily lives of American consumers and the growing percentage of the gross domestic product for which this sector accounts, the FTC's advocacy efforts have been particularly robust in the health care sector. When asked, the FTC frequently has provided input to federal, state, and local governments regarding the benefits of choice and competition in health care—and, conversely, the costs of excessive and unduly burdensome regulations. Injecting more competition into this sector is an appropriate focus,<sup>3</sup> as the cost of health care consistently polls as one of the issues of top concern for Americans.<sup>4</sup>

The health care sector now faces a new challenge: COVID-19. With more than 1.9 million confirmed coronavirus infections in the United States as of early June, authorities have pursued every conceivable angle to ensure a sufficient supply of medical personnel, hospital beds, and associated equipment to care for patients with this disease. Quarantine orders and talk of “flattening the curve” have been accompanied by the waiver, suspension, or repeal of myriad limitations on the provision of health care—a reduction in the regulatory burden, as the FTC has long championed.

It is gratifying to see these changes, though unfortunate that a global pandemic was necessary to prompt them. As a society, we can choose to focus on the positive and preserve, even after the crisis passes, the enhanced levels of choice and competition in health care now emerging. Legislators and regulators should consider which laws and rules are truly necessary for patients' safety, and which ones create unnecessary barriers to market entry. It is our sincere hope that COVID-19 swiftly becomes a historical relic—but if its threat lingers, eradicating burdensome regulations will be even more beneficial.

In this article, we examine several major constraints on health care competition: certificates of need that force providers to seek government permission to expand health care resources; certificates of public advantage that immunize potentially anticompetitive arrangements from antitrust scrutiny; occupational licensing regimes that restrict the mobility of medical professionals and the fullest use of their medical expertise; and regulations that inhibit innovations in health care delivery like telemedicine. While all of these are state-imposed restrictions, we recognize the states' traditional police power over the health and safety of their residents. The question is not whether the states should regulate health care; it is whether some regulations serve the interests of market incumbents more than those of patients. The exigencies of a public health emergency may clarify for states what they can do to free health care providers to meet demand in more conventional circumstances as well.

## Certificates of Need and of Public Advantage

The COVID-19 pandemic has increased the volume of calls for greater “resiliency”—typically in the form of redundancy—in the provision of goods and services, particularly with respect to health care. For example, the Organization for Economic Co-operation and Development and the Open Markets Institute on April 23 hosted a discussion in which several participants attributed various supply shortages to the business focus on efficiency.<sup>5</sup> In contrast with this preference for redundancies, state certificate of need (CON) and certificate of public advantage (COPA) laws generally seek to achieve greater efficiency in the delivery of health care services by reducing the duplication of resources and controlling costs.

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The National Health Planning and Resources Development Act, effective in 1975, put forward a federal model for state CON programs.<sup>6</sup> These regulatory programs empowered state authorities to decide whether hospitals and other medical facilities could make certain general purpose capital expenditures, add new services, or acquire medical equipment for inpatient use. The federal government would reimburse health care providers only for large capital expenditures approved by the state health planning agency.<sup>7</sup> Not surprisingly, every state except Louisiana had created a CON program by the end of 1982.<sup>8</sup> Following changes in reimbursement policies, Congress repealed the Act in 1986.<sup>9</sup>

Yet CON laws remain on the books in 35 states, and the District of Columbia. Michigan and Minnesota not only retained their CON laws, they imposed moratoria on adding hospital beds. In responding to the COVID-19 pandemic, the governors of both states had to authorize the regulators to grant waivers for increasing the number of hospital beds and mobile health care facilities.<sup>10</sup> As Iowa's Proclamation of Disaster Emergency put it, "[S]trict compliance" with the state law requiring a health facility to obtain a certificate of need before operating additional bed capacity will "prevent or hinder efforts to contain this public health disaster."<sup>11</sup> Alabama, Connecticut, Georgia, Indiana, Nebraska, New Jersey, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Virginia, and Washington State also have suspended CON laws.<sup>12</sup>

The number of hospital beds in the U.S. fell from almost 1.5 million in 1975 to nearly 900,000 in 2015.<sup>13</sup> Noting this decrease, some anti-monopoly activists have blamed insufficient health care provider capacity in the pandemic on excessive consolidation and held the FTC accountable for irresponsibly permitting that consolidation.<sup>14</sup> In reality, many mergers are pro-competitive and do not inherently prevent new entry to meet demand. Moreover, the FTC has challenged dozens of anticompetitive hospital mergers,<sup>15</sup> though its efforts sometimes have been stymied by courts that deny injunctions<sup>16</sup> or by states that choose to immunize these mergers from federal antitrust scrutiny.

For example, when the FTC sued to block Phoebe Putney's acquisition of Palmyra Park Hospital, in Albany, Georgia, the federal district court initially refused to enjoin the deal and the parties consummated their merger.<sup>17</sup> When the FTC won on appeal, the state's CON law created a hurdle to divestiture.<sup>18</sup> In March 2015, the FTC ultimately entered into a consent decree requiring Phoebe Putney to notify the agency of plans for any future acquisitions in the Albany, Georgia area, and to refrain for five years from objecting to Certificate of Need applications made by potential competitors.<sup>19</sup> Phoebe Putney had previously sued the state to prevent it from relaxing the CON requirements.<sup>20</sup>

Lee County, Georgia—also in the Albany area—had no hospital beds. It applied in May 2017 for a CON that would permit the development of a 60-bed medical center. While the FTC does not typically intervene on individual CON

applications, Lee County invited the agency to file comments with the Georgia Department of Community Health on the application. The FTC supported the application: "Consistent with Georgia's CON laws, we encourage you to foster 'competition that is shown to result in lower patient costs without a loss of the quality of care' in order to improve the welfare of Georgia health care consumers, not on behalf of any particular provider or would-be competitor."<sup>21</sup>

The health department approved the CON application for Lee Medical Center in November 2017.<sup>22</sup> But then the Georgia Alliance of Community Hospitals, Crisp Regional Health Service, and neighboring Dougherty County—where Phoebe Putney is based—each sued separately to block Lee County's application on the grounds that the new medical center would harm existing hospitals.<sup>23</sup> Phoebe Putney had conducted a study showing it would lose more than \$50 million of revenue each year if the Lee County hospital were built.<sup>24</sup> The role of Phoebe Putney in the southwest Georgia hospital market illustrates how certificates of need can undermine enforcement against anticompetitive mergers and enable incumbents or their allies to erect hurdles to new entrants.

Regulatory barriers such as certificates of need prevent markets from responding promptly to increased demand with increased supply. For example, while the population of Lee County has nearly tripled since 1980, to an estimated 30,000 people, Dougherty County's population has dropped from more than 100,000 people to just over 91,000.<sup>25</sup> Ideally, hospital capacity in each geographic area could evolve to meet the population's needs. But regulation, especially including the opportunity for competitors and other counties to fight against Lee County's application, has contributed to the delay in opening the new medical center.

Observers have raised particular concerns about insufficient capacity in rural areas and faulted consolidation for the lack of hospitals in some counties.<sup>26</sup> Part of the original motivation for CON regulations was to protect existing rural hospitals from competitive pressure and "cherry picking" of profitable procedures by specialist providers like ambulatory surgical centers.<sup>27</sup> Legislators feared that if the community hospital were not the monopolist health care provider for an area, it would not be able to fund charitable care and other public policy goals. Indiana, which had repealed its CON regulations in 1999, created a new program in 2018 by requiring the state Department of Health to establish requirements and exemptions for certificates of need. State legislators justified the return of CONs by pointing to a lack of services in rural communities.<sup>28</sup> Yet a study by the Mercatus Center at George Mason University concluded that "as barriers to entry, CON programs do not promote access to rural care in the form of rural hospitals. CON laws are associated with a decrease, not an increase, in the number of hospitals, rural or otherwise."<sup>29</sup>

More generally, CON laws have been found in dozens of empirical studies to increase inefficiencies—costs that are

passed on to payors as higher prices—without improving patient outcomes.<sup>30</sup> States that repealed these laws experienced lower costs per patient and lower mortality for coronary artery bypass grafts, and had more providers.<sup>31</sup> CON laws are associated with longer wait times in emergency rooms.<sup>32</sup> A review of the literature concluded that if CON laws have any effect on the rate of deaths from all causes, “They are more likely to increase mortality than decrease it.”<sup>33</sup>

While CON regimes can protect incumbent health care providers from competition, certificates of public advantage can protect health care providers’ cooperation from antitrust scrutiny. Since the 1990s, several states have passed COPA laws and regulations that immunize health care providers’ cooperative agreements from antitrust scrutiny. The federal antitrust laws already permit health care collaborations and mergers between competitors that benefit consumers.<sup>34</sup> However, in comments to the FTC last year, the American Hospital Association argued that state legislatures and hospitals turn to the COPA process in response to the courts’ and agency’s high hurdles for proving merger efficiencies, even when there are “demonstrable benefits for patients and their communities” that seem relevant under the Horizontal Merger Guidelines.<sup>35</sup> As lower court judges often note, the Supreme Court has not recognized the existence of an efficiencies defense against a merger challenge, though federal appellate courts and antitrust agencies’ guidelines have done so.<sup>36</sup> Yet even where efficiencies are nominally recognized, they face a heavier burden of proof than findings of likely anticompetitive effects.<sup>37</sup> Providers also have claimed that antitrust exemptions enable them to fulfill the public interest in achieving the size, scale, and degree of clinical integration necessary to participate in new delivery and payment models, like population health initiatives and value-based payment models.<sup>38</sup>

The FTC is conducting retrospectives on several of these immunized arrangements, known as the COPA Assessment Project. Agency staff issued a notice in November 2017 seeking public comments and encouraging academic and industry research on the impact of certificates of public advantage on prices, quality, access, and innovation for health care services.<sup>39</sup> Studies already have found that at least some of these arrangements have resulted in net harm to competition.<sup>40</sup> Having permitted anticompetitive mergers, states that simply repeal COPA laws can leave in place “an unregulated monopoly.”<sup>41</sup>

State legislatures appear to have passed some COPA laws with the intent of exempting specific proposed hospital mergers from pending or expected antitrust challenges. For example, the FTC in November 2015 sued to block Cabell Huntington Hospital’s acquisition of St. Mary’s Medical Center, but the case was stymied when West Virginia in March 2016 passed a law granting antitrust immunity to health care providers’ actions that complied with orders by the state’s Health Care Authority.<sup>42</sup> Similarly the Tennessee

Department of Health in September 2017 granted a COPA to Mountain States Health Alliance/Wellmont Health System after the FTC raised concerns about the merger.<sup>43</sup>

States’ CON and COPA laws create explicit regulatory barriers to procompetitive supply increases and effective antitrust enforcement. These barriers can be exploited by incumbents seeking to maintain monopoly profits, and the federal antitrust agencies have consistently, across presidential administrations of both parties, supported the narrowing and repeal of CON and COPA laws. These laws are of questionable benefit in normal times and are an outright harm when facing a public health emergency such as COVID-19.

### Licensing Restrictions

While an acute-care hospital cannot readily move physically from an area of lesser demand to one of greater demand, health care professionals can. But the mobility of medical personnel is hindered by licensing restrictions that prevent them from moving across state lines to provide care where it is needed the most. Interstate barriers particularly harm the spouses and partners of military service members, who frequently must move from one state to another and may face prohibitive costs and difficulties in obtaining re-licensure in each state.

Several states have eased the rules specifically for military spouses, by mandating the issuance of a state occupational license if the spouse is licensed in another state with substantially equivalent or more stringent licensing requirements.<sup>44</sup> Arizona in April 2019 went a step further, with a universal licensing recognition law that obligates state boards to issue licenses to applicants who have been licensed in another state for at least one year, are in good standing in all states where they are licensed, pay applicable fees, and meet all residency, testing, and background check requirements.<sup>45</sup>

States have a valid interest in ensuring that the medical professionals who serve their citizens are competent, in good standing, and up to date on their continuing medical education. However, incumbents claim health and safety justifications for state-specific licensing and constraints on the scope of practice when there is reason to believe they may be more interested in erecting barriers to entry and foreclosing competition. Ideally, any restrictions would be narrowly tailored to permit competition to the fullest extent possible while honoring the state’s legitimate goals of protecting residents from malpractice.

The FTC has advocated for greater reciprocity of occupational licensing among states. In July 2017, the agency’s Economic Liberty Task Force hosted a roundtable on streamlining licensing across state lines. In September 2018, the task force issued a report that highlighted steps that states could take to improve the portability of occupational licenses. Well before the COVID-19 pandemic, the report warned: “Multistate licensing requirements can also limit consumers’ access to services. For example, licensure requirements can prevent qualified service providers from addressing time-sen-

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sitive emergency situations across a nearby state line or block qualified health care providers from providing telehealth services to consumers in rural and underserved locations.”<sup>46</sup>

Physicians and registered nurses take exams based on national certification standards, and in every state, the instruction and the exams are in the same language (English), yet do not automatically enable successful exam-takers to practice nationally. In contrast, despite its multitude of languages,<sup>47</sup> the European Union requires Member States to permit qualified medical personnel to practice across borders.<sup>48</sup> The EU has particularly encouraged cross-border movement during the pandemic, as some Member States face severe shortages of health care resources relative to the prevalence of COVID-19 in their populations.<sup>49</sup>

Sensibly, in response to the COVID-19 pandemic, authorities in the United States are waiving some regulations on health care professionals. At the federal level, the U.S. Department of Health and Human Services has announced that it temporarily will refrain from enforcing its requirement that “physicians or other health care professionals hold licenses in the State in which they provide services, [so long as] they have an equivalent license from another State.”<sup>50</sup> This development enables health care professionals to move physically to regions with surges in COVID-19 cases. In addition, it facilitates the provision of medical services in a different state through telecommunications, enabling local practitioners to deal with COVID-19 cases while drawing in remote practitioners to address other medical needs.

Similar developments have occurred at the state level. For example, Connecticut has established interstate reciprocity for health care licenses, permitting “health care practitioners who are licensed in another state to provide temporary assistance in Connecticut for a period of 60 days.”<sup>51</sup> Florida’s surgeon general issued an executive order that allows health care providers with valid out-of-state licenses to help address COVID-19 for 30 days.<sup>52</sup> Louisiana temporarily suspended the requirement for out-of-state physicians and registered nurses to obtain a local license.<sup>53</sup> The governor of Colorado said he has asked the state’s occupational regulator “to cut through the red tape on licensing our medical professionals so that medical professionals—including pharmacists, nurses, doctors—who are licensed in other states but residing here can be immediately licensed in Colorado as quickly as possible to address this shortage.”<sup>54</sup>

But as with the suspension of CON laws, these temporary regime changes leave in place procedural barriers that inhibit seamless adaptation to surges in demand. If states had a pre-existing rule that waived licensing requirements and fees for medical professionals in good standing in another state—even if only when a state of emergency has been declared—that could speed the provision of needed services.

The Interstate Medical Licensure Compact, which became operational in April 2017, is a good first step. It is an agreement among participating states to cooperate in streamlining the licensing process for qualifying physicians who want to

practice in multiple states, in part by enhancing states’ ability to share investigative and disciplinary information about physicians. Three years after it became operational, the compact now includes 29 states, the District of Columbia, and Guam, encompassing 43 different medical and osteopathic boards.

Similarly, the Nursing Licensure Compact enables nurses to be licensed in one state yet practice in other states that are part of the voluntary agreement. In 2018, 25 states implemented the Enhanced Nursing Licensure Compact with additional requirements, such as state and federal fingerprint-based criminal background checks. Nurses who are first licensed in an eNLC state can practice in all eNLC states without delay, reducing costs on application fees and license renewals.

However, the nurse licensing compact does not establish a single standard for the scope of practice. Although nurses and physician assistants are crucial to the provision of medical services—especially now—many states’ “scope of practice” restrictions inhibit the ability of these professionals to capitalize fully on their education, training, and experience. Although scope of practice restrictions take many forms, one of the most common requires the active supervision of a doctor for specified tasks. The FTC in its 2014 report on “Competition and the Regulation of Advanced Practice Nurses” urged state legislators and policymakers to consider whether restrictions of this type are supported by valid safety concerns.<sup>55</sup> More recently, agency staff have expressed support for the proposal of the U.S. Department of Veterans to grant “full practice authority” to Advanced Practice Registered Nurses (APRNs).<sup>56</sup> Earlier this year, staff urged the Kansas legislature to pass a bill that would allow APRNs to prescribe medication without having a collaborative practice agreement with a physician.<sup>57</sup> Physician assistants also face constraints from state regulations.<sup>58</sup>

The Centers for Medicare & Medicaid are issuing waivers so that hospitals can use medical professionals such as physician assistants and nurse practitioners more fully, but this still must be in accordance with state law.<sup>59</sup> Several states have relaxed these limitations during the pandemic. For example, Louisiana has expanded the scope of practice for APRNs and Certified Registered Nurse Anesthetists (CRNAs) by temporarily suspending requirements for collaborative practice agreements or practicing only under the direction and supervision of a physician or dentist licensed to practice in Louisiana.<sup>60</sup> Alabama has authorized nurse practitioners to prescribe medication and perform all skills that are within the scope of their education and training.<sup>61</sup>

The general need for “all hands on deck” in a pandemic is fairly obvious. What may be less obvious are the particular needs of rural areas where few if any licensed physicians are actually situated to provide supervision. As FTC staff pointed out in a comment to the Texas Medical Board last December, imposing additional supervisory requirements on licensed CRNAs in administering anesthesia increases the

risk for people in rural and other medically underserved areas.<sup>62</sup> Of the 85 critical access hospitals in Texas, 33 are in counties where CRNAs are the only licensed, specialized providers of anesthesia and anesthesia-related services. In communities like these, precluding capable nurses and physician assistants from deploying their skills in the absence of a doctor could have fatal consequences.

### Telemedicine

Telemedicine is also of special benefit to otherwise underserved areas. As FTC staff commented when supporting a proposed rule that would permit Veterans Administration health care providers to use telehealth, notwithstanding state laws to the contrary: “Especially in large rural states, telehealth is a highly effective means of improving health care delivery by expanding patients’ access to both out-of-state and in-state practitioners.”<sup>63</sup> FTC staff have made similar points in comments to state legislators.<sup>64</sup> In a 2004 report on health care competition, the federal antitrust agencies said that when properly used, telemedicine can broaden access, lower costs, and improve health quality.<sup>65</sup>

Going beyond advocacy to enforcement, the FTC investigated the Texas Medical Board for a possible violation of federal antitrust law because the board adopted rules restricting the practice of telemedicine and telehealth. The agency closed the investigation in June 2017 after elected officials in Texas overrode those rules with a pro-telemedicine law.<sup>66</sup>

Fortunately, many of the coronavirus-driven waivers on interstate practice also apply to telemedicine. The Department of Health and Human Services has loosened the HIPAA requirements on telemedicine, allowing doctors to provide medical care to patients using apps like FaceTime and Skype that are not HIPAA compliant.<sup>67</sup> It has created a website about telehealth.<sup>68</sup> The Centers for Medicare & Medicaid Services have permitted hospitals to bill for a broader range of services provided off-site, including telehealth services, at the same rate as in-person visits. FTC staff supported these provisions to reduce or eliminate restrictive Medicare payment requirements for telehealth.<sup>69</sup> The staff’s comment also suggested additional reductions on unnecessary restrictions, and that CMS use this experience to determine which temporary waivers should be made permanent. According to the Federation of State Medical Boards, as of May 5, 2020, 49 states have modified their in-state licensure requirements for telehealth in response to COVID-19.<sup>70</sup>

Following a proposal by Federal Communications Commission Chairman Ajit Pai,<sup>71</sup> the CARES Act allocated \$200 million for the FCC’s Emergency COVID-19 Telehealth Program. This program builds on the connected care proceeding that Commissioner Brendan Carr launched in 2018. Even before the pandemic, the telehealth initiative sought to lower health care costs and improve outcomes for veterans, low-income, and rural Americans. Welcoming the agency’s first grants from the COVID-19 Telehealth Program, Carr noted the importance of enabling patients to receive high-

quality care while maintaining social distancing.<sup>72</sup> The grants, which can be up to \$1 million each, enable health care providers to obtain telecommunications equipment and broadband services. The FTC’s advocacy for lowering barriers to telemedicine, and the FCC’s funding of telehealth, typify the whole-of-government approach necessary to serve Americans in an emergency.

### Conclusion

All of these ideas—reforming state CON and COPA laws, reducing licensing barriers, boosting telemedicine—were discussed in a report submitted by the Departments of Health and Human Services, Treasury, and Labor to President Donald Trump in December 2018.<sup>73</sup> The FTC was closely involved in this effort, and the resulting document provides a detailed blueprint for injecting greater choice and competition into America’s health care system. But these are not partisan proposals. They have been the consistent refrain of the federal antitrust agencies for decades, under both Democratic and Republican administrations, and in particular have been the subject of unanimous recommendations from FTC commissioners on both sides of the aisle.

The COVID-19 pandemic appears likely to reshape the global economy and societies in incalculable ways. It has reminded us of the everyday heroism of health care workers who put their lives at risk to help others. It has shown how the private sector can respond quickly and creatively to public health threats, including turning bridal shops into manufacturers of face masks and repurposing automobile assembly lines for the production of ventilators. By freeing health care providers to react similarly swiftly to changes in demand—through building more facilities, moving seamlessly across state lines, practicing to the full extent of their abilities, and offering care through new technology—we can take some good from this tragedy. ■

<sup>1</sup> Goldfarb v. Va. State Bar, 421 U.S. 773, 782 (1975) (nothing that “in terms of restraining competition and harming consumers like petitioners the price-fixing activities found here are unusually damaging”).

<sup>2</sup> North Carolina State Bd. of Dental Examiners v. FTC, 574 U.S. 494, 503 (2015) (“If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States’ power to regulate”).

<sup>3</sup> In addition to advocacy, the FTC also has devoted significant enforcement efforts to the health care sector, which, including medical devices and pharmaceuticals, made up 46% of all competition enforcement actions in fiscal years 2015 through 2019. Fed. Trade Comm’n, Annual Highlights (Apr. 2020), [https://www.ftc.gov/system/files/documents/reports/annual-highlights-2019/2019\\_annual\\_highlights\\_report.pdf](https://www.ftc.gov/system/files/documents/reports/annual-highlights-2019/2019_annual_highlights_report.pdf).

<sup>4</sup> Frank Newport, *Top Issues for Voters: Healthcare, Economy, Immigration*, GALLUP.COM (Nov. 2, 2018), <https://news.gallup.com/poll/244367/top-issues-voters-healthcare-economy-immigration.aspx>. (“80% say healthcare is extremely or very important to their vote . . . Voters’ views of the importance of health care have been generally stable over recent midterms.”); *Public’s 2019 Priorities: Economy, Health Care, Education and Security All*

- Near Top of List, Pew Research Center (Jan. 24, 2019), <https://www.people-press.org/2019/01/24/publics-2019-priorities-economy-health-care-education-and-security-all-near-top-of-list/> (“As economic and security concerns have become less prominent, the domestic issues of reducing health care costs (69% top priority) and improving the educational system (68%) now rank among the top tier of public priorities”); Carl M. Cannon, *New Poll Shows Health Care Is Voters’ Top Concern*, Real Clear Opinion Research (May 15, 2019), [https://www.realclearpolitics.com/real\\_clear\\_opinion\\_research/new\\_poll\\_shows\\_health\\_care\\_is\\_voters\\_top\\_concern.html](https://www.realclearpolitics.com/real_clear_opinion_research/new_poll_shows_health_care_is_voters_top_concern.html); *Poll: Voters Name Health Care as Top Issue Going into 2020*, THE HILL (Dec. 12, 2019), <https://thehill.com/hilltv/rising/474327-voters-name-health-care-as-top-issue-going-into-2020>.
- <sup>5</sup> *Shock-proof: Building Resilient Systems in the 21st Century*, New Approaches to Economic Challenges/Open Markets Institute Roundtable (Apr. 23, 2020), <https://www.oecd.org/naec/events/systemic-linkages/building-resilient-systems-in-21st-century.htm>.
  - <sup>6</sup> National Health Planning & Resources Development Act of 1974, Pub. L. No. 93-641, 2225 Stat. 88.
  - <sup>7</sup> Social Security Act § 1122, 42 U.S.C. § 1320, applying to Medicare, Medicaid, and Maternal and Child Health programs.
  - <sup>8</sup> James B. Simpson, *State Certificate-of-Need Programs: The Current Status*, 75 AM. J. PUB. HEALTH 1225 (1985).
  - <sup>9</sup> Pub. L. 99-660, § 701, 100 Stat. 3799 (1986). At the time the National Health Planning and Resources Development Act was passed, Medicare and other payors reimbursed hospitals based on their actual costs, including building and major equipment costs, which might incentivize hospitals to buy more than they needed. As insurers have mostly switched from cost-based payments to fixed payments for services, hospitals now lose money if their costs exceed payments, encouraging them to build and buy only as much as they can use.
  - <sup>10</sup> Mich. Exec. Order No. 2020-49 (2020): Temporary enhancements to operational capacity and efficiency of health care facilities, [https://www.michigan.gov/whitmer/0,9309,7-387-90499\\_90705-525889--,00.html](https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-525889--,00.html); Minn. Exec. Order No. 20-32 (Apr. 8, 2020): Ensuring that Healthcare Providers Can Respond Quickly and Safely During the COVID-19 Peacetime Emergency, [https://mn.gov/governor/assets/1a.%20EO%2020-32%20Final\\_tcm1055-427412.pdf](https://mn.gov/governor/assets/1a.%20EO%2020-32%20Final_tcm1055-427412.pdf).
  - <sup>11</sup> Iowa Proclamation of Disaster Emergency (Mar. 17, 2020), <https://governor.iowa.gov/sites/default/files/documents/Public%20Health%20Proclamation%20-%202020.03.17.pdf>.
  - <sup>12</sup> Ala. Proclamation (Apr. 2, 2020), [https://www.opelika-al.gov/DocumentCenter/View/2458/2020-04-02-Fifth-Supplemental-SOE\\_COVID-19](https://www.opelika-al.gov/DocumentCenter/View/2458/2020-04-02-Fifth-Supplemental-SOE_COVID-19); Conn. Exec. Order No. 7B (Mar. 14, 2020), <https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2020/03-2020-Governor-Lamont-Coronavirus-Update-March-14-2020-5PM>; Ga. Exec. Order (Mar. 20, 2020), <https://gov.georgia.gov/document/2020-executive-order/03202002/download>; Ind. Exec. Order No. 20-05 (Mar. 19, 2020), [https://www.coronavirus.in.gov/files/N%20-%20EO\\_20-05.pdf](https://www.coronavirus.in.gov/files/N%20-%20EO_20-05.pdf); Neb. Exec. Order No. 20-12 (Mar. 31, 2020), <http://govdocs.nebraska.gov/ocds/pilot/pubs/eofiles/20-12.pdf>; N.J. Temporary Operational Waivers during a State of Emergency (Mar. 13, 2020), [https://www.nj.gov/health/healthfacilities/documents/CN/temp\\_waivers/03-13-2020\\_Memo-Licensed%20Inpatient%20Facility%20Administrators\\_Temp\\_Operational\\_Waiver.pdf](https://www.nj.gov/health/healthfacilities/documents/CN/temp_waivers/03-13-2020_Memo-Licensed%20Inpatient%20Facility%20Administrators_Temp_Operational_Waiver.pdf); N.Y. Exec. Order 202.1 (Mar. 12, 2020), <https://www.governor.ny.gov/news/no-2021-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency>; N.C. Exec. Order 130 (Apr. 8, 2020), <https://files.nc.gov/governor/documents/files/E0130-Meeting-North-Carolinas-Health-and-Human-Services-Needs.pdf>; S.C. Exec. Order 20-21 (Apr. 10, 2020), <https://governor.sc.gov/sites/default/files/Documents/Executive-Orders/2020-03-19%20FILED%20Executive%20Order%20No.%202020-11%20-%20Additional%20Emergency%20Measures%20%26%20Regulatory%20Relief%20re%20COVID-19.pdf>; Tenn. Exec. Order No. 15 (Mar. 19, 2020), <https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee15.pdf>; Va. Exec. Order 52 (Mar. 20, 2020), [https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/E0-52-Increases-in-Hospital-Bed-Capacity-in-Response-to-Novel-Coronavirus-\(COVID-19\).pdf](https://www.governor.virginia.gov/media/governorviriniagov/executive-actions/E0-52-Increases-in-Hospital-Bed-Capacity-in-Response-to-Novel-Coronavirus-(COVID-19).pdf); Wash. Proclamation 20-38 by the Governor amending Proclamation 20-05 (Mar. 30, 2020), <https://www.governor.wa.gov/sites/default/files/proclamations/20-38%20-%20COVID%2019%20DSHS%20Facilities%20%28tmp%29.pdf>.
  - <sup>13</sup> Centers for Disease Control and Prevention, *Hospitals, Beds, and Occupancy Rates, by Type of Ownership and Size of Hospital: United States, Selected Years 1975–2015* (2017), <https://www.cdc.gov/nchs/data/abus/O17/089.pdf>. A significant part of the decline has been a long-term trend in care shifting out of the inpatient setting. As hospitals have been sites of infection even before COVID-19, enabling patients to spend less time in them without a reduction in the quality of care may be beneficial.
  - <sup>14</sup> Andrea Flynn & Ron Knox, *We’re Short on Hospital Beds Because Washington Let Too Many Hospitals Merge*, WASH. POST, Apr. 8, 2020, <https://www.washingtonpost.com/outlook/2020/04/08/were-short-hospital-beds-because-washington-let-too-many-hospitals-merge/> (“The wave of takeovers the FTC oversaw has contributed to the loss of rural hospitals and a decline in the number of beds around the country.”).
  - <sup>15</sup> See FTC Bureau of Competition Health Care Division, *Overview of FTC Actions in Health Care Services and Products* (June 2019), [https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview\\_health\\_care\\_june\\_2019.pdf](https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_june_2019.pdf). Since that report, the FTC has sued to block the proposed merger of Jefferson Health and Albert Einstein Healthcare Network.
  - <sup>16</sup> See, e.g., Timothy J. Muris, *Everything Old Is New Again: Health Care and Competition in the 21st Century*, 7th Annual Competition in Health Care Forum (Nov. 7, 2002) (“[I]n the last eight years the Commission and Department of Justice are 0 for 7 in hospital merger cases.”).
  - <sup>17</sup> *FTC v. Phoebe Putney Health Sys., Inc.*, 793 F. Supp. 2d 1356 (M.D. Ga. 2011).
  - <sup>18</sup> *FTC v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216 (2013).
  - <sup>19</sup> Statement of the Federal Trade Comm’n In the Matter of Phoebe Putney Health System, FTC Docket No. 9348 (Mar. 31, 2015), [https://www.ftc.gov/system/files/documents/public\\_statements/634181/150331phoebe\\_putneycommstmt.pdf](https://www.ftc.gov/system/files/documents/public_statements/634181/150331phoebe_putneycommstmt.pdf). (“While it would have been the most appropriate and effective remedy to restore the lost competition in Albany and the surrounding six-county area from this merger to monopoly, Georgia’s certificate of need laws and regulations unfortunately render a divestiture in this case virtually impossible, leading us to accept this less-than-ideal remedy”).
  - <sup>20</sup> Petition and Complaint for a Declaratory Judgment as to the Invalidity of an Agency Rule, Ga. Alliance of Community Hospitals and Phoebe Putney Memorial Hospital, Inc. v. Ga. Dep’t of Community Health and Albany Surgical, P.C. (Dec. 31, 2007) (seeking to overturn rule that would allow general surgeons to open physician-owned surgical centers without first obtaining a certificate of need), <http://www.ciclt.net/ul/gach/GACH%20Suit.pdf>.
  - <sup>21</sup> Letter from Tara I. Koslov, D. Bruce Hoffman & Michael G. Vita, Fed. Trade Comm’n to Frank W. Berry (Oct. 16, 2017), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-georgia-department-community-health-regarding-certificate-need-application-filed/v180001gaconleecounty\\_and\\_attachments.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-georgia-department-community-health-regarding-certificate-need-application-filed/v180001gaconleecounty_and_attachments.pdf).
  - <sup>22</sup> Press Release, Lee County, Ga., *Certificate of Need Approved for Lee County Medical Center* (Nov. 15, 2017), <http://www.lee.ga.us/publicnotice/files/CON%20Approval%20Press%20Release%20111517.pdf> (“If all goes according to plan, the County expects to break ground on the hospital in early 2018.”).
  - <sup>23</sup> Mary Green, *Dougherty County Cites Increased Costs, CON Legitimacy in Lee Hospital Lawsuit* (Apr. 24, 2018), <https://wfxl.com/news/local/dougherty-county-cites-increased-costs-con-legitimacy-in-lee-hospital-lawsuit/> (“Right now, all is quiet outside the future site of the Lee County Medical Center, at the former location of the Grand Island Golf Course just off Ledo Road. If Dougherty County has its way, it will stay like that.”). All three plaintiffs ultimately withdrew their complaints. Andy Miller, *Lee County Will Get Its Hospital, But What Will That Mean?* GA. HEALTH NEWS (June 19, 2018), <http://www.georgiahealthnews.com/2018/06/lee-county-hospital-mean/>.
  - <sup>24</sup> Jennifer Parks, *Certificate of Need Filed for Lee Hospital*, ALBANY HERALD (May 19, 2017), [https://www.albanyherald.com/certificate-of-need-filed-for-lee-hospital/article\\_16b35880-209d-582b-8e45-73249cf083d1.html](https://www.albanyherald.com/certificate-of-need-filed-for-lee-hospital/article_16b35880-209d-582b-8e45-73249cf083d1.html); Jennifer Parks, *Phoebe Denies Involvement in Certificate of Need Opposition*, ALBANY HERALD (Nov. 12, 2017), [https://www.albanyherald.com/phoebe-denies-involvement-in-certificate-of-need-opposition/article\\_99b739a4-9341-59deb710-6334e2fb4fc6.html](https://www.albanyherald.com/phoebe-denies-involvement-in-certificate-of-need-opposition/article_99b739a4-9341-59deb710-6334e2fb4fc6.html).
  - <sup>25</sup> This is a size that might plausibly support a 60-bed medical center, as the U.S. averages roughly 2.8 hospital beds per thousand people. Am. Hosp.

- Ass'n, Fast Facts on U.S. Hospitals (Jan. 2020), <https://www.aha.org/system/files/media/file/2020/01/2020-aha-hospital-fast-facts-new-Jan-2020.pdf> (924,107 staffed beds); Census.gov, Population estimates, July 1, 2019 (328,239,523 people in the United States).
- <sup>26</sup> See *supra* note 14.
- <sup>27</sup> See, e.g., *N. Atlanta Scan Assocs. v. Dep't of Community Health*, 627 S.E. 2d 67, 70 n.4 (Ga. Ct. App. 2006) ("According to its president, [the Georgia Association of Community Hospitals] . . . seeks strong enforcement of the [certificate of need law] so that diagnostic, treatment, and rehabilitation centers will not 'cherry-pick' profitable patients, leaving the community hospitals to serve a disproportionate share of the 'medically indigent'"). However, since 1997, Medicare has paid critical access hospitals, limited to 25 beds and mostly operated in rural areas, based on their reported costs rather than fixed fee for service. MedPAC, Critical Access Hospitals Payment System (Oct. 2018), [http://medpac.gov/docs/default-source/payment-basics/medpac\\_payment\\_basics\\_18\\_cah\\_final\\_sec.pdf?sfvrsn=0](http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_cah_final_sec.pdf?sfvrsn=0).
- <sup>28</sup> Shari Rudavsky, *Could Limiting Hospital Growth in Indiana Lower State's Health Costs?*, INDYSTAR (Feb. 5, 2019), <https://www.indystar.com/story/news/2019/01/29/certificate-need-legislation-would-regulate-indiana-hospital-growth/2699972002/>.
- <sup>29</sup> Christopher Koopman & Thomas Stratmann, *Certificate-of-Need Laws and North Carolina: Rural Health Care, Medical Imaging, and Access* (May 17, 2016), <https://www.mercatus.org/publications/corporate-welfare/certificate-need-laws-and-north-carolina-rural-health-care-medical>.
- <sup>30</sup> Matthew D. Mitchell, *Do Certificate-of-Need Laws Limit Spending?*, (Mercatus Working Paper, Mercatus Center at Geo. Mason Univ., Sept. 2016) (summarizing four decades of studies).
- <sup>31</sup> Vivian Ho, Meei-Hsiang Ku-Goto & James G. Jollis, *Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON*, HSR: Health Services Research 44:2, Part I, Apr. 2009; Ho & Ku-Goto, *State Deregulation and Medicare Costs for Acute Cardiac Care*, Medical Care Research and Review (2013).
- <sup>32</sup> Molly S. Myers & Kathleen M. Sheehan, *The Impact of Certificate of Need Laws on Emergency Department Wait Times*, 35 J. PRIV. ENTER. 59 (2020).
- <sup>33</sup> James Bailey, *The Effect of Certificate of Need Laws on All-Cause Mortality*, HSR: Health Services Research 53:1 (Feb. 2018).
- <sup>34</sup> Fed. Trade Comm'n & U.S. Dep't of Justice, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Share Savings Program* (2011), <https://www.govinfo.gov/content/pkg/FR-2011-10-28/pdf/2011-27944.pdf>; Fed. Trade Comm'n & U.S. Dep't of Justice, *Antitrust Guidelines for Collaborations Among Competitors* (2000), <https://www.ftc.gov/sites/default/files/attachments/press-releases/ftc-doj-issue-antitrust-guidelines-collaborations-among-competitors/ftcdojguidelines.pdf>; Fed. Trade Comm'n & U.S. Dept. of Justice, *Statements of Antitrust Enforcement Policy in Health Care* (1996), <https://www.justice.gov/sites/default/files/atr/legacy/2007/08/14/0000.pdf>.
- <sup>35</sup> Am. Hosp. Ass'n, *Letter Re: COPA Assessment*, Project No. P181200 (June 5, 2019), <https://www.aha.org/system/files/media/file/2019/06/aha-response-ftc-request-for-comments-copa-assessment-project.pdf> ("The AHA urges the Commission—which has made no secret of its opposition to these laws—to consider the possibility that the drive to enact COPA laws and to obtain COPAs is fueled, in part, by the agency's overly harsh treatment of efficiencies claims made by merging hospitals. If the FTC were to credit legitimate claims of efficiencies more frequently, the pressure to enact additional COPA legislation might well diminish, as might the number of hospitals seeking COPAs in the future.").
- <sup>36</sup> *FTC v. Procter & Gamble Co.*, 386 U.S. 568, 580 (1967). *But see*, e.g., *FTC v. H.J. Heinz Co.*, 246 F.3d 708, 720 (D.C. Cir. 2001).
- <sup>37</sup> Daniel A. Crane, *Rethinking Merger Efficiencies*, 110 MICH. L. REV. 347, 348 (2011) ("The government is accorded greater evidentiary leniency in proving anticompetitive effects than the merging parties are in proving offsetting efficiencies."). See also Ardagh Group, S.A., *FTC File No. 131-0087* (Apr. 11, 2014) (Wright, J., Comm'r, dissenting), [https://www.ftc.gov/system/files/documents/public\\_statements/568821/140411ardaghstmt.pdf](https://www.ftc.gov/system/files/documents/public_statements/568821/140411ardaghstmt.pdf) ("The burden facing the agency with respect to the likelihood of anticompetitive effects should be in parity with that faced by the parties with respect to efficiencies.").
- <sup>38</sup> See, e.g., Healthcare Financial Management Ass'n, *Health Care 2020 Report 3: Consolidation* (Fall 2016), [https://www.hfma.org/content/dam/hfma/document/research\\_reports/PDF/51087.pdf](https://www.hfma.org/content/dam/hfma/document/research_reports/PDF/51087.pdf) ("[O]utright acquisitions are likely to dominate if providers hold to the belief that consolidation offers economies of scale, opportunities to improve care coordination, and greater impact on their population health initiatives").
- <sup>39</sup> Fed. Trade Comm'n, *FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments* (Nov. 1, 2017), [https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa\\_assessment\\_public\\_notice\\_11-1-17\\_revised\\_3-27-19.pdf](https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf) ("FTC staff are not aware of any empirical evidence demonstrating that COPA statutes and regulations produce better results for consumers than market-based competition. We recognize, however, that there is limited empirical research on the impact of COPAs on prices, costs, and quality of health care services, patient access to services, or innovations in care delivery models.").
- <sup>40</sup> Gregory S. Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health* (Charles River Associates, Feb. 10, 2011), <http://www.ncdhhs.gov/dhsr/ncmcc/pdf/copareport.pdf>. ("By expanding into lower-margin markets, MHS can reduce its average margin, thus allowing MHS to raise price without violating the Margin Cap. MHS can also lower its average margin, thus allow it to increase price, by incurring additional expenses that are not covered by the COPA's Cost Cap").
- <sup>41</sup> Erin C. Fuse Brown, *To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law*, Milbank Memorial Fund Issue Brief (Jan. 2019) ("A provider can use a COPA to acquire a state-sanctioned monopoly and later seek to be freed of state oversight, leaving the monopoly provider . . . with the potential to raise prices . . . In North Carolina's case, nothing changed to eliminate the need for oversight of Mission Health's monopoly, except the state's political commitment to it. Once the COPA law was repealed, technically the immunity from antitrust enforcement was also gone because the merged entity was no longer subject to state supervision").
- <sup>42</sup> *Statement of the Fed. Trade Comm'n in the Matter of Cabell Huntington Hospital*, FTC Docket No. 9366 (July 6, 2016), [https://www.ftc.gov/system/files/documents/public\\_statements/969783/160706cabellcommstmt.pdf](https://www.ftc.gov/system/files/documents/public_statements/969783/160706cabellcommstmt.pdf) ("This case presents another example of health care providers attempting to use state legislation to shield potentially anticompetitive combinations from antitrust enforcement. The Commission believes that state cooperative agreement laws such as SB 597 are likely to harm communities through higher health care prices and lower health care quality.").
- <sup>43</sup> Fed. Trade Comm'n Staff's Third Submission to the Tennessee Department of Health Regarding the Certificate of Public Advantage Application of Mountain States Health Alliance and Wellmont Health System (July 18, 2017), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staffs-third-submission-tennessee-department-health-regarding-certificate-public-advantage/ftc\\_-\\_third\\_comment\\_to\\_tennessee\\_-\\_final\\_public\\_version.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staffs-third-submission-tennessee-department-health-regarding-certificate-public-advantage/ftc_-_third_comment_to_tennessee_-_final_public_version.pdf) (FTC staff "conducted a detailed investigation into the proposed merger" and "concludes that the benefits of the proposed Certificate of Public Advantage ("COPA") do not exceed the likely harm to health care competition and consumers in Northeast Tennessee and Southwest Virginia").
- <sup>44</sup> U.S. Dep't of Labor, *Military Spouse License Recognition Options*, [https://www.veterans.gov/milspouses/military\\_spouse\\_txt.htm](https://www.veterans.gov/milspouses/military_spouse_txt.htm).
- <sup>45</sup> Ariz. Rev. Stat. § 32-4302 (2019).
- <sup>46</sup> Fed. Trade Comm'n, *Policy Perspectives: Options to Enhance Occupational License Portability* (Sept. 2018), [https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license\\_portability\\_policy\\_paper\\_0.pdf](https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper_0.pdf).
- <sup>47</sup> A study commissioned by the European Commission identified language requirements for medical professionals and the high cost of certified translations of documents showing the professional's qualifications as two of the three most significant barriers to practicing across the EU. Ecorys, Erasmus University Rotterdam, and Spark Legal Network and Consultancy Ltd., *Study on Cross-Border Health Services: Potential Obstacles for Healthcare Providers* (May 2017), [https://ec.europa.eu/health/sites/health/files/cross-border\\_care/docs/potentialobstacles\\_cbhprovision\\_frep\\_en.pdf](https://ec.europa.eu/health/sites/health/files/cross-border_care/docs/potentialobstacles_cbhprovision_frep_en.pdf).

- <sup>48</sup> Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications sets the rules for temporary mobility as well as for professionals who want to work on a permanent basis in a different Member State than where they obtained their qualification. It grants automatic recognition across the EU for professions—including nurses, midwives, general practitioners, and specialist physicians—that have harmonized minimum training standards.
- <sup>49</sup> Press Release, Eur. Comm’n, Coronavirus: Commission Encourages and Facilitates Cross-border Treatment of Patients and Deployment of Medical Staff (Apr. 3, 2020), [https://ec.europa.eu/commission/presscorner/detail/en/ip\\_20\\_590](https://ec.europa.eu/commission/presscorner/detail/en/ip_20_590).
- <sup>50</sup> Press Release, Centers for Medicare & Medicaid Services (CMS), Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge (Mar. 30, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19>.
- <sup>51</sup> Conn. Dep’t of Public Health Order (Mar. 23, 2020), <https://portal.ct.gov/-/media/Coronavirus/20200323-DPH-order-allowing-outofstate-practitioners-to-render-temporary-assistance-in-Connecticut.pdf?la=en>.
- <sup>52</sup> Scott A. Rivkees, *Suspension of Statutes, Rules and Orders, Made Necessary by COVID-19*, DOH No. 20-002 Emergency Order, Pursuant to the authority granted by Exec. Order No. 20-52 (Mar. 16, 2020) (“I find that strict compliance with the provisions of certain regulatory statutes and rules prescribing the procedures for conduct of state business by the Florida Department of Health will prevent, hinder, or delay necessary action in coping with the emergency caused by COVID-19”), <http://www.flhealthsource.gov/pdf/emergencyorder-20-002.pdf>.
- <sup>53</sup> La. Proclamation No. 38 JBE 2020 (Mar. 31, 2020), <http://www.lsbn.state.la.us/Portals/1/Documents/news/govproclamation.pdf>.
- <sup>54</sup> Press Release, Colorado Dep’t of Regulatory Agencies, DORA Working to Increase Available Healthcare Workforce for Coronavirus Response (Mar. 13, 2020), <https://www.colorado.gov/pacific/dora/news/dora-guidelines-for-healthcare-workforce-coronavirus>.
- <sup>55</sup> Fed. Trade Comm’n, Competition and the Regulation of Advanced Practice Nurses (Mar. 2014), <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicy.pdf>.
- <sup>56</sup> Press Release, Fed. Trade Comm’n, FTC Staff Supports Department of Veterans Affairs Proposed Rule to Grant Full Practice Authority to Advanced Practice Registered Nurses (2016), <https://www.ftc.gov/news-events/press-releases/2016/07/ftc-staff-supports-department-veterans-affairs-proposed-rule>.
- <sup>57</sup> Letter from Bilal Sayyed, Director, Fed. Trade Comm’n Office of Policy Planning, to the Honorable Daniel R. Hawkins (Jan. 9, 2020), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-kansas-house-representatives-concerning-kansas-house-bill-2412/v200006kansashb2412aprncomment.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-kansas-house-representatives-concerning-kansas-house-bill-2412/v200006kansashb2412aprncomment.pdf). FTC staff also supported a bill in Pennsylvania that would eliminate the requirement for nurse practitioners to continue to have collaborative agreements with physicians after completing three years of practice in such an agreement. Letter from Tara I. Koslov, Michael G. Vita & D. Bruce Hoffman to the Honorable Jesse Topper (Jan. 3, 2018), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/federal-trade-commission-staff-comment-pennsylvania-state-house-representatives-regarding-likely/v180002\\_ftc\\_staff\\_comment\\_to\\_pa\\_state\\_house\\_re\\_house\\_bill\\_100\\_and\\_aprn-cnps.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-pennsylvania-state-house-representatives-regarding-likely/v180002_ftc_staff_comment_to_pa_state_house_re_house_bill_100_and_aprn-cnps.pdf).
- <sup>58</sup> FTC staff have commented that “patients would likely benefit” if physician assistants “can practice with as few restrictions as possible, consistent with their education, training, skills, and experience. Physician assistants can provide more choice among health care providers, leading to more accessible, affordable, safe, and effective health care.” Letter to Iowa Board of Physician Assistants Regarding Proposed New Rules: 645-327.8: Definition of physician supervision of a physician assistant (Dec. 20, 2016), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-professional-licensure-division-iowa-department-public-health-regarding-proposed/v170002\\_ftc\\_staff\\_comment\\_to\\_iowa\\_dept\\_of\\_public\\_health\\_12-21-16.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-professional-licensure-division-iowa-department-public-health-regarding-proposed/v170002_ftc_staff_comment_to_iowa_dept_of_public_health_12-21-16.pdf).
- <sup>59</sup> Press Release, CMS, Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge (Mar. 30, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19>.
- <sup>60</sup> La. Proclamation No. 38 JBE 2020 (Mar. 31, 2020), <http://www.lsbn.state.la.us/Portals/1/Documents/news/govproclamation.pdf>.
- <sup>61</sup> Ala. Proclamation (Apr. 2, 2020), [https://www.abn.alabama.gov/wp-content/uploads/2020/04/2020-04-02-Fifth-Supplemental-SOE\\_COVID-19.pdf](https://www.abn.alabama.gov/wp-content/uploads/2020/04/2020-04-02-Fifth-Supplemental-SOE_COVID-19.pdf).
- <sup>62</sup> Federal Trade Comm’n Comment to Texas Medical Board on Its Proposed Rule 193.13 (Dec. 6, 2019), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-comment-texas-medical-board-its-proposed-rule-19313-add-supervision-requirements-texas-certified/v200004\\_texas\\_nurse\\_anesthetists\\_advocacy\\_letter.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-comment-texas-medical-board-its-proposed-rule-19313-add-supervision-requirements-texas-certified/v200004_texas_nurse_anesthetists_advocacy_letter.pdf).
- <sup>63</sup> Letter from Tara I. Koslov, Michael G. Vita & D. Bruce Hoffman to Director, Regulation Policy and Management, Dep’t of Veterans Affairs (Nov. 1, 2017), [https://www.ftc.gov/system/files/documents/advocacy\\_documents/ftc-staff-comment-department-veterans-affairs-regarding-its-proposed-telehealth-rule/v180001vatelehealth.pdf](https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-department-veterans-affairs-regarding-its-proposed-telehealth-rule/v180001vatelehealth.pdf).
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