FTC Policy Perspectives on Certificates of Public Advantage

Staff Policy Paper

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Contents

Introduction 1

What is a COPA and why do hospitals seek them? 1

Why should state lawmakers be concerned about hospital consolidation? 2

Competition results in better outcomes than consolidation subject to COPAs 3

Hospital arguments in favor of consolidation subject to COPAs are flawed 4

FTC efforts to prevent harmful hospital consolidation are undermined by COPAs 6

Case studies: COPAs do not prevent hospitals from exploiting market power 7

- Mission Health System (North Carolina) 8
- Benefis Health System (Montana) 8
- Palmetto Health System (South Carolina) 9
- MaineHealth (Maine) 10

Recent COPAs and Developments 11

- Ballad Health System (Tennessee/Virginia) and Cabell Huntington Hospital (West Virginia) 11
- Hendrick Health System and Shannon Health System (Texas) 12

Conclusion 12

Endnote References 13

Questions may be directed to FTC staff at CopaAssessment@ftc.gov.

Introduction

This paper by Federal Trade Commission staff presents information for state lawmakers considering proposed legislation regarding Certificate of Public Advantage ("COPA") laws.[1] The FTC routinely challenges hospital mergers that would substantially lessen competition, and therefore would raise healthcare prices for patients, reduce quality of care, limit access to healthcare services, and depress wage growth for hospital employees. COPA laws attempt to immunize such hospital mergers from the antitrust laws by replacing competition with state oversight and limiting the FTC's ability to challenge them. COPAs thus allow for hospital consolidation that is likely to harm patients and employees. The existing research shows that COPAs' purported benefits are simply unproven, so there are many reasons to be skeptical of their use. Experience and research demonstrate that COPA oversight is an inadequate substitute for competition among hospitals, and a burden on the states that must conduct it. Hospital competition, on the other hand, has proven to result in lower prices and improvements in quality of care, expanded access to healthcare services, and even higher wages for some hospital employees. For these reasons, the FTC advocates against the use of COPAs to shield otherwise illegal hospital mergers.[2] Indeed, both Democratic and Republican administrations and several leading academics have raised concerns about COPAs, cautioning states not to rely on them in the absence of evidence that COPAs produce better results than market-based competition.[3]

FTC staff invites state lawmakers to work collaboratively with competition policy experts to minimize the negative effects of further anticompetitive hospital consolidation and avoid using COPAs. We also urge states that have existing COPA laws to consider repealing those laws if they do not have an active COPA in place. We welcome the opportunity to speak with any state lawmakers who wish to better understand the FTC's hospital merger review process or the COPA studies described in this paper.

What is a COPA and why do hospitals seek them?

COPA laws are enacted to replace competition among healthcare providers with regulatory oversight by state agencies. In states with COPA laws, officials allow hospitals to merge if they determine the likely benefits from a particular merger outweigh any disadvantages from reduced competition and increased consolidation. States often impose various terms and conditions on COPA recipients intended to mitigate harms from a loss of competition, including price controls and rate regulations, mechanisms for sharing cost savings and efficiencies, and commitments about certain contractual provisions between hospitals and commercial health insurers. Once granted, COPAs purport to shield provider mergers and other types of collaborations from federal antitrust enforcement under the state action doctrine.[4] State departments of health – often in consultation with state attorneys general offices – are responsible for implementing COPA regulations, evaluating COPA applications submitted by hospitals, and actively supervising any approved COPAs in perpetuity.

Hospitals that wish to merge seek COPAs when a specific merger would otherwise violate antitrust laws. Indeed, most COPAs that have been approved so far resulted in a single hospital monopoly.[5]

Mergers that lead to lower prices or better health outcomes for patients are unlikely to violate antitrust laws and thus would not require COPAs to mitigate anticompetitive harms.[6]

Why should state lawmakers be concerned about hospital consolidation?

Healthcare experts consistently find that highly concentrated healthcare markets are more likely to have higher prices for consumers (e.g., patients and employers who fund employee health plans), reduced quality of care and patient health outcomes, and reduced access to healthcare services. Most studies show that competition among health systems – not consolidation – results in the lowest prices and optimal quality benefits for patients,[7] as well as optimal wages and benefits for employees.[8]

Hospitals compete for inclusion in insurance plans, and insurers rely on that competition to negotiate better prices and higher quality of care commitments for plan members. When hospitals have substantial market power, their negotiating leverage with health insurers increases and they often are able to demand higher rates (i.e., prices), which are then passed on to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses.[9] Notably, this finding holds true with *both* for-profit and not-for-profit merging hospitals.[10] By eliminating competition among hospitals, a merger can create or exacerbate this market power. When considering a request for a COPA to permit a merger that will eliminate competition, we urge state lawmakers to consult local health insurers regarding the impact that COPA legislation could have on their ability to negotiate competitive rates or implement value-based delivery and payment models, as this could have a big impact on patients and employers. Also, employers facing higher costs may limit insurance coverage for their employees or eliminate insurance coverage altogether. Studies show that rising healthcare costs caused by hospital consolidation are often passed through to employees in the form of lower wages and less generous benefits.[11]

In addition to raising consumer prices, eliminating competition may reduce hospital incentives to maintain or improve quality and patient access to care.[12] Studies demonstrate the net effect of mergers of competing hospitals on quality is often negative, and increased competition is associated with better quality.[13] Based on the available evidence, we cannot presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.

Finally, a recent study found that mergers that significantly increase hospital concentration in local labor markets, reducing the number of hospital employers, result in slowed wage growth for workers whose employment prospects are closely linked to hospitals. This study showed that four years after such high-impact mergers occurred, nominal wages were 6.8% lower for nurses and pharmacy workers and 4.0% lower for non-medical skilled workers than they would have been without the merger.[14] State lawmakers and health departments must evaluate whether COPAs are in the best interest of the public and the impact on labor markets is highly relevant to this analysis. This type of wage depression could dissuade qualified hospital employees (already in short supply in many parts of the country) from seeking employment, which could undermine the quality of patient care and access to services.[15]

Lower income levels for hospital employees may also worsen population health in local communities where hospitals are leading employers.[16] FTC staff are not aware of any COPA that has attempted to address a merger's impact on hospital employee wages.

Competition results in better outcomes than consolidation subject to COPAs

Competition has proven to be more reliable and effective than COPAs for controlling healthcare costs while preserving quality of care, including in rural areas facing economic challenges. Competition between hospitals benefits area employers and residents. It enables health insurers to negotiate lower hospital reimbursement rates (i.e., prices) on behalf of customers, which reduces the prices that area employers and residents must pay in premiums, copayments, deductibles, and other out-of-pocket expenses. That competition also incentivizes hospitals to improve healthcare quality and the availability of services and new healthcare technologies, as the hospitals compete to attract patients to their respective systems. As a result, area employers and residents – commercially insured, those covered by Medicare and Medicaid, and the uninsured – have benefited from this competition.

Research demonstrates that COPAs have resulted in significant price increases and contributed to declines in quality of care. Sometimes these adverse effects may occur after the COPAs have expired (often at the hospitals' urging), but they may also manifest while the COPAs are in effect, due to the difficulties inherent in implementation and monitoring. In 2017, the FTC announced a policy project to assess the impact of COPAs on prices, quality, access, and innovation for health care services.[17] This project has included research of past COPAs, a public workshop highlighting practical experiences with COPAs and related policy considerations, and an ongoing study of recently approved COPAs.[18] As discussed in more detail beginning on page 7 below, key findings from specific COPA case studies are:

- **Mission Health COPA Studies:** The first study found substantial increases in commercial inpatient prices during early COPA years (at least 20%). The second study found substantial price increases during later COPA years (an average of 25%) and even greater price increases after the COPA was repealed (at least 38%). Both studies demonstrate that price regulations during the COPA were ineffective, and the second study demonstrates the risk of eventually having an unregulated monopolist.

- **Benefis Health COPA Study:** Substantial increases in commercial inpatient prices after the COPA was repealed (at least 20%), demonstrating the risk of eventually having an unregulated monopolist.

- **MaineHealth COPA Study:** Substantial increases in commercial inpatient prices at an unregulated hospital during the COPA (at least 38%), as well as after the COPA expired at both hospitals – for a total price increase of at least 50% during the COPA and post-COPA period. The study demonstrates the risk of selectively regulating hospitals within a larger system –

MaineHealth exercised its market power by raising prices at the unregulated hospital. It also demonstrates the risk of eventually having an unregulated monopolist. Perhaps more importantly, there was a measurable decline in quality at the acquired hospital after the COPA expired.

The next section describes some of the purported benefits that hospitals often claim as justification for COPAs. We are not aware of any studies showing that these purported benefits are ever actually achieved.

In addition, COPAs can be extremely difficult to implement and monitor, requiring significant state resources over many years, sometimes decades. Regulatory fatigue, staff turnover, and changes in funding priorities at state agencies can lead to less vigorous supervision over time. Also, the hospitals subject to COPAs often lobby for repeal of COPA oversight or fewer COPA conditions, citing costs and difficulties of compliance. When this happens, the practical effect is that the merged healthcare system that was previously subject to state COPA oversight is then able to exercise increased market power (in most cases, monopoly power) unconstrained by either state regulation or antitrust enforcement against merger-related harms.

> *"My bottom line is that COPA regulation is fraught with difficulties. Regulations can become obsolete and less effective over time. State regulators became referees to resolve competitive battles, and the political pressure is considerable. And most significantly, the end game or exit strategy can be a problem and might leave you with a concentrated, but unregulated market power."*
>
> *Mark Callister, Monitor for Benefis Health COPA*

Hospital arguments in favor of consolidation subject to COPAs are flawed

Hospitals offer a variety of justifications when lobbying state lawmakers to enact COPA laws, but there are many reasons for lawmakers to be skeptical. Hospitals seeking COPAs commonly claim their proposed mergers would result in cost savings and efficiencies that would allow for improvements in clinical quality outcomes. Experience and evidence demonstrate, however, that many hospital mergers do not result in significant efficiencies, despite hospital projections that they will.[19]

Hospitals seeking COPAs have also cited concerns about low reimbursement rates or future reductions in reimbursement that may occur as a result of declining admissions and healthcare reform efforts. They argue their proposed mergers would improve their financial condition and enable them to meet such challenges. In each of the last four hospital mergers the FTC investigated that received a COPA, and in our experience more broadly, hospitals seeking COPAs have had adequate financial resources to continue operating independently and to maintain quality and access to healthcare services without requiring a merger – contrary to the claims often made by the hospitals. Indeed, if a hospital is truly failing financially and the proposed merger is the only way for it to remain viable, the FTC is unlikely to challenge such a merger and the hospital does not need COPA protection against antitrust enforcement.

Hospitals often claim their proposed mergers would create jobs and ensure local access to healthcare facilities and services. In the FTC's experience, though, hospitals frequently project cost savings premised on facility consolidation, the elimination of services, and job reductions. Therefore, lawmakers should examine these claims carefully and consider how they align with post-merger plans for integration and operations, as cost savings projections may indicate that a merger would reduce employment and patient access to healthcare services in local communities.[20]

Hospitals frequently argue that proposed mergers should proceed subject to COPAs because they would create a larger combined patient base, allowing them to improve population health efforts. Merging hospitals also claim that increasing their patient base would facilitate cost-saving, value-based payment models with health insurers. However, population health initiatives can be (and usually are) pursued by the hospitals independently, so mergers are generally not necessary to gain these benefits. And recent empirical research suggests that consolidation among healthcare providers has *not* facilitated the increased use of value-based payment models. Instead, providers in concentrated markets may be better positioned to resist such initiatives.[21] Related research suggests that health systems with increased scale are not more likely to engage in or be more successful at value-based contracting.[22] Indeed, the shift to value-based initiatives is already occurring among many hospital systems and insurers nationwide, and is mandated by Centers for Medicare & Medicaid Services in some circumstances.[23]

Hospitals also claim their proposed mergers would eliminate unnecessary and duplicative costs associated with competition, sometimes referred to as "wasteful duplication," allowing them to save money by avoiding capital expenditures. But again, it is unclear whether hospitals are really interested in avoiding unnecessary or duplicative expenditures or simply want to avoid the pressures of competition. Many hospital mergers do not result in significant cost savings,[24] and some studies have found that hospital competition leads to improved patient health outcomes with more effective resource utilization, as compared to highly concentrated markets with less competition.[25] Competition can incentivize hospitals to invest in facilities, technology, and equipment that improve access and quality.[26] For example, these types of investments can result in shorter wait times, more convenient service options for physicians and patients, and the continued availability of services when a piece of equipment fails. In this regard, competition is good for patients, not unnecessary or wasteful.

Finally, hospitals argue lawmakers should not be concerned about the negative effects of their proposed merger, because the states can impose various types of regulatory conditions on COPA recipients that would mitigate the harms resulting from consolidation. Common examples include price controls and rate regulation, mechanisms for sharing cost savings and efficiencies with local residents, public reporting of quality metrics, and commitments regarding certain contractual provisions between the hospitals and commercial health insurers. But such conditions do not replicate the benefits of competition; rather, they distort competition. They are also challenging and costly to implement, requiring considerable supervision, as hospitals subject to COPAs often have strong financial incentives to evade the regulatory conditions, thus undermining their efficacy.[27]

FTC efforts to prevent harmful hospital consolidation are undermined by COPAs

The FTC is an independent, bipartisan agency with a dual mission of promoting competition and protecting consumers. Under its statutory mandate, the FTC challenges mergers and acquisitions that are likely to substantially lessen competition and harm consumers.[28] Anticompetitive mergers and conduct in healthcare markets have long been a focus of FTC law enforcement, research, and advocacy.[29] The FTC has considerable experience in evaluating mergers involving hospitals, outpatient facilities, and physician groups to determine whether they are, on balance, likely to benefit or harm consumers.[30]

At the heart of FTC investigations is how healthcare mergers impact patients, employers, and employees in local communities. FTC staff considers a wide range of factors, including the impact on prices charged to patients, wages paid to hospital employees following greater employer concentration, patient health outcomes and quality of care, patient access to healthcare services, and the potential for the merger to result in innovative healthcare delivery and payment models. We often consult physician experts with experience in both clinical and academic research settings, to help us evaluate the hospitals' quality of care and health improvement claims. Staff also speaks to local business and community members, including other healthcare providers, public and private employers, and health insurers, to understand how mergers will impact them. We examine a significant amount of public and non-public information, including business documents and data from the merging hospitals and other market participants. Staff also performs an economic analysis of hospital discharge data, as well as a financial analysis of the merging hospitals. Notably, these factors are similar to those that state health departments are required to consider when evaluating COPAs. However, the FTC has spent several decades and substantial resources to develop expertise evaluating mergers, and state health departments often have different areas of expertise.

There are certainly circumstances where a bona fide regulatory approach that has the side effect of limiting competition may be an appropriate way to implement important public policy goals. Yet, the available evidence shows COPAs do not achieve the purported policy goals of reducing healthcare costs and improving quality. Instead, COPAs shield specific hospital transactions from vigorous antitrust enforcement, to the detriment of those very goals. Antitrust authorities are better positioned to

challenge anticompetitive mergers that are likely to result in higher prices and reduced quality of care for patients when we do not face the litigation obstacles presented by COPAs. We invite state lawmakers to engage with us in addressing the problems associated with anticompetitive hospital consolidation and avoid the use of COPAs.

Case studies: COPAs do not prevent hospitals from exploiting market power

Many states have enacted COPA legislation since the 1990s. FTC staff are aware of nine states that have approved hospital mergers pursuant to such legislation: North Carolina, South Carolina, Montana, Maine, Minnesota, and most recently, West Virginia, Tennessee, Virginia, and Texas.[31] But some of these states have decided to do away with COPAs. North Carolina, Montana, and Minnesota have repealed the underlying legislation so that hospitals in these states are no longer allowed to obtain COPAs. Unfortunately, these legislative changes also eliminated state regulatory oversight of the hospital systems that were allowed to merge under COPAs. Furthermore, antitrust enforcement was no longer practical since the mergers had long been consummated. As a result, these systems can now exercise their substantial market power unconstrained by state oversight or antitrust enforcement against merger-related harms.

FTC staff has evaluated several of these COPAs, and the findings illustrate the significant challenges of trying to regulate a hospital with substantial market power in perpetuity. COPAs can be difficult to implement and monitor over time, and are often unsuccessful in mitigating merger-related price and quality harms. Furthermore, when COPA oversight is removed, which happens frequently, the risk of price and quality harms increases significantly because of the absence either of the preexisting competition or regulation. For these reasons, FTC staff recommends that state lawmakers not enact COPA laws. In states where COPA laws already exist, FTC staff recommends repealing these laws provided there is not an active COPA currently in place. If there is already an active COPA in place, states should not approve any new COPA applications.

> *"Almost all of the COPAs established prior to 2015 have expired or were repealed, leaving the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality. States considering the use of a COPA to grant antitrust immunity to merging hospitals should carefully weigh this risk of harm against the possibly short-run and limited benefits of the merger."*
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> *Christopher Garmon & Kishan Bhatt*

Mission Health System (North Carolina)

In December 1995, Memorial Mission Hospital and St. Joseph's Hospital, the only two general acute care hospitals in Asheville, North Carolina, entered into an agreement under the state's COPA law for certain collaborative activities. In 1998, the two hospitals merged and amended their agreement with the state to approve the merger subject to certain terms and conditions – including margin, cost, and physician employment caps, as well as quality and contracting commitments. The merged hospital, renamed Mission Health System, operated under these terms for nearly 20 years. In 2015, the North Carolina legislature repealed the state's COPA law after lobbying by Mission Health, and the Mission Health COPA ended in September 2016 – leaving no competitive or regulatory constraint on Mission Health's monopoly power in Asheville. In February 2019, Mission Health was acquired by the for-profit healthcare system HCA Healthcare – despite the fact that the COPA was originally approved, in part, to prevent out-of-state for-profit healthcare systems from acquiring the local hospitals.

Empirical research on the price effects of the Mission Health COPA for inpatient hospital services from 1996 to 2008 shows that Mission Health increased its prices by at least 20% more than peer hospitals during the COPA period, suggesting that despite the margin and cost regulations, state COPA oversight did not prevent Mission Health from raising prices more than similar hospitals.[32] A second study found an average price increase of 25% through 2015, driven by large increases several years into the COPA period. It also found prices increased by another 38% after the COPA was repealed in 2015 and before Mission Health was acquired by HCA Healthcare – indicating the post-COPA price increase likely reflects the removal of the COPA oversight rather than the conversion to a for-profit hospital system.[33] In addition, an attorney from the North Carolina Attorney General's office, responsible for overseeing the Mission Health COPA for nearly 20 years, stated that he does not recommend using COPAs due to the potential for regulatory evasion during the COPA period, and the ability of hospitals to eventually be freed of COPA oversight, which leaves the community with an unregulated monopoly.[34] And a healthcare economist hired to evaluate the Mission Health COPA in 2011 discussed the difficulty of designing a regulatory scheme that prevents evasion *and* is flexible enough to allow for industry changes over the full COPA duration.[35]

Benefis Health System (Montana)

In July 1996, the Montana Department of Justice allowed Columbus Hospital and Montana Deaconess Medical Center – the only two general acute care hospitals in Great Falls, Montana – to merge pursuant to a COPA and form Benefis Health System. COPA conditions included revenue caps, quality commitments, and other cost-saving commitments. In 2007, at Benefis Health's urging, the Montana state legislature passed a bill that effectively terminated the COPA agreement, despite the Montana Attorney General's objections. As a result, Benefis Health has been able to freely exercise its market power in Great Falls with no regulatory or antitrust oversight for merger-related harms since 2009, when the legislation took effect.

Empirical research on the price effects of the Benefis Health COPA for inpatient hospital services from 1992 to 2013 shows that Benefis's prices closely tracked the prices of peer hospitals in duopoly markets during the COPA period, but then increased by at least 20% following the repeal of the COPA.

This suggests that the COPA was effective in constraining prices to the level of peer hospitals, but that the COPA removal led to higher prices consistent with the exercise of market power by an unconstrained hospital monopoly.[36] The CEO of Benefis has stated that, although he did not observe the post-COPA price increases found in this study, he does not believe COPAs adequately address the rising costs of healthcare.[37]

An attorney hired by the Montana Department of Justice to oversee the Benefis Health COPA stated:

> My bottom line is that COPA regulation is fraught with difficulties. Regulations can become obsolete and less effective over time. State regulators become referees to resolve competitive battles, and the political pressure is considerable. And most significantly, the end game or exit strategy can be a problem and might leave you with a concentrated, but unregulated market power.[38]

Also, a policy advisor for the Montana Insurance Commissioner explained that his office proposed legislation in 2019 to repeal Montana's COPA law to enhance competition in provider and insurance markets. His office viewed COPAs as a "regulatory incentive for consolidation" at a time when the research has clearly shown "that hospital consolidation leads to poor outcomes for both quality and costs." [39] He claimed that since the Benefis Health COPA expired, "their market power has played out in several different high-profile circumstances," including dramatic cost increases and most recently, "Benefis was able to be the last holdout of the Montana employee state health plans reference pricing initiative to lower health costs."[40]

Palmetto Health System (South Carolina)

In May 1997, Baptist Healthcare System and Richland Memorial Hospital, two general acute care hospitals in Columbia, South Carolina, merged to form Palmetto Health System. The South Carolina Department of Health and Environmental Control ("DHEC") approved the transaction, subject to terms and conditions of a COPA. During the initial five-year period of the COPA, Palmetto Health was subject to rate and revenue controls, as well as commitments to achieve cost savings and to provide a portion of its revenues to fund public health initiatives and community outreach programs. Several conditions were changed or eliminated in November 2003, although Palmetto Health continued to report annually to DHEC. In November 2017, Palmetto Health merged with Greenville Health System to create the largest health system in South Carolina, now known as Prisma Health System.[41]

Empirical research on the price effects of the Palmetto Health COPA for inpatient hospital services from 1992 to 2008 shows that prices at Palmetto Health did not increase more than prices at other comparable hospitals. This may be due to COPA oversight, but it may also be the result of hospital competition that remained in the area after the merger.[42] Unlike the other COPAs studied that involved mergers to monopolies, Palmetto Health continued to face competition from other hospitals serving the Columbia area, including most notably Providence Health (later acquired by LifePoint Health) and Lexington Medical Center.[43] Indeed, in its COPA application submitted to DHEC, Palmetto Health highlighted this competition as a constraint on its ability to exercise post-merger market power.

In 2020, Prisma Health persuaded DHEC to expand the original COPA to include LifePoint's hospital and emergency room assets in the greater Columbia area. This maneuver potentially would have allowed Prisma Health to acquire these facilities without facing an antitrust challenge.[44] The FTC had significant concerns about this proposed acquisition, as it would have eliminated much of the remaining hospital competition in the area. After a legal challenge from rival hospital Lexington Medical Center, a South Carolina Administrative Court held that DHEC's incorporation of the LifePoint facilities into the original COPA was "outside the scope of the COPA law's purposes."[45] Prisma and LifePoint then announced that they would no longer pursue the proposed acquisition.[46] Since then, the LifePoint assets were acquired by another health system that did not raise anticompetitive concerns. The court's decision is the first known holding that a COPA modification did not pass muster under the state action doctrine, and underscores that there are important and meaningful limitations to using COPAs to shield hospital mergers from antitrust scrutiny.

MaineHealth (Maine)

In March 2009, MaineHealth acquired Southern Maine Medical Center ("SMMC") under a COPA issued by the Maine Department of Health and Human Services. SMMC is located about 20 miles from MaineHealth's flagship general acute care hospital in Portland, Maine Medical Center ("MMC"), and the combined organization has a dominant share of patient discharges in the SMMC service area. The COPA terms required MaineHealth to limit SMMC's operating profit margin and reduce expenses, as well as expand access and maintain quality. But the COPA did not impose any conditions on the other hospitals operated by MaineHealth, including MMC. In accordance with the state COPA law, the MaineHealth COPA expired after six years in May 2015.

Empirical research on the price and quality effects of the MaineHealth COPA for inpatient hospital services from 2003 to 2018 showed varying results for the regulated SMMC hospital and the unregulated MMC hospital. During the COPA period, SMMC's prices increased by about 8% to 13% compared to peer hospitals, but this increase was not statistically significant and the conclusion is that the COPA was largely effective at constraining SMMC's prices during the COPA period. However, SMMC's prices increased by almost 50% following the expiration of the COPA in 2015. At MMC, prices increased by 38% during the COPA period, and by 62% following the expiration of the COPA (for an average of 50% during the entire post-merger period). Furthermore, SMMC's quality declined across most measures following the expiration of the COPA.[47] The study summarizes as follows:

> These results highlight the deficiencies of the MaineHealth COPA, which only placed restrictions on SMMC's price, not that of MMC or any other MaineHealth hospital. The evidence suggests that MaineHealth was able to exercise the market power gained in the SMMC acquisition (and possibly other acquisitions) through a price increase at the unregulated MMC.[48]

Recent COPAs and Developments

Ballad Health System (Tennessee/Virginia) and Cabell Huntington Hospital (West Virginia)

In January 2018, Mountain States Health Alliance and Wellmont Health System – competitors in the geographic region that straddles the border of southwestern Virginia and northeastern Tennessee – merged to form Ballad Health System under COPA approvals from the Tennessee and Virginia Departments of Health.[49] Both states imposed terms and conditions, including a price increase cap, quality of care commitments, a prohibition of certain contractual provisions, and a commitment to return cost savings to the local community. The Tennessee Department of Health has already agreed to amend these conditions on three separate occasions, on July 31, 2019, April 27, 2021, and July 1, 2022.[50] On March 31, 2020, the Tennessee Department of Health and Tennessee Attorney General's Office temporarily suspended several COPA conditions due to the COVID-19 pandemic.[51] Approximately two years later, some of these conditions were resumed on January 1, 2022, and the remaining conditions were set to resume on July 1, 2022.[52] Some concerns have been raised about recent modifications to these conditions, however, most notably Ballad Health resuming the ability to oppose certificate of need applications filed by providers seeking to enter the market.[53]

In May 2018, Cabell Huntington Hospital and St. Mary's Medical Center – both located in Huntington, West Virginia – merged after receiving a COPA approval in 2016 from the West Virginia Health Care Authority ("Authority").[54] COPA conditions include annual reporting, regulatory rate review, the prohibition of certain contracting practices, quality of care and population health commitments, and the maintenance of St. Mary's Medical Center as a free-standing general acute care hospital for a minimum of seven years. The COPA is set to terminate in 2024. Soon after the COPA was approved, the West Virginia legislature made significant changes to the Authority, including eliminating the salaried board of directors (including those who approved the COPA), a 50% reduction in funding, and large staffing reductions (including those who evaluated the COPA). In addition, the Authority's autonomy was eliminated, and it was placed under the direction of the West Virginia Department of Health and Human Resources.[55] The Authority is still responsible for continued oversight of the Cabell COPA, although with substantially fewer resources and a lack of independent authority.

In October 2019, the FTC announced that it would study the Ballad Health and Cabell Huntington COPA effects on prices, quality, access, and innovation of healthcare services, as well as the impact of hospital consolidation on employee wages. The FTC intends to collect information over several years that will help FTC staff to conduct retrospective analyses of the Ballad Health and Cabell COPAs, and we will report these findings publicly when the study is complete.[56]

During a panel discussion on early observations of the Ballad Health COPA, staff from the Tennessee Attorney General's office and the Virginia Department of Health described the lengthy process by the states to approve and monitor the COPAs.[57] A representative for Ballad Health described the COPA implementation as successful.[58] However, representatives from an independent physician group and health insurer raised concerns about the early COPA performance, including reduced access and

pricing issues relating to the rapid closure of outpatient surgical facilities, trauma centers, and NICUs, as well as difficult payer negotiations that they claim have hindered the transition to value-based contracting.[59] And a former member of the Tennessee COPA Local Advisory Council described the significant public concerns with the COPA, primarily relating to facility closures and staffing shortages.[60]

Hendrick Health System and Shannon Health System (Texas)

In October 2020, Hendrick Health System and Shannon Health System – both located in Texas – received COPA approvals from the Texas Health and Human Services Commission for their respective mergers.[61] FTC staff conducted preliminary investigations of these mergers and determined that they were likely to lessen competition substantially and lead to price increases and quality reductions for patients, as well as depressed wages for nurses.[62] In an attempt to mitigate any merger-related harms, the state imposed limited terms and conditions as part of the COPA approvals, primarily consisting of regulatory rate review and reporting requirements. Although it is too early to assess the price and quality effects of these COPAs, we will continue to monitor developments.

Conclusion

To summarize, the weight of the empirical evidence indicates that "[i]n the long run, hospital mergers shielded with COPAs often lead to higher prices and reduced quality from unconstrained provider market power."[63] Despite hospital claims that COPAs will result in lower costs and improved population health outcomes, we are not aware of any proven benefits of COPAs. For these reasons, FTC staff urges state lawmakers to avoid using COPAs to shield otherwise anticompetitive hospital mergers.

Questions may be directed to FTC staff at CopaAssessment@ftc.gov.

Endnote References

[1] This policy paper represents the views of the staff of the Federal Trade Commission. It does not necessarily represent the views of the Commission or of any individual Commissioner. The Commission, however, has voted to authorize staff to issue this policy paper.

[2] *See, e.g.*, FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health; FTC Staff Comment to Texas Health and Human Services Commission Regarding Certificate of Public Advantage Applications (Sept. 11, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf.

[3] *See. e.g.,* U.S. DEP'T OF THE TREASURY, THE STATE OF LABOR MARKET COMPETITION 48 (Mar. 7, 2022), https://home.treasury.gov/system/files/136/State-of-Labor-Market-Competition-2022.pdf; U.S. DEP'T OF HEALTH & HUMAN SERVICES, U.S. DEP'T OF THE TREASURY, & U.S. DEP'T OF LABOR, REFORMING AMERICA'S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION 57-59 (Dec. 2018), https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf; Martin Gaynor, WHAT TO DO ABOUT HEALTH-CARE MARKETS? POLICIES TO MAKE HEALTH-CARE MARKETS WORK 22 (Brookings Institution, The Hamilton Project Policy Proposal 2020-10, Mar. 2020), https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf; Liam Bendicksen & Christopher Koller, *The Risk of Repeal: Examining the Use of State-Action Immunity for Hospital Mergers*, HEALTH AFFAIRS FOREFRONT (Aug. 10, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210806.481073/full/. *See also* Executive Order on Promoting Competition in the American Economy (Jul. 9, 2021), https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/ (discussing the importance of hospital competition).

[4] To obtain antitrust immunity for conduct by private actors that might otherwise violate the federal antitrust laws, the state action doctrine requires both a clear articulation of the state's intent to displace competition in favor of regulation and that the state provide active supervision over the regulatory scheme or body. *See* N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1114 (2015); FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1013 (2013).

[5] Of the ten COPAs that have been approved, seven of them involved mergers between the only two general acute care hospitals serving a local region. Only three COPAs involved situations where any significant competition remained in the local region post-merger, but even these mergers created hospitals with dominant market shares. *See* Case Studies section, *infra* page 7, for further discussion of previously approved COPAs.

[6] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES § 10 (2010). Antitrust laws are not an impediment to legitimate, procompetitive collaboration that would benefit consumers. Antitrust agencies have provided extensive guidance to healthcare providers seeking ways to collaborate without running afoul of the antitrust laws. *See, e.g.*, U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antitrust/hlth3s.pdf; Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Fed. Trade Comm'n & U.S. Dep't of Justice Oct. 28, 2011), http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf.

[7] *See, e.g.*, Zack Cooper, Stuart Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51 (2019), https://healthcarepricingproject.org/sites/default/files/Updated_the_price_aint_right_qje.pdf; Nancy Beaulieu, Leemore Dafny, Bruce Landon, Jesse Dalton, Ifedayo Kuye & J. Michael McWilliams, *Changes in Quality of Care after Hospital Mergers*

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and Acquisitions, 382 NEW ENG. J. MED. 51 (Jan. 2, 2020), https://www.nejm.org/doi/pdf/10.1056/NEJMsa1901383?articleTools=true. For surveys of the research literature, *see, e.g.*, Martin Gaynor & Robert Town, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE (Robert Wood Johnson Found., The Synthesis Project, Policy Brief No. 9, 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Martin Gaynor, Kate Ho & Robert Town, *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LITERATURE 235 (2015), https://www.researchgate.net/publication/278676719_The_Industrial_Organization_of_Health-Care_Markets.

[8] *See, e.g.,* Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, 111 AM. ECON. REV. 397 (2021), https://www.aeaweb.org/articles?id=10.1257/aer.20190690 [hereinafter Prager & Schmitt Study]; Daniel Arnold & Christopher Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages*, (2021 working paper), https://www.ehealthecon.org/pdfs/Whaley.pdf.

[9] *See* Erin E. Trish & Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104 (2015), http://www.sciencedirect.com/science/article/pii/S0167629615000375.

[10] *See, e.g.*, Robert Town, *The Economists' Supreme Court Amicus Brief in the Phoebe Putney Hospital Acquisition Case*, 1 HEALTH MGMT. POL'Y & INNOVATION 60 (2012), http://www.hmpi.org/pdf/HMPI-%20Town,%20Phoebe%20Putney.pdf; Gaynor, Ho & Town, *supra* note 7.

[11] *See, e.g.*, Arnold & Whaley, *supra* note 8; Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006), https://www.hks.harvard.edu/fs/achandr/JLE_LaborMktEffectsRisingHealthInsurancePremiums_2006.pdf; Priyanka Anand, *Health Insurance Costs and Employee Compensation: Evidence from the National Compensation Survey*, 26 HEALTH ECON. 1601 (2017), https://onlinelibrary.wiley.com/doi/10.1002/hec.3452; Gaynor, Ho & Town, *supra* note 7, at 236; Gaynor & Town, *supra* note 7, at 1.

[12] *See* Gaynor, Ho & Town, *supra* note 7; Gaynor & Town, *supra* note 7; Beaulieu, Dafny, Landon, Dalton, Kuye & McWilliams, *supra* note 7, at 56; Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, MED. CARE RES. REV. 1-18, at 14 (2019), https://journals.sagepub.com/doi/pdf/10.1177/1077558719828938; Patrick Romano & David Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Hospital*, 18 INT'L J. ECON. BUS. 45 (2011), http://www.tandfonline.com/doi/abs/10.1080/13571516.2011.542955.

[13] *See* Gaynor, Ho & Town, *supra* note 7, at 249; Gaynor & Town, *supra* note 7, at 4.

[14] *See* Prager & Schmitt, *supra* note 8.

[15] *See, e.g.*, David Card, *Who Set **Your** Wage?*, Annual Meeting of the American Economic Association (Jan. 2022), https://davidcard.berkeley.edu/papers/Card-presidential-address.pdf; Vicky Lovell, SOLVING THE NURSING SHORTAGE THROUGH HIGHER WAGES, Institute for Women's Policy Research (2006), http://people.umass.edu/econ340/rn_shortage_iwpr.pdf.

[16] *See* FTC COPA Workshop Transcript: Session 2 (Afternoon) at 30-31 (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session2_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 2] (statement by Christopher Garmon on the impact of the Prager & Schmitt Study as applied to COPAs). *See also* Mikael Lindahl, *Estimating the Effect of Income on Health and Mortality Using Lottery Prizes as an Exogenous Source of Variation in Income*, 40 J. HUM. RESOUR. 144 (2005), http://jhr.uwpress.org/content/XL/1/144 (finding higher income generates better health); J. Paul Leigh & Juan Du, *Effects of Minimum Wages on Population Health*, HEALTH

AFFAIRS HEALTH POLICY BRIEF (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180622.107025/ (suggesting higher income is correlated to improved population health).

[17] *See* 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.

[18] *See* FTC Public Workshop, *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets* (Jun. 18, 2019), https://www.ftc.gov/news-events/events/2019/06/health-check-copas-assessing-impact-certificates-public-advantage-healthcare-markets [hereinafter FTC COPA Workshop]; FTC Press Release, *FTC to Study the Impact of COPAs* (Oct. 21, 2019), https://www.ftc.gov/news-events/press-releases/2019/10/ftc-study-impact-copas [hereinafter FTC COPA Study].

[19] *See, e.g.*, Hannah Neprash & J. Michael McWilliams, *Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence*, 82 ANTITRUST L.J. 551, 553 (2019), https://www.americanbar.org/digital-asset-abstract.html/content/dam/aba/publishing/antitrust_law_journal/alj-82-2/neprash-mcwilliams-alj-82-2.pdf; Anil Kaul, K.R. Prabha & Suman Katragadda, *Size Should Matter: Five Ways to Help Healthcare Systems Realize the Benefits of Scale*, PwC Strategy& (2016), http://www.strategyand.pwc.com/reports/size-should-matter. Furthermore, in some hospital merger cases courts have found that efficiency claims do not rebut a presumption of anticompetitive effects. *See e.g.*, Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011).

[20] *See* David Arnold, *Mergers and Acquisitions, Local Labor Market Concentration, and Worker Outcomes* (2021 working paper), https://darnold199.github.io/jmp.pdf.

[21] *See, e.g.*, Hannah Neprash, Michael Chernew & J. Michael McWilliams, *Little Evidence Exists to Support the Expectation that Providers Would Consolidate to Enter New Payment Models*, 36 HEALTH AFFAIRS 346, 353 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0840; Cooper, Craig, Gaynor & Reenen, *supra* note 7, at 104.

[22] *See, e.g.*, David Muhlestein, Robert Saunders & Mark McClellan, *Medical Accountable Care Organization Results for 2015: The Journey to Better Quality and Lower Costs Continues*, HEALTH AFFAIRS BLOG (Sept. 9, 2016), http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/.

[23] *See* Centers for Medicare & Medicaid Services, *Value-Based Programs*, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs (last accessed Aug. 4, 2022).

[24] *See, e.g.*, Neprash & McWilliams, *supra* note 19; Kaul, Prabha & Katragadda, *supra* note 19.

[25] *See* Dan P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. ECON. 577 (2000), http://qje.oxfordjournals.org/content/115/2/577.full.pdf+html; Martin Gaynor, Rodrigo Moreno-Serra & Carol Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL'Y 134 (2013), https://www.aeaweb.org/atypon.php?doi=10.1257/pol.5.4.134.

[26] *See* David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFFAIRS 11 (Sept. 2001), http://content.healthaffairs.org/content/20/5/11.full.pdf+html.

[27] *See, e.g.,* Gregory S. Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health* 11 (Feb. 10, 2011), http://www.mountainx.com/files/copareport.pdf; Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health*

System 32 (May 2, 2011). *See also* FTC COPA Workshop Transcript: Session 2, *supra* note 16, Erin Fuse Brown remarks at 18-20; Erin C. Fuse Brown, *Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage* (Milbank Memorial Fund 2018), https://www.milbank.org/publications/hospital-mergers-and-public-accountability-tennessee-and-virginia-employ-a-certificate-of-public-advantage/; 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 2019), https://www.milbank.org/publications/to-oversee-or-not-to-oversee-lessons-from-the-repeal-of-north-carolinas-certificate-of-public-advantage-law/.

[28] *See* Clayton Act, 15 U.S.C. § 18; Federal Trade Commission Act, 15 U.S.C. § 45.

[29] *See, e.g.*, *Competition in the Health Care Marketplace*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care; FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2022.04.08%20Overview%20Healthcare%20%28final%29.pdf.

[30] *See* FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, *supra* note 29, at Section III.

[31] Hospital systems that have been awarded COPAs include: HealthSpan Hospital System (Minnesota, 1994); Mission Health System (North Carolina, 1995); Benefis Health System (Montana, 1996); Palmetto Health System (South Carolina, 1998); MaineHealth (Maine, 2009); Cabell Huntington Hospital (West Virginia, 2016); Ballad Health System (Tennessee and Virginia, 2018); Hendrick Health System (Texas, 2020); Shannon Health System (Texas, 2020). In April 2021, a COPA law was enacted in Indiana to allow for a possible merger between Union Health and Terre Haute Regional Hospital. *See* Howard Greninger, *Talks Focus on Terre Haute Hospitals' Future: New State Law Opens Door to 'Merger' of Trauma Hospitals, Requires Certificate Approval*, TRIBUNE-STAR (Dec. 2, 2021), https://www.tribstar.com/news/indiana_news/talks-focus-on-terre-haute-hospitals-future/article_685467e6-3bba-58c7-bf1b-4966091383b1.html. And in July 2022, State University of New York Upstate Medical University and Crouse Health System announced they would seek a COPA for their proposed merger. *See* Anna Langlois, *Syracuse Hospitals Seek Antitrust Immunity*, GLOBAL COMPETITION REVIEW (Jul. 28, 2022), https://globalcompetitionreview.com/gcr-usa/article/syracuse-hospitals-seek-antitrust-immunity.

[32] Lien Tran & Rena Schwarz Presentation at FTC COPA Workshop, *The Mission Health COPA: Evidence on Price Effects from CMS HCRIS Data* (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/slides-copa-jun_19.pdf at 37.

[33] Christopher Garmon & Kishan Bhatt, *Certificates of Public Advantage and Hospital Mergers* at 19 (Feb. 2022, paper forthcoming in J. Law Econ.).

[34] FTC COPA Workshop Transcript: Session 1 (Morning), Kip Sturgis remarks at 43 (Jun. 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session1_transcript_copa.pdf [hereinafter FTC COPA Workshop Transcript: Session 1].

[35] FTC COPA Workshop Transcript: Session 1, *supra* note 34 Cory Capps remarks at 34-35. *See also* Randall R. Bovbjerg & Robert A. Berenson, URBAN INSTITUTE, CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER? (2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf; Vistnes COPA Study, *supra* note 27; Capps COPA Study, *supra* note 27. In this prior research, health policy experts and economists evaluated certain aspects of the Mission Health COPA, but they were unable to reach conclusions about whether the COPA successfully constrained prices, reduced healthcare costs, or improved quality.

[36] Garmon & Bhatt, *supra* note 33, at 20.

[37] FTC COPA Workshop Transcript: Session 1, *supra* note 34, John Goodnow remarks at 40, 43-44.

[38] FTC COPA Workshop Transcript: Session 1, *supra* note 34, Mark Callister remarks at 38. Mark Callister informed us that the Benefis Health COPA was opposed by medical professionals and citizens of Great Falls, and was supported by the payers. *Id.* at 37.

[39] FTC COPA Workshop Transcript: Session 1, *supra* note 34, Kendall Cotton remarks at 40.

[40] *Id.* at 41.

[41] The Palmetto Health hospitals still operate under the COPA that was originally approved in 1997, although the degree of current active supervision by DHEC is questionable. In 2013, South Carolina cut funding for its Certificate of Need program, which encompasses the COPA program, thereby reducing the level of state monitoring.

[42] *See* Garmon & Bhatt, *supra* note 33, at 20, 42.

[43] At that time, four general acute care hospitals served the Columbia Core-Based Statistical Area in addition to Baptist Healthcare and Richland Memorial: Providence Health in Columbia (later acquired by LifePoint), Lexington Medical Center in West Columbia, Kershaw Health in Camden (later acquired by LifePoint), and Fairfield Memorial Hospital in Winnsboro (closed in 2018). *See* Garmon & Bhatt, *supra* note 33, at 42 ("Baptist and Richland together represented 55 percent of the bed capacity in the Columbia CBSA and treated 66 percent of the commercially insured inpatients.").

[44] *See* South Carolina Department of Health and Environmental Control, Final Staff Decision In Re Prisma Health Midlands COPA (Feb. 28, 2020), https://www.scdhec.gov/sites/default/files/media/document/FINAL-STAFF-DECISION-IN-RE-PRISMA-HEALTH-MIDLANDS-COPA_2-28-2020.pdf; Palmetto Health-USC Medical Group, *Prisma Health to Acquire KershawHealth and Providence Health* (Mar. 5, 2020), https://phuscmg.org/news/prisma-health-to-acquire-kershawhealth-and-provide.

[45] In the Matter of Lexington County Health Services District Inc. v. South Carolina Department of Health and Environmental Control, Prisma Health-Midlands, Providence Hospital, LLC, Order Denying Cross-Motions for Summary Judgment, Docket No. 20-ALJ-07-0108-CC (SC Admin. Law Court, Nov. 2, 2020).

[46] *See* Dave Muoio, *Prisma Health, LifePoint Health Call Off Sale of 3 South Carolina Hospitals*, FIERCE HEALTHCARE (Apr. 13, 2021), https://www.fiercehealthcare.com/hospitals/prisma-health-lifepoint-health-call-off-sale-three-south-carolina-hospitals.

[47] Garmon & Bhatt, *supra* note 33, at 21-22, 34.

[48] *Id.* at 21.

[49] FTC staff investigated the proposed merger of Mountain States and Wellmont for more than two years. FTC staff submitted public comments and testimony to the Virginia and Tennessee state departments of health and offices of Attorneys General recommending denial of the COPA. *See* FTC Staff Submissions Regarding the Proposed Merger and COPA Applications of Mountain States Health Alliance and Wellmont Health System, https://www.ftc.gov/enforcement/cases-proceedings/151-0115/wellmont-healthmountain-states-health.

[50] *See* Tennessee Dep't of Health, *Certificate of Public Advantage (COPA)*, https://www.tn.gov/health/health-program-areas/health-planning/certificate-of-public-advantage.html (last accessed Aug. 4, 2022).

[51] *See* Letter from Tennessee Office of the Attorney General to Ballad Health CEO (Mar. 31, 2020), 2020-03-31 Temporary Suspension-Letter -executed.pdf (tn.gov) (last accessed Aug. 4, 2022); Tennessee Dep't. of Health, List of Suspended

Provisions, https://www.tn.gov/content/dam/tn/health/documents/copa/copa-emergency-declaration-memo.pdf (last accessed Aug. 4, 2022).

[52] *See* Letter from Tennessee Office of the Attorney General to Ballad Health CEO (Dec. 3, 2021), 2021-12-03-AG-and-TDH-Reasonable-Recovery-Letter-to-Ballad.pdf (tn.gov) (last accessed Aug. 4, 2022).

[53] *See* Jeff Keeling & Ashley Sharp, *Changed Ballad COPA Restrictions Draw Docs' Criticism*, WJHL-TV (Jul. 13, 2022), https://www.wjhl.com/news/investigations/changed-ballad-copa-restrictions-draw-docs-criticism/.

[54] In November 2015, the FTC issued an administrative complaint alleging that the proposed merger of Cabell Huntington Hospital and St. Mary's Medical Center violated antitrust laws. In March 2016, while litigation was pending, West Virginia enacted COPA legislation purporting to extend antitrust immunity to certain hospital mergers under the state action doctrine. Subsequently, the West Virginia Health Care Authority approved a COPA application submitted by the hospitals. The FTC opposed the legislation and COPA application. In July 2016, the FTC dismissed its administrative complaint against the proposed merger in light of the COPA approval. *See* Statement of the Federal Trade Commission in the Matter of Cabell Huntington Hospital, Inc., Docket No. 9366 (Jul. 6, 2016), https://www.ftc.gov/system/files/documents/public_statements/969783/160706cabellcommstmt.pdf.

[55] *See* West Virginia Health Care Authority, *About HCA*, https://hca.wv.gov/About/Pages/default.aspx (last accessed Aug. 4, 2022).

[56] *See* FTC COPA Study, *supra* note 18.

[57] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Janet Kleinfelter and Joseph Hilbert remarks at 3-6.

[58] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Richard Cowart remarks at 8-10. *See also* Richard Cowart Submission on behalf of Ballad Health to the FTC (Aug. 2, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0174; Ballad Health Submission to the FTC (Aug. 2, 2019), https://www.regulations.gov/document?D=FTC-2019-0016-0173.

[59] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Scott Fowler and John Syer remarks at 11-16.

[60] FTC COPA Workshop Transcript: Session 2, *supra* note 16, Daniel Pohlgeers remarks at 16-17. *See also* numerous submissions to the FTC from concerned citizens, https://www.regulations.gov/docketBrowser?rpp=25&so=DESC&sb=commentDueDate&po=0&dct=PS&D=FTC-2019-0016.

[61] *See* Texas Health and Human Services, *Certificate of Public Advantage*, https://www.hhs.texas.gov/providers/health-care-facilities-regulation/certificate-public-advantage (last accessed Aug. 4, 2022).

[62] FTC staff submitted a comment to the Texas Health and Human Services Commission recommending denial of both COPAs. *See* FTC Staff Comment to Texas Health and Human Services Commission Regarding Certificate of Public Advantage Applications (Sept. 11, 2020), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-health-human-services-commission-regarding-certificate-public-advantage/20100902010119texashhsccopacomment.pdf.

[63] Garmon & Bhatt, *supra* note 33, at 1. "Overall, COPA regulation, if properly designed, may result in hospital prices that are consistent with the pre-merger market. However, COPA-regulated hospitals have a strong incentive to evade regulation and pursue the removal of the COPA. Almost all of the COPAs established prior to 2015 have expired or were repealed, leaving the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality. States considering the use of a COPA to grant antitrust immunity to merging hospitals should carefully weigh this risk of harm against the possibly short-run and limited benefits of the merger." *Id.* at 26.