A Health Check on COPAs

Assessing the Impact of Certificates of Public Advantage in Healthcare Markets

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PANEL 3 – BALLAD HEALTH COPA: EARLY EXPERIENCES AND OBSERVATIONS

[MUSIC PLAYING FOR 3:14 MINUTES]

GOLDIE WALKER: Welcome back for our afternoon panels. This morning, we heard some empirical research and experiences with COPAs that were approved back in the 1990s. Now we would like to discuss an active, present-day COPA issued by Tennessee and a cooperative agreement granted by Virginia to cover the hospital merger that created Ballad Health. Both the COPA and the cooperative agreement were approved in late 2017, and took effect in early 2018. For ease, the panel will often refer to the Tennessee COPA and the Virginia cooperative agreement jointly as the Ballad Health COPA.

The FTC was opposed to the issuance of the Ballad Health COPA, but since it was approved, we are taking this opportunity now to check in on its status in its early stage. Although it may be a few years before we can fully understand the impact of the COPA, today you will hear from several stakeholders about how things are going and what they have observed so far. We have seven panelists who can provide their unique observations. Let's hear, first, from our panelists representing state agencies from Tennessee and the Commonwealth of Virginia.

Janet and Joe, what can you tell us about the new COPA framework, and can you share your initial observations of Ballad Health's performance under the COPA?

JANET KLEINFELTER: Well, good morning, I'm Janet Kleinfelter. I am with the Tennessee Attorney General's office, and I was involved-- have lived this for the past four years, and am currently the Attorney General's representative in the active supervision of the Ballad COPA.

The Tennessee statute was actually passed in 1993, so it's been on the books for quite some time. But it was amended in 2015, specifically to allow for cooperative agreements between hospital systems. And after that legislation was passed, in February of 2016, the two health systems, Mountain States and Wellmont, submitted their application to the state of Tennessee. And under our statute, the COPA can only be issued if it is determined that the applicants have demonstrated, by clear and convincing evidence, that the likely benefits resulting from their agreement outweigh any disadvantages attributable to a reduction in competition that can result from the agreement. And the statute lists a number of statutory factors that are to be considered, both the benefits and the disadvantages.

The process in Tennessee took a long time. The application was submitted in February of 2016. The application was approved in September of 2017, but subject to certain conditions. And if those conditions were not met, then the COPA would not be issued. Fortunately for Ballad, the conditions were met, and the COPA was issued January 31 of 2018. So we've only been in effect now, operating for about 16 months.

As part of negotiating and putting in place, we looked and said this is active supervision. And for us, active supervision, as my boss said, that's active and that's supervision. It's not monitoring, it's not reporting. It's supervision. And so we put in place a structure that utilizes a number of different players.

During the application process, we utilized a number of different experts, including one that you heard from in the last panel, Dr. Capps. He was our economic expert. We also used legal

and financial experts. We continue to retain those experts to advise us throughout the process. We have population health experts that are advising us, as well as process experts. And some of these, Tennessee is using only, some Virginia's using, some we use together.

In Tennessee, the framework is set up where we have, at the immediate level, sort of on the grounds, is the COPA compliance officer. This individual has to be approved by the Commissioner of the Department of Health. And while this individual is an employee of Ballad Health, he reports directly to the audit committee of the Ballad board of trustees. And again, his or her employment is subject to the approval of the Commissioner.

The next level up is the COPA monitor. This individual was actually hired by our office. The current COPA monitor is Larry Fitzgerald, who is the former CFO of the University of Virginia Medical system. We were very fortunate that, right as we were looking for a monitor, he had retired from the University of Virginia, and was actually originally from middle Tennessee, and was moving back to middle Tennessee. He serves as our COPA monitor, and he is really our eyes and boots on the ground. And he brings with him 30 to 40 years' worth of experience, and is really the one that is doing the day-to-day monitoring supervision.

The next level up is we do have the Local Advisory Council, which is comprised of individuals located up there in Upper East Tennessee and Southwest Virginia. They conduct an annual meeting, as well as issue an annual report, and that report is available on the Department of Health's website. And then, of course, you have the Department of Health and the Attorney General's office, who jointly are charged under the statute with the active supervision, the active and continuing oversight of the COPA.

I'm not going to go into all the details of the Terms of Certification. But if you've seen that document-- again, on the website-- it is a very comprehensive document. We were fortunate that we had the benefit of looking at what happened in Montana, and in North Carolina, in South Carolina, as well as a couple other states. There was actually a COPA up in Maine, and there's a couple others that we've looked at, in addition to what had been negotiated by the Attorney General in West Virginia.

So we had the benefit of their experiences to look at, and recognize that-- again, as Kip said, I don't make the decision. Joe doesn't make the decision. There are people way above us that make those decisions. We're the ones who have to implement it. We're the ones who have to come up with the regulatory scheme. And so what we attempted to do was try and pick out the best things that we could, as well as adding our own provisions.

I will say, some of the provisions in our Terms of Certification, specifically, were intended to address the issues of, if your COPA statute gets repealed while your COPA is still ongoing. So for example, our Terms of Certification has provisions in it which says that the repeal of the act any time prior to the 25th anniversary of the issue date does not cause termination or withdrawal of the COPA or the Terms of Certification. In addition, Addendum 1, which is the provision that governs the pricing-- we have a specific provision that says that those provisions remain in effect and survive termination of the COPA, the Terms of Certification, the repeal of our statute, the termination or dissolution of Ballad, its bankruptcy or receivership, and they last until the commissioner of the Department of Health determines that they're no longer necessary to prevent anti-competitive conduct.

There's a couple of other provisions like that that were intended to address these concerns of, well, you've created, essentially, a monopoly, and what happens when the statute gets repealed or the regulatory scheme goes away? We tried to make it so that that regulatory state scheme stays in place as much as possible. However, this document-- contrary to Justice Scalia, this document is not written in stone. It is a living, breathing document, and we fully recognize that there will be numerous instances throughout the years that we will need to make modifications and adjustments to be flexible to the changes that are ongoing in the community.

Joe is probably going to speak a little bit in more detail about the ongoing supervision. But as you know, it's two states that have to actively supervise. And from the very beginning, we determined that there needed to be close contact, communication, and coordination between our states. So we entered into a memorandum of understanding between the two states. We have weekly phone calls. And during the application process, we actually had a couple of meetings together in determining where we were going with the application process.

In terms of the performance, what I can tell you right now is it's too soon to tell. We've only been in effect for 16 months. Most of what has been happening during this 16-month time period has been processes, trying to get processes in place. Now, from that perspective, that's been very successful as far as we're concerned. There have been some issues, there have been some hiccups. There has been a report that's been issued by the COPA monitor and by the Department of Health, both of which are available on the Department of Health's website. Those reports reflect that, yes, for where we are and for what can be accomplished in 16 months, things have gone well.

There's always room for improvement. And I think that the real test of how effective this COPA is going to be is going to be probably not beginning until years three, four, five, when we're starting to see the effects of those processes, how effectively they have been implemented, and are they producing the results that we're hoping that they will produce. Joe?

JOSEPH HILBERT: Well, thank you, and good afternoon, everyone. My name is Joe Hilbert. I'm the Deputy Commissioner for Governmental and Regulatory Affairs at the Virginia Department of Health, and I too have been living this for the last four years. And I also wish I had the benefit of attending this type of conference about four or five years ago. It would have been very helpful.

But like Janet said, we had a whole big, long approval process that we went through, working with Tennessee, as she indicated. We also worked with our Southwest Virginia Health Authority, which was an established entity in Virginia. And the cooperative agreement statute that was passed by the General Assembly in 2015 gave the Southwest Virginia Health Authority an initial review role in any application that would be filed. And they did review the application and make a recommendation of approval to the commissioner.

In terms of the active supervision framework, we are still at work with Tennessee, with Ballad, on developing, finalizing, fleshing out what we're calling an Active Supervision Framework for the cooperative agreement. The approval of the cooperative agreement in Virginia was-- we have a different instrument than-- we don't have the Terms of Certification like Tennessee has. The Commissioner, rather, issued an order, and attached to it 49 conditions that have to be met throughout.

Those conditions included the requirement that Ballad submit, to the Health Department of Virginia, a series of plans. A plan for population health, a plan for children's health, rural health, behavioral health, regional health, health information exchange, and health research and graduate medical education. So those plans have been submitted. Most of them have been approved. A couple, we're still working to approve.

One of the important things for me is that each of those plans contains strategies that are really aimed, overall, at improving the health status of Southwest Virginia/Northeast Tennessee Ballad service area. So 31 strategies in all. So we have all these strategies. So a big part of the Active Supervision Framework is intended to give the state health commissioner in Virginia a clear line of sight as to the extent to which whether, in fact, these strategies are being implemented as Ballad said that they would be. So that's a big part of what we're after.

The Active Supervision Framework contains a series of metrics, different measures. And I would summarize these by saying that it's a combination of long-term outcome metrics designed to get at answering the question, is the health status in Southwest Virginia improving? Because again, this is a region that has long defied attempts to improve the health of the population. We all know how important that is.

And then, another series of metrics that are really more short-term or intermediate in nature, and they're really more process or output metrics. So we don't want to have a situation, a framework, where we simply have a series of outcome measures that are long-term in nature, and we don't find out until too late that the strategies haven't been implemented in such a way to really affect those outcomes in a meaningful way. So coming up with additional series of intermediate, short-term process and output metrics is also part of the framework.

Our Active Supervision Framework is also built around a series of deep-dive meetings and lighter-dive meetings with Ballad, whereby we go through all of the metrics and identify areas for improvement, what's working well, what's not working well. We had our first deep-dive meeting on May 15 down in Johnson City, Tennessee. So that cycle of meetings is built into the Active Supervision Framework as well.

I would say one challenge that we've encountered so far in implementing an Active Supervision Framework has been identifying appropriate measures and data sources, and establishing baselines for these various metrics. And again, as well as ensuring that all of those 31 strategies across Ballad's six plans have clearly-defined process and output metrics that can be looked at in the short and intermediate terms so that we really have confidence, in Virginia, that they are doing what they said they would do.

To address that ongoing challenge, we have established a metrics work group with Ballad and with Tennessee that will begin work this summer to identify-- to address certain gaps in metrics that we've identified over the past 16 months. We are required to have, in Virginia, a technical advisory panel that reports to the commissioner, whose job it is to recommend metrics and revised metrics to the commissioner. So our plan of action is for this metrics work group to work over the summer to bring recommendations to our technical advisory panel, which will meet in November. The technical advisory panel will consider the work of the metrics work group, and then make its own recommendations to the commissioner for final action.

In terms of how we've structured ourselves to do this, we have brought on a number of staff. We have staff in our commissioner's office, in our Office of Licensure and Certification, and

in our Population Health Unit within the department, all contributing to our staff work on this. We also have assistance from our Department of Medical Assistance Services, which administers the Medicaid program. We also are coordinating with the Southwest Virginia Health Authority. We are working to finalize a memorandum of understanding with that group so that they will with the intention of that authority serving as our local advisory council in Southwest Virginia. So again, that local input is very important.

In terms of just some initial observations on Ballad's performance over the past 16 months, I would concur with Janet's comments that it is too soon to tell, in terms of substance. Certainly, this is a big merger. It's my observation-- it's our observation that Ballad has a lot of balls in the air right now. They're juggling a lot of things. So again, those process and output metrics, can they actually pull this off? Can they actually do what they said they wanted to do? Can they deliver on what they promised?

I would say that Ballad's work to stand up the accountable care community in Southwest Virginia has been very impressive to date. But again, a lot more work to do there. We're looking for results on the population health outcomes for the region.

I guess the only other thing I would say, just in the way of opening remarks, is one of the benefits through the COPA that we hope to see is improvement in the health status of the people in the region, across many, many dimensions. Again, this is a part of our state that, unfortunately, over an extended period of time, has demonstrated really pretty poor health outcomes across a number of metrics. And that's not in anybody's best interests, certainly not in the state's interest. If we're looking to control health care costs, we want to take an upstream approach here. It's easier to keep healthy people healthy later in life than it is to try and turn around someone who's got many, many co-morbid conditions going on at the same time.

So we expect Ballad to be the leader in Southwest Virginia--

JANET KLEINFELTER: (WHISPERING) And Northeast Tennessee.

JOSEPH HILBERT: --and Northeast Tennessee.

[LAUGHTER]

You were supposed to say that. So this isn't something that they can farm out. You can't contract this away. They have to be the leader. That's our expectation.

GOLDIE WALKER: Well, thank you, Joe and Janet. Next, we'll have Dick-- if you could pass this down-- as the legal counselor to Ballad Health. Can you describe Ballad's experiences since the COPA and cooperative agreement were approved? And what efforts has Ballad had to implement the COPA and comply with the state's terms and conditions that Joe and Janet just discussed? And if you can, what challenges has Ballad faced, and what successes has Ballad achieved so far?

RICHARD COWART: Well, I have a lot to cover in six minutes.

[CHUCKLING]

So this is actually a six-year story for me. I was board counsel to Wellmont, which began a strategic options study. Basically, if they did nothing, they could sustain their existence, but couldn't improve anything much of anywhere. They went through an RFP process, decided they didn't want to sell to a for-profit and have just investor-owns making health care decisions. And their choice was to be either an outpost for a super-regional nonprofit, or-- or, as what had been their arch rival said, why don't we do something nobody's ever done before?

And it was an unexpected offer from Mountain States, but one that quickly got to the core of why people serve on health system boards and why they are leaders of any community. Because if we listen to the stories this morning, the story of Ballad is not the story you've heard this morning. The story of Ballad is about the why. It's not about the how.

And so I'm going to give you a little bit-- I can show pictures faster than I can talk. And to tell you a little bit, for those of you who know, it is a large nonprofit health system that covers 21 hospitals. It's the only children's hospital in a region. Each of the systems had about a billion dollars in revenue, so it was a merger of almost equals.

And the last year has been extremely intense, as you can imagine, just merging two organizations of that scale who had been arch rivals for 20-plus years. They treat almost half a million emergency visits. They have 800 other employed professionals. And at 15,000 employees, they are the number one employer in the region. The number two employer is Eastman Chemical, with 6,000 employees. The university employs 2,500 employees, to give you an idea of the scale of significance. And also, the importance of why they decided, if they were going to address the core issues, they needed an infrastructure, and a leadership structure, and a management structure to do it.

This area is roughly the size of New Jersey, but it's only a million people. The COPA area covers 21 counties in two states. The service area would add another eight or so counties, so say about-- a little bit in Arkansas-- I mean in Kentucky and a little bit in North Carolina. But this is not the Great Plains. I mean, there's literally a county in here that there's one way in and one way out. And so the ability to kind of serve a lot of microregions and micromarkets, because they've been communities. And of course, one of the real challenges to this region has been how to function regionally. This is Appalachia. There is a lot of territorial rivalries on a micro scale. But the ability to do what needed to be done next required a different view.

This is a little bit about the health status. There are some areas, like Washington County, where the university is located-- that's Johnson City, Tennessee. And to give this perspective, Johnson City, Tennessee is smaller than Billings, Montana, which you heard mentioned in the earlier presentation. So that's the largest community in this market. But it's a university community, and it's reasonably healthy. It's young, healthy, vibrant. But there are also, certainly in the more outlying rural areas, you have some of the most difficult health status conditions in the state of Tennessee, and very much in the state of Virginia. Health status is the problem. That's the problem. And that became the why about why Ballad was formed.

This, again, shows you about half the hospitals make money, about half lose money. And some of them lose a lot of money. But if you're going to have an ecosystem, you're going to try and keep it all in balance, and keep it all rationalized to a regional approach. This is a very significant-- this is not light supervision. We've heard the light COPA, and well, this one is 150 pages in Virginia and probably an equal number in Tennessee. And it's got all the behavioral covenants you're used to seeing, which really is not the story.

And I know that's kind of been the talk of the morning. But the story really here wasn't, how do we combine, create some efficiencies, and improve our bond rating, or how do we combine, and create some efficiencies, and get some revenue flow, because we can negotiate with our payer? The story here was, if we're going to address the health status of our community, where are we going to get the money? And if it's not us, who, and if not now, when? And those are the literal words at a board meeting, from the board chair, not from me. And the commitment was, we're going to take the money we save from this combination, and we're going to attack the problems that are endemic in our community. Because only that is going to change the socioeconomics.

And this became what is-- there is no COPA like this anywhere in America, nothing even close. And it's not about the active supervision. And we are actively supervised. And I think we've had a very professional relationship, but we talk to the state daily. The COPA monitor comes and spends three days a month-- that's a man month a year-- looking at things. The Attorney General and the Commissioner of Health come to board meetings twice a year. The Commissioner of Health in Tennessee is one of the child abuse specialists. She's a child maternal health specialist. She knows what's going on here. She ran rural hospitals in West Tennessee.

We are all trying to do something that's never been done. And we're trying hard, but we have no misunderstanding. This is hard. It will be difficult. We are accountable and we are being supervised.

Here's what we've said we will do, and we've been presenting the last 15 months. We've been active for 15 months. We've got an $85 million investment towards behavioral health, which includes, by the way, getting telemedicine into the schools. We've got telemedicine behavioral health into schools already. The big problem in behavioral health was not we need a new psych hospital. It's we don't have any mental health professionals. It's the same problem the military faces. Until we recruit mental health professionals-- and the marketplace doesn't do that. Somebody's got to recruit them, and it takes an infrastructure to do it.

The next was on academics and research. The public health program for Tennessee is at East Tennessee State University. Vanderbilt, for example, is a rock star medical school. It trains no primary care physicians-- none. ETSU, that's what they do. So beefing up that training program and focusing on population health, focusing on primary care.

Population health needs. Robert Wood Johnson says, of the major indices of population health, we're bad in almost all of them. And it is what you would think it is. It's the opioid crisis. It's ground zero. Obesity, it's in a terrible state. Obesity leads to cardiovascular disease. It's high in smoking. All those things, you don't treat in the ED. You've got to treat before they get to the ED, before they get to the emergency. How are you going to do it?

So these are some of the different areas. We developed plans, strategies, milestones, accountability. We've submitted them in two states. They're not even fully approved yet. But they're very comprehensive plans, and I think you should be impressed, and I encourage you to see them.

Again, children's services has been another one. It's the only children's hospital, but it's still a challenge. Nashville has 2.5 million people. It has one children's hospital. Memphis has 2 million people, one children's hospital. This area has 1 million people. And they will tell you

that's hard to get a full-scale, full-service children's hospital up for a million people. You're not going to have a bunch of those.

Same thing with level 1 trauma center. You can Google level 1 trauma center. It takes 2 million people. We've got 1 million, we had three. We have two level 1's 20 miles apart. It cost a million dollars just for neurosurgery coverage, and it's the same neurosurgeons covering two hospitals. I mean, really? Aren't there some very evident things we can do better and more efficiently?

And then the money on health information, we can cover some of this. The key thing here, I think there has been not just, we're going to take $300 million and we're going to attack the health status of our community. We also said, we're going to create an index to prove we did it. And we've been working with both states to say, what are those metrics? And they really are the supermetrics. I mean, there's about 70 in our COPA right now.

But if you look at-- one of the key socioeconomic metrics is our children reading at third-grade level when they're in the third grade. And that's an indicator of incarceration. That's an indicator of teenage pregnancy. That's an indicator of a lot of significant things. But when you take four measures of, are you ready for kindergarten at kindergarten, are you ready for the third grade at the third grade, the things that really make a difference require a community to attack it. It takes an entire community to attack it. And it takes a leadership structure, and a management structure, and an infrastructure-- not just a big grant-making organization-- to do it.

And that's what's been formed this year. It doesn't exist anywhere in America. 250 organizations who have committed to this plan, and all these cities, what Joe just referred to, where they are part of the elements. Because yes, Ballad doesn't teach school. They're not going to do what needs to be done in the schools. That's going to have to be done in the schools. There are various elements of this. There's Healthy Kingsport. There's a lot in the university program. There are a number of the employers. The major employers here are almost all self-insured. And so they have to own their piece of it. And getting them to do it is part of getting a plan and getting milestones and accountability.

And I'll close with the fact that, to do this, it is a 10-year program. And these are 10-year plans. For example, I think the studies will tell you, if you're 50 years old and you're smoking, it's hard to get you to quit smoking. Yes, it can work. But if you bring up children not to smoke, and they've gotten to a certain age, the likelihood of them starting to smoke in large numbers is much smaller. So these programs about what are the early interventions, how do we move those to the next level? On each one of these major indexes, there's a plan, there's a navigation process. And I think that's really a core to what we're doing.

And I think it's interesting to say here that this is one of the great population health stories in America. It may be a little confounding, from the COPA point of view, because COPAs make one-- but the problems that have to be addressed here are not going to be addressed in the marketplace in a pricing model. I mean, pricing models and capitalism got us to the opioid crisis. Now we're going to have to do it. But the ability to deal with those problems takes a different approach, and that's what we're trying to do.

GOLDIE WALKER: Thank you, Dick. Next, we will hear from market participants who will share their observations of the Ballad Health COPA. From Tennessee, we will hear from Dr.

Scott Fowler, representing Holston Medical Group, and from Virginia, we'll hear from John Syer, who's representing Anthem.

SCOTT FOWLER: Thank you. Good afternoon. My name is Scott Fowler. I'm the president and CEO of Holston Medical Group. I want to thank the FTC and the Office of Policy and Planning for having me here to speak today. I'm delighted to get an opportunity, really, to speak out about the COPA, and give our perspective on what's happening, boots on the ground.

Before I do that, I want to talk a little bit about the perspective of Holston Medical Group. So Holston Medical Group is an independent medical group. It's owned by physicians. It's led by physicians. It's dedicated to a patient-first, or patient-centric, model of care, and has been for quite a while. It's been in this Northeast Tennessee/Southwest Virginia region for 42 years. It was started with a Robert Wood Johnson Foundation grant to serve the underserved areas of Appalachia. And I think, over the last 42 years, it's really focused on doing that.

Today, we manage over a third of the patients in the entire service area. We see about 60,000 patients a month. We're a multi-specialty. We're about 70 percent primary care, but we have 18 different specialties. I am a physician. I'm a partner in HMG-- an equal partner with my other partners. I've been the president and CEO for the past 10 years.

Ten years ago, as a new CEO, and with the leadership of the board, we had a new opportunity to take stock and reevaluate the future and the plan for how to meet and exceed our mission for our patients in our region. That year, HMG signed its first contract to be paid, not on services or volume, but on value and value improvement. Since then, we've succeeded every year in growing that population of patients, driving higher-quality and lower-cost markets into the region.

Now, almost 30 percent of our revenue that we receive every year is paid in value. HMG wouldn't even be here and couldn't survive on the fee-for-service that's paid in our region without these value-based payments, which are paid on a risk contract, and are paid based on how well we perform, in terms of both cost control for our patients, but mostly for outcomes. We've scored in the top few percentile nationally, year after year, and have been part of a community of mostly independent providers in our region, both Southwest Virginia and Tennessee, that have been successful in medical shared savings programs and in building infrastructure that you need for value. Our region is truly exceptional, and is recognized nationally.

So what did we see 10 years ago when we did our analysis and when I started as COO, which we still see today? It's often said that every system is perfectly designed to get the results that it gets. And what we saw was a health care system in the United States that was built around volume and pricing, and was centralized around services in very high-cost centers, hub-and-spoke systems that brought patients into the highest-priced parts, usually a hospital system. Health care was, at that time, extremely costly in our region and across the United States. And in fact, the United States government had made a clear indication that it would bankrupt the payment systems that we had.

Much of what we saw was there was a radical difference between inpatient and outpatient pricing, and that the major hospital systems in a region could demand much higher pricing that it could then pass on to raise pricing in other settings. We knew, at the time, that much of the care that used to be in the hospital-- so when the hospitals first developed, it's where you went

for IVs, it's where you went for antibiotics. You couldn't afford to have three MRI machines so you had it at the hospital. It was a place you could keep open 24/7, and it wasn't as pricey as it is now. Most technology and specialties have advanced now so that most things can be done outpatient. And so the ability to keep those things inside a high-pricing model is part of the problem that we saw had to be fixed.

Per capita spending on health care is estimated to be 200 percent greater in the United States than in other economically developed countries. The number one reason people give for bankruptcy is that they can't pay their medical bills. And that's true in Appalachia Tennessee as it is anywhere else.

Despite these high costs, the indicators of quality in the areas were low, and traditional models of care were not really affecting that. So we saw that the system, as it was, was fragmenting care, that it could be made better. And we set out on a 10-year quest to do that.

A hub-and-spoke model bankrupts the rural hospitals and takes services out of the areas where they should be given locally. It overestimates the value of providers that are in high-specialty centers over the need to have providers that are out in more rural areas. It sometimes underestimates the need for acute care facilities, which need to be very, very close to the people that need them, and wants to centralize that into a hub out of economies and efficiency.

So we recognize the need for change to empower the system to move from fee-for-service to fee-for-value. And we recognize it meant the system-- the structure of the system, not the behavior of the system-- the structure of the system had to change.

One of the things that we did early on was we decided we needed a common medical record for all our patients. We needed to know where our patients were in the system. And we know our patients wanted us to know that. Did you go to the urgent care? Were you in the hospital? And so the independent physicians invested and sponsored, basically, a health information exchange in our region, which had failed previously under other grant models and sponsorship.

Currently in our health information exchange that we have in the region, we have 80 to 90 percent of all the data in the region. If you want to know what the data in the region is, you can come to us, if you have permission, to see this kind of data. We can tell you what the admissions to the hospitals are because we get those in our data system. If a patient's admitted to the emergency room at our hospital, one out of four of those patients have data in this system within the prior seven days. It may be data that they had a CT scan or they saw their doctor. It's very valuable data. And we use it everyday in our value-based contracting, but the ER physicians at the hospital don't have it, and the hospital hasn't adopted it.

Instead of using a system sponsored by the community-- as a matter of fact, since the COPA, they've now decided that they're going to spend hundreds of millions of dollars to build a hospital-centric health information system, which may make our system less functional and less compatible with the value things that we desired to accomplish. We presented a letter, in November of 2016, to the Department of Health after the COPA application was filed in Tennessee, which basically said what's in the application is not strong enough. Not that we're against it or that we think there aren't good things that can come out of it, but that the regulatory requirements and governance in other areas that were in here were not sufficient to make this into something that we could guarantee that the benefits would outweigh the risks.

The hospital-centric governance financial operational system proposed in the COPA were weak. The impact of the monolithic monopoly-- which in this region, it is the biggest employer, as you heard. It has tentacles in everything that happens in our community. It will impact the local economy. It will impact outpatient markets. It will impact the geographic distribution of services, not necessarily based on where patients need them, but based on what's economically efficient for the systems. Maybe we don't need two trauma centers, but maybe we need the trauma center in Kingsport. Maybe we don't need two children's hospitals, but maybe where the children's hospital is, it needs to be looked at more carefully, and not just on financial grounds.

At any rate, price transparency and parity, as you heard today, in the outpatient marketplace has to be part of the metrics of success. The ability to block or to squat on value-- and I get the whole idea that value is something that we need to coordinate, we need to be interoperative and interactive with. And I applaud all the efforts, and I think they can be successful to bring people together to do value. But we know that, historically, the financial interests of a company drive its behavior. And it's in the financial interest of these hospitals to drive service lines and work into the hospital, where the prices are higher, and to use the hub-and-spoke models that have traditionally been used.

CMS, in its final rule this year on Medicare Shared Savings Program, specifically noted that hospitals were forming ACOs that were actually blocking the access for patients to get into ACOs that were doing value. Because by building those ACOs, those patients would not be attributed to another model. We were skeptical, to say the least, and did not think the application would meet the standard. As an attorney-- I went to law school before I went to medical school-- but as an attorney, the clear and convincing standard seemed overwhelming to me. And we just didn't think that it would happen.

So what's happened since the COPA? Impacting patient care, rushing changes, having things happen too quick. Of all the models that I saw up here today, the one at Phoebe Putney reminded me of what I'm seeing on the ground, which is a lot of confusion in an effort to coordinate, between a business and the government, rapid changes on the ground which impact patients.

So let me give you just a couple of examples. Shortly after the COPA, we had about 10 outpatient surgical rooms that were operating in town. Those were places that you could take your patients as an alternative to surgery in the hospital. Shortly after the COPA, all of the beds were closed. This center that we were owners in was dissolved against our objections. And when we offered to buy the center so that we could continue the care, that was refused. As a result of that, Bristol went without an open surgery center for quite a few months.

Now, eventually, will that get fixed? Yes. Did it need to happen? No, it didn't need to happen. It created bad care and bad experiences, and it was dissolved where there was another opportunity. So we think that it was probably done in order to help them control the outpatient marketplaces. We have a lot of information that that may be part of what was done. In Kingsport, the same model will limit rooms, will allow the closure of one of the surgery centers there, and will bring other players into the marketplace, possibly with higher-priced national contracts.

CON law, adjustments in the COPA, will eventually hopefully fix this. We were able to go and get a CON. The hospital was not allowed to object to the CON, which was in keeping with the

COPA. And I applaud the fact that we were able to get that CON. But it won't be open for a year. So between now and then, it won't be. In the meantime, the outpatient ambulatory surgery center that is there is being restructured to put restrictive covenants on the doctors that are owners there so that if they leave, they can't be owners in other centers.

This type of behavior is perhaps predictable, but is not the kind of behavior you expect from people who are trying to do the right thing. The connection to the HIE in Knoxville, the plan to build a separate HIE, and the HIE in Knoxville won't connect to our HIE. The threatened-- and the confirmed, I guess-- loss of the NICU and the trauma center in Kingsport, bad for patients. It's bad for the geographic region. It will affect the economies in Kingsport. There is a lot of discussion about whether it would have been much better to just sell to an outside system. There's widespread confusion. It could have been avoided.

In summary, let me just say I think our skepticism has perhaps turned to some opposition. But I want to be careful to say that it's in specific areas. I do think the COPA has the potential benefit to the community if it can be regulated and monitored, just like we said in our original. And although what I've heard today makes me even more concerned that it's a bad idea, I do think that there are certain areas.

I think we have to recognize that it maintains and empowers an old paradigm, and that's a hospital-centric model of care. Perhaps it's the most common paradigm in America, but it's not the future paradigm, and it's probably going the wrong direction in maintaining the status quo. There's no question it will interfere, block, or perhaps subsidize and inhibit other efforts that might have been made in the region. Because it will become the dominant place where people look for change, and there's a lot of other players in the marketplace that can bring change besides the hospitals.

I believe that it will fragment between hospital-based and non-hospital-based providers. It creates an economy of scale, which can change, really, real estate. We know our leases are changing. Immediately after the COPA, the hospital is moving things into buildings that it owns, rather than leasing from other places. So there's a lot of financial need to make this money to reinvest, I suppose, that they do the things that they plan to do, which is create economies of scale.

At this point, it appears that the risks outweigh the benefits of the COPA. And we'll have to see if some of these things can be addressed. So those are my comments. Thank you.

GOLDIE WALKER: Thank you, Scott.

[APPLAUSE]

Now I will ask John, can you describe Anthem's experiences negotiating with Ballad Health since the COPA was implemented, and whether this differs from before the COPA was issued?

JOHN SYER: Sure, I'm glad to. Let me give a little bit of background first. My area contracts across the entire service area in Virginia, and then one or two contiguous counties that border the state of Virginia. In addition, we own an Amerigroup plan in Nashville that services Medicare and Medicaid membership, inclusive of Northeast Tennessee. So we have a very, very vested interest in Southwest Virginia and Northeast Tennessee. It is extremely important

to us. We are the largest payer on the commercial side in that geography. So when the COPA came to light, we were very focused on it.

There were seven counties and one city in the state of Virginia that there would be no other alternative. As it was alluded earlier, I mean, this geography is 14,000 square miles without an alternative, with a geomonopoly. So this really got our attention, and we were very, very engaged. And we thank the FTC for their engagement with us in the investigation of the COPA process.

We share many of Dr. Fowler's concerns and observations. Before, there were two health systems serving this geography. Mountain States had a 59 percent market penetration, Wellmont had a 41 percent. So there were two viable alternatives in this geography.

Something that we brought up in December of 2015, in an affidavit, really focused on the unintended consequences. And one of those unintended consequences which was of particular concern for us were around hospital-based physicians. And by that, I mean radiologists, anesthesiologists, ER doctors, NICU doctors, pathologists. Because often, what happens, within a given hospital, they will give exclusive rights to those hospital-based physicians for those services in that facility. Well, what we have found with Ballad is that it's a geomonopoly granting, essentially, monopoly, services for those hospital-based physician specialties I just described.

And in fact, we are dealing with an issue now. The one ER group in the state of Virginia that is not participating with Anthem at the current time is the ER group that services Ballad. So that is of extreme concern for us. That has taken things front and center, frankly, in our discussions with Ballad. And we really need to work through this and this issue before we can engage in others. We were worried that it would come to fruition two, three years ago, and it has. So that is of utmost concern for us.

The fact that there is no competition within 60 miles of Bristol is worrisome to us. The fact that there is no tertiary hospital competition in a broader area than that is also worrisome to us. And really, consumer choice, which is so important, that really doesn't exist in this geography.

Dr. Fowler mentioned value-based contracts. We have a huge focus on contracting with independent physicians. We have a physician-centric-oriented model around value-based contracting and improving outcomes. And not enabling physicians to have a choice of where they send services is very detrimental in those models. For example, laminectomies previously could have been done at a Wellmont facility, and all other back surgeries may have been done at Mountain States because the outcomes were better. That dynamic no longer exists. And that's problematic for us, and it's problematic for our customers. A lot of national accounts, large group customers, they are extremely interested in these models. They've seen it work across the country. They want it in Virginia. And that portion of the state, an important portion to us, that's hard for us to do now. That's very challenging.

We do have another incentive program, our Quality Insights Hospital Incentive Program. Ninety-five percent of the admissions in the state of Virginia take place at a Q-HIP-- the acronym-- participating hospital, over 800 hospitals across the country. So we have benchmarks from 2015 through '17 for the 10 Ballad hospitals that are in that program. And we will continue to watch and really monitor their performance in that program going forward, as we do with all hospital systems.

And then I guess, in closing, finally, something that worries us as well-- and Dr. Fowler also alluded to that-- the movement of services back into the hospital setting. You had mentioned the AMSURG centers. They're often less expensive than the outpatient arena and the hospital. But we're also worried about things like drug, lab, some imaging services, and having those services flow back into the hospital setting at much higher rates.

And then, finally, we discussed the compounding effect of certificate of need in conjunction with COPA. That's such a challenge. I mean, COPA grants, essentially, a geomonopoly. And then you have COPN on top of that, which restricts more barriers to entry. It restricts others coming into that market to help alleviate that competitive environment.

GOLDIE WALKER: Thank you, John. Dan, you heard our last panelists, Scott and John, speak about their initial experiences as a health care provider and as an insurer. Can you describe some of your observations of the Ballad Health COPA, as well as public reaction to the COPA?

DANIEL POHLGEERS: Sure, thank you, Goldie. And thank you, Stephanie and the FTC, for inviting me to participate in this panel. I wanted to give you a little bit of background about me first, before I answer the question. I've been in health care, as a provider and as an administrator, for 30 years now. My original training is an occupational therapist and certified hand therapist.

I actually have been in Northeast Tennessee for 23 of those years, and I have the privilege and advantage of sitting on many local organizations' boards. I also sit on the local advisory board for the COPA. I do want to make sure that everyone understands that I'm not here representing the Tennessee COPA Local Advisory Council or any of those organizations that are in my bio. I'm here as a consumer and advocate for the people of Tennessee.

I've been following this issue since March of 2015, even before the April 2 announcement of the merger. I was given some information concerning the COPA law changes. I watched, and listened, and participated in emergency rule changes that were held by the Tennessee Department of Health. I attended and participated in the COPA Index Advisory Group, which was a group of citizens that were brought together to help form the index, and many of the things that have already been discussed today, like changes to CON, physician caps, those types of issues that the people in the community felt were important to be put into the COPA and to the certificate.

I also attended and spoke at every COPA public hearing during the process. And in September of 2018, as I have alluded to previously, I was appointed to a Local Advisory Council by Dr. John Dreyzehner. The Local Advisory Council-- and the information I'm giving you, all of this information can be found on the state's website. It's all public information.

But the Local Advisory Council really has no regulatory supervision of the COPA. Quite simply, I explain to people that our goal is to be a conduit to the public, to the Tennessee Department of Health and AG's office, to gather information and to relay that information to the departments.

The main purpose of the Local Advisory Council is to recommend to the Department of Health how those funds are spent, the money that was described by Mr. Cowart. Also, we hold an annual listening session. And this year, that annual listening session was held in February. And we got quite a different type of reaction during the listening session than I had ever experienced on anything else prior to the COPA being awarded to the health systems. We had about 40

speakers at that listening session. All 40, with the exception of one, gave very negative comments about what had happened since the certificate of public advantage had been awarded.

People were able to give written and verbal testimony at that hearing. We had several municipalities-- Scott County, Virginia, Sullivan County, Tennessee, Hawkins County, Tennessee-- actually put together this, which they were in opposition of the downgrade of the level 1 trauma center and the downgrade of the neonatal intensive care unit in Sullivan County.

Of the 40 speakers that attended the meeting and spoke, most were concerns over the level 1 trauma and NICU closing. There was also a great deal of discussion about ongoing nursing shortages in the hospital, and care, diversion of patients-- not because hospitals were full, but because hospitals didn't have the staff to keep those patients in the hospital. Long waits in the emergency room, holding areas in the emergency rooms where patients were being held. Not, again, because the beds were full at the hospital, but because there was no staff to take care of those patients, and floors were closed in the larger hospitals in the area.

Staff physicians actually came forward-- these were physicians that had been on the level 1 trauma center-- and discussed some of the changes that were occurring, that they had no input into those changes to the level 1 trauma center. EMS and nursing professionals came forward to talk about the impact of the loss of the level 1 trauma center in Sullivan County, and the significant burden that this would be placing on the people of Southwest Virginia.

I did want to talk briefly about some of the things that were also described earlier, especially about CON and independent doctors, and how CMS looks at independent physicians. In December of this past year, CMS, on their report for accountable care organizations, actually recommended that there would be fundamental changes to how ACOs are run, because independent physicians were outperforming hospital-based physicians on cost and quality pretty significantly.

The cap on physicians has been something that has been discussed in several meetings. It's been discussed among the Local Advisory Council. I've also participated in phone conferences with the Tennessee Department of Health as to what is driving physicians to hospital settings. I believe that CMS, the U.S. Department of Health and Human Services are in agreement that consolidation of health care systems and consolidation of physicians to hospital-run organizations not only increases cost, but it decreases access to care. Those are things that have been discussed very recently, over the last several months. And I see those as being big barriers to the continued quality of care in Northeast Tennessee.

I also have heard, from a community standpoint, several times that we're coming up on a very big milestone where the health system will be able to fully integrate their resources, I believe, in 18 months. And I guess one of the things that we keep hearing in the community, if there's so many things up in the air, or if the health care system is struggling so much to get everything in place that it needs to get in place, that maybe the Tennessee Department of Health and the AG's office may want to delay the full implementation of the COPA until we have a little bit more certainty as to whether or not this is going to be a clear and convincing evidence of public advantage. Thank you.

[APPLAUSE]

GOLDIE WALKER: Thank you, Dan. And last is Erin. Dick, if you could pass down the clicker for Erin. She'll need this for her opening remarks. By going last, Erin, you benefit from hearing from all the panelists. From your perspective as an academic, what are your observations on the challenges that state regulators face when establishing COPA regulatory regimes? Does the retrospective empirical research presented this morning factor into your impressions regarding recently-approved COPAs?

ERIN FUSE BROWN: Thank you. And I will echo my fellow panelists' gratitude to the FTC, and to Goldie and Stephanie, for organizing this event. I think it's really been terrific, and an incredible opportunity to hear from so many different perspectives, to hash out what seems like this narrow issue, but it has much larger implications for the larger cost and the future of the delivery system of health care in the country.

So the way I-- again, just a quick background, why am I here? Everyone else, it's clear why they're here on this panel. I am a law professor, so I don't do COPAs. I don't administer them. But the reason I'm here is that the Milbank Memorial Fund commissioned two reports that I wrote. One was a really deep dive into the Ballad health COPA, just documenting the process, the approval process, the statutory authority, and then coming up with some policy implications, which I'll touch on here. And then I did a follow-up report, just a shorter report, reflecting on what have we learned from the Mission Health experience, and what information can be gleaned from there? So that's the perspective I bring.

So policy implications. The policy implications that-- hearing today's presentations, this is echoing what I came up with in my reports, in some ways. My thinking is enriched today than just what was in my report. But I remain convinced that there are certain takeaways, to the extent that Professor Dafny said, if you've seen one COPA, you've seen one COPA. I think that's true. And I also think that there are lessons learned. We have all the folks from-- Kip and Mark, from North Carolina and Montana, saying it would have really been helpful to know this before they embarked on COPA. And even our experience-- Tennessee and Virginia are improving the COPA process, and really putting a lot of thought into it, building on what has gone before. But there is still more to learn.

So one of the takeaways is that COPAs are incredibly resource-intensive. This is not a light version of regulation. It's complete regulation in a region. So instead of statewide rate regulation, it's rate regulation, quality regulation, access regulation, population health regulation, all rolled up into one, but it's focused on a region instead of-- or on a system instead of on the whole state.

So COPAs can be-- and I think, increasingly, we're seeing where states are thinking of pursuing a COPA are areas like what we see in Virginia and Tennessee-- rural populations or semi-rural populations, populations that struggle with their health status and health statistics. And I think that that is a driving factor of what's-- it's not that everyone thinks that this is the best-case scenario. If you could design a perfect system, a COPA would not be it. But when you're facing the population health struggles of these rural areas, I think that sometimes, there's few options left. And so a COPA feels like it's a way to allow some of the resource consolidation without losing some of the ability to extract those population health commitments.

Coordination is key for a multi-state COPA. I think Janet and Joe made a great point about that. I'm not going to go into it further. I think that they illustrate entirely why coordination is critical here in a multi-state situation.

COPA conditions. As we've heard throughout the day, there's this tension between wanting the initial COPA terms and conditions to be incredibly detailed and incredibly enforceable and specific. Because this is the moment where there's negotiating power, everyone's excited, but everyone's also very concerned. There's the most motivation that there will probably ever be in the whole process when you're entering into that initial set of terms and conditions. However, it can't be so rigid that, as the system changes, as dynamics and payment reforms roll out and the health status of the region hopefully improves, that those COPA conditions can't change as well.

And so it's not about, necessarily, going all the way up to the legislature or even getting a new rule passed, although sometimes that's necessary. I think a lot of it can be done in this sort of-- the terms and conditions negotiating, that's more nimble. And so I think, in some ways, the states, by being so involved, can bake into the-- renegotiate, revisit the terms and conditions of the COPA over time to get that flexibility, but also keeping the enforceability of hard, say, price obligations, for example.

And the last two I'm going to go into a little more-- states must define what a successful COPA looks like to them. They have to know and keep very clear in the forefront of their mind what it is that this whole enterprise is setting out to do. And because they are so risky, because it's such a risky undertaking, the state has to really commit to remain vigilant, not for 10 years, not for 20 years, but forever, in perpetuity. Once you grant that monopoly, unless new competition enters the market-- if you have a monopoly, you need a COPA. You need oversight. Unless there is other competition, the other option is an unregulated monopoly.

So I think, in some ways, what Tennessee and Virginia have done, they have the resources, they have the capacity. They've taught us that, in some ways, if anyone is poised to do this well, it's Tennessee and Virginia. I think they've done an admirable job. And at the same time, the empirical research, based on what we've heard, yeah, it's possible that well-equipped states who have data, who have the resources and the capacity, which both Virginia and Tennessee have, have the possibility of constraining cost growth, of maybe even measuring and keeping a thumb on quality and listening to the community.

So it's possible that there could be strong COPA oversight and that the net benefit is achievable. There is also a very high risk that the COPA will be-- that all of this enthusiasm-- it's like a prenuptial agreement. All of this enthusiasm is there on day one. We're still in the honeymoon phase. Everyone's still excited, everyone's still in love. But 30 years from now, it might be a completely different story. And so how do we build in, as Janet mentioned, those sorts of survival provisions, or a plan of separation that is actually actionable to force, potentially, divestiture? If things start to go south, the state needs another option other than just unregulated monopoly.

And so I'll just speed through these. Again, this is my 30,000-foot bird's-eye view, not particularly steeped in the day-to-day. But what does a COPA look like? What are we setting out-- what are the red flags? If a state were to encounter significant closure of rural facilities among the COPA entity, that would be a red flag that something is going wrong.

The initial commitments from Ballad last for five years. And so you have to revisit those over time. Maintenance or improvement of access to key services. How do we measure maintenance of access, improvement of access? Is what's going on with the NICU, and the trauma facility,

and the ambulatory surgery center, does that rise to the level of a loss of access? And how do we know when we're losing access to key services for the population?

Price increases and spending in line with more competitive markets-- in some ways, this is what the economists are very good at measuring. It seems like we have models, we have data, and I think it sounds like we need to get outpatient data as well.

Maintenance and improvement over quality metrics, I think that's critical. But of course, going outside of just the four corners of the hospital, it's not just inpatient quality. Yes, we don't want that to decline. But the population health in general has to also improve. Otherwise, again, once an entity has been granted a monopoly, it has taken ownership over the population health of the entire region. And so looking at those upstream measures as well.

And so the admonition is just that states must remain incredibly vigilant. And I think that the systems that Tennessee and Virginia have built, the indices, that they really do touch on all of these dimensions-- price, quality, and access. The main concern that I would have is just how do we resist the incentives to evade or repeal the COPA oversight 20 or 30 years from now? How do we avoid what happened in North Carolina and in Montana in Virginia and Tennessee?

Twenty or thirty years from now, these officials and their collective institutional memories will potentially have moved on, and so that there is no-- how do we build in that commitment to be in perpetuity, and understand that if Ballard is performing well and is being a good actor, that is not a reason to remove the COPA? That means the COPA is working well and that it should stay in place.

Detailed and updated plan of separation-- again, I don't even know if this is a possibility. But as much as possible, maintain the possibility of a separation. Because if the COPA oversight disappears, then there has to be a way to at least restore some modicum of competition. And then, again, building that resource and capacity for oversight in perpetuity-- emphasis on in perpetuity. Until there is no longer a monopoly, there needs to be a COPA.

There needs to be oversight, whether that's in the form of a COPA or some other state oversight mechanisms, we'll hear more about that in the next panel. There has to be some level of oversight. Because you either have competition or you have regulatory oversight. You can't have neither. And that's, I think, the takeaway from the empirical studies this morning told us.

GOLDIE WALKER: Well, thank you, Erin. I have several questions to pose to the entire panel. And to save time, I may cluster a few of them so that we can save some time. Has Ballad Health been meeting the states' terms and conditions so far? Are there known instances of Ballad Health not meeting the states' terms and conditions? And are any amendments being considered to either Tennessee's Terms of Certification or Virginia's Order with Conditions?

JANET KLEINFELTER: So I can speak on behalf of Tennessee's Terms of Certification. To date, yes, Ballad has met all the requirements under the Terms of Certification. We've had one or two very minor instances of noncompliance that were actually reported by Ballad-- immediately reported by Ballad, along with a corrective plan of action. And those corrective plans of action were implemented, and we have confirmed they have in fact done everything that they said they were going to do.

So in terms of their regular ongoing compliance, that has all been met. With respect to discussions about amendments to the Terms of Certification, I think this is probably reflected in both the COPA monitor's report and the department's annual report, that one of the big areas we are looking at is population health. If you compare the subindex for population health in Tennessee's Terms of Certification with the Virginia Order and their conditions, you'll see a big disparity between the two. Tennessee has somewhere in the neighborhood of, I believe, 52 measures that we are measuring in the population health index, whereas Virginia has significantly less than that. And there has been considerable discussion with Virginia, Tennessee, and with Ballad about looking at that index and maybe narrowing some of those indices.

The concern is that if we try and require Ballad to meet all of those, we won't meet any of them. And particularly given the success that we have seen to date in creating the affordable care community that Ballad is standing up, we want to make sure that we're not doing anything with the population health index that is contrary to, or that is going to actually be an obstacle or impediment to, the work of the accountable care community. So that's probably the biggest area.

The other area is in Addendum 1 because it is currently set up as a retrospective look at pricing. And we have no intent upon changing it, particularly since we've only been in place for 16 months. But we do want to look at it to see if retrospective is the best way to be testing the pricing, or is there a better way of testing it? So that's really more just of an ongoing process that we are reviewing with our experts to make sure that we are utilizing the best format to put in place those pricing controls.

JOSEPH HILBERT: In Virginia, there haven't been any confirmed noncompliance events under the Virginia Order. Our cooperative agreements staff do review complaints and have reviewed complaints that were submitted alleging violations of the commitments and conditions of the order. However, thus far, our investigation of those complaints has not revealed any violations of the Virginia Order.

RICHARD COWART: Yeah, and I think my comment would be we are in compliance. And we have-- one of the self-reported kind of foot faults here was that in post-acute care, you're supposed to give the discharged patient a list of their options. And we did it for the county, but I think it was supposed to be for the county and every contiguous county. And we found out later that it was just the county. And so we corrected it and self-reported ourselves. And so otherwise, I think we're in a very active discussion with the state about how to do this right, and are engaged quickly with them.

I think the other thing we found-- and I think the state has seen this-- is that most of our complaints have nothing to do with the COPA. Just like we heard from Montana, all of a sudden, every business issue becomes a COPA issue. I mean, what Anthem just referred to is an emergency room group that is billing out of network. That's happening in every city in America today. And the physician group that's doing it is doing it every city in America, without regard to the COPA. It has nothing to do with the COPA.

And so there can be any number of things-- wait in an ED. I mean, wait in an ED. People want to be seen immediately. I mean, they put on giant billboards in Nashville, it's going to take you 20 minutes when you walk in the door. It takes 12, and they're upset. That's going to happen.

So we get that. They've all of a sudden-- and so they go through our COPA complaint log, and they see that these are sort of normal things that are going to happen. They're not related to any of these terms and conditions. But we understand they are patient satisfaction and they are important, and we deal with them in the normal course, but not as a compliance issue.

JOHN SYER: I would argue that the ER situation, it is impacted by the COPA because you no longer have two alternative health systems. You've got one with one, essentially, ER group. Had that happened in the past, members could have gone to Wellmont, or they could have gone to Mountain States, and seen an in-network ER doctor. So it is not a compliance issue relative to the specific conversation, but it is definitively an outcome of the COPA and the granting of, essentially, a monopoly within a monopoly.

DANIEL POHLGEERS: I think, also, sometimes we get caught in the weeds as to what's officially a compliance issue and what's not. There are some unintended consequences when, as a community, you're told during the process-- the 2015-2016 process-- that the COPA is necessary to maintain local control, reduce cost, and improve quality. And it may not be a "violation" of the COPA, but when cost increased with no evidence of improved quality, I think that does at least go to the spirit of the COPA and the certificate.

And there are several examples of this happening right now in Northeast Tennessee. We had an oncology outpatient Dr. Fowler mentioned, and John also mentioned the fact of movement of services from outpatient settings to hospital settings. Hospital settings are the most costly settings to provide care.

In real simple terms, if I'm an oncology patient and I have a commercial payer as my insurance company, going to an outpatient facility, I may have a copay of $20, $30, or $50. If I go and get that same type of care at a hospital setting, I have a facility fee. But also, as important is my policy doesn't cover that as an outpatient services. So I have to pay 100 percent up to my deductible or a coinsurance of 80/20 until my deductible is met. So instead of $20, $30, or $50 for that payment for the oncology services, I may have $160 worth of care for that day.

And I think also what happens when-- and Dr. Fowler mentioned this briefly, too-- when you shut down every ambulatory surgery center in a town-- Bristol, Tennessee-- and move those cases to an outpatient-- even if it's hospital-based outpatient services-- on average, you're paying 60 percent more. That's the payer. That's to the commercial insurance, that's to the Medicare, that's the Medicaid. And if you're a commercial-paying patient that has a high-deductible health plan, you're going to pay 60 percent more for that.

We also have a situation where there's been a sale of some of the assets of ambulatory surgery centers to an outside entity. And it's widely known throughout the community that part of the reason why that was done was so that they could then access higher national contracts. So again, it's a way of kind of gaming the system. We heard discussion about that from the folks from Montana in earlier panel discussions. But it's something that's increasing the cost of care, and it's certainly not local control of that care.

[APPLAUSE]

GOLDIE WALKER: The questions that I had planned to pose, I think you had started to address, Dan, as well as Scott and John, in regards to the circumstances that may have popped up due to the COPA. But are these circumstances that you've describe unique to the COPA, or

are they generally applicable to other COPA regimes going forward? Is this an area where future states should consider?

SCOTT FOWLER: Well, I think I've suggested that maybe there's some areas that we need to regulate in the current COPA that we're not, or at least it appears that we're not. One thing I think is, when you have a COPA that's like this, this isn't a 2-to-1, this is two systems to one. I mean, this is an unprecedented type of arrangement that literally will affect every bit of every economic decision that gets made in these three little cities. And they are almost a million people, so it's not insignificant. It's the entire population of Montana that's being affected here.

I think regulation of what happens between the inpatient and the outpatient market in a place where an inpatient COPA or inpatient monopoly has been granted has to recognize that that monopoly can create vertical monopolies inside, and it can go to home health, it can go to lab, it can go to surgery centers. These surgery centers would have never been closed if it wasn't for the COPA. They're competitive moves in the outpatient marketplace by a competitor in the marketplace that now has a monopoly in the inpatient marketplace.

So I think, in the future, we should have recognition of that. And maybe even in the present, we should have more active supervision of what happens in the outpatient marketplace.

GOLDIE WALKER: Well, that leads to a question on the future. Does the panel have any reaction to the empirical research presented during today's morning session? Does anyone have any thoughts regarding the possibility of the FTC conducting a study in the future on the impact of the Ballad Health COPA once more data becomes available?

ERIN FUSE BROWN: I think that it's not just a good idea, I think it's imperative that this be studied.

[APPLAUSE]

SCOTT FOWLER: I would say the opportunity to prospectively, now-- because we probably can go back. This COPA was thought of years before it actually became a COPA. During the period between the time that it was first proposed and the time it became a COPA, behavior did change between the hospitals. So even though they were going about their business, there was behavioral change. I'd like to carry this study back far enough to really legitimately understand what the market was like when they were competing, and then prospectively carry it forward. That would be awesome.

JOHN SYER: And then from a payer's perspective, and I'm sure Anthem is not the only one, we're going to look at the performance in our pay-for-performance programs. I mentioned the Quality Insights Hospital Incentive Program. We've already got a baseline, 2015 to 2017. We know the performance of the 10 hospitals that participated in that program. And we're going to be looking at that going forward, as we do across our entire networks. Our customers are asking for that kind of feedback.

ERIN FUSE BROWN: And I think it's important to not focus solely on inpatient prices. Of course, that will be very important, but you can't get the impact on the value-based purchasing or on the outpatient dynamics that you're describing if you only study the inpatient pricing, and I think, also, the total spending. Because again, moving more people into higher-cost settings

will be reflected in those types of total spending analyses, as opposed to just focusing on the effect of the COPA on inpatient prices.

JOHN SYER: Totally agree. So our program has 37 metrics—NCQF (National Quality Forum), Society for Thoracic Surgery, ACC (American College of Cardiology). So it's not Anthem dictating these measures. These are independent, third-party measures for all places of treatment, inpatient and outpatient. And you're exactly right, that's extremely important to get the whole episodic view of the cost of care and outcome quality.

RICHARD COWART: I'd like to offer, perhaps, another view, is to say that the three ones that we've been talking about today-- and West Virginia's been barely talked about-- is that we've got, in health care terms, a couple of cadavers and a baby. And so we've got some the ability to study something that's 15 months old. I mean, we've literally renegotiated one payer contract in 15 months.

And so with all the activity that at least we have to do under what we hope is our noble mission to deal with this-- to say, well, let's get a CID for a million documents so we can say that the federal government studying this is, I think, bordering on irresponsible, frankly. And so I think that the ability to continue to watch and monitor, have panel workshops-- we are being actively supervised. But if the thought here is that we're going to do a pseudo-investigation by calling it a study, when we have complied with everything that's constitutional and legal, I don't think that would be right.

JANET KLEINFELTER: So I'll speak from the state's perspective here, or at least from Tennessee's perspective, because our COPA statute applies statewide. And some of the issues and some of the reasons why the COPA was ultimately approved in Tennessee exist elsewhere, not to the degree that they exist in Upper East Tennessee. But Tennessee leads-- only second to Texas do we lead the nation in the number of rural hospitals that are closing. And the vast majority of the counties in Tennessee are classified as rural counties. And the health of the state of Tennessee, if you look at the health rankings, we're usually in the bottom 10 percent. That's only multiplied by multiple factors in Northeast Tennessee.

So from our perspective, contrary to what you might have heard from some of the panel participants, this was not an easy decision for the state of Tennessee to make to approve this COPA. It was a very, very difficult decision, evidenced by the fact that it took us almost two years to actually approve and issue the certificate.

From our perspective, the more information that we have, the more analysis, the more empirical data that we have as to the effectiveness of the COPA-- and not just from a pricing perspective, and not just from a quality perspective, but from how have we actually been able to improve the health of the population? How have we been able to improve access to health care? All of the factors that are listed in the index by which we are testing this COPA-- the more information that we have to help us go forward with the next application that we may see, we think, is entirely beneficial. But we do think it needs to be a universal testing study, and not just focusing upon one aspect, just focusing on pricing or just focusing on quality.

JOSEPH HILBERT: And I would concur with those remarks from Janet. It definitely was not an easy decision. It was not one that was entered into lightly. It was the result of many, many hours, months of work by many people.

A lot of good comments today. And I would definitely echo Janet's remarks about the importance that we placed on population health improvement in the region as part of our overall review and analysis of the COPA and of the cooperative agreement.

One of the statements that I heard during our review process that really has stuck with me ever since then was actually from one of our local health directors in Southwest Virginia. And this person wrote to us. She said, "the strong competition between the applicants has failed to provide meaningful visible benefits to the people of Southwest Virginia in terms of access to care and improvement in health status."

So not to denigrate the competition in any way, but we were hearing alternative views that, again, speak to the complexity and difficulty that went into this decision.

GOLDIE WALKER: Well, thank you. Thank you, all. Due to time, I can't go through these wonderful questions that the audience has posed. But my sincere thanks to the distinguished speakers on this panel for agreeing to speak today despite having such busy schedules. I also thank you all for attending and livestreaming our discussion this afternoon. There will be a 10-minute break before our next panel, which is entitled *Policy Considerations for COPAs: Competition, Wages, and Beyond*.

[APPLAUSE]

[BREAK: MUSIC PLAYING FOR 10:39 MINUTES, PROGRAM RESUMES AT 1:43:24]

PANEL 4 – POLICY CONSIDERATIONS FOR COPAS: COMPETITION WAGES, AND BEYOND

KATIE AMBROGI: If they could please take their seats.

[SIDE CONVERSATION]

KATIE AMBROGI: Welcome back from the break, and thanks so much for staying with us for our fourth and final panel of the day, *Policy Considerations for COPAs: Competition, Wages, and Beyond*. This panel will address factors that state legislatures, agency officials, policymakers, and other stakeholders may wish to keep in mind when considering COPAs.

We will touch on three distinct topics. First, potential wage effects following hospital mergers. Second, advocacy that COPAs are warranted because there is local duplication of services. And third, other state approaches to rising health care costs. We'll follow initial presentations on each of these topics with moderated Q&A.

So first, we'll start with the topic of wage effects. Wage effects can be considered relevant to COPAs as, in some circumstances, these may be considered merger-related competitive effects that COPAs do not address. Elena Prager from the Kellogg School of Management at Northwestern University will present the working paper that she co-authored with Matt Schmitt.

ELENA PRAGER: Thanks very much, Katie. Thank you also to the Office for Policy Planning and the Bureau of Economics for putting together this workshop. As an academic, I found it very informative to sit and hear about the boots on the ground perspective here. And so I'm going to do my best to shed some light on a set of issues that hasn't really been discussed throughout the day, and that is the effect of hospital consolidation, both outside of COPAs and specifically within COPAs. At the end of my few minutes of remarks, on pay for hospital workers. And I'm going to need the clicker to go through slides, which I think we've misplaced.

KATIE AMBROGI: Do we have the clicker?

ELENA PRAGER: Anyone got it?

CHRISTOPHER GARMON: I think it's all the way down here.

[LAUGHTER]

TRACY WERTZ: This is nice.

ROBERT FROMBERG: Collaboration.

ELENA PRAGER: Right, yeah, this is a hot potato. All right, very good. So the economic theory that underlies predictions about the pay effects of something like hospital consolidation is actually pretty straightforward. If you've got two employers in a labor market that are competing for the same pool of workers merging or entering into some other form of cooperative structure, then workers in that affected industry will have fewer employers competing for their services, fewer employers bidding up pay or bidding up other working conditions in order to try to attract those workers.

And so what you might see in a case like this is, essentially, downward dynamic pressure on worker pay over time. Normally, we wouldn't expect this downward pressure to be large enough to actually get us negative wage growth, because of course there's an underlying trend of increasing wages from year to year. Workers get raises and so forth. But what you might expect to see is a slowdown in worker wages over time.

So that's sort of the first piece of the economic theory. And in a lot of ways, you can think of this as being analogous to standard monopoly power and product markets. So whereas monopoly power is a firm's ability to set higher prices than the competitive equilibrium would allow, the labor market side of this that you can think of as monopsony power, is the firm's ability to set wages lower than the competitive market would normally allow. And they are essentially two sides of the same coin, in theory.

The second piece of the economic theory that then becomes relevant here is that the effects of this kind of employer consolidation should depend on the degree of underlying concentration in the labor market to begin with. So if you consider, for example, a merger between two dry cleaner shops on opposite sides of the same street corner in a market where there are two dozen other independently-owned dry cleaner shops, well, that's probably not going to do very much to competition for dry cleaning workers, and we wouldn't expect to see such a big effect on wages.

Hospitals, of course, are pretty different from dry cleaner markets. As we've seen today, hospital markets tend to be highly concentrated even before a COPA comes in, and particularly after a COPA, which is often, as we saw, a 2-to-1 kind of arrangement. And so in order to understand whether these pay effects will actually obtain in practice, when we look at consolidation of hospitals specifically, we have to go to the data and look at exactly that question, which is what I've done in a recent working paper with my co-author Matt Schmitt.

So in this study, what we do is examine what happens to workers' pay and its growth after a hospital merger. The bottom line, as you'll see, is that worker pay within these hospital markets that experience large mergers does grow slower than in other hospital markets that do not experience that type of employer consolidation. The headline number that I'd like you to keep in mind as I progress through the slides is that you lose about one-third of the baseline growth rate of worker pay following really large mergers. And I'll come back at the end to how we interpret those numbers, and give you some dollar figures.

First, I want to tell you how we actually came up with these numbers to begin with. So what we do in the paper is we take 10 years of consummated hospital mergers within the United States, from 2000 to 2010, primarily because of data availability issues. And we bin those mergers into one of five categories as a function of how large of a concentration increase they're inducing in the market for hospital workers. So we're not talking about concentration increases on the service provision side. This is strictly about concentration increases on the side of employment.

And what we do is we use what should be a pretty familiar and standard measure to a lot of the antitrust folks in the room. We're using the Herfindhal-Hirschman Index, or HHI, to calculate essentially how concentrated a given market is, both before and after the merger is consummated. Now, whereas normally, HHI would measure how much power companies have to set prices or drive down competition on the product market side, meaning the services that they're selling or providing to the community, we're going to apply that HHI calculation on the

employment side. So in other words, how much power do the employers here have to keep wages from growing as quickly as they normally might?

And so when we apply that categorization, we end up with five bins of markets. One bin of markets, which is going to be our main control group, is ones that don't experience any sort of meaningful employer consolidation in the hospital space over the course of our sample period, plus some burn-in time on either end, for those of you interested in the nitty-gritty. And in the remaining markets that do experience some mergers, we're going to divide them into four bins as a function of the size of that HHI increase.

Once we have that, we can't simply take the largest bin, in terms of the largest mergers by the HHI increase and say, well, what happens to wages for hospital workers within this bin? Because of course, even in the absence of a merger, you would expect to see changes in worker pay over time. So instead, what we need to do is to be able to difference out things like general inflation or the Great Recession. And so what we're going to do in practice is essentially statistically implement the comparison of markets that experience these large HHI increasing mergers of hospital employers against markets in the same years that are not experiencing such consolidation, or that are experiencing much smaller degrees of consolidation. So essentially, that's what our empirical model ends up doing.

And what we find is that, following the really large mergers, so the ones in our fourth bin by changes in HHI, we do see worker pay growing slower than in markets that don't experience hospital employer consolidation. And that slowdown is about one-third of the underlying baseline growth rate in worker pay, which is usually about 3.5 to 4 percent a year. That's the average number nationally for pay raises, just in nominal dollars. And what we see is that pay grows by about 1.1 to 1.7 percentage points slower following really large mergers, which comes out to be about a third of that 3.5 to 4 percent number.

Now, I promised you that I would give you an interpretation of what this actually means in dollar terms. If you consider, just as an example, a worker who, at baseline, immediately prior to a merger, makes $50,000 a year, and you say, well, suppose without the merger, this worker's wages would have grown by 3.5 to 4 percent a year for the next four years. Instead we have this large merger between two hospital employers. There's now less competition for this worker. As a result, this worker will experience, in expectation about $5,500 to $9,000 less in raises over those four years. And off of a baseline salary of $50,000 a year, you can see that that turns out to be a meaningful amount of money for workers. And you can extrapolate this out for other kinds of baseline salaries.

Now, I want to caveat these results with really two points. The first is that the data that we are using in order to come up with these estimates don't allow us to perform these kinds of wage calculations for every type of hospital worker that a state or the FTC might be interested in. One of the key categories that we're missing are physicians who are not reliably reported in the data. So clearly, there is scope for additional work here. And all we can say is that, for the types of workers that we do observe in our data, which comprise certain types of nurses, pharmacists, and a whole slew of other clinical and non-clinical hospital employees, we do see these wage growth slowdowns following very large mergers.

Now, I've been harping on very large mergers for most of my remarks just now. And I should mention also that we have looked at what happens following mergers that aren't quite as big of a shock to local labor market concentration. What we find there is that our point estimates, for

those of you who are statistically-minded, are still negative, but not statistically significant. In plain English, what that means is either it's the case that smaller mergers have some negative impact on pay growth, but it's not big enough for us to detect, or they actually don't have an impact, and that's why it's not statistically significant. There's not much that we can do to really statistically distinguish between those two explanations and, in principle, at least, they are both equally plausible.

So with that caveat in mind, you might ask, well, if we can only make strong empirical conclusions about the really large mergers, what can we actually learn from all this about enforcement surrounding COPAs? That would be a very sensible question to ask. And in fact, the answer turns out to be that COPAs fall very squarely into our category of the very largest mergers.

So to give you just some idea of the kinds of figures I'm talking about, within the study, the very largest bin of mergers, in terms of changes in labor market concentration, starts at increases in HHI, which is that measure of concentration I mentioned earlier, of at least 1,115 points. Anything above that belongs in our fourth bin of very large mergers. I've been able to calculate the equivalent HHI increase for four of the existing or previously-existing COPAs. And in all four of those cases, they surpassed the threshold for our fourth bin of mergers by at least a factor of two. So we're talking over 5,000 HHI points in one case, and at least 2,000 HHI points for all three of the others.

So let me just conclude by saying that, while COPAs are, of course, not exactly like a "regular" hospital merger, the types of labor market effects that we might expect to see, and that states might worry about if they care about constituent pay, as well as community access and many of the other goals that were mentioned earlier today, this might be a consideration worth having in mind. Thank you.

KATIE AMBROGI: Thanks, Ellie. A question for you. Your paper says that retrospectives, like the paper, generate "both economic insights and guidance for antitrust regulators." What insights and guidance should antitrust enforcers take away from your findings?

ELENA PRAGER: That's an excellent question, and I think it's really a two-part answer. The first piece of the puzzle is that it seems we don't have sufficient evidence to conclude that every merger out there is adversely impacting workers. It takes a merger of fairly large magnitude before we're able to see statistically distinguishable effects. And so what that means is that probably, in at least a large fraction of cases, the product market guidelines that the FTC and DOJ are using to determine whether to pursue a given merger will probably do the job just fine, even if you take the position that regulators should worry about what's happening with worker wages.

The flip side of that coin, though, is that we have, now, what I think is fairly strong evidence that, at least for about a quarter of the mergers that we're seeing in hospital markets, there is actually a substantial and detectable effect on worker pay. And to the extent that, perhaps, if not the agencies, then certainly the states that have a broader mandate of public interest want to take those things into account, there's certainly evidence to suggest that there's something there.

KATIE AMBROGI: Another question for you, Ellie, and others can feel free to weigh in. How can you distinguish a labor monopsony effect, like the type that you were discussing in your paper, from a merger-related efficiency?

ELENA PRAGER: Sure. So if the wage slowdowns that we are documenting in this study were in fact a result of just pure merger efficiencies, what you might expect is to see evidence of the same kinds of efficiencies occurring, irrespective of whether a merger drives labor market consolidation or not.

In other words, what you would expect is that if two hospital systems that are three states apart from one another and, therefore, don't really share most of their worker pool were to merge, you would still get the same managerial efficiencies that perhaps drive down labor costs that we document in the main part of the empirical study. And when we dig into the data on mergers that occur across these market borders that we really don't think have overlapping workforces, we don't see any of those effects, which suggests that what we're observing in the main part of the analysis is not attributable to efficiencies, or at least that you would need a very peculiar type of efficiency in order to explain the totality of the results.

KATIE AMBROGI: Anyone else want to respond to that question?

CHRISTOPHER GARMON: Well, if I could just interject, I think you could have efficiencies, say, from-- and they may not even be cognizable merger-specific efficiencies, but eliminating the-- if you have two health care systems that both have human resource departments, you only need one. I think what this paper goes at is nursing markets, for instance. That's not really an efficiency if what's happening after a merger is wage growth is slowing and fewer nurses are being hired. That could affect patient care, and it could certainly increase inequality in that area. And that's not, in my opinion, the kind of efficiency that the FTC is looking for in a merger review.

THOMAS GREANEY: And in fact, the D.C. courts rejected that in the Anthem-Cigna merger, when that very issue was raised. Depressing physician reimbursement was cited as an efficiency, and they rejected that as a cognizable merger-specific efficiency.

KATIE AMBROGI: Another question for the group. What other work has been done on labor monopsony issues, and how might it apply in the health care context? And Tim, did you have something that you wanted to weigh in on here?

THOMAS GREANEY: Other work being done outside of the health care context?

KATIE AMBROGI: That's right.

THOMAS GREANEY: Well, I know there's a lot of attention now being paid to the problem of monopsony as it affects workers. And that's an area that's been pretty much neglected by antitrust. There is even a view that if you can't show a price effect in the ultimate good, a depressing of an input is not a cognizable antitrust violation. I think that's been rejected by most observers. But there is a lot of attention now to revitalizing attention to labor market monopsonies.

KATIE AMBROGI: Any other reactions to the paper, or potential takeaways on labor monopsony issues for policymakers?

CHRISTOPHER GARMON: Just one other point, and I go back to the previous panel. The concern was mainly about population health and the population health of the Tri-Cities area of Eastern Tennessee and Southwest Virginia. Well, what's the leading social determinant of health? And that's income. And if what's happening with these mergers is it's leading to lower wage growth for a leading employer-- many of these health care systems are, by far, the biggest employer in the area-- that seems to increase the risk of economic inequality in that area, which might worsen population health. So I think that's something that we should consider. And I applaud the authors of this paper for focusing on that.

ROBERT BERENSON: And I'll just sort of pose the alternative option. Rather than keeping wages high and addressing potential inequality is that the hospital that now has merged and reduces wages should pass those savings back to purchasers, but they don't. Because we all know, and the literature is very strong on the fact that mergers result in an increase in price. So it's more evidence that we are not getting social benefit from creating local monopolies.

KATIE AMBROGI: Okay, thank you. We'll move on to our second topic, and that is concerns about local duplication of provider services. This is a position that's often advanced by hospitals advocating for COPAs in support of their underlying merger. So first we'll hear from Rob Fromberg at Kaufman Hall. Kaufman Hall is an organization that works with hospitals and health systems on strategy and financial planning.

ROBERT FROMBERG: Great. Thank you very much, Katie and Stephanie, for organizing this. It's really humbling to be here over the course of the day, and listen to all these people struggling and straining to deal with a dysfunctional health system through this narrow but incredibly revealing lens of the COPA.

And I'm a bit of an outlier here. I'm not an attorney. I'm not an economist. I'm essentially a writer. I've been writing about health care for more than 30 years. I'm not a journalist. I've been writing for health care associations, and I've been writing about quality and about strategy. And I spend a lot of time talking with health system C-suite individuals. With Kaufman Hall, over the past five years or so, I've been talking even more intensively with CEOs, and CFOs, and COOs, and CSOs, and every C you can imagine, about this issue of efficiency, duplication of services, but most especially within the context of mergers. So I think my role here really is to try to offer, insofar as I can, a window into the discussions that take place among senior health system and hospital executives on this question of duplication efficiencies in the context of mergers.

So I'll make a few points here, and then very interested in the discussion. I think that it's important, first, to start with the fact that efficiencies and duplication of services is an absolute central feature of any conversation any health system is having, whether it is merging or whether it's not merging. And that's natural. Any industry that's seeing its core business have a decline in demand is going to have to attend to its costs.

But it's important, I think, also to understand the context for these conversations about efficiencies and duplications, especially within a merger. And that context really goes beyond the hospital as we know it today. Health system executives are very concerned about a new kind of competitor. They're concerned about for-profit companies with huge geographic footprints, huge digital footprints, and huge access to capital. United Health, Optum, and CVS-Aetna are often mentioned. They are 10 times larger than the largest health systems. Optum just announced a few days ago that it plans to go from being a $16 billion company to a $100

billion company within the next nine years. And CVS just announced plans to take its three-hospital health hub primary care experiment to 1,500 locations by 2021. And one analysis suggested that that would mean there would be a health hub within 10 miles of about 75 percent of the United States.

So what these new competitors are doing-- and this is, again, part of the conversation that I hear on a regular basis-- is they're trying to unbolt outpatient care from the inpatient care chassis. There are many reasons this is happening, and one reason is in the lap of hospitals. They're vulnerable in not necessarily providing the kind of convenience and access and experience that some of these upstarts and technology-savvy companies want to offer.

And so moving through to the nature of this discussion about efficiencies, the next thing you always hear and you always notice is a discussion about mission. And Dick Cowart mentioned this in the previous panel-- the concept of needing to have the resources necessary to make the kinds of decisions that a mission-based organization makes. And those are decisions that are focused on community health more than focused-- or not exclusively focused on the organization bottom line. And there's a fear that these larger new entrants are not making decisions with that kind of a context.

The other thing that executive discussions about reduction in duplicated services and achieving efficiencies, particularly in the context of mergers-- one of the other things that's always discussed is the incredible difficulty and complexity of achieving the goal of efficiency. The most significant efficiencies arise not necessarily with a duplicated IT or duplicated HR back office. But the real efficiencies, from a dollar and from a consumer standpoint, are efficiencies in having a best-care model scaled across a broad organization and a broad geography, and reducing duplicative or underused clinical services.

And this is a highly complex initiative. I'm thinking again back to Dick Cowart's slide of the accountable care communities. Did you see that slide? There were 249 members of that effort. Incredibly complicated. There are interdependencies. There are multiple constituencies. There are histories of processes and structures that need to be changed. So the difficulty and the challenge of designing and executing these kinds of efficiencies is something that is really a concern, and has been an ongoing concern for health systems. And when health systems merge, they know this is something that needs to be taken care of, but it's hard work.

We're also concerned, frankly-- and health system executives are concerned-- about the FTC position on mergers and the resulting interest in COPAs. I mean, our observation is that, in general, health system executives view the FTC's approach to health system mergers as insensitive to the new competitive environment and it's insensitive to the realities of the challenges involved in taking the steps necessary to really reach the kinds of efficiencies that are needed to make a difference.

And we're also concerned about the effect, on consumers, of the FTC's stance. Throughout the country, hospitals operate with occupancy rates that are at best inefficient, and at worst make it difficult for hospitals to maintain the kind of clinical coverage and the kind of procedure volume that's necessary to deliver the highest quality outcomes. And with the decline in inpatient demand, these volume challenges are likely to continue.

So consider the scenario of a two-hospital community, where one is doing reasonably well and another is struggling-- low demand, low occupancy rates, and financially challenged. A

merger-- again, this is the view as we discuss this issue with health system executives. A merger is a systematic approach to managing a very complex transition to reduce duplication and to create the best mix of services and locations. And by the way, that includes locations outside the hospital, and it includes virtual access. Health system executives view that sort of a collaborative process is far more positive for the community than the alternative, allowing one organization to decline over a period of years, which includes a decline in its ability to serve the community.

So faced with an inability to have those kinds of conversations about reducing duplication of services outside of the context of a merger, and concern that the FTC will view unfavorably a merger of a two-hospital-- two small health system-- community, it's really no wonder that a COPA is viewed as a viable alternative. I'm thinking about the people who have testified so far today to their experiences with COPAs. And the last panel, I think-- maybe it was the panel before-- the amen moment was when somebody said, after I've done it once, I don't ever want to do it again. And everybody was pretty much, yeah, yeah. And the folks who had designed the COPAs in Tennessee and Virginia certainly looked like they had been through the ringer. And it's obviously a very, very challenging process.

So why would a hospital or a health system want to go through that process? Why would anyone want to go through that process? And our sense is that when we have a two-hospital community, that even that is a better alternative than to do nothing for the organizations involved and for the community involved.

This is the end of my allotted time. I would refer you to the Kaufman Hall comment letter that was submitted, which has a good deal more detail. But I really appreciate this opportunity to offer these observations. And this is based on a lot of years of service to health systems and health care organizations, and it's based on a deep belief that mission-driven hospitals are an incredibly important component to our nation's well-being, even as we're seeing a shift to a more outpatient-based health system. So thank you.

KATIE AMBROGI: Thank you, Rob. We have a second presenter on this topic. And after Thomas presents, then we'll have some Q&A on this topic. Another regulatory approach that states have used to manage local duplication of services are certificate of need laws. These have been brought up at various points today.

CON laws are different from COPAs in a lot of ways. For example, CON laws apply to all providers in a region, whereas COPAs only apply to the specific hospital that has obtained a COPA. But the underlying policy rationale for CON laws-- that is, certain health care services should be rationalized-- is similar to at least one of the principles behind COPAs.

So Thomas Stratmann, professor of law and economics at George Mason University, will present his research on CON laws.

THOMAS STRATMANN: Thank you. I'll be an outlier on this panel, and stand. I'll feel a little bit more comfortable doing that. Thank you, Katie and Stephanie, for inviting me. Thanks for everybody in the audience for participating, including the panel. And I would like to share with you some of the research I have done in the last five, six years, on certificate of need laws, or briefly called CON laws, or in Virginia called certificate of public need.

So certificate of need laws, or CON laws, limit the ability to obtain medical treatment. And the way they do that is by limiting supply. They limit supply without having any public health justification, without having a safety justification. Separate laws determine whether a nurse or physician is qualified to treat a patient. But CON laws basically require, if you want to put it bluntly, a government permission slip to compete. They require-- these are state laws existing in 36 states, where providers have to go to the state agency or the state health department and apply for this CON, which then allows them to perform the services they were trained to do.

A quick background. They were first introduced in '64. The federal government thought then, well, this is a great idea. At that point, in '74, the Ford administration incentivized states to adopt CON laws by withholding, I believe, Medicaid funds in case there were no-- these CON laws were not adopted.

And then, the idea was we want to control cost. That was the idea. And then at that point, people used to say, "a bed billed is a bed filled." That was the saying at that point. And at that point, also, the way hospitals were compensated was very different than they are now. Nowadays, hospitals are not necessarily compensated on how many times they send someone through an MRI machine, but by the DRG system.

Anyway, the federal government recognized that apparently CON laws do not help to control costs, repealed, basically, the statute that incentivized states to adopt these laws. But still, 35 states have CON laws on the books. Here's a quick picture of where they are located. So some maps also include Arizona, but they have a CON law only-- it was fitting one service. And you see Pennsylvania. Coming back to Pennsylvania, Pennsylvania removed its CON law in 1990.

So what are these CON laws doing? They are, for example, if you're already licensed and you have an office, and you'd like to provide cardiac catheterization equipment, you cannot do so. You have to first-- in 26 states, you have to ask for a permission from the state government to do so. Ambulatory surgery centers, 27 states have it on their books that you have to get state government permission. Hospital beds. If you want have a hospital and you want to expand a bed, or you want to expand your number of beds, or you want to add a hospital bed, 28 states basically require that you have to go to the state regulator to get permission for this.

So basically what I'm saying, there are various types of CON laws, like on number of hospital beds, burn centers, the dialysis, so on and so forth. Over here, I categorize, basically, that Vermont is at the very top. You cannot see that. In D.C. and Hawaii, with about 30 different types of CON laws. And the average of states with CON laws is roughly 14. This picture is meant to tell you that CON law is not like CON law. Some states have more restrictions than others.

So what are the objectives? What are the proponents of CON laws saying? They say they ensure the adequate supply of health care resources and to ensure health care for rural communities. The idea is to prevent, perhaps, hospitals from closing down in a rural area, or to prevent unfair competition through ambulatory surgical center is another rationale.

The other idea is it's supposed to promote high-quality care. The idea, I suppose, is if you have one hospital, and a physician performs, therefore, many, many, many surgeries, the physician is getting really good at doing it, as opposed to, if you have many hospitals, the physician in each hospital performs the surgery only a few times.

Charity care is another claimed benefit of certificate of need laws. Because in exchange for basically getting some monopoly power from the state-- because the state is preventing entrants from coming in-- hospitals, often they say, well, in exchange for getting this extra monopoly power, we will therefore provide extra charity care. And the idea is, then, finally to restrain cost of health care services.

So my co-authors and I, we took on all these different things and said, well, is there really something to these benefits? Or do those benefits really occur in the real world out there?

Before I tell you some of the results, real quick, the regulatory process of getting a certificate of need is very cumbersome. Not only you have to pay maybe up to a $45,000 non-refundable fee, but your lawyer's cost can go into the hundred thousands of dollars. I talked to a Virginia regulator. He said he had some applications that had as many as 6,000 pages. So there's a public hearing. The public hearing, your competitors can come and say, well, there is no need for this extra service. And therefore, we recommend that this certificate of need is not being granted. And finally, the state agency makes a determination whether there is a need or not.

So we conducted several studies comparing medical services provided in states with CON laws and in states without CON laws. And we found that states without CON laws have more hospital beds, more MRI machines, so on and so forth. So CON laws reduce medical inputs, they reduce the number of medical providers. You see fewer hospitals, you see fewer ambulatory surgery centers in states that regulate hospitals and ambulatory surgery centers via CON laws. And consequently, you also see reduced access to care because you see fewer providers out there. People may travel out of state if you live in a state with a CON law because there are not that many providers there.

And finally, we have some evidence that actually the quality is reduced. Quality of medical services in states with CON laws is lower just because there is not sufficient incentive to compete. Now, if you give some rough numbers, in states with CON laws, they have roughly 27 percent per capita fewer hospital beds. There are about 35 percent fewer MRI machines, and 37 percent fewer CT scanners. CT scanners, MRI machines, hospital beds-- all of those are regulated via CON laws.

Then we looked also at the quality of medical services, as I just mentioned. Hospitals often have a tough time competing on price because much of their clientele comes from Medicare and Medicaid-insured individuals, where prices are fairly set. So therefore, there is non-price competition. They have more stronger incentive than to compete on quality.

So what are measures of quality? Well, we looked at measures of quality collected by CMS, like deaths among surgical patients with serious complications, pneumonia mortality rate, heart failure mortality rate, and heart attack mortality rates. We compared hospitals in CON laws with hospitals without being subject to a CON law, but within a given market so that we could compare hospitals that were subject to the same type of conditions in terms of the healthiness of the population. And overall, what you find, in fact, these CON laws backfired. That means they receive higher mortality rates among people with pneumonia, higher mortality rates with people suffering from heart failure, ranging between 2 and 5 percent. So we do not see any promised benefit from CON laws in this dimension either.

And then we compared charity care. Supposedly, hospitals are providing more charity care if they have a CON certificate. However, if you compare states with and without CON laws, there

is no difference in charity care provided between the hospitals in states with CON and without CON.

Finally, let's look at-- I apologize, it's a little tiny, but let's look at the graph over here that shows you basically from 1990 to 2010, what a world would have looked like without CON law. On the vertical axis, we have the hospital beds per capita-- I believe per 100 individuals. You see the red line is Pennsylvania, which repealed its CON law. The green line is Ohio, which has a very weak CON law, and does not cover hospital beds. And you have Virginia, which has a very strong CON law. And you see the strongest decline in hospitals, the biggest reduction in access, is in Virginia, a state with a CON law. You see more hospitals in states without CON law, here being Ohio and Pennsylvania. The reason I picked Ohio and Pennsylvania and Virginia is because they are roughly similar, in that they have two urban centers and a large rural aspect to it.

You see a similar picture, in terms of competitors to hospitals-- ambulatory surgery centers. Again, the red line is Pennsylvania; Ohio, the green line. You see there a rapid increase in the ambulatory surgery centers. They are not regulated there. However, Virginia regulates its ambulatory surgery centers, meaning whether you want to open one, you have to get permission from the state regulator. And there, we see a much lower growth. And you see this both in rural areas and you see this in urban areas. So the fact that somehow the rural population benefits from these restrictions on ambulatory surgery centers, that is not borne out in the data.

Finally, one potentially concerning aspect which goes a little bit beyond the medical issue is that CON laws invite gaming the system. There is a prize to be gotten. The prize is a certificate of need, which guarantees, basically, you're being shielded from competition. Some firms are just going to use-- or hospitals, of course, will use lobbying or campaign contributions to influence regulators. In fact, you see evidence of corruption in Alabama and Illinois. And there, actually, cases went to court where corruption was proven where CON commissioners were being bribed.

And so, to get a sense of whether CON laws give an incentive to be politically active, I compared, for example, several states. But here, I'm focusing on Georgia. The other states are the same. We compared hospitals that applied for a CON law versus hospitals that did not apply for a CON law. And you see that non-applicants have much fewer campaign contributions to, say, state legislators than hospitals that applied. So this suggests that trying to get approval from a state regulator might give incentives to hospitals to lobby their state legislators so that the state legislators can put in a good word with the state regulator, for which there is plenty of anecdotal evidence.

Last slide on this, which shows something similar, just focusing on the blue graphs. The blue graphs basically show the mean approval rating of a CON law in Georgia. And if you give a contribution, the mean approval rating is around 70 percent. And if you do not give a contribution as a hospital, the mean approval rating in Georgia is roughly 40 percent. So it is not saying there is causation there, but it raises a red flag. Why is it the case that those politically active hospitals are more likely to receive this permission slip to compete, if you want to?

So overall, this suggests that we have, actually, more access-- as I showed you from the graphs showing Virginia, Ohio, and Pennsylvania, we have more access to medical care in both rural and urban populations when there is no CON law. We have higher quality of care and we have more competition. Competition, in the end, is likely to reduce health care costs. Thank you.

KATIE AMBROGI: Thank you, Thomas. Staying with this topic for a couple of questions, we heard from Rob that certain communities cannot support two hospitals. And I'm wondering, from the panel's perspective, whether there's a difference between providers merely competing with each other and this so-called wasteful duplication of services.

CHRISTOPHER GARMON: I just wanted to-- in terms of duplication of services, Cory Capps mentioned this in the earlier panel, in merger review, the FTC and Department of Justice consider this. There's a failing firm portion of the merger guidelines. If you have a city that can only support one hospital, chances are that one of those hospitals will be struggling. As Mr. Fromberg mentioned, their occupancy rates may be very low. They may be financially struggling. If they are going to fail without the merger, that's not a merger that the FTC or Department of Justice would block. So I don't think that's a justification for a COPA.

I also wanted to comment on the efficiencies. Mr. Fromberg mentioned, looking at a best care model, improvement of quality, consolidation of underused services. I couldn't agree more. I think those are great examples of improvements in quality that can occur with a hospital merger. And those are situations that the FTC and DOJ take seriously when looking at a merger. I know that, in my experience, I've worked on mergers where there was a serious overlap. It looked like diversion ratios were high. It looked like a loss of competition. But the merger-specific and cognizable quality efficiencies were compelling, and the community strongly supported the merger. And the FTC let that merger go through. And I've looked at that merger retrospectively, and it was a good decision. Prices actually went down. The community benefited.

So I would disagree that COPAs are needed because the FTC or DOJ don't take quality and failing firm issues seriously. I think that the antitrust agencies do. And when those are compelling, merger-specific, cognizable efficiencies, they, in some cases, can carry the day.

KATIE AMBROGI: Tim.

THOMAS GREANEY: Let me offer a word about efficiencies. I think the truth of it is that efficiencies are very easy to promise and hard to achieve. There's a number of studies about failures of mergers. The one I saw was Price Waterhouse Cooper found that 50 to 70 percent of publicly-traded large mergers failed to increase shareholder value. And it's no surprise that that's the case. Because there's a lot of uncertainty in mergers. You don't have perfect information about who you're merging with. And indeed, there are culture clashes. There are lots of reasons that things don't fit together. Information is far from perfect.

And for that reason, antitrust has been appropriately skeptical. It's never approved a merger to monopoly based on efficiencies. And the skepticism is reflected in the law's insistence that they be verifiable-- in other words, really provable, the efficiencies-- that they be merger-specific, that they be attributable to the merger and not achievable elsewhere. So I think that's an important point to remember. And that's why I think the easy-promised efficiencies are greeted with some skepticism.

And if you want to look into the CVS-Aetna merger, a really good analysis of the promise of the Minute Clinic hubs was done by Professor Rob Burns from Wharton, before the California Department of Insurance. And he really went through why that is really not an efficiency. In fact, it's inserting another entity with another silo in the middle of health care. So there are a lot of reasons to be skeptical about promised efficiencies.

And just finally, a word on the CON-COPA. Congratulations to Professor Stratmann. I think that's a really interesting analysis and an important one. Because I think, at the end of the day, CON and COPA have something in common. They have the earmarks of special-interest legislation. They do serve an economic interest of the parties that advance those laws.

KATIE AMBROGI: Thomas, did you have something to say?

THOMAS STRATMANN: Yeah, just something with respect to duplication of services. I mean, I don't mean to come over as contrarian, but I am really confused by this notion, what it means, duplication of services. If I have a Burger King next to a McDonald's, is that duplication of services? Same with if there are gas stations next to each other.

So I would more tend to think, let the market determine what duplication of services are. If there are for-profit hospitals, then if they're buying too much equipment, some for-profit hospitals will go under. And relating to this, really my last comment to efficiency, yes, in a city, we could only have two or three MRI machines or something like that, instead of maybe 20, or we could have 100 percent occupancy rate in a hospital. But just imagine there's also a cost to consumers. Consumers have to travel further. So this also means more efficiency for hospitals for them becoming perhaps more profitable. It may also impose a cost on consumers.

ELENA PRAGER: I would add, on the efficiencies point, even beyond costs to consumers via things like travel. It's lovely to speak about duplication of services or promised efficiencies if those promised efficiencies obtain, but are not in any way passed through to consumers, and are in fact met with-- or rather go with reductions in access and quantity, and increases in price, then even if the cost of providing the services and the ability of the providers to remain financially afloat is improved, you're not going to see improvements in patient care.

KATIE AMBROGI: I think, in the interest of time, we have to move on to the next topic unless you have anything-- no one has anything else to comment on. I know these topics are fairly broad, and we could probably spend all day talking about these issues. But we will move on to our third topic, and that is comparison of other state-based approaches. Hospitals and COPAs exist against the backdrop of states grappling with higher health care costs, including provider costs. And states have been trying many different approaches to stem the tide. Some strategies may have similarities to COPAs, but are markedly different from COPAs in other ways.

State attorneys general have been active bringing antitrust litigation, and also entering into consent decrees with conduct remedies in an effort to remedy anti-competitive effects. Tracy Wertz, the Chief Deputy Attorney General in the antitrust section of the Pennsylvania Office of the Attorney General, will talk about what they've done in Pennsylvania.

TRACY WERTZ: Okay, well thank you. First of all, thank you for inviting me, and to the FTC for sponsoring this workshop. And then, second, a disclaimer. These are my views and not those of the Pennsylvania Office of Attorney General.

I actually want to start my remarks with describing health care markets and how they're very different than other marketplaces. And I think because they are very unique, that's why we're having these types of conversations today-- whether we should address them under the antitrust law, should we look at COPA, what should we do?

And so just a couple of points of how health care is very different than other markets. First, it's a service that people need whether they want it or not, and the alternative is not very good if they don't choose it. It's also often needed on an emergency basis, and you can't always plan when you're going to need health care. Most consumers aren't medical professionals, so they don't know what service they need, and they rely on their trusted physician to help them through that. And oftentimes, the physicians have to do testing to evaluate what the patients need.

Consumers. The majority of them will pay for health care through a third party. They don't pay for it themselves. They use insurance. And on top of that, they have no idea the price of the health care they're consuming. They're working towards greater price transparency, but we're certainly not there. And even if you knew the services you needed, you wouldn't be able to compare pricing.

Health care is also highly regulated. You have regulated facilities, licensed professionals, licensed facilities, and you have government payers. On top of that, and near and dear to our hearts in Pennsylvania, a lot of the hospital systems are non-profit charitable institutions. And that needs to be taken into account as well. They have charitable missions, and they're actually subsidized by the communities through donations, tax-exempt financing, exemption from taxes. And they're supposed to serve their communities consistent with their mission.

Again, because health care is unique, I think that's why we see these types of programs-- should we do CONs, should we have COPAs, should we let antitrust do everything? And there are some states-- fortunately, Pennsylvania is not one of them. We do not have CON. We do not have COPA. Other states do.

But what Pennsylvania does have, we have the antitrust section, which I'm in. We also have a charitable trust section and we have a health care section. The antitrust section focuses on competition issues, but our charitable trust section, which is right down the hall from us, they focus on preserving charitable assets and ensuring that these institutions comport with their charitable mission, which most of these is to serve the public.

So to get back to your question, so what have we done in terms of merger review? Well, unlike COPAs, we don't have one. We use the antitrust laws, and we do an antitrust analysis, and we focus on the competition issues. In certain circumstances, we'll review a merger and there's no competitive problem. Other times, there could be a competitive problem. And when there is a competitive problem, we've been to court. We've challenged transactions, in coordination with the FTC most recently, to challenge a merger.

In other instances, there might be special circumstances about that transaction that we have to take into account-- if a hospital is struggling financially and they really don't have a viable alternative to purchase it. Other circumstances we've seen is when a system says, we're just going to close it. We're just going to close the hospital, and we don't really care what the office has to say about it. Unless this merger goes through, we just close.

We also have to consider litigation risk. I mean, for a long period of time, we were losing these cases. The FTC was losing these cases. We were watching this. It all turned on market definition. So there is litigation risk in these cases. And market definition is not an exact science. So in those certain circumstances where someone's struggling financially and they're not viable, perhaps they're not meeting the failing firm defense.

But again, attorneys general wear many hats. Like I said earlier, I'm in the antitrust section, but we have a charitable trust section as well. And so the Attorney General really has to value both of those sections, look at the competitive issues, but also an attorney general is not going to allow charitable assets to just exit the marketplace. He has to consider that. He also has to consider that, oftentimes, these are the largest employers in the community. And are they going to have the largest employer leave the community, taking with it its charitable assets, and favor everything in front of antitrust? And he has to balance those.

So what has happened in Pennsylvania is we have entered into some consent decrees, again, in those types of circumstances. And what we've tried to do in those consent decrees is-- really the biggest thing is to make sure that that community hospital or even larger hospital remains in the community, providing the same level and scope of services that it did before, so that it doesn't exit.

The other things we focused on are really preventing that entity from exercising market power. And so a way that we would do that is through restrictive contracting practices. And so on our consent decrees, we've prohibited terms like most favorite nations, prohibitions on tiering and steering, prohibitions on gag clauses or prohibiting price transparency, no must-have facility, or no all or nothing-- you contract with all of us or none of us-- that type of thing.

We've also really focused on the nondiscrimination provisions in our consent decrees. And those are really to protect the physicians in the marketplace. They need to have privileges. And to be able to see their patients, they still need to be able to have OR time. So ensuring that they can't discriminate against physicians and having access, not discriminating against patients depending on what type of insurance they have, making sure that patients are able to access the community hospital.

And two more provisions that we've really focused on is contract resolution provisions. And what we've done there-- I mean, I've heard a lot about COPA today, and the rate-setting, and the complicated formulas and things like that-- what we've tried to do with these contract resolution provisions is to put it back to the parties and the payers.

And what we've done is set up a two-step process. The first step is you need to negotiate in good faith for a period of time, between each other, and try and work this out on your own. If you can't do that, then the payer who's trying to obtain the contract has the option of doing a last best offer arbitration. It's binding. And the last best offer, the arbitrator panel, is five entities who are in the community. So the parties each get to pick an arbitrator, and then perhaps the largest employer has someone, the smallest employer has someone. And so there are people who have skin in the game who are the arbitrators. And this provision, to my knowledge, has never been triggered, in part because no one wants to have these arbitrators decide their fate. The parties have always been able to work this out on their own. And so that's a provision we've used.

And finally, we've heard today how health care changes, I've heard with COPAs today. Well, what happened 10 years ago, health care evolves, and you have to be able to adjust to that. So a provision that also is in our consent decree is a modification provision. And that provision permits the parties to agree to changes during the life of that decree if things need to change. If Medicare all of a sudden has reimbursed something differently and it's not viable for this hospital to offer the service, that's something that can be considered. And we can agree upon that.

If we can't agree, and somebody really thinks it's in the public interest to modify the consent decree, then you're able to go to court and seek that modification, but you bear the burden of persuasion to the court that it's in the public interest. And so at the end of this, the consent decrees are not in agreement just with our office and the parties. They are through the courts and they are court-approved.

KATIE AMBROGI: Thanks, Tracy. And now we'll hear from Robert Berenson, followed by Tim Greaney, who will discuss various other approaches, from market-based to regulatory, that states have taken to address rising provider costs.

ROBERT BERENSON: Thank you very much. I was at the last session and then, so far at this session, I'm reminded of a comment that a prominent governmental official recently said, "who knew health care was so complicated?"

[CHUCKLING]

But we will move on from that. First, I want to do a disclaimer, disclosure, whatever it is. I was initially invited by Stephanie to be on one of the COPA panels this morning because I co-authored an issue brief on the Mission COPA in North Carolina. And I declined the offer, partly because I came away from that experience with a sense of "on the one hand, on the other hand." It was very fact-specific, and it was really hard for me to believe that there was some general point of view that would extend to all COPAs. And even though the FTC has talked about a proliferation of COPAs, I think we're talking about three or four, and a couple of them are not in existence anymore.

One of the negatives that we did identify in that issue brief about Mission was, well, what happens when the COPA goes away? And that's exactly what happened. And now HCA owns what is essentially a monopoly for all the western counties. So I very much encourage that the Tennessee-Virginia COPA has a provision that extends the oversight even if the legislature decides-- it gets captured, let's say.

But now I want to get on to the point of what I'm here for, which is to present a range of options for addressing high and variable provider prices. And I've detected-- or maybe I want to be the contrarian on the panel. I've detected a little complacency. CON laws should be abolished. There's no role for COPAs. Antitrust is doing a great job at weighing the pros and cons and making good judgments.

So let me just ground my discussion in the facts of what's going on with prices, which I don't think people on the panel ignored, but I want to give more urgency to this issue, and then present a range of what are we going to do about it. So according to an ARC study between 1995 and 2000, commercial rates for inpatient hospital care was 10 percent above Medicare. AHA has been following this along, and their data now is at about 145 percent of cost, which equates to about 160 percent of Medicare.

The CBO did a study using a HCCI data a couple years ago. I think the year was 2014. They had 189 percent of Medicare. And I should say that that ARC study just showed a steady rise in what these rates were. And now, we have a Rand study that just came out a couple of weeks ago, looking at 20 states, looking at employer data. And they came up with 240 percent of Medicare.

Hospital margins are at an unprecedented high level. Operating margins is between 7 and 8 percent for the last few years. Many not-for-profit hospitals have literally $5 billion or more sitting in reserves. And I think, by some estimates, are not providing adequate community benefits for their not-for-profit status.

And recent studies have pretty well documented that the reason the US spends so much more than all the other countries-- almost two times as much as the next competitor-- is high prices. I was interested in hearing the employment data that American health care workers get higher salaries in relationship to the median salary in the country than any other country. So I think this is a huge problem. Employees haven't had a real wage increase for years because all of what would've been wage increases are going to health care costs.

So with that introduction-- do I get to move this? Where's the mover?

KATIE AMBROGI: Yes, they will pass the clicker.

ROBERT BERENSON: I will very quickly-- because I've used up some of my time-- go through a range of options that, roughly, from the most competitive try to create real market competition, to the most overtly regulatory that states-- or the federal government, in some cases-- would choose to adopt or consider adopting to address this problem. And I should emphasize, which I didn't do, it's not only high prices, but we have huge variations in prices. So the 10th through the 90th percentile of hospital payment rates is about a 1-to-2 ratio. Massachusetts has probably done the closest studies where their community hospitals are barely at Medicare levels, which pays a little under cost, and they've got some powerful monopoly systems, getting 200, 250, 300 percent of Medicare. So we also have not only high rates, but we have highly variable rates.

So the most market-related is abolish CON. You heard an argument for doing that in the states where it's still in place. Liberalize state practice act, so you have more health professionals without restricted care, more telemedicine. There's a range of things that people are talking about. I'm not sure that's going to bring new hospitals into a market, but that's clearly trying to promote more market entry.

Greater price transparency. And there, I want to emphasize that there's two different purposes for price transparency. One is to serve a function of shining a light, or some have called it public shaming. Later, in a moment, I'm going to talk about North Carolina. The treasurer of North Carolina, on behalf of public payers-- teachers and active employees-- released data on how much they are currently paying hospitals and doctors. They released the lowest, the highest, and sort of the mean. There was a medical group in North Carolina getting 994 percent of Medicare. That's the highest I've heard, but I've certainly heard of similar exorbitant, unjustified price rates.

And that's, I would argue, some of the negative effects of letting the market just function the way it's functioning, that you can get inordinate market power. And yet I'm not sure anybody wants to come in and break up medical groups. So I would have liked to see the name of that medical group, and then public shaming might work a little better. I would point out that, in Massachusetts, one of the catalysts for the activity in Massachusetts to get on this issue was a Boston Globe article which described a secret handshake between Blue Cross Blue Shield, the dominant payer, and Partners, the dominant provider-- in which the basic thing was, we will

give you good rates as long as we get the most favored rates. That's what's going on in a lot of places. Shaming that kind of thing, I think, serves a very useful purpose.

The second purpose is to just promote price-conscious consumerism with complementary benefit designs, where-- this is a work in progress and I'm pretty skeptical about it, but the idea is that you would have consumers given price information and, ideally, quality information, and they would be active shoppers for care. That's another reason for the need for transparent prices. But they need information about how much their personal exposure is, not how much the hospital or the medical group has negotiated, although that would be useful as well.

What's getting some new attention is to prohibit anti-competitive insurer-provider contract provisions. And I was surprised, frankly, to see that in the draft Alexander-Murray legislation in the HELP committee, there actually are prohibitions against contract provisions by powerful providers that would have gag clauses, all-or-nothing contracting, anti-steering provisions by law, rather than relying on antitrust enforcement. At least that bill would prohibit those kinds of contract provisions. And some states have a few of those on the books already.

Active purchasing by public payers. Montana and Oregon have it already on the books, where they have put limits on how much the public payers will pay. North Carolina is in the process of considering that. It's in the legislature. On the same continuum-- I'm using a euphemism here-- harmonizing network adequacy requirements to encourage narrow networks. The whole point here is to not have such onerous network adequacy provisions that it makes it really difficult to create narrow networks, which right now is really the only thing that an insurer can do to have any leverage with powerful health care systems. You have to have at least more than one system to have this be effective. But the idea is to not have any willing provider laws or make it too tough to have narrow networks.

Enhanced antitrust enforcement, both federal and state-- and again, we've talked about COPAs, and in the next line, I've even mentioned COPAs. But what's really going on out there in a dramatic way are cross-market mergers. Leemore Dafny spoke to you this morning in the role as a commenter on COPAs, but she is the one who has developed the data that demonstrates cross-market mergers, meaning it's a merger that happens in different service areas, but within the same state, that gives enormous market power to a system of care.

So in North Carolina, again, Atrium Health, which had something like 26 hospitals in South and North Carolina, are in a position to have market power. Well, antitrust isn't going after that kind of thing. As I understand it, they don't even have a good theory as to why that raises prices. I think the data and Leemore have presented the data and the theory.

The other thing that is going on is vertical integration. And in other parts of the economy, that seems to be potentially pro-competitive. There are increasing data that the vertical integration between hospitals and physicians is raising prices significantly without an improvement in quality. And yet, that doesn't seem to be something that is getting a lot of attention by antitrust enforcers.

We've heard about conduct remedies and post-merger monitoring, and recent consent decrees, state action immunity with active supervision of mergers-- that's where COPA fits into all of this. Again, it's worth this conversation, but it's a relatively small part of what's going on out there.

Oversight of premium increases, including the ability to review and approve insurer contracts. Rhode Island is the prototype of this, where they not only review requests by insurers for premium increases and have to have rigorous justification, but they have the ability to follow to the contract between the insurer and the hospital system, largely to see what's happening at that level of price. With the concern being that if they limit the insurer's premium increase, the powerful hospital systems will get a significant increase, and then the insurer takes it out on the hospital systems without market power. They are able to go below that insurer request, to look and regulate those price increases.

And let me finish very quickly, because I'm over time. I'm basically arguing that price regulation actually promotes competition over the more important stuff, like quality, service, access, things like that. So the example that demonstrates this point is what Medicare does. And Medicare Advantage, which is pretty competitive-- about a third of Medicare beneficiaries opt into a private plan. They leave traditional Medicare.

Why is that a viable option? Because there's a prohibition in Medicare that prevents hospitals or doctors from billing patients more than the Medicare-allowed charges. That means you can be in Medicare Advantage at Medicare rates or you can be out-of-network with Medicare Advantage at Medicare rates. You can't be getting 220 percent of Medicare, which is what commercial insurers do. So that form of price regulation, limiting strict limits on balance billing or outside billing, permits that market to work, is basically what I'm arguing.

And then, there is increasing consensus developing looking at the failure of marketplace ideas to limit cost increases, to at least in some ways, put some limits on prices, whether it's establishing ceilings, perhaps as a percentage of Medicare, starting at a high level-- 250 percent of Medicare-- and coming down over time. Or giving limits on updates, which over time, you narrow the differences between hospitals. And then ultimately, you can go to full-fledged rate-setting, à la Maryland. And there are actually a few states in addition to Maryland-- Vermont and rural Pennsylvania-- that is moving to hospital budgets in a very rate-regulated sense.

So that is the range. My basic belief, it's not one or the other. It's that states or the federal government-- but more likely that states, because the federal government is paralyzed-- we will see some combinations in some of these states to try to address the pricing problem. Thank you.

THOMAS GREANEY: Okay, well, thank you. Let me start first with a little brown-nosing. I want to compliment the FTC on their great successes in the hospital merger area, the physician merger area, and of course, in pharma issues. They really have brought cases that establish, I think, enduring precedents that should curb future mergers in those areas, at least mergers by dominant firms.

That said, I'll turn to the glass is half empty. I would urge them to go forward in the areas that Bob just described-- cross-market mergers, where there's growing evidence that that's an issue. Ask any payer whether cross-market issues exist. And secondly, and I think very importantly, hospital acquisitions of physician practices. The FTC stepped aside and didn't pursue that case in St. Luke's. That's a really important area, and we now have growing evidence that those mergers, those accumulations of physician power by dominant hospitals, raise prices of physician services. The economic evidence is coming out. And we pay for those years of quietude when we don't bring cases. We went seven years without bringing hospital merger cases, and now we're living with the consequences.

Okay, let me follow up. I'll try to move quickly here, and it'll be easy because I agree with so much of what Bob has said in the past and what he's trying to do here. Let me try to organize our thinking a little about how to look at this smorgasbord of regulatory options he's presented. The first thing I'll-- and I'll just talk first about the goals of what we're trying to do by these regulations. And then secondly, talk about what the prime targets of those regulations are. And finally, just throw out a few conundrums and problems in dealing with market power by regulation.

First of all, what are the goals? Well, the most obvious goal is we're trying to reduce total cost of care, or at least curb the growth of total cost of care. But beyond that, there are other important goals and, I think, competition-enhancing objectives that regulation might achieve. One might be to find means to redistribute resources to primary care and to what Bob has called the have-not hospitals, the ones that are struggling. Another regulatory objective might be to move away from fee-for-service to APMs, bundle payments, et cetera. A third might be, certainly, in doing all this, to preserve competitive incentives-- not to destroy incentives, to innovate. And finally, we want to have regulation that actually improves quality, advances quality, and the incentives to do so. So that's sort of the multiplicity of goals we've got out there. We want to find that mix of regulation that does all of those, or most of those.

Secondly, what are the targets of regulation? Well, again, when we look at these different options, clearly, I think the most important is dominant providers. There's a host of evidence now that shows that dominant providers, especially must-have hospitals, but also some dominant specialty groups, are the main leading cause of high cost in America. The Massachusetts Attorney General study a couple of years ago showed that. And I call this extant competition. Antitrust doesn't do very much with extant competition. We really don't break up monopolies. So the question is, what do you do with monopoly power once it's there? And the question is, what regulatory tools can we devote to it? Other important targets of course are improving infrastructure, and importantly, reducing administrative burdens. That goes hand in hand with competition because these very effective primary care ACOs, primary care practices that can be a counterforce, are burdened tremendously by the paperwork and other burdens.

Okay, so let me just move on to a few conundrums that are present in picking out among his list of things to do. Well, one is, can we target dominant providers, dominant hospitals, and still protect competition by others? In other words, whatever we're doing, price caps, et cetera, are we going to preserve the opportunity for others to compete, and not encourage other problems?

One problem might be that price caps, setting a cap on prices-- in antitrust, we used to call that a magnetic ceiling-- if that's the cap, well, everybody should go up that way. On the other hand, sometimes caps or price controls can freeze disparities and, as Bob said, we have huge disparities. So you want to find regulatory tools that don't do that either.

A third problem that comes up, and is an important one, because we want to build in all of the mechanisms that Bob mentioned about promoting competition by improving the way markets work-- and by the way, I wrote a piece with Professor Barak Richman of Duke. It's on the American Antitrust Institute website. It was a two-part series, and we tried to just catalog all the things you could do to make markets work better, including removing some regulations and imposing others-- but a market-improving mechanism. Bob's done some of that, as has Marty Gaynor, a very good economist.

So the question is, what can we do? Well, one problem with some of these solutions is they're only partial solutions. Reference pricing, which we haven't talked about, which sets a price and that's the only price the payer will pay or the employer will pay to everybody. That's a good idea and it had remarkable success in California with hip replacements and so forth. But the problem there is there are only so many services that are shoppable, that are standardized and you can meaningfully compare them. And also, you need information to make sure that people are getting the right choice.

Another problem, of course, is there's a certain tension between value-based pricing and transparency. And in some instances, Maryland has run into this and others have run into this, that some of the regulations that actually force some providers to pay less because they have too many readmissions, et cetera. To the consumer, that looks like a good deal. And it doesn't mean that they're higher quality or more efficient. It means they have actually been penalized. So there are those problems when you try to design it.

Okay, let me just close with a few unkind words about COPAs. I wrote an article a couple years ago called *Coping with Concentration*. And I took a look at COPAs, not specifically with the-- it was before the decisions at Wellmont and so forth. But what I was trying to do was lay out, what are the problems with these kind of regulatory arrangements as opposed to others? And I think-- I'll just incorporate, by reference, the wonderful job Cory Capps did this morning of showing how a COPA mechanism has to be dynamic. You've got politics. You have a lot of problems in doing that, the problems with price caps I mentioned earlier.

So I think COPAs are, unfortunately, maybe a bad idea whose time has come. But I don't think that's a solution. And it's only operating at a very small margin. The horse is out of the barn when you're down to two hospitals, right? The horse is gone. It's got an apartment downtown. It's left you. So there's only so much a COPA can do. And I think that's why what Bob's research is doing is very important.

Let me close with one reference that I've become interested in, and that's what one state is doing. Not the state that first jumps to mind as the most innovative state in the country, but it's Rhode Island. And Rhode Island has put in a series of regulations. And what it's doing is it's using the Department of Insurance approval rating for insurance policies, for insurance plans. It's using that as a lever over dominant provider pricing. And what it's done, it's put price inflation caps based on the Medicare price index. It's also done other things compelling hospitals essentially to transform into DRG kind of payments, not fee-for-service.

And finally, on the other hand, it's forced the increase. It's made plans increase their spending on primary care. So it's trying to raise the spend where it should be spent, lower the spend on dominant hospitals. And it has an effective mechanism to do that. It's the insurance commissioner, who can tell plans, you have to impose this or the plan won't be approved. And it's across the board. It applies to all commercial insurers. So I think that's a start, and that achieves some of the things that are important to achieve. I'm trying to work out some improvements on that, but I think it's a good thing.

And what's interesting about what's happened in Rhode Island, a study showed it changed the negotiation dynamic between insurers and dominant providers. It gave the insurers that extra leverage they needed to compel the must-have hospitals, the ones that are charging the most, that there is a ceiling on what you can charge. It's a difficult rate-regulation process. But my view is that if we're going to impose regulation, if we're going down that road-- and we may

have to with the dominant entities-- we should target that regulation, not throw the baby out with the bathwater. Thank you.

KATIE AMBROGI: Thanks, Tim. And we're winding down on time, but I wanted to give the panelists an opportunity to give any last comments on what they've heard on this panel.

CHRISTOPHER GARMON: I wanted to make just one final point for me, at least. I don't know if others want to mention anything. But we've been talking a lot today about, should we regulate or should we have competition? That seems to be the choice. And I think that's a false choice in many respects.

If we decide as a society to go with price regulation-- maybe we do Medicare-for-All, maybe we do something short of that, like the Maryland system or the Vermont system-- I think you could make the argument that competition is even more important in those systems. Think about a situation where price is fixed and there's no competition. You have a monopoly. What incentive does that monopoly have to invest in quality? It has no incentive. It can't steal patients from its competitors. It can't benefit by improving its quality by increasing its price. It won't have any incentive to improve its quality.

So in a situation like that, it becomes very important, if you have regulated prices, to make sure that you're monitoring quality well. But no matter how many quality metrics you use-- mortality rates, readmission rates, patient satisfaction, leaving the foreign body in after the surgery-- all those things-- you're always going to miss something. There's going to be some aspect of quality that you're not measuring. And maybe you put all of those measures in your value-based purchasing formula, but there's going to be stuff that you leave out that that monopoly provider won't be investing in, and will be focusing on those things that are measured.

So we see this with the United Kingdom. The United Kingdom has the National Health Service. Their hospitals are actually owned by the government. But they've found-- Marty Gaynor has done research and others have done research showing that, even in that system, competition is important, and competition benefits patients and improves quality.

So I think that even if we decide we need to control costs through price regulation, there's still a role for antitrust enforcement to make sure that patients have choices and they're not beholden to just one health care provider. They can choose to go to multiple providers and choose that higher-quality provider.

ROBERT BERENSON: And if I could just emphasize that point, Maryland is the prototype of rate regulation. It's been doing it for 35 years. And in fact, in the '90s, when HMOs were really big, Maryland had its share of HMOs. Kaiser is in Maryland, a number of other-- I mean, it's not a perfectly competitive situation on the purchaser side, but there are competing health plans. There are competing providers.

I don't know how you move to area budgets, which is what they want to do, and still preserve competition. But short of that, I think that price regulation and competition are compatible. And so I think your point is well taken. So I just wanted to make that point.

KATIE AMBROGI: Great. And with that, we'll conclude the panel. And since I was giving closing remarks anyway, I will truncate them in the interest of time, and just thank everyone again for participating today. And a big thanks to our FTC staff who works behind the scenes,

all the event folks who helped to put on today's workshop. And a PSA to remember to submit public comments if you haven't already. We are accepting them through July 31. So thanks again to everyone.

[APPLAUSE]

[MUSIC PLAYING – END OF AFTERNOON SESSION]