MITCHELL | HAMLINE School of Law

Mitchell Hamline Law Journal of Public Policy and Practice

Volume 45 | Issue 1 Article 1

2024

Certificates of Public Advantage: A Valuable Tool or Diminishing Allure?

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CERTIFICATES OF PUBLIC ADVANTAGE: A VALUABLE TOOL OR DIMINISHING ALLURE?

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I. INTRODUCTION

In 2022, the Department of Justice ("DOJ") successfully continued its pursuit of antitrust litigation against violators with more favorable court rulings than in recent history.[1] Historically, regulators had limited success litigating antitrust enforcement before the courts.[2] The Biden administration's agenda prioritized antitrust enforcement by hiring more antitrust lawyers.[3] The administration's efforts include prosecuting "no-poach" agreements or other wage-fixing schemes, going after the board of directors who serve on competing organizations, or regulating other monopolies and colluding activities by corporations.[4]

The DOJ and Federal Trade Commission ("FTC") triumphed litigating various industries and economic sectors from the publishing press to health care.[5] The FTC successfully enjoined four hospital mergers in the health care sphere and plans to continue limiting further consolidations.[6] Hospital merger arguments traditionally focused on improving efficiency, reducing costs, and providing savings that can be passed onto consumers.[7] However, federal regulators argue that these mergers enable the creation of

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[1] Perry Stein, *After a String of Losses, Justice Dept. Notches Antitrust Victories*, WASH. POST (Nov. 11, 2022, 5:00 AM), https://www.washingtonpost.com/national-security/2022/11/11/antitrust-biden-random-house-schuster/.

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] Harris Meyer, *Biden's FTC Has Blocked 4 Hospital Mergers and Is Poised to Thwart More Consolidation Attempts,* KAISER HEALTH NETWORK (Jul. 18, 2022), https://khn.org/news/article/biden-ftc-block-hospital-mergers-antitrust/. *See also* Jeffery H. Perry and Richard H. Cunningham, *Effective Defenses of Hospital Mergers in Concentrated Markets,* 27. AM. BAR ASS'N ANTITRUST 43 (2013), https://www.weil.com/-/media/files/pdfs/effective-defenses-of-hospital-mergers_by_jeff_perry.pdf (outlines that efficiencies, non-profit status, quality of care outcomes, and health care reform itself are the key defenses merging hospitals use to justify proposed mergers or acquisitions).

[7] Meyer, *supra* note 6.

super conglomerates which have driven up U.S. health care expenditures that are the highest in the world.[8]

The Biden administration tasked the FTC and DOJ to investigate merger activity in this space because merger and acquisition activity has now resulted in ten of the largest health care systems controlling over 25% of the market.[9] This activity led to hospital closures in rural or underrepresented areas.[10] These actions are a part of the overall strategy to use antitrust laws to regulate industries that evaded regulatory oversight over the past few decades.[11]

It is worth noting that this aggressive enforcement strategy has been in effect since 2022. Four cases exemplify this point. First, the FTC halted RWJBarnabas Health's proposed acquisition of St. Peter's Healthcare System in New Jersey after citing concerns about increased prices and decreased quality of patient care.[12] Second, the FTC's hindrance in HCA Healthcare's (which operates 182 hospitals) attempted acquisition of five Steward Healthcare System facilities in Utah, resulted in HCA unsuccessfully being able to merge.[13] Third, the FTC's willingness to procure an injunction ultimately persuaded Hackensack Meridian Health and Englewood Healthcare Foundation from merging.[14] Finally, the FTC triumphed

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[8] *Id.*

[9] THE WHITE HOUSE, *Fact Sheet: Executive Order on Promoting Competition in the American Economy* (Jul. 09, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/07/09/fact-sheet-executive-order-on-promoting-competition-in-the-american-economy/.

[10] *Id.*

[11] *Id.*

[12] FED. TRADE COMM'N, *Federal Trade Commission Opposition to Transaction Leads New Jersey Healthcare Rivals RWJBarnabas Health and Saint Peter's Healthcare System to Abandon Proposed Merger,* FTC (Jun. 14, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/06/federal-trade-commission-opposition-transaction-leads-new-jersey-healthcare-rivals-rwjbarnabas.

[13] HCA Healthcare, Inc, Steward Health Care System, LLC, and Ralph de la Torre, M.D., Docket No. 9410 (F.T.C. June 22, 2022), https://www.ftc.gov/legal-library/browse/cases-proceedings/2210003-hca-healthcaresteward-health-care-system-matter.

[14] FED. TRADE COMM'N, Hackensack Meridian Health, Inc. and Englewood Healthcare Foundation, In the Matter of, FTC (Jul.06, 2022),

by preventing Rhode Island's two largest hospital systems, Lifespan and Care New England Health System from pursuing their merger.[15]

This winning streak emboldened the Executive Branch to push forward with increasing regulatory and litigation activities. In August 2022, the Federal Trade Commission warned states that issuing Certificates of Public Advantage ("COPA"), which allow states to oversee hospitals' consolidation activities and therefore shield these entities from federal antitrust laws, is detrimental to consumers.[16] The regulators warned that merger activities under the purview of a state COPA agreement result in higher prices, reduced quality outcomes, negative patient care, and lower worker wages.[17] The agency's direct warning to the states and the public suggests that two or more entities seeking to merge or consolidate find the COPA arrangement a tantalizing option to avert federal antitrust regulation. Considering these recent shifts in regulatory strategy, this paper considers the role of COPAs in the context of competition and antitrust law. The scope of this paper focuses on the horizontal mergers of hospitals through a brief discussion on the types of antitrust activities regulated under federal antitrust law outlined in the background section to provide context for the comprehensive purview of federal antitrust enforcement.

Part II of this paper provides a brief primer on key federal antitrust laws and regulations. First, I list the key statutes governing federal antitrust enforcement. These include the Sherman Act, Clayton Act, and the Federal Trade Commission Act. Next, I describe dual-level enforcement when considering state-level regulatory oversight. I set the background for this tension created

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https://www.ftc.gov/legal-library/browse/cases-proceedings/2010044-hackensack-meridian-health-inc-englewood-healthcare-foundation-matter.

[15] *See* FED. TRADE COMM'N, Lifespan/CNE, In the Matter of, FTC (Mar. 02, 2022), https://www.ftc.gov/legal-library/browse/cases-proceedings/211-0031-lifespancne-matter.

[16] FED. TRADE COMMI'N, *FTC Policy Paper Warns About Pitfalls of COPA Agreements for Patient Care and Healthcare Work,* FTC (Aug. 15, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-policy-paper-warns-about-pitfalls-copa-agreements-patient-care-healthcare-workers.

[17] *Id.*

by federal versus state preemption that plays a role in the justification for COPA exemptions discussed in Part IV.

Part III focuses on the real-world regulatory landscape of antitrust enforcement. The first half of the section focuses on the enforcement strategies of the Department of Justice and the Federal Trade Commission using their agenda and policy statement publications. The latter half of the section considers what types of actions are not regulated or litigated. For instance, the FTC has its interpretation of what merger activities they choose not to regulate as a matter of policy by carving out safety zones offering exemptions to merger regulations.[18]

Part IV of this paper concentrates on a type of antitrust exemption mechanism central to considerable controversy in the current climate: certificates of public advantage (COPA). Federal regulators are targeting this regulatory scheme in which states can preempt federal antitrust laws by offering to regulate the merged entities themselves.[19] This creates tension between states and the federal government. What policy values should be prioritized against antitrust enforcement? Does a state's right to control the public health and welfare of its residents preempt the need to maintain competitive markets to protect consumer interests?

This segment of the paper defines what COPAs are and provides a survey of state-level COPAs in the nineteen jurisdictions where COPAs are recognized and some key features of them. This exhibits that the piecemeal approach to these state-specific agreements yields nonuniformity or unclarity on expectations and standards. Next, I discuss the federal regulatory perspective and their current enforcement strategy for targeting these COPA agreements. Finally,

Part V concludes with criticisms of COPAs by assessing the consequences of COPAs that ultimately failed and were subsequently repealed. Next, I highlight the need for uniform

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[18] Janet D. Steiger, *Health Care Antitrust Enforcement Issues,* FTC (Nov. 9, 1995), https://www.ftc.gov/news-events/news/speeches/health-care-antitrust-enforcement-issues.

[19] Lina M. Khan et al, *FTC Policy Perspectives on Certificates of Public Advantage*, FTC 1-2 (Aug. 1, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf.

standards and efficiency considerations. I end by providing some examples of novel solutions and schemes that could be used to achieve a more reasonable outcome.

II. BACKGROUND: A BRIEF ANTITRUST OVERVIEW

Antitrust regulation and enforcement in the health care setting is complex. It has evolved over the decades. While the general framework for preventing monopolization and promoting competition might be considered a bedrock principle of the U.S. free market economy, antitrust regulation's evolution in the health care industry is best defined by legal precedence and activity observed within the past fifty years.[20] Antitrust enforcement encompasses all types of actions that might occur in the health care space from agreements amongst professionals, such as physicians, pricing schedules and agreements, and mergers and acquisitions of organizations.[21]

Antitrust regulations were created to respond to the economic disadvantages and harmful effects of the monopolization of markets.[22] These regulations aimed to promote competition in the marketplace rather than giving all the powers and scope of influence to one or two powerful entities.[23] Enforcement in the health care industry catalyzed in the 1980s.[24] Key federal statutes that govern antitrust litigation and enforcement include the Sherman Act, the Federal Trade Commission Act, and the Clayton Act.[25] Antitrust regulations are notable for being general since they don't specify

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[20] BARRY FURROW, ET AL., THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE 757-58 (8th ed. 2018).

[21] *Id. See also* Goldfarb v. Virginia, 421 U.S. 773, 785 (1975) (providing a useful example of how the Court determined that services, not just goods or products such as those provided by attorneys, are subject to antitrust enforcement under the Sherman Act).

[22] *See* Furrow, *supra* note 20.

[23] *Id.*

[24] Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*. 102 COLUM. LAW REV. 545, 548 (2002).

[25] FED. TRADE COMM'N, *The Antitrust Laws,* FTC, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/antitrust-laws (last visited Dec. 22, 2022).

acceptable or prohibited behaviors.[26] Congress vested federal courts to set precedence on these matters.[27] A discussion of these federal statutes and some important interpretive principles are outlined below. States may also have location-specific antitrust legislation and multiple entities can therefore enforce antitrust laws.[28] Part A provides the general statutory framework upon which antitrust regulations are derived and enforced. Part B looks at this relationship when state-level antitrust enforcement might be involved.

A. *Federal Statutes: The Sherman, Clayton, and Federal Trade Commission Acts*

The Sherman Act can be divided into two sections. Section One of the Sherman Act prohibits "every contract, combination … or conspiracy, in restraint of trade." [29] Section Two of the Sherman Act forbids monopolization, attempts to monopolize, and conspiracies to monopolize.[30] Monopolization can be distilled into two elements: (1) possession of monopoly power and (2) the willful acquisition or maintenance of that power.[31] The possession of monopoly power includes the power to control market prices or exclude competition.[32]

Sanctions for violating Sherman Act provisions are severe. There are both civil and criminal penalties that the regulators enforce upon violators.[33] The FTC traditionally pursues civil litigation while the DOJ can criminally prosecute offenders and impose penalties up to $100 million for corporations and $1 million for individuals in addition to a ten-year prison sentence for

[26] *See* Furrow, *supra* note 20 at 758.
[27] *Id.*
[28] *Id.*
[29] 15 U.S.C. § 1.
[30] 15 U.S.C. § 2.
[31] *United States v. Grinnell Corp.,* 384 U.S. 563, 570-71 (1966).
[32] *United States v. E. I. du Pont de Nemours & Co.,* 351 U.S. 377, 391 (1956).
[33] *Id.*

violators.[34] The fine amounts can double the amount gained from the illegal actions if the amount exceeds $100 million.[35]

To address regulating mergers and acquisitions, the Clayton Act bans mergers and acquisition activities whose effects may substantially lessen competition or "tend to create a monopoly."[36] The Clayton Act addresses the specific concern of mergers or interlocking directories which the Sherman Act does not directly address.[37] The Robinson-Patman Act of 1936 amended the Clayton Act.[38] The Robinson-Patman Act banned discriminatory pricing, services, and allowances in deals between merchants.[39] In 1976, another amendment strengthened the Clayton Act. This amendment, the premerger notification amendment, required entities intending to merge to notify regulators of their merger proposals.[40] It requires a premerger filing, a filing fee, and waiting for regulatory approval to ensure that antitrust or interstate commerce concerns are not implicated with a proposed merger.[41]

The Federal Trade Commission Act outlaws "unfair methods of competition" and "unfair or deceptive acts or practices."[42] Violations of the Sherman Act are also violations of the FTC Act.[43] This act authorizes the Federal Trade Commission to regulate and litigate antitrust infractions.[44] It also authorizes the FTC to protect consumers from other harms not directly prohibited under the Sherman Act.[45]

B. *State-Level Antitrust Enforcement*

Most states have some form of antitrust enforcement program with statutory language that often parallels the federal

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[34] *Id.*
[35] *Id.*
[36] 15 U.S.C. §§ 12-27.
[37] *See* FED. TRADE COMM'N, *supra* note 25.
[38] 15 U.S.C. § 13.
[39] *Id.*
[40] 15 U.S.C. § 18a.
[41] *Id.*
[42] 15 U.S.C. §§ 41-58.
[43] *See* FED. TRADE COMM'N, *supra* note 25.
[44] *Id.*
[45] *Id.*

provisions.[46] This creates dual jurisdiction between federal and state authorities to regulate antitrust activities.[47] State Attorneys Generals (AG) can coordinate with FTC or DOJ officials for investigating or analyzing merger activities.[48] AGs can either enforce federal antitrust laws with FTC's or DOJ's support or bring cases under their respective state statutes.[49] States AGs have also collectively organized to establish the National Association of Attorneys Generals ("NAAG") Multistate Antitrust Task Force.[50] They can bring suits in federal court on behalf of their residents, or on behalf of the state as a purchaser.[51]

III. FEDERAL ENFORCEMENT LANDSCAPE AND POLICY CONSIDERATIONS

This section begins with an introduction with a description of key regulators and a high-level overview of the enforcement tools at their disposal. Next, an outline of FTC's regulatory enforcement agenda and prioritization list is discussed. Finally, this section concludes with the types of activities that the FTC does not litigate or find offensive to antitrust laws under their interpretations or their policy considerations.

A. *Overview of the Regulator Activity*

As previously mentioned, under the Federal Trade Commission Act, the FTC was created and tasked with preventing parties or entities from using unfair methods of competition.[52] This statute empowers the FTC to enforce the Sherman Act in civil

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[46] *Id.*
[47] FED. TRADE COMM'N, *Protocol for Coordination in Merger Investigations,* FTC, https://www.ftc.gov/advice-guidance/competition-guidance/protocol-coordination-merger-investigations.
[48] NAT'L ASS'N OF ATTORNEYS GENERAL, *State Antitrust Litigation and Settlement Database,* NAAG, https://www.naag.org/issues/antitrust/state-antitrust-litigation-and-settlement-database/.
[49] *Id.*
[50] *Id.*
[51] FED. TRADE COMM'N, *The Enforcers,* FTC, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/enforcers.
[52] 15 U.S.C. § 45.

litigation and administrative proceedings, encompassing both corporate and nonprofit organizations.[53] The Department of Justice's Antitrust Division divides enforcement with the Federal Trade Commission.[54] The FTC's purview includes health care since it's a high consumer expenditure industry.[55] Premerger notification filings can trigger an FTC investigation.[56] The Justice Department is capable of filing criminal sanctions, whereas the FTC lacks that capacity.[57] This then requires cooperation between the organizations if this strategy is pursued. Finally, states or private parties can bring suits alleging antitrust law violations.[58]

Often, the FTC attempts to secure voluntary compliance from an entity by issuing a consent order where the entity consents to comply with its requirements and to follow the outlined conditions to resolve the monopolistic effects of a proposed merger.[59] Next, if a consent agreement cannot be reached, the agency can then issue an administrative complaint or seek injunctive relief to enjoin a proposed merger from a federal court judge.[60] Administrative complaints are heard by administrative law judges who oversee the trial-like process.[61] The administrative law judge's finding can result in a cease-and-desist order.[62] Appeals can be heard by the FTC for the final decisions rendered by the

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[53] *Id. See also* Furrow, *supra* note 20 at 760. *See also* FED. TRADE COMM'N, *Federal Trade Commission Act*, FTC (listing the scope of authority of the FTC including being tasked with such as preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce; seeking monetary or other relief for conduct injurious to consumers; prescribing rules defining what acts or practices that are unfair or deceptive and establishing requirements to prevent such acts or practices; compiling information and conducting investigations relating to the organization, business, practices, and management of entities engaged in commerce; and producing reports and legislative recommendations to Congress and the public), https://www.ftc.gov/legal-library/browse/statutes/federal-trade-commission-act.
[54] *See* FED. TRADE COMM'N, *supra* note 56.
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] *Id.*

agency.[63] FTC decisions are appealable to the U.S. Court of Appeals and potentially to the U.S. Supreme Court.[64]

In practice, regulatory authorities, including the Department of Justice and Federal Trade Commission, carve out exceptions that do not sanction certain group activities. These defenses, also called antitrust safety zones, allow organizations practical leeway to operate in the health care system without excessive fear of repercussion or regulatory scrutiny.[65] This section first discusses antitrust enforcement zones and the regulatory agency enforcement agenda for hospital mergers.

B. *Statements of Antitrust Enforcement Policies*

To keep with its mission and goals, the Federal Trade Commission's scope for enforcement must promote its objective to keep health care markets competitive, protect consumers, and help consumers benefit from lower costs, and better care and quality.[66] Enforcement requires regulation under the antitrust laws which dissuade anticompetitive conduct and provide proactive guidance to the industry participants.[67] This requires constant research and issuing reports including empirical data. and economic analysis to study the effects of mergers, such as those involving non-profit hospitals.[68] These collective legal, practical, and academic experts enable the FTC to provide the industry with guidance. Perhaps of most importance, the Statements of Antitrust Enforcement Policy in Health Care provide the most cogent guidance on how the FTC and DOJ collectively view the purpose of antitrust laws and how they believe these rules should be enforced.[69] Collectively, nine statements were issued that addressed various merger activities in

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[63] *Id.*
[64] *Id.*
[65] *See* Furrow *supra* note 20 at 796-99.
[66] FED. TRADE COMM'N, The FTC's Health Care Work, FTC, https://www.ftc.gov/news-events/topics/competition-enforcement/health-care-competition.
[67] *Id.*
[68] *Id.*
[69] U.S. DEPT. OF JUSTICE AND FED. TRADE COMM'N, *Statements of Antitrust Enforcement Policy in Health Care,* https://www.justice.gov/atr/page/file/1197731/download.

health care including, to name a few, (1) hospital mergers, (2) joint ventures between hospitals and medical device and technology providers, (3) physicians' provision of information to purchasers of health care services, (4) inter-hospital participation to exchange price and cost information, (5) health care providers' joint purchasing agreements, and (6) physician joint network ventures.[70] The first statement addresses hospital mergers and is the focus of this paper as it deals with addressing an exemption to merger activity.

C. *Antitrust Safety Zones*

Many hospital mergers and acquisitions do not implicate competitive concerns and are not often scrutinized under regulatory lenses.[71] Using their experience, the FTC and DOJ devised a strategic framework from which they analyze these merger activities. As part of this, the agencies provided in their policy statement a carveout for antitrust safety zones, which provides the industry with guidance about what types of mergers would not be challenged under the agencies' interpretation of antitrust law.[72]

Mergers between acute care centers would not be challenged where one hospital had an average of fewer than 100 beds and the average inpatient census was fewer than forty patients over the most recent three years.[73] However, the antitrust exemption would not apply to new facilities that are less than five years old.[74] This is because such acute centers are generally the only hospitals in a relevant market and therefore do not implicate anticompetitive concerns in a given area or reduce competition substantially.[75]

D. *Regulatory Perspective of Hospital Mergers*

Hospital mergers that occur outside of the antitrust safety zone conditions are not necessarily offensive to competition

[70] *Id.*
[71] *Id.* at 8.
[72] *Id.*
[73] *Id.* at 9.
[74] *Id.*
[75] *Id.*

concerns.[76] If a merger does not result in an anticompetitive effect or conduct once the agencies conduct their analysis, the agencies will not challenge a merger.[77] Some mergers do not substantially lessen the competition in scenarios where market concentration might otherwise raise an inference to a finding of anticompetitive effects.[78] Examples include mergers that would not increase the likelihood of the exercise of market power either because of the post-merger existence of strong competition or when the merging entities are sufficiently different in character and scope.[79] Another scenario includes mergers that still allow hospitals to achieve significant cost savings that could not otherwise be achieved individually.[80] A third case involves mergers that would eliminate the hospital that likely would have failed in the existing market absent the merger with a more powerful partner.[81]

In practice, the FTC and DOJ have not challenged many hospital mergers.[82] Under the Hart–Scott–Rodino Antitrust Improvements Act pre-merger filing requirements, most FTC reviews of merger proposals are completed promptly within about thirty days.[83] The FTC has an administrative mechanism for addressing perspective merging parties who are seeking merger approval or a determination of whether or not they qualify for an antitrust safety zone exemption.[84] The FTC provides opinion letter procedures or issues an advisory opinion for merging entities if they require more clarity for what the FTC might do should the merger proposal continue.[85] This provides a more proactive approach to regulatory oversight than litigation or enforcement post-merger. If however, all else fails, the FTC can seek injunctive relief from a federal court to enjoin a merger that raises competitive concerns.[86]

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[76] *Id.*
[77] *Id.*
[78] *Id.* at 10.
[79] *Id*.
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] *Id.*
[86] *Id.*

The Federal Trade Commission also retrospectively studies the quantified changes in market outcomes, prices, product variety, quality, innovation, consumer welfare, firm efficiency, and profits after a merger changes the overall market structure.[87] The FTC's Bureau of Economics (BE) helps drive the decision-making process the Commission takes when considering enforcement decisions for merger activity.[88] The purpose of the program is to retroactively determine how a particular merger affects equilibrium behavior in one or several markets.[89]

There are two objectives of these studies. First, it is to understand whether the threshold for the agency's decision to bring an enforcement action in a merger case is too permissive thereby allowing too many harmful mergers to take place and result in greater anticompetitive markets.[90] The second goal is to assess the performance of tools that the agency officials use to predict the effects of proposed mergers proactively.[91] These retrospective studies are of particular importance in key industries like health care or energy. [92] This is because there are numerous merger activities and FTC has specific enforcement responsibilities.[93]

In health care, the FTC Hospital Merger Litigation Task Force produced studies on the effects of hospital mergers beginning in the early 2000s resulting from the essential abandonment of the FTC and DOJ pursuing hospital merger enforcement.[94] This initiative stemmed from the agency's lack of success in challenging mergers in federal court for decades.[95] The studies retroactively looked at the effects of enforcement dormancy on competitive performance in hospital markets and the insights derived from these

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[87] FED. TRADE COMM'N, *Overview of the Merger Retrospective Program in the Bureau of Economics*, https://www.ftc.gov/policy/studies/merger-retrospective-program/overview.
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] *Id.*
[93] *Id.*
[94] *Id.*
[95] *Id.*

studies revived enforcement momentum in recent years.[96] These studies correlated with more successful enforcement actions.[97] The FTC successfully obtained thirteen federal injunctions between 2008 and 2018 compared to two injunctions between 1997 and 2007.[98]

IV. CERTIFICATES OF PUBLIC ADVANTAGE (COPA)

In recent years, state involvement in the enforcement and oversight of antitrust law for hospitals has increased. One area involves the state utilization of COPAs to shield merging hospitals from federal enforcement by allocating oversight responsibility to the state.[99] However, states that attempt to replace federal oversight by granting these COPAs have come under recent scrutiny by the FTC.[100] The FTC warns that these agreements often result in higher prices and reduced quality outcomes.[101]

This section of the paper focuses on these recent trends. First, I further define COPA agreements. Next, I list the states that currently deploy COPA agreements to exhibit the variety and piecemeal approach to state-level enforcement from state to state. Finally, I highlight the concerns of the federal agency, including their current ire with COPAs and their desire for states to eliminate or stop using them.

A. *Certificates of Public Advantage Overview*

A COPA is a legal mechanism in which a state governs an agreement between the entities where the state approves their merger and subsequently shields the merged entity from antitrust enforcement in exchange for state oversight and supervision of the

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[96] *Id.*
[97] *Id.*
[98] *Id.*
[99] FED. TRADE COMM'N, *FTC Policy Paper Warns About Pitfalls of COPA Agreements for Patient Care and Healthcare Workers,* (Aug. 15, 2022), https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-policy-paper-warns-about-pitfalls-copa-agreements-patient-care-healthcare-workers.
[100] *Id.*
[101] *Id.*

merged entities' conduct.[102] COPAs, therefore, grant merging institutions federal antitrust immunity.[103] States traditionally held the authority to regulate health care delivery for their constituents.[104] This includes regulation of physicians, licensure, and certification.[105] Such regulation is therefore, not preempted by federal laws like the antitrust statutes.[106]

The Supreme Court postulated a two-factor test for state action immunity from federal laws.[107] A state or local policy choice against the competition will be honored if the state has both (1) clearly articulated its alternative policy such as its intention to reject competition as a policy instrument and (2) provided for active supervision of private actions resulting from that stated articulated policy.[108] The state must also be acting as a sovereign since it is overseeing the entities and this would indicate that state-run institutions might not be protected under this doctrine.[109]

In the past fifty years, states took action to regulate hospitals like controlling spending through rate-setting which would run counter to competitive pricing ideals.[110] States began issuing COPAs with endorsement from the American Hospital Association because it protected certain hospital mergers or other coordinated

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[102] Erin F. Fuse, *To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law,* MILBANK MEM'L FUND, (Jan. 17, 2019), https://www.milbank.org/wp-content/uploads/2019/01/MMF-North-Carolina-COPA-Repeal-Issue-Brief-FINAL.pdf.

[103] Chris Garmon and Kishan Bhatt, *Certificates of Public Advantage and Hospital Mergers: Evidence from Maine, Montana and South Carolina* (Jun. 24, 2020), http://dx.doi.org/10.2139/ssrn.3634577.

[104] Randall R. Bovbjerg and Robert A. Berenson, *Certificates of Public Advantage: Can They Address Provider Market Power?* URBAN INST., 4 (Feb. 2015), /https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf.

[105] *Id.*

[106] *Parker v. Brown*, 317 U.S. 341 (1943); *see also* Bovbjerg and Berenson*, supra* note 106, at 4.

[107] *California Liquor Dealers Ass'n v. Midcal Aluminum, Inc*., 445 U.S. 97 (1980).

[108] *Id.* at 97-99.

[109] *Id.* at 105.

[110] Bovbjerg and Berenson*, supra* note 106 at 4.

activities believed to promote efficiency from antitrust inquiries.[111] Provider cooperation was a better regulatory scheme than protecting competition.[112] To successfully comply with the *Midcal* requirement for active supervision, COPA laws required a quasi-regulatory oversight of entities seeking mergers.[113] Between 1992 and 1995, nineteen states had COPA laws on their books.[114]

B. *State Adoption of COPAs*

As of 2023, there are still nineteen states which have some form of COPA legislation in place.[115] In 2021, Indiana most recently enacted a COPA agreement that allows for mergers of predominantly rural county hospitals with a population cap, and hospitals that have no more than two units in their statewide trauma care system.[116] Five states have repealed their COPA statutes over the past two decades.[117] COPAs can vary from state to state.

I chronologically group each state's COPA highlighting portions of these COPAs to illustrate the variety and the breadth of the legislation passed. The geographic regions are grouped by paragraph. This illustrates that there may exist the potential for more uniformity or a need to address this merger activity exemption in a different manner that still achieves the intended COPA goals of increased access and reduced costs, especially in low-access regions. Part one therefore outlines COPA legislation from 1990 to

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[111] *Id. See also* Christopher Garmon and Kishan Bhatt, *Certificates of Public Advantage and Hospital Mergers,* 65 J. LAW & ECON. 465, 482 (2022) (extrapolating in their analysis that COPA regulation, if "properly designed" may result in prices that are consistent with the pre-merger market but that hospitals have strong incentives to evade regulation and pursue removal of a COPA thereby creating a monopoly with unregulated prices and reduced quality outcomes and therefore the balancing tradeoff test between short-term gains against long-term risks from monopolization).

[112] *Id.*

[113] *Id* at 4-5.

[114] *Id.*

[115] Amy Y. Gu, *Updated: States with Certificate of Public Advantage (COPA) Laws,* THE SOURCE ON HEALTHCARE PRICE & COMPETITION, (Aug. 10, 2021), https://sourceonhealthcare.org/updated-states-with-certificate-of-public-advantage-copa-laws/.

[116] Ind. Code §§ 16-21-15-1 to 16-21-15-11 (2021).

[117] Gu, *supra* note 117.

the new millennium while part two covers recent state COPA statutes that become law in the 21st century.

1. First Wave COPA Agreements: (1990-2000)

A sizeable proportion of COPA statutes were enacted in the 1990s. Wisconsin's COPA legislation has the longest legacy having been originally enacted in 1991 but revised in 2011.[118] Its scope, process, and criterion for granting a certificate are like other state COPA legislations. Criteria for granting COPAs include increased quality health outcomes, hospitals retaining their existing patients after the merger, cost reductions and increased efficiency in health services rendered, utilization of resources optimized, and duplication of resources avoided.[119] The department's decision to deny a certificate to an entity is subject to review.[120]

In the Midwest, Kansas included a balancing requirement in their COPA where health care providers have the option to negotiate a cooperative agreement if the likely benefits from the agreements outweigh any disadvantages which would have resulted from the reduction in competition in 1994.[121] In 1995, Nebraska legislators included provisionary language that grants entities intending to merge immunity under a COPA if the basis stems from conduct reasonably necessary and foreseeable to carry out the approved agreement.[122] Ohio's COPA provisions include immunity for board members and directors of one organization for specific communications.[123] These communications include those who engage in conversations with other entity board members where the nature of the conversations is limited to achieving goals that facilitate the reduction of health care costs for consumers.[124] Other provisions include improving access or improving the quality of

[118] Gu, *supra* note 117.
[119] WIS. STAT. § 150.85 (2011).
[120] *Id.*
[121] KAN. STAT. ANN. § 65-4955 (1994).
[122] NEB. REV. STAT. § 71-7709 (2007).
[123] OHIO REV. CODE ANN. § 3727.21 (1992).

[124] *Id*.

patient care.[125] The language protecting individual actors is a unique provision compared to other COPA legislation.

Several northwestern states adopted COPA laws in the early 1990s. Washington enacted their statute in 1993 and amended it in 1997, where the legislation recognized the importance of competition but carved the exemptions for issuing COPAs and defined state oversight responsibility.[126] The legislation intended to exempt from state antitrust laws and provide immunity from federal antitrust laws through the state action doctrine for activities approved that might otherwise be constrained by laws to displace competition in the health care market.[127] Washington's COPA goals included a desire to contain the aggregate cost of health care services and promote the development of comprehensive and cost-effective health care delivery systems via cooperative activities amongst health care competitors.[128] Washington also believed granting these COPAs would increase health care access, reduce costs, and improve quality outcomes.[129]

In 1993, Oregon implemented a more limited perspective on COPA adoption where only kidney and heart transplant facilities could acquire a COPA.[130] This limited COPA scope is unique and might have served as a model for Indiana's more geographically restrictive COPA that was passed in 2021.[131] Idaho enacted its COPA legislation in 1994.[132] The legislation granted the state attorney general the power to authorize a COPA agreement between entities intending to merge and to do so when the "likely benefits resulting from the agreements outweigh the disadvantages attributable to a reduction in competition that may result from such

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[125] *Id.*
[126] WASH. REV. CODE §§ 43.72.011 - 43.72.916 (1997) (Washington's statutory language regarding purpose, goals, and intent are like that of the rest of the COPA statute and therefore used as an example to highlight these features as they were one of the primary adopters of COPA statutes).
[127] WASH. REV. CODE ANN. § 43.72.300 (2) (1997).
[128] *Id.*
[129] *Id.*
[130] OR. REV. STAT. § 442.700 (1993).
[131] *See infra* note 146.
[132] IDAHO CODE ANN. § 39-4903 (1) (1994).

agreements."[133] Similarly, Wyoming enacted its COPA statute in 1995 to promote the quality of health care, access to health care, and containment of health care costs.[134]

In the Southeast, South Carolina enacted its COPA statute in 1994, and its COPA provisions are like other states' legislation requiring entities intending to merge to apply to the state to attain a COPA certificate.[135] Tennessee and Louisiana have similar broadly constructed COPA provisions.[136] Florida enacted a COPA statute to augment its Office of Rural Health program initiative for establishing a rural health network.[137] These networks are open to all health care providers and can be funded by the public.[138] The primary objectives of cost reduction and improving efficiency are the primary objectives of the COPA allowance.[139]

In the Deep South, Texas first enacted COPA laws in 1993 with subsequent modifications in recent years, allowing hospitals to enter cooperate agreements if there are no discussions of price fixing or predatory pricing.[140] In 2019, a companion bill adopted language like Indiana limiting cooperative agreements to entities in rural counties with population limits below 100,000 residents.[141]

2. Second Wave COPA Agreements: (2000-present)

Indiana's most recent 2021 COPA legislation limits granting immunity to rural hospitals.[142] The county must have a population of fewer than 140,000 people and must not be adjacent to another county with a population exceeding 250,000 residents.[143] The county must also have only two hospitals that participate in the

[133] *Id.*
[134] WYO. STAT. § 35-24-101 (1995).
[135] S.C. CODE ANN. § 44-7-530 (1994).
[136] TENN. CODE. ANN. § 68-11-1303 (2015); *See also* LA. REV. STAT. ANN. § 40:2253 (1997).
[137] FLA. STAT. § 381.0406 (2008).
[138] *Id.*
[139] FLA. STAT. § 381.0405 (2008).
[140] TEX. HEALTH & SAFETY CODE § 314.002 (2015).
[141] TEX. HEALTH & SAFETY CODE § 314A.002 (2019).
[142] IND. CODE § 16-21-15-1 (2021).
[143] *Id.*

statewide comprehensive trauma care system.[144] Additionally, one of the hospitals is a teaching hospital with a residency program.[145] Finally, the county must be "predominately rural."[146]

In the South, Virginia defined geographic limits when it established the Southwest Virginia Health Authority to include representatives from local hospitals and certain county officials in that region.[147] Virginia and Tennessee are also unique in that a multi-state COPA agreement exists between two hospital systems.[148] West Virginia's unique COPA defined certain qualified hospitals that could merge under a COPA as either teaching or academic hospitals, which are not critical access hospitals.[149] Mississippi's COPA statute, also called the Rural Health Availability Act, was created to induce hospitals to stay open and provide care in rural areas where health services challenges exist.[150]

Finally, two Northeastern states adopted their COPA statutes in recent years. New York enacted their COPA statute in 2011 but amended the statute in 2017 to include more inviting, rather than permissive, language for COPAs.[151] The provision states that it is the policy of the state to encourage "where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and acquisitions among health care providers or among others who might otherwise be competitors, under the active supervision of the commissioner." [152] Notably,

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[144] *Id.*
[145] *Id.*
[146] *Id.*
[147] VA. CODE ANN. §§ 15.2-5368 (2018); *See also* VA. CODE ANN. §§ 15.2-5370 (2018).
[148] Erin C. Fuse Brown, *Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage,* MILBANK MEM'LFUND, (Sept. 2018), https://www.milbank.org/wp-content/uploads/2018/09/MMF-Hospital-Mergers-and-Public-Accountability-Report-FINAL-2.pdf (Tennessee and Virginia approved the cooperative agreement allowing the merger of Wellmont Health System and Mountain States Health Alliance to form Ballad Health, a single health system in north east Tennessee and southwestern Virginia).
[149] W. VA. CODE § 16-29B-28 (2016).
[150] MISS. CODE ANN.§ 41-9-303 (2004).
[151] N.Y. PUB. HEALTH LAW § 2999-aa (Consol. 2017).
[152] *Id.*

Maine has a dedicated section of its COPA legislation outlining the requirements of the state for continuous supervision and time thresholds for which these reviews must take place.[153] Considering that the active supervision requirement is a necessary precondition for state preemption of federal antitrust law, it is perplexing to note why more clear requirements are not necessarily outlined in other state agreements.[154]

V. COPA Criticisms and Proposing New Solutions

COPAs have garnered significant criticism in recent years. Federal agencies have expressed their skepticism regarding their purpose and efficacy. Part A of the paper outlines the major concerns listed by these agencies. Part B looks at states that have repealed their COPA statutes and the legacy COPAs left behind. Part C then considers other variables and solutions that could be used to better optimize and regulate COPAs.

A. Federal Regulatory Agency Perspectives

The FTC's perspective on COPA utilization is well-documented. In August 2022, the FTC issued a policy paper warning against the pitfalls of COPA agreements, citing data that they resulted in higher prices and reduced quality outcomes.[155] Moreover, hospital mergers subject to COPA supervision resulted in increased hospital concentration and affected labor rates and wages.[156] Most COPAs resulted in single hospital monopolies in which there were fewer incentives to reduce costs and increased access or quality outcomes due to a lack of competition.[157] It is interesting to note that the FTC defined COPAs as "regulatory regimes" intended to displace competition among health care

[153] ME. STAT. tit. 22, § 1845 (2011).
[154] Zachary E. Sproull, *Collaboration Versus Competition in Health Care: The Role of State Antitrust Immunity in New York's Medicaid Reform Initiative*, 45 FORDHAM Urb. L.J. 875 (2018).
[155] *See* Fed. Trade Comm'n, *supra* note 103.
[156] *Id.*
[157] *Id.*

providers.[158] COPAs immunize hospital mergers from antitrust laws replacing competition with state oversight.[159]

The FTC has appealed several or provided public comment and testimony for states that recently adopted COPA statutes or specific COPA agreements.[160] The FTC's position has been that hospital consolidation is a key driving factor for increased health care costs compromising the quality of care.[161] In its policy position, the FTC also urged states to stop using or avoid COPA agreements.[162] Their studies have shown that North Carolina's COPA with Mission Health resulted in steady growth for price increases with a 20% increase in the early days of the COPA adoption.[163] Prices then increased 38% when the COPA was repealed but the entity was fully merged and now had a monopoly over the region.[164] Another study from Montana resulted in a similar 20% increase in inpatient prices after their COPA repeal.[165] A COPA from MaineHealth's agreement with the state resulted in a 50% increase in prices after the COPA agreement expired.[166]

Some disadvantages and long-term effects exist with COPA agreements or their subsequent expiration. First, COPAs aggravate hospital consolidation concerns.[167] Second, COPAs can reduce employee wages or wage growth due to limited options and bargaining power.[168] Third, active surveillance and ensuring

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[158] FED. TRADE COMM'N, *Certificates of Public Advantages (COPAs),* https://www.ftc.gov/news-events/features/certificates-public-advantage-copas (last visited Sep 2023).
[159] *Id.*
[160] *Id.*
[161] FED. TRADE COMM'N, *Key COPA Facts,* https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf (last visited Sep. 2023).
[162] *Id.*
[163] *Id.*
[164] *Id.*
[165] *Id.*
[166] *Id.*
[167] *Id.*
[168] FED. TRADE COMM'N, *Key COPA Facts,* https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf (last visited Sep. 2023).

compliance with COPAs are difficult for states.[169] Fourth, COPA agreements do not fully consider all the ways hospitals affect market power and reduce competition.[170] Finally, COPAs expire. Either the statute is repealed or the agreement expires, is revoked, or can be terminated.[171] Once the agreement with the state expires, there is no more oversight, and the market is left with a hospital monopoly that can affect markets without constraint.[172]

In a 5-0 vote, the FTC concluded, that "[i]n the long run, hospital mergers shielded with COPAs often lead to higher prices and reduced quality from unconstrained provider market power."[173] Despite hospital claims that COPAs will result in lower costs and improved population health outcomes, there is no demonstration of proven benefits of COPAs. For these reasons, FTC staff urges state lawmakers to avoid using COPAs to shield otherwise anticompetitive hospital mergers."[174]

A. *COPA Repeals*

It is prudent to look at examples where COPAs either failed or were repealed. Five states have repealed their COPA legislation: Montana, Minnesota, North Carolina, North Dakota, and Colorado.[175] One observation of a post-COPA agreement is an increase in consumer prices and reduced quality outcomes from unconstrained provider market power.[176] North Carolina's COPA, which was enacted in 1993, initially resulted in allowing a health system to merge and achieve a quasi-monopoly.[177] In 1995, Memorial Mission Hospital and St. Joseph's Hospital entered into under agreement under state COPA regulations.[178] They merged in

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[169] *Id.*
[170] *Id.*
[171] *Id.*
[172] *Id.*
[173] FED. TRADE COMM'N, *FTC Policy Perspectives on Certificates of Public Advantage* 12 (Aug. 15, 2022) https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf.
[174] *Id.*
[175] Amy Y. Gu, *supra* note 117.
[176] Garmin & Bhatt, *supra* note 113.
[177] Fuse, *supra* note 104.
[178] *Id.*

1998 and sought state approval and regulation once again.[179] In 2014, they lobbied the state legislature to repeal the state COPA statute resulting in the COPA agreement expiring in 2016.[180] In 2019, Mission Health was acquired by a national health care system, HCA Healthcare, since there was a regulatory void even though the original state COPA intended to prevent out-of-sate acquisitions.[181] Costs increased by at least 20% during the COPA period and ballooned to 30% after the COPA was repealed.[182]

Montana's COPA repeal resulted in similar outcomes.[183] The Montana Department of Justice allowed Columbus Hospital and Montana Deaconess Medical Center to merge under a state COPA agreement in 1996.[184] These were the only two acute medical centers in the geographic region of Great Falls, Montana.[185] In 2007, the merged entity, Benefis Health Systems, lobbied the state legislature to repeal the COPA agreement despite protest from the state attorney general.[186] Benefis now operates without regulatory oversight and patient costs have increased by 20% after the repeal took place.[187]

Criticism of COPA agreements suggests a long-term risk for states or regulators in which entities form monopolies either after a COPA expires or when a COPA statute is repealed, thereby undermining the original intent of the legislation.[188] COPA laws permit hospitals in a concentrated market to merge and shield the merger from federal antitrust enforcement.[189] The FTC warns that limited state resources, regulatory fatigue, and repeals of COPA laws, once a merger takes place, reduce a state's ability to ensure hospitals cannot leverage greater market power or increase market

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[179] *Id.*
[180] *Id.*
[181] *Id.*
[182] *Id.*
[183] FED. TRADE COMM'N, *supra* note 172.
[184] *Id.*
[185] *Id.*
[186] *Id.*
[187] *Id.*
[188] *Id.*
[189] FED. TRADE COMM'N, *supra* note 172.

share.[190] Their key hypothesis postulates that substituting market competition among hospitals with state regulatory oversight will result in increased costs or decreased health outcomes.[191]

B. *Other Variables to Consider for Optimized Outcomes*

1. The Need for Uniformity

From the litany of COPA cases litigated and the rationale for state or federal regulators to enforce certain merger activities but not others, there exists an opportunity for clarity in this arena. Such clarity requires more concise guidelines from the regulators, such as the Federal Trade Commission, and greater collaboration with other regulatory agencies. An example of this would be the Department of Health and Human Services who might be better subject matter experts in this arena to help distillate clear guidelines or even decide certain controversies where the facts are convoluted or complex. Guidance documents, including the Horizontal Merger Guidelines which were last updated in 2010, suggest that more timely guidance is required for the industry.[192]

However, uniformity in standards would yield desirable outcomes for the health care industry. If the COPA experiment taught the health care provider sector anything, it is that a piecewise individual agreement with the proposed merged entity results in mixed outcomes. Federal enforcement should enhance or supplement state oversight where regulatory resources are limited. These COPA experiments have now had nearly three decades' worth of data to assess the long-term effects of the arrangements. However, consumers might be paying the price when these agreements end or when COPA legislation is haphazardly repeated, creating super conglomerates resulting in limited choice and higher prices. The intended purpose of protecting consumers not only offends the bedrock antitrust principle of protecting competition but

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[190] *Id.*

[191] *Id.*

[192] Debra A. Valentine, *Health Care Mergers: Will We Get Efficiencies Claims Right? See also* FEDERAL TRADE COMMISSION (Nov. 14, 1997) https://www.ftc.gov/news-events/news/speeches/health-care-mergers-will-we-get-efficiencies-claims-right.

also the most vulnerable participants in this competition: the consumers these laws were meant to protect.

Such clarity could result in savings where the courts are not faced with complex decision criteria which could then be passed onto the consumers and result in better health quality outcomes overall. Most importantly, courts could apply more cogent interpretations of competition law principles to allow for more consistent application of enforcement and determination of exceptions and exemptions. In a regulated industry like health care, more clarity in the form of safe harbors or exemptions that provide for favorable treatment from enforcement would simplify the current complexities.

2. The Need for Efficiency

As demonstrated by the complexities in the laws and antitrust enforcement, one common theme that comes up repeatedly is this balancing of the countering principles of competitive effects versus other benefits achieved from engaging in such conduct. This is the bedrock argument for states that adopt COPA statutes or hospitals arguing to get one to shield themselves from federal enforcement.

One such benefit is efficiency. For instance, achieving higher efficiencies is a consideration, though not a defining factor, for whether an antitrust safety zone exemption might apply for a given enterprise when organizing as an accountable care organization.[193] While arguments favoring efficiency have been pleading in mergers and acquisitions, these are often not successful.[194] Antitrust laws must be balanced with other laws and regulations, including the Affordable Care Act, where quality and efficiency considerations are raised.[195] Solutions have been

[193] Markus Meier, et. al, *Overview of FTC Actions in Health Care Services and Products*, FED. TRADE COMM'N, (Jun. 2019), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_june_2019.pdf at 105.
[194] Jamie L. Bjorklund, *St. Alphonsus Medical Center v. St. Lukes Health System: The Uncertain Application of the Efficiencies Defense is Leading to Unpredictable Outcomes in Healthcare Mergers*, 53 IDAHO L. REV. 577 (2018).
[195] *Id.* at 607.

proposed which suggest that certain quality or access efficiencies be weighted more for determining the pro-competitive effect in a possible merger. Consumer welfare is the main purpose of these competitive principles that antitrust regulations attempt to honor because it promotes more choice and lowers costs.[196]

Sorting out efficiencies is considered a "mixed bag" in health care.[197] However, there are some practical considerations when arguing an efficiency defense. These include cost savings from administrative and back-office functions, reducing capital expenditures, sharing technology and data systems, sharing best operating practices, consolidating service lines, and integrating a value-based, risk-taking enterprise such as an accountable care organization.[198] While horizontal mergers are usually looked at with a critical lens by regulators, this does not mean that efficiency arguments should not be used.[199]

3. The Need for Novel Solutions

Hospitals are subject to many regulations such as needing to provide data to certain governing entities to maintain their status whether for credentialing, licensing, or funding. One example is a charitable hospital maintaining its non-profit status. A non-profit hospital must provide and quantify community benefits delivered to maintain its non-profit status.[200] They must pass the organizational

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[196] *Id.* at 613-14

[197] Leigh L. Oliver & Robert F. Leibenluft, *A Mixed Bag: Sorting Out Efficiencies Arguments in Hospital Mergers* ANTITRUST L. J. AM. BAR ASS'N, Vol. 30, No. 1 (2015), https://www.americanbar.org/content/dam/aba/administrative/healthlaw/13_efficiencies.authcheckdam.pdf.

[198] *Id.* at 21-23.

[199] *Id.; See also* Norman Armstrong Jr. & Subramaniam Ramanayanan, *Taking Stock of the Efficiencies Defense: Lessons from Recent Health Care Merger Reviews and Challenges.* 82 ANTITRUST LAW JOURNAL. AMERICAN BAR ASS'N. (2019) *(*discussing the need to provide specific and quantifiable metrics).

[200] INTERNAL REVENUE SRVC., *Charitable Hospitals - General Requirements for Tax-Exemption Under Section 501(c)(3),* (last visited Dec. 12, 2022), https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3.

and operational tests to justify their tax-exempt status.[201] The community benefit standard requires an entity to operate for the charitable purpose of promoting health and organize itself in such a manner.[202]

COPA agreements could be subject to similar premerger qualifications including the need to demonstrate an increase in community benefit post-merger. Specifically, a board comprising regulators and community stakeholders should oversee the COPA agreements to ensure active oversight and not leave this task to a burdened entity such as the Attorney General's office. The board should set provider rates or third-party payors such as CMS should set caps for amounts reimbursable to merged entities which diminishes payments.[203]

Incentive regulation is another regulatory tactic that might offer potential benefits. Incentive regulation gives a merged firm the ability to increase profits by being more efficient.[204] It not only formalizes the process but also puts the hospitals at risk of achieving the anticipated or claimed efficiency gains.[205] Incentive regulation is based on setting price caps and therefore incentivizes the entity to become more efficient since the amount of reimbursable revenue is limited. State public utility commissions to make such regulation effective in other public services sectors.[206]

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[201] *Id.*

[202] *Id.* Factors for demonstrating community benefit include: operating an emergency room open to all, regardless of ability to pay, maintaining a board of directors drawn from the community, maintaining an open medical staff policy, and providing hospital care for all patients able to pay, including those who pay their bills through public programs such as Medicaid and Medicare, using surplus funds to improve facilities, equipment, and patient care; and using surplus funds to advance medical training, education, and research.

[203] Erin C. Fuse and Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L.J. 55 (2016) (discussing control measures for health care integration overall).

[204] Erwin A. Blackstone & Joseph P. Fuhr, *Hospital Mergers: The Shift From Federal Antitrust Enforcement to State Regulation,* J Health L. 33(1),103-27 (2000).

[205] *Id.*

[206] *Id.*

VI. Conclusion

While antitrust regulations have been a part of American jurisprudence for over a hundred years dating back to the Sherman Act, their application to health care is complex and ambiguous at times. Enforcement sometimes results in a paradoxical clash of principles—the procompetitive principle to protect consumers from the harmful effects of monopolization contrasted with access issues where many participants in the marketplace are not even for-profit organizations. At the heart of this debate, there exists a fundamental tension between state and federal oversight regarding whose authority should supersede the others.

At its core, a COPA agreement is a symbol of this tension. COPAs substitute federal enforcement with state-level oversight. The public must balance the risk long-term of increased costs and reduced quality outcomes associated with monopolization from a merger under COPA supervision or even its eventual repeal with the short-term gains that might be achieved. The real-world implications highlight the need for uniformity, efficiency, tools, and tactics needed by regulators to ensure that a COPA achieves its intended purpose. This may require novel thinking and borrowing models of regulation from other public services sectors where self-enforcement using incentivization to maintain one's status should be used for entities entertaining merger activity.