# A Health Check on COPAs

## Assessing the Impact of Certificates of Public Advantage in Healthcare Markets

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# Workshop Transcript: Session 1 (Morning)

(Corresponds to Video for Session 1)

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# WELCOME AND INTRODUCTORY REMARKS

[MUSIC PLAYING FOR 7:30 MINUTES]

STEPHANIE WILKINSON: Okay, ready? Okay, I think we're going to go ahead and get started if everybody can take their seats. Good morning, and welcome to the Federal Trade Commission's Workshop to assess certificates of public advantage, known as COPAs. My name is Stephanie Wilkinson. I'm an attorney advisor in the FTC's Office of Policy Planning.

This workshop is part of a broader policy project announced in 2017, in which staff from the Office of Policy Planning, the Bureau of Economics, and the Bureau of Competition are trying to better understand whether COPAs achieve their desired outcomes. We have spent many months organizing today's workshop, and we are pleased to have several speakers who will share their research and experiences with us regarding COPAs and related topics. We hope this information will help to advance the agency's policy and enforcement strategies.

Now, before we get started, I'm required to review some administrative and safety details with the audience, so please bear with me here. Please take a moment to silence any mobile phones and other electronic devices. If you must use them during the workshop, please be respectful of the speakers and your fellow audience members. Please be aware that if you leave the Constitution Center Building for any reason during the workshop, you will have to go back through security screening when you return, so please plan accordingly.

Most of you received a lanyard with a plastic FTC event security badge. We reuse these for multiple events, so when you leave for the day, please return your badge to security. If an emergency occurs that requires us to leave the conference center but remain inside the building, please follow the instructions that will be provided over the building PA system.

And if an emergency occurs that requires us to evacuate the building, an alarm will sound. We ask that everyone exit through the main lobby and proceed to the FTC Emergency Assembly Area, which is located near Seventh and E Streets. Please remain in the assembly area until instructed to return to the building.

And if you notice any suspicious activity, please alert building security. Also, please be advised that this event may be photographed, webcast, or recorded. By participating in this event, you are agreeing that your image and anything you say or submit may be posted indefinitely at ftc.gov or on one of the Commission's publicly available social media sites.

Okay. As we begin our substantive program, I want to let everyone know that all of today's presentations will be available on our workshop website, ftc.gov/copa. We will also be live tweeting the workshop at the Twitter handle #CopaFTC, in case people would like to follow that discussion. Both the website and the Twitter handle are displayed at the bottom of the program agenda.

I'd also like to remind everyone that we are accepting written public comments through July 31. While we are limited in the number of people we can invite to participate on our panels, we want to hear from everyone who would like to share relevant information about the impact of COPAs. Instructions for submitting comments are available on our workshop website. Now I would like to introduce the Chairman of the FTC, Joe Simons, who was sworn into office on

May 1 of last year. We are excited that he is joining us to give the opening remarks for today's workshop. Thank you.

[APPLAUSE]

# OPENING REMARKS

JOSEPH SIMONS: Well, good morning, everyone, and welcome. Welcome to today's workshop, *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Health Care Markets*. I would like to extend our thanks, first of all, to all the workshop participants. This is a terrific set of panels that Stephanie and her colleagues have put together. And I'd especially like to thank our colleagues from the state attorneys general offices for traveling all the way to D.C. to join us, some of them from fairly far away.

Thank you also to the folks in the audience, and thanks to those of you who are joining us via live webcast. Finally, I want to express my extreme appreciation to the many staff members at the FTC across our different bureaus and offices who helped organize today's event. In particular, I want to recognize the staff from the Office of Policy Planning and the Bureau of Economics, who took the lead in putting together today's terrific program.

Today, we're going to have a conversation about what we know-- and what we don't know-- about the effects of certificates of public advantage, or COPAs. As part of our effort to encourage additional learning and scholarship, we've invited presentations about ongoing research, and we have really great stuff in store for you.

Here's what we know. COPAs are regulatory regimes developed and supervised by states. They are undertaken by hospitals or other health care providers in the context of mergers, acquisitions, and other collaborations. COPAs typically require hospitals to make a number of behavioral commitments-- ranging from rate regulation, price caps, to quality and community investments, and to promises to keep facilities open for a set time.

Importantly, from the FTC's perspective, these regimes purport to grant hospitals immunity from the antitrust laws under the state action doctrine. The Supreme Court has said that private organizations can engage in conduct that would otherwise violate the antitrust laws so long as the state has clearly articulated an intent to displace competition in favor of regulation and that the state is actively supervising that conduct. The FTC is further interested in clarifying the precise metes and bounds of the state action doctrine, as we have done before the Supreme Court in the *North Carolina Dental* and the *Phoebe Putney* cases, but we will leave that topic for another day.

For the purposes of framing today's discussion, I want to note that in several recent hospital mergers, COPAs have prevented the FTC from challenging problematic transactions. For example, in 2016, in the midst of an active FTC investigation, West Virginia passed additional COPA legislation that granted COPAs to Cabell Huntington Hospital and St. Mary's Medical Center, the only two hospitals in Huntington, West Virginia. The Commission ended up closing its investigation and dismissing its litigation, and the hospitals merged. More recently, the states of Virginia and Tennessee granted COPAs to Mountain States Health Alliance and Wellmont Health System during an FTC investigation, and the FTC ultimately had to abandon its challenge there as well.

At least four COPAs are active and operational today. Those four COPAs exist against a backdrop of almost two dozen states that have COPA statutes on their books, creating the possibility for even more health care providers to seek COPAs. We are also seeing an uptick in the interest in COPA legislation activity in the statehouses across the country. For example,

the state of Texas recently passed a bill expanding its COPA statute to apply to hospital mergers.

The Commission has been skeptical of the use of COPAs to protect consumers from competitive harm. We continue to believe that competition is the best way to reduce prices and improve service quality for health care consumers, just as it is in most other markets. While we understand and are sensitive to the challenges faced by providers in today's complex health care ecosystem, we generally think that antitrust law is flexible enough to let pro-competitive deals proceed while targeting only those transactions that would truly harm consumers.

Having said that, we also believe that the FTC's enforcement and policy decisions must be grounded in sound economics and rigorous empirical analysis. That's why it's so important for us to test empirically the effects of COPAs on health care markets and ultimately on consumers. Then we can better understand what COPAs do or do not do with respect to prices, clinical quality, patient access, and innovation. There has been little research into the actual harms and benefits associated with COPAs, and for that matter, we don't know enough about what happens to markets when COPAs go away-- as they almost surely do eventually.

Today, we are taking a big step forward in developing that understanding. This workshop is a great example of what the FTC does so well, using its unique policy and study tools to conduct original empirical research and bringing together expert stakeholders for rigorous discussions. This will not only inform our own analysis at the FTC but also aid others in considering these issues.

We will hear presentations about four retrospective studies-- two by members of the FTC's Bureau of Economics and two by BE alums. Three of these studies will evaluate price effects of hospital mergers operating under COPAs in Montana, North Carolina, and South Carolina. One study will examine the effects of the Phoebe Putney and Palmyra hospital merger in Georgia.

Today's workshop will also importantly incorporate perspectives from stakeholders with direct and extensive experience with COPAs. Notably, we will hear from past and present state attorneys general who oversee and monitor COPAs. We will also hear from representatives of hospitals operating under COPAs as well as other health care providers and commercial health plans doing business in markets where a COPA is in place. The workshop includes academics, health policy experts, and others who will address broader issues in the health care markets that are relevant to COPAs.

Finally, and very importantly, let's not lose sight of the patients in the discussion. Health care policy deeply affects people and communities all across the United States, and it is critical that we get it right. The FTC will continue to work tirelessly to advocate on behalf of US health care consumers and to promote competitive health care markets that generate lower prices and better clinical quality.

Thanks again for all of you being here today, and I hope and feel confident that you will enjoy the program. Thank you.

[APPLAUSE]

## FRAMING PRESENTATION – HISTORICAL CONTEXT FOR COPAS AND RECENT RESURGENCE IN COPA ACTIVITY

AILEEN THOMPSON: Good morning. My name is Aileen Thompson. I'm an assistant director in the Bureau of Economics at the Federal Trade Commission. And it is my pleasure to introduce our first speaker, Professor James Blumstein. He is a professor of constitutional law and health policy at Vanderbilt School of Law, and he'll be providing an historical perspective on COPAs and also discuss recent activity. Thank you.

JAMES BLUMSTEIN: Thank you, Aileen. I'm Jim Blumstein. I want to thank the FTC staff for inviting me to participate-- at least I think I want to thank them, until it's all over, we don't know-- and to do this framing presentation. This is the second time that I have done an FTC framing presentation, and it's always an interesting challenge.

I also want to thank Stephanie Wilkinson and Katie Ambrogi for kind of babysitting me on this project over the telephone and talking me through this and asking me to participate. They did a great job. And I have to say as an academic, I'm pleased that three articles I did in the 1990s-- 1994, '96, and 98-- are still relevant and important in thinking through these issues, and it just goes to show that flattery will get you anywhere with respect to my participation.

There's a story I'd like to tell about the importance of promoting understanding, and it's important to develop in a program like this-- common terminology. And we had some years ago a jurist, very prominent jurist from Great Britain, tell us what he said was a true story-- but anyway, it's for what it's worth. And he told the story about Great Britain trying to get a good sense of the demographics of the court and the judges sitting on their courts.

They sent out a questionnaire that asked the Chief Judge of these courts, the district courts, to list members of the court broken down by sex. And one questionnaire struck the Lord Chief Justice as interesting. The Chief Judge answered that there were none broken down by sex. There were two broken down by age and three broken down by alcohol, but none broken down by sex. So this shows it's important to have in communication an important vocabulary that's shared and understanding. And so I'm going to be talking a little bit about the use of language, and it's important in our understanding.

I have renamed slightly the talk that I'm going to give, and I have called it *The Historical Context for COPAs: Ways of Thinking About Medical Care and Federalism*. In my more avant-garde moments, I thought that I could call this The Role of Two Tensions-- The Different Paradigms in Federalism. But those are two overarching themes that I think are going to be very important in understanding the push for antitrust, the pushback against antitrust, and the role that COPAs have played in the pushback against antitrust.

So let me start. I want to talk about different ways of thinking about medical care, how language shapes perception, what the different paradigms are-- professional and the market paradigm. Secondly, the role of antitrust in promoting the market paradigm. Antitrust emphasizes economic efficiency and consumer welfare. There's less emphasis on considerations of equity, for example, across subsidization for worthy purposes. And thirdly, the role of federalism in promoting the professional paradigm, *Parker v. Brown*, the state action case, and the rise of state action immunity. And then ultimately, the response by use of *Parker* is a form of resistance to the use of the market and the application of antitrust in health care marketplaces.

So let me get going. The importance of language. Think about the old Soviet Union in which there was a race between the Soviet car and American car, and this is how it was reported in the Soviet press-- “We're proud to announce that there was a race in which the US and the USSR participated, and we're proud to say the USSR finished second and the Americans finished next to last.”

[LAUGHTER]

Think about that for a minute, okay? Language is meant to clarify but can be used to obfuscate as well. And so in the health care arena, I want to focus on how we think about health care. Do we think about it as a delivery system? Or do we think about it as an industry?

The use of the terminology "system" suggests a social services delivery model. It suggests a health planning approach. "Non-system" is a pejorative. It connotes that there should be an organized system but that there is not one, in fact.

The use of the term "industry" suggests an economic sector in which principles of supply and demand economics have relevance. Industry comports with an antitrust view that trade or commerce is involved. The "non-system" terminology has limited applicability in a market context. We don't think of a personal computer delivery system or a system of legal services delivery. We think of markets for personal computers or legal services, and they are not necessarily organized along social services lines.

Now let me come to the different paradigms, the different ways of thinking about medical care, the professional and the market-oriented paradigms. These are competing visions of medical care, and they reflect political or even ideological tensions. The professional and the market paradigms are broad categories, and in truth, elements of both must exist. So I think it's wrong to think that either the market approach or the professional approach is the one right approach. I think a continuum is a better way of thinking about the issue.

And I like to tell Yogi Berra stories. Yogi Berra was once asked, “What is more important in baseball, physical ability or mental attitude?” Yogi thought for a moment, and then he responded, “Well, you know, 90 percent of the game is mental, the other half is physical.” And that's pretty much what I think about in the medical care context. One might say that 90 percent of the issue is professional, the other half is economic.

All right, let's turn to the professional model. What are the assumptions and implications? It reflects an approach to perceived market failure. It observes a lack of knowledge on the part of consumers and the scientific expertise of physicians, what is typically referred to as information asymmetries. The professional model substitutes professional control of decision-making for that of consumers, this vast authority to determine quality and volume of services and ultimately costs on professional providers.

The assumption is that patients are uninformed and that the market cannot function in the face of such consumer ignorance. This provides the basis for health planning and other substitutes for the market model. Hospital cooperation laws are grounded in these traditions.

And if you like to think about a story, I saw in the last election cycle, an interview, kind of a man-on-the-street or person-on-the-street interview, and the reporter asked this guy, “Well, what is the worst problem today regarding the political process, voter ignorance or voter

apathy?" And the guy thought for a moment, and he says, "You know, I don't know, and I don't care." And that is basically the assumption of the professional paradigm, which has vested enormous authority in professionals to make fundamental decisions regarding medical care.

Further assumptions of the scientific approach is that diagnosis and treatment decisions are not influenced by financial incentives. That is, financial incentives do not affect professional judgment. There's no moral hazard in that situation. This was once an empirical claim. It's now more a normative claim that the introduction of economics corrupts medical judgment, an important value judgment. So what are the consequences of these assumptions? This allowed for development of third party payment with a blank check and minimal oversight because the assumption that the flow of dollars does not affect levels of utilization. It supports health planning and the use of cross-subsidizations to achieve policy goals and objectives.

So what about the market paradigm? What are the assumptions of the market model? The market-oriented response to consumer ignorance is education and an improved flow of information. Enhance disclosure, improve patient participation in decision-making so that there's a shared decision-making model. This contemplates a greater role in decision-making for patients either directly or through information intermediaries, such as the navigators under the Affordable Care Act. Payers or consumers control decisions regarding levels of quality and overall levels of service and quantity provided.

Clinical uncertainty poses a real challenge to the professional model because it calls into question the scientific assumptions that are the undergirding or the foundation of the professional model. The goal in the market model is to develop a system where incentives are proper and where private decision makers make both self-interested and socially appropriate decisions.

So what are the consequences of a move to the market model? Very briefly, efficiency is the objective of markets, and it reduces super-competitive returns. And ultimately, this challenges the agenda of using cross-subsidies to achieve health policy goals, such as improved access. Ultimately, the market model rechannels competition, and it focuses upon a changed mindset-- what I like to think of as a culture struggle or kulturkampf with more entrepreneurial activity, where economics takes over and economics becomes king.

There's a more active role for managers, for business principles, and the growth of networks for efficiency in marketing. And payers are important, are critical in a marketplace. And to the extent that payers are disadvantaged or hamstrung, that becomes a problem for those pursuing market objectives. And critically, again to re-emphasize, the importance of cross-subsidization is diminished. In a marketplace, excess profits, supernormal profits, are competed away, and the ability to rechannel these dollars for worthy purposes, worthy goals, is diminished. In the marketplace, payers, not providers, are sovereign, and empowerment is important for payers and consumers.

So what's the role of antitrust in this kind of structure? In my view, antitrust is the engine of the market paradigm. Application of antitrust doctrine has both substantive and symbolic importance, and it facilitates this cultural transformation from one way of thinking about medical care to another. Antitrust is both symbolically and substantively important.

Symbolically, it shifts the vocabulary, back to language. The elimination of wasteful duplication is the planner's watchword. In the marketplace, in the antitrust world, this looks a

lot like territorial market division. Coordination in the planner's world is a good thing. In the antitrust world, it looks like conspiracy, an illegal act. Antitrust focuses upon trade and commerce, which are economic terms. So symbolically, antitrust is important as an important bulwark of the inroad of the market paradigm on the professional paradigm.

Substantively, antitrust conduct is evaluated based upon efficiency. It encourages competing away super-competitive or supernormal profits, and it reduces the opportunity for cross-subsidization. And it certainly reduces the role for a worthy purpose defense as a defense against anti-competitive conduct. And antitrust courts typically do not weigh pro-competitive virtues against competing views.

This is part of the *Parker* analysis, and it is a challenge between the market view of the world and the professional view of the world. This undermines the professional commitment to quality at any cost, and it challenges the egalitarian ideal that money should not matter in medical care. So to summarize on the antitrust front, the focus on efficiency necessarily submerges equity concerns about of access egalitarians and quality and autonomy concerns of professionals, and it suggests a shift in culture from the professional model to the economic model.

The groundwork for the application of antitrust in the health care arena comes as a precursor to the use of these hospital cooperation laws with COPAs. We saw starting in the '70s, the Supreme Court definitively said that there is no learned professional exemption, that the health care market or the professional market is subject to antitrust considerations.

We had the Health Care Quality Improvement Act of 1986 that repealed much of the federal health planning and regulation superstructure, including federal incentives for certificate of need. We saw the different method of payment for Medicare under DRGs. We saw a challenge and a threat to the traditions of the professional paradigm, and we saw evidence of the effectiveness of the use of economic incentives, which challenged or called into question one of the tenets of the professional model. And we saw, as I said before, the clinical uncertainty that challenges the professional model.

So then we see federalism as an antidote to the inroads of the market paradigm, and I think we have to see the use of these federalism doctrines reflected in the initial round of hospital cooperation legislation. In the 1980s, this was a pushback against these market-based reforms. The regulatory and the planning model were used and the focus on a wide array of potential benefits from cooperation. And so I view the COPA legislation as a pushback.

*Parker v. Brown* emerged in the late '80s, and a case called Patrick against Burget in the early '90s—1992, and the *FTC v. Ticor* case as a response that said there will be teeth in the antitrust laws. If the states want to confer antitrust immunity on private parties, they have to have and exercise oversight-- they have to articulate the values, which I think is satisfied, but they have to supervise what's going on so that these are not private cartel decisions, they are actually decisions of the state government.

So the supervision must be actual, not theoretical. It has to be done by an agency that has political accountability and some visibility. And as a result, I think the industry backed away from the use of this type of legislation because there was a worry of excessive oversight, that the government would be engaging in a political colonoscopy of these mergers, and that this

was too painful a prospect. And so I think that explains the backing away. For 20 years or so, these were not very often used. The FTC ran a bunch of cases unsuccessfully.

Now we see the reemergence of these COPAs, and I think that's correlated with the success that the FTC has had from its research on the effects of some of these mergers, where they begin to raise these cases and have had greater success.

The focus going forward is going to be on what the meaning of active supervision is and how the government oversees these anticompetitive conducts, how they oversee the anticompetitive conduct. And so that's going to be the next battleground. So far, the Supreme Court has not required that the states-- that the *Parker* immunity-- engage in a substantive analysis.

What the courts have required is that states do this, but not that the federal law commands a particular outcome. It's just an accountability structure that the states have to, in fact, embrace the regulatory model as the state's own and take political responsibility for it, but not necessarily what the outcome should be. That's left to the states under principles of state sovereignty and federalism.

So I think that what we've seen is that the industry has thought that the active supervision is worth a candle now, and I think they've been concerned about some successes that the FTC has had and the reemergence of antitrust and its application to the health care industry. And so we now have the COPAs, which are much more robust than they were originally thought to be 20 or 25 years ago, and we're going to see some examples of that here in the discussion in this workshop.

So in conclusion, this is really a story of the tug and pull between the different ways of thinking about health care, the professional and economic paradigms. Antitrust enforcement is an important component of the struggle or the kulturkampf on behalf of the market model. Proponents of the professional paradigm have found some recourse under the *Parker* state action antitrust doctrine-- a doctrine which empowers states to substitute regulation for competition, but that safe harbor is now rigorously policed and is rigorously policed on an ongoing basis. We still don't know what that means. How ongoing does it have to be? How often? But states are not just passively ratifying private anticompetitive conduct, but acting independently in a politically accountable manner.

So that's the struggle with the tales of these two tensions between the market model and the professional model-- market model advanced by antitrust law and the pushback of the professional model using *Parker* state action immunity, where the political battle is at the states and the meaning of what active supervision is is the frontier to be faced. Thank you very much.

[APPLAUSE]

## PANEL 1 – RETROSPECTIVE EMPIRICAL STUDIES OF COPAS

AILEEN THOMPSON: Thank you very much. So our next session is on retrospective empirical studies of COPAs. We're going to start with four presentations of empirical analyses of mergers that took place in the context of a COPA or, in the case of our last study, in the context of another form of state action. Following that, we'll have two discussants share their reactions to the studies. If you have questions during the session, please fill out a question card. There will be volunteers in the aisles with cards for you to fill out. And time permitting, we'll try to address those questions at the end of the session during a moderated question and answer period.

So the first three studies are all empirical studies of COPAs that took place in the 1990s, and they rely on Medicare cost report data, which are publicly available. And our first speaker is Chris Garmon. Chris is a professor in the School of Management at the University of Missouri Kansas City, and he's going to be talking about his work on the Benefis Health COPA.

CHRISTOPHER GARMON: All right. Thank you, Aileen. And thank you for inviting me and putting out the call to do empirical research on COPAs. I'm not sure if the-- pull the slides. I'll use these. Okay, excellent. Let's see. There we go.-- The other thing I just wanted to mention, this is preliminary work, but I welcome your comments and suggestions for ways to improve this. Hopefully, we will get this out in published form at some point later in the year.

So just a little bit of background about the Benefis Health in Great Falls, Montana. So in 1993, the Montana State Legislature passed COPA legislation granting authority to the Montana Department of Justice to review health care combinations in Montana and also grant certificates of public advantage if it felt that the benefits of the merger were such that they would benefit the community, subject to conditions that the Montana Department of Justice could impose through the COPA.

A few years later in 1996, Columbus Hospital and Montana Deaconess Medical Center, the only two hospitals in Great Falls, Montana, applied for a COPA for their merger. They were granted a COPA from the Montana Department of Justice, who ruled that combination would be beneficial to consumers, subject to certain conditions, which I'll discuss in the next slide. And then those two hospitals merged to form Benefis Health Care, then renamed their combination Benefis Health a few years later.

Fast forward 10 years to 2006. In that COPA legislation, there was a clause that said the COPA had to be reviewed every 10 years, and the Montana Department of Justice reviewed it, determined that it should continue. Benefis did not want it to continue. Then Benefis lobbied the Montana legislature, and they passed an amendment in 2007 to amend the COPA legislation to basically cap COPAs at 10 years. And they included Benefis in that cap, so that effectively ended the COPA in 2007, retroactive to 2006.

The COPA itself had a number of conditions. Principally, the one that I'm really looking at, related to price. So the COPA set up what was called a total cost target-- what the Montana Department of Justice felt was the costs that the merged hospital should have if it's operating efficiently-- and then based a patient revenue cap on that total cost target, the total cost target plus 6 percent. The patient services portion of that overall revenue cap was the patient revenue cap, and that price cap essentially was what Benefis had to work within.

There was a little bit of wiggle room, accumulative excess revenue of $3.5 million, so Benefis could go over a little bit. And if it went under a little bit, that would also count for it. But if it went cumulatively over 3.5, then there could be consequences. There were also conditions for quality, which was monitored by the Montana Department of Public Health and Human Services, and access. The hospitals were required to maintain all of the services that were available on December 31, 1995. There were additional conditions for abortion, but other than that, all the services that were there at the end of 1995 had to be maintained.

Unfortunately, because of a lack of data, I can only really look at the price impacts of the Benefis Health merger and COPA. So the objective of this research is to estimate the impact on the commercial inpatient price of the merger and COPA, and the repeal of the COPA in 2006. For an empirical researcher, it's a nice opportunity to separate the effect of the merger from the effect of the COPA. So I can look at what was the effect of the merger without COPA regulation once that was taken off. Unfortunately, I don't have data that allows me to fully look at outpatient prices or quality or access to care, which are very important for considering COPAs, as well. So everything here is just looking at the commercial inpatient price.

So the data that I use, as Aileen mentioned, this is public data from CMS from the Healthcare Cost Report Information System-- or just the cost reports, HCRIS. And this is a method that was developed by Leemore Dafny, who we're very fortunate to have as a discussant on this panel. She did one of the first comprehensive studies of hospital mergers in 2009, and many of the papers on hospital mergers in recent years have used this same method to measure hospital prices. It's, I think, a very good method for measuring price changes as long as Medicaid shares are relatively constant. If Medicaid shares for the hospital are relatively constant, the research that I've done and others have done have shown that it's a good measure of price changes for hospital mergers. So I use that for the primary results looking at the commercial inpatient price.

Unfortunately, that data only goes back to 1997. The merger was in 1996. So to get an idea of how things changed relative to the pre-merger period, I also supplement that data with the compliance reports that were issued by the Montana Department of Justice, where they reported the price changes, the nominal price changes, relative to 1995. They didn't report the actual prices, but how did the price changes relative to what they were in the year before the merger.

So when you're trying to estimate the effects of a merger-- price effects in this case-- what you have to do to do that appropriately, you have to know what would have occurred had the merger not happened, had the merger and COPA not happened. So we have to have a proxy for the world that would have occurred without the merger.

In Montana, there are three urban areas, metropolitan statistical areas as defined by the Office of Management and Budget-- Great Falls, Billings, and Missoula. The presumption is that had the merger not occurred in Great Falls, Great Falls would have continued as a two-hospital city. Billings has two competing hospitals, Missoula has two competing hospitals, so the natural control group for trying to understand what would have happened in Great Falls had the merger not occurred would be Billings and Missoula. So that's my primary control group, what I call the Montana Duopoly Group, those other markets in Montana that are duopolies, have two hospitals.

Unfortunately, that gives me only four hospitals for the control group, and so that makes it sensitive if there's any idiosyncratic shock to one of those hospitals that could throw off the results. So I want to make sure that the results are robust to other control groups. So I also use

what I call the Montana Cohort, which are nine large prospective payment system hospitals that are identified in the reports that were prepared by White and Buckner for the Montana Department of Justice when studying hospitals in recent years.

These are all hospitals with at least 50 beds and at least 1,000 admissions every year. They include the Billings hospitals and the Missoula hospitals, but unfortunately, they also include many hospitals in Montana that are in rural areas and that are monopolies. So they may not be the best counterfactual for what would have occurred in Great Falls without the merger.

So I also go beyond the borders of Montana and look for other duopoly markets in the Upper Great Plains, so these are other cities a similar size to Great Falls with two competing hospitals, places like Bismarck, North Dakota, Dubuque, Iowa, Fargo, and the other places listed on here. So the primary control group are the hospitals in Billings and Missoula, but I also looked to see whether those results were robust to these other control groups.

So first off, what happened right after the merger, relative to 1995, the inpatient and outpatient prices fell initially and then gradually increased until 2005, when both the inpatient and outpatient prices were about 50 percent more than they were in 1995. That doesn't really tell you how things changed, how they were compared to other control hospitals.

So looking at the data from the cost reports, as you can see in this slide. And this is Benefis's price relative to the primary control group-- the hospitals in Billings and Missoula. Benefis during the COPA period. And I'm sorry, there should be a vertical line that comes down right when the COPA was repealed, and it didn't show up in this slide unfortunately. But the COPA was repealed in 2007, retroactive to 2006. But as you can see through 1997 through 2005, Benefis's price closely tracked the prices of the Billings and Missoula hospitals on average. But then after 2007, Benefis's price increased above that control trend, and that price increase is 20 percent, and that's statistically significant.

Looking at the other control groups, we see a very similar pattern. So looking at all of the large prospective payment system hospitals in Montana, the COPA repeal resulted in a price increase of also roughly 20 percent. And then if you expand beyond the borders of Montana to look at all of those duopoly hospitals in the Upper Great Plains, the price increase after the COPA was repealed is roughly 33 percent, also statistically significant.

So what can we conclude from this? I think what this shows is that during the COPA period, the commercial inpatient price for Benefis closely tracked the control hospitals' prices, and that's robust to all of these control groups. And it suggests the COPA was effective in constraining the prices to the level of other duopoly markets in Montana and the Upper Midwest.

After the COPA repeal, the commercial inpatient price increased by at least 20 percent, statistically significant, and that result is robust to other control groups. That suggests that the COPA removal led to higher prices consistent with the unconstrained health care provider with market power. Again, I want to stress the limitations of this study. We don't have the data to look at outpatient prices thoroughly, and don't have the data to look at how quality changed with the removal of the COPA or with the COPA itself, and we don't have the data to look at how things affected access to care. So thank you very much.

[APPLAUSE]

AILEEN THOMPSON: Thank you, Chris. Our next speaker is Kishan Bhatt. Kishan is a graduate fellow in the Bureau of Economics at the Federal Trade Commission, and he's visiting us from Princeton University, where he's a graduate student at the Woodrow Wilson School of Public and International Affairs. And he's going to be discussing his work on the Palmetto Health COPA.

KISHAN BHATT: Thank you, Aileen. And I want to reiterate the standard disclaimer that these results are preliminary and that they express views that are mine and not of the Federal Trade Commission.

I'll jump right into a brief background of the timeline of COPAs in South Carolina, and the story starts in the 1994 legislative session, where the state legislature passes a law that allows the state health department to issue a COPA if it believes that the benefits outweigh the risks. And the statute was pretty specific about outlining some of those benefits, like better care quality, preventing provider closures, and also avoiding resource duplication. The statute describes a few risks as well, though, and those are potentially a decrease in the level of quality or service availability or even higher prices.

With that in mind, in June of 1995, the health department issues its final regulation that operationalizes the process by which hospitals can apply for COPAs. And it doesn't take too long for the first application to come in. In October of 1996, when two not-for-profit hospitals in Columbia, South Carolina, which are Baptist Health Care System and Richland Memorial Hospital, they apply for a COPA. And they cite declines in hospital utilization and a slowing in government and commercial reimbursements as reasons why the COPA would allow them to remain financially viable in their view. And that's a persuasive argument to the state health department, which, seven months later, issues a COPA to those hospitals in May of 1997. That paves the way for the hospitals to begin operating under the new name of Palmetto Health in February of 1998.

Now it's important to note that this initial COPA sunsets after five years of being in effect, meaning that the hospitals and state health department needed to renegotiate their terms, and that renegotiated COPA comes into effect in November 2003. That's the form in which it remains today.

I want to pause here to give a brief overview of what hospital services look like in Colombia, where we see four hospitals in a 10-mile stretch that would take about 30 minutes to drive from one end to the other, and that's different from the COPA situations that we see in other states that have no nearby hospitals. And just to clarify here, those two hospitals that say Prisma Health are the Palmetto hospitals.

That said, though, even though there is this presence of other hospitals, Baptist and Richland are the two largest hospitals in the city by the share of inpatient discharges that they see. That share is roughly 60 percent through the study period, with the other two hospitals in the city, which are Lexington Medical Center and Providence Health, splitting that remaining 40 percent share. So we see the creation of the largest health care provider in the city.

That landscape is important to keep in mind as we turn to what the initial terms of the COPA actually include. And I see five categories of responsibilities here-- oversight, population health, clinical service availability, some conditions related to the labor market, but finally and

most importantly, the conditions related to price and cost are going to be the focus of this study, where we see promises to reduce the charges levied to payers in each of those first five years.

Now, a few things changed in 2003, and principally related to those price and cost conditions, we see them drop off in that renegotiated COPA. However, in this new form, the state health department retains the right to come in and set a price ceiling if it believes that the operating margins of the Palmetto hospitals have unexpectedly risen. And that's a change that's important if you think that there could be price effects that are different in this renegotiated period.

Which leads to the question of interest. I want to look at what happens to prices over time in both periods, which requires an estimation of what happens at Palmetto and what happens in this but-for counterfactual world of similar hospitals that are not merged during this period. I'm only going to be able to look at inpatient prices, similar to the other studies here, because of the data set, and that's the exact same data set from CMS, the publicly available Healthcare Cost Report Information System.

I'll use the same methodology to estimate a single average price that a hospital will charge to a commercial insurer, and I use a difference-in-differences model, because I'm not as interested in the absolute price levels here as I am the relative price changes. And again, that's relative to this counterfactual of the merger not occurring. I show the regression equation here just to illustrate that that first term is going to tell me what happens in the initial period with Palmetto relative to the counterfactual, and the second is going to tell us what happens in that revised period.

But one of the limitations of my data set is that I can't look beyond the first decade of the COPA. And that's because, if you'll remember in the prior presentation, Chris Garmon mentions that the methodology to estimate prices assumes a stable share of folks on Medicaid. Where we see on that left-hand side graph a drop off after 2008. We don't see a similar drop off in the Medicare population or here in the proportion of South Carolinians that are insured by Medicaid. It's just that discharge there that falls, which will limit me to studying until 2008.

I want to talk here about what I'm comparing to, where I use six different control groups across three different categories. The first category is the geographic cohort. So who are the hospitals that are nearby? The second is hospitals that exist in cities with similar landscapes, and I define that as cities with two to four hospitals in the area. That would make them similar to Columbia. And then finally, I look at characteristics of the hospital, trying to capture other facilities in South Carolina that treat comparably complex patients, and they are comparably large. I'll take out any hospitals from my control groups that are involved in a merger to, again, get at that counterfactual but-for unmerged world.

And what I find here is that there are large price increases at Palmetto, about 80 percent in that first decade, but we see large price increases across a lot of the control hospitals as well. Moving beyond the punchline, though, I want to show you the results broken up by time period and by control groups. So these bars show the difference-in-differences coefficients, and we see interestingly that some of them are above zero, some of them are below, depending on the control group required. And what this means is that, for example, on that bed capacity control group, we see a negative 13 percent bar. So if Palmetto raises its prices by 45 percent in the first five years, then that control group raises its prices by 58 percent.

Now, the punchline here, though, is that in this original COPA period, we don't see statistically different price changes at Palmetto relative to most of these controls. The exception is just this bed cohort hospitals, where we only see two hospitals actually fitting the inclusion criteria to be seen as a comparison. A similar story emerges in that revised COPA period after 2003, when we see, again, a lack of statistically different price changes at Palmetto relative to most of these control groups.

So as I close, I want to reiterate that main finding. There are large price increases at the merged hospitals, but with comparison to all the other sort of control hospitals in the South Carolina data set, we don't see anything that's statistically distinguishable. But that's limited to the inpatient prices. I'm not able to look at outpatient services or changes in clinical care quality, which are two things that further studies might want to examine.

And this finding is important to contextualize given the situation in South Carolina, where we see some level of state oversight across the entire study period. The COPA is amended, but it's never repealed like in some of the other situations. And secondly, there's always been some degree of having other hospitals in the area to keep sort of a competitive landscape, and that's something that we don't always find in COPA situations.

And so as I close here, I want to point out that these price effects from COPAs are complex. And they depend on the nature of competition, they depend on the nature of regulation-- whether it's going to expire or not-- and finally, how other hospitals will react even if they're not directly involved in the COPA merger. And with that, I look forward to further discussion.

[APPLAUSE]

AILEEN THOMPSON: Thank you, Kishan. Our next speaker is Lien Tran. Lien is an economist in the Bureau of Economics at the Federal Trade Commission, and she's going to be discussing her work on the Mission Health COPA.

LIEN TRAN: Thank you, Aileen. This is joint work with Rena Schwarz. The usual disclaimer applies here. The views and the conclusions in this study are our own, and they are not the views of any of the commissioners or the Commission staff here.

So the Mission Health COPA has been the subject of study of many researchers. Several of them are here today at the workshop. Our study is a little different in that it focuses on the price regulations of the Mission Health COPA and the extent to which these price regulations achieved their intended purposes.

First, a little background. In 1993, the North Carolina State Legislature enacted the COPA law. In 1995, St. Joseph and Memorial Mission entered into a COPA agreement. And in 1998, they fully merged their assets and operated under a single hospital license. In 2016, the state legislature repealed the COPA law, effectively ending the Mission Health COPA. And as of this year, Mission Health System has been acquired by HCA.

This map shows the hospitals in Western North Carolina. As you can see, at the time of the full-asset merger in 1998, Memorial Mission and St. Joseph were the only two general acute care hospitals in Asheville, and they were the two largest hospitals in this entire 15-county stretch at the border of North Carolina and Tennessee.

The regulations under the COPA included a $74 million in cost savings commitment, commitment to maintain access to care for patients, as well as maintenance of quality. The terms also included fair dealings with payers. In this study, we will focus on the price regulations, which included two essential components, the margin caps and the cost caps.

The margin caps required that the operating margin of Mission Health to not exceed the mean operating margin of comparable hospitals for any three-year period. It also established a floor for the margin to be no less than 3 percent. The cost cap works in a similar way. It requires that the average cost per adjusted admission of Mission Health not to exceed the mean average cost for adjusted emissions at comparable hospitals.

The comparable hospitals were defined in the COPA to be non-profit, non-teaching hospitals with 300 licensed beds or more. Another term under the COPA restricted the share of physicians at Mission Health to be no more than 20 percent. In the two primary service area counties of Buncombe and Madison counties, I believe that cap has been increased to 30 percent in the latter years.

Related literature-- in theory, those two margin caps and cost caps are elements of a cost of service regulation. Can you hear? Oh, okay. This type of regulation allows a reasonable rate of return for a regulated firm, but it does not incentivize managerial effort. And in fact, two studies by Vistnes, who is here as one of the discussants on this panel, and Cory Capps discuss the incentives under the caps to evade regulation through the acquisition of new facilities or provision of new services. Another avenue for evasion of those caps is through manipulation of the average cost per adjusted admission.

The McCarthy report compared the margins, prices, and costs of Mission Health to those of the COPA Benchmark Group. McCarthy concluded that they were comparable, and therefore, Mission Health was in compliance with the COPA requirements. The Urban Institute report provides an account of the COPA structure, performance, and compliance, but it did not find definitive evidence as to whether the COPA replaced competition successfully or to what extent the COPA was effective in constraining prices or overall health expenditures or changes in quality under the COPA period.

So our objective here is to estimate the change in inpatient prices at the Mission Health System relative to what prices would have been absent a merger. We would have liked to study changes in quality or changes in the prices of other services, such as outpatient services, but due to the limitation in the HCRIS data, we were not able to pursue these additional lines of research. And so this study will focus, as the other studies, on inpatient prices.

So in order to estimate the change in Mission Health prices relative to what they would have been absent a merger, we estimate a difference-in-difference model with fixed effects. What is a difference-in-difference? Well, it's simply defined as the change in the prices at Mission Health minus the percentage change in control hospitals, controlling for trend.

Our panel, our data panel, runs from 1996 to 2008. 2008 is the year of the Great Recession, and we've noticed changes in the data that might have had confounding effects on our results, and so we cut the panel period in the year 2008. And a further note is that if the period is too long, then there may be additional factors that could affect the results.

So the data is the same as for the other studies. In order to address a concern that Medicaid patients' payments could affect our coefficient estimates, we added an additional valuable to control for Medicaid share, and it did not affect our results. The control groups are selected on the basis of beds, type of hospitals, length of stay, case mix index, and local merger activity. In contrast, the COPA Benchmark Group includes hospitals that may have merged, government-owned hospitals, but it excludes hospitals that were included in our control groups.

So those are the characteristics of the Mission Health hospitals, and we tried to match those characteristics when selecting the control groups. So here are the results. The height of each bar chart represents the price increase at Mission Health relative to the control groups. The last three bar charts represent the price changes at Mission Health relative to the control groups of hospitals that did not locally merge, and those are the important results to look at. The first three bar charts represent the price change relative to control groups, including the COPA Benchmark Groups. The bar charts that have in red outlines are the ones where the merger effect is significant.

And what do we take away from those results? Well, the merger effect is significant for most control groups, but not significant for the COPA Benchmark Group and the 300 licensed bed groups. And this is consistent with the fact that the monitor found Mission Health to be in compliance with the COPA requirements. The statistical significance of the merger effect for the other control groups suggest that despite the caps, the price caps, the COPA oversight was not able or did not prevent the Mission Health from raising prices under the COPA. With that, I look further to your comments, and thank you.

[APPLAUSE]

AILEEN THOMPSON: Thank you very much, Lien. Our next speaker is Laura Kmitch. Laura is a manager at Bates White Economic Consulting Firm, and she's going to discuss her work on the Phoebe Putney merger, and in particular, she's going to focus on the quality of care effects. Laura.

LAURA KMITCH: Thank you for inviting me. It's nice to be back. Chris and I did this research when we were both working in the FTC, so in case we need it, these are our own views. So we thought it was important to understand the effect of health care consolidation on price, cost, and quality when antitrust enforcement is replaced by local regulatory control. And Phoebe Putney's health acquisition of Palmyra Medical Center in Albany, Georgia, in 2011, which was a likely anti-competitive hospital merger that was allowed due to state action immunity, provided a nice natural experiment for us.

So unlike other retrospective analyses that were presented here, we looked at price and quality. As Aileen said, I'm mostly going to focus on quality results, but we give you a preview of the price results as well. So we found that after a large post-merger price spike, possibly reflecting the elimination of the lower priced Palmyra, that the post-merger commercial inpatient prices return back towards the trend of the control group.

It's unclear why the prices fell after the initial post-merger spike, but it may be in response to local regulation. Phoebe is overseen by a hospital authority in Georgia. It may have been a response to ongoing legal challenges to the merger. But we also found a significant post-merger reduction in inpatient hospital quality relative to controls across many metrics, and this decline was most pronounced at the time of the merger and shortly thereafter.

So as background, Phoebe Putney Memorial Hospital and Palmyra are located two miles apart in Albany, Georgia. They are the only two short-term general acute care hospitals there. Phoebe Putney Health also owns three other hospitals in Southwestern Georgia, including the only other short-term general acute care hospital in the Albany metropolitan statistical area.

The FTC and the state of Georgia challenged the acquisition. The FTC's complaint alleged that Phoebe Putney would have an approximately 86 percent market share in the six-county area surrounding Albany, Georgia. So this wasn't actually a COPA, so I'm going to talk for just a second about the local regulations that were in place.

Under a 1941 Georgia law, the local governments, cities, and counties were allowed to form an entity called a hospital authority that has the ability to own and operate health care facilities. Phoebe Putney Memorial Hospital is owned by the Hospital Authority of Albany-Dougherty County. The Hospital Authority leases the hospital to Phoebe Putney. And its context, in 2013, there were 37 hospitals in Georgia that were owned by a hospital authority.

So the FTC and state of Georgia challenged this in district court and lost on state action for this antitrust immunity. It was appealed, and the FTC and Georgia lost again. So in December of 2011, the merger was allowed to consummate. And I want to add this-- so lest you think that the people in D.C. at the FTC or DOJ are the only people worried about competition here, this was local press from the day the merger was announced that highlights the years of fierce competition between these two hospitals.

So the FTC brought this case to the Supreme Court. And in 2013, the Supreme Court ruled that the hospital authority law did not articulate a policy to replace competition and remanded it to the district court. By that time, Phoebe Putney had converted Palmyra to Phoebe North, and they had moved both facilities onto a single state license. So unfortunately, the FTC was not able to obtain a structural remedy here with a divestiture because of Georgia's certificate of need laws, so the FTC settled for a consent order with Phoebe Health in March of 2015.

We are aware of no other studies analyzing price and quality of hospital mergers in the context of price regulation, although there's some other literature on both topics. And as an additional motivation for looking at quality, economic theory is that competition between hospitals raises quality when prices are fixed. But then there's also the FTC focus here, which is that the Horizontal Merger Guidelines call on enforcers to look at non-price harms, especially quality. It's also reasonable to think that people may care about health care quality more than they do about the quality of some other goods or services they consume. And finally, health care spending was almost 18 percent of GDP in 2017.

We measure quality in three ways. We looked at three main metrics that I'm going to talk through now. So first, we looked at the CMS Hospital Compare mortality and readmission rates, and these metrics focus on the Medicare population and look at mortality rates and inpatient hospital readmission rates for the 30 days after a patient was admitted for a specific condition. We looked at heart attack, heart failure, and pneumonia because those are the metrics that were defined consistently over time, and so all of these are risk adjusted by CMS.

The second thing we looked at was also part of CMS Hospital Compare's patient satisfaction survey, the HCAHPS, the surveys administered to a sample of patients discharged from all Medicare certified hospitals. We focus on just one question which is, how would you rate the hospital overall? And people respond to that with a numerical score.

The last metric that we looked at, we used discharge data from the Georgia Hospital Association to calculate AHRQ quality indicators. So this would include the entire patient population, not just limited to Medicare patients. So for these we focused on inpatient quality indicators for selected inpatient procedures and conditions and for patient safety indicators, which provide incidence rates for complications, errors, and other potentially preventable adverse outcomes. So for this group of metrics, we focused on IQIs and PSIs that are endorsed by the National Quality Forum and have numerators of at least 15 for reliability. So we pull Phoebe Putney and Palmyra in these to get robust estimates.

And then for all of these metrics, all three of them, at the time that Phoebe Putney merged, CMS was just collecting this data. But since then, all of these are now used in star ratings. They're also used in how Medicare calculates the quality incentive payments under Medicare's hospital value-based purchasing program. So CMS has been collecting them for a while, but now they're actually used to help incentivize hospitals on quality. So just to kind of give you the context of the relevance there.

So we found that the quality decreased, mostly decreased, and so I'm going to talk through this table with you for a minute here. So for most of the metrics, everything except the last row here, objectively lower is better. For mortality rates and readmission rates and patient dissatisfaction, you want your numbers to go down. Patient satisfaction you want to go up.

But in the first column of numbers, the post-merger change at Phoebe Putney, that's the difference between the pre and post-merger scores. And then in the next column we have, this is for the control group, which is hospital authority hospitals in Georgia that had emergency departments and weren't critical access hospitals and weren't part of mergers. So this is the mean post-merger change for the control group hospitals because it matters not just what Phoebe Putney did after the merger, but how it compares to the control group. And so the difference-in-difference results that we present in the last column, when they are red, Phoebe did worse than the control group, and when they're green is where Phoebe did better than the control group. And the stars indicate statistical significance. So across most of the indicators, Phoebe Putney did worse than the control group in a statistically meaningful way.

So we can talk through one example. So for patient satisfaction, Phoebe Putney's score went down five points post-merger, so fewer patients were satisfied with their service overall. At the control group hospitals, the other hospital authority hospitals, their scores actually went up. It increased, so their patients were more satisfied. And so that actually makes a big difference between Phoebe and the control group because they're moving in opposite directions there.

So then these are line graphs that present the AHRQ results. This one is for an inpatient quality indicator for heart attacks. And if you focus in at 2011, which is when the merger occurred, you see the blue line is Phoebe Putney and Phoebe North pooled together there. The red line is the control group hospitals, and the green line is the Georgia overall trend.

And in 2011, you see that the rate at Phoebe Putney went up significantly. It stayed higher than the control groups in 2012. And in 2013, everything trends back towards the national. But since all the lines move, we think that's unrelated to the merger. I think one of the possibilities we've talked about is that even though the Affordable Care Act was passed in 2010, some of the quality aspects were rolled out later and that this may reflect those incentives changing that all of the hospitals had this extra incentive to improve.

So we find similar quality for other indicators here. So you've got heart failure, which is the one that we don't have significant results for. Stroke and pneumonia, we see another statistically significant increase post-merger. And this is accidental lacerations. So most of the quality metrics, with the exception of heart failure, indicate a substantial quality decrease post-merger. The timing in 2011 and 2012, when the merger occurred and right after, may indicate that these were quality disruptions related to the merger.

So the price results are presented in the paper, and there's an appendix in the slide deck. But to remind you, the prices spiked immediately, but then returned back to the level of the control. So we think these findings should give pause to state and local governments considering placement of antitrust enforcement with local price and quality regulation for health care providers.

Careful regulation may control health care costs, but the experience at Phoebe Putney and Palmyra suggest that regulators may have difficulty adjusting to provider mergers. And when prices are capped, this reduction in competition typically leads to a strong incentive to reduce investments and maintain quality, which we think is part of what we're picking up in the Phoebe results. So overall, we think this highlights some of the problems that can occur when competition is replaced and reduced in the context of antitrust immunity. So thank you.

[APPLAUSE]

AILEEN THOMPSON: Thank you very much, Laura. So we've invited two discussants to share their thoughts about these presentations. Our first discussant is Leemore Dafny, who is a professor at the Harvard Business School and the Kennedy School of Government.

LEEMORE DAFNY: Okay. So first of all, I want to start by thanking the Federal Trade Commission, the Office of Policy Planning, and the core team of organizers from OPP and BE, including Aileen Thompson here, Lien Tran, Katie Ambrogi, Stephanie Wilkinson. So thank you for putting on this very important event. I also want to thank you for inviting me to do something I do often in my life, which is as an academic economist, I read papers, I figure out what we can take from them, what are their limitations, what is left to be done.

So I get to do this exercise here and play the roulette wheel associated with traveling to D.C. in thunderstorm season. But more than that is that it isn't just a thought exercise, this is a phenomenon that is currently reshaping our health care landscape and may continue to do so, and it's something very important to study. So thank you for putting together this event.

All right. So why are we here? What are the questions that this research is trying to answer? Well, we want to know what the effects are of mergers and the certificates of public advantage relative to not having these transactions take place. And there are a number-- when I say effect, there are a number of possible effects to consider.

So first effect, I think, because it is measurable and also very important given we're approaching $1 in $5 in this country spent on health care as well as not performing very well on international comparisons of U.S. quality, is what is happening to spending. Now, we've seen a bunch of studies on price.

Ideally, we would also like to see what happens to quantity of services and to multiplying that in getting what total spending is. Because even if prices are constant, if regulated entities are

redirecting services, say, to more expensive sites of care or opening lines of business and building them up, leading to higher spending with potentially good or potentially bad consequences for consumers, these are not things that we would observe in these price studies. So spending is something that really counts and that it would be great if we could study. And I think we'll talk about that more in the discussion.

All right. Quality, of course, is important. We saw one of the studies was able to get a very robust set of quality measures, and that is terrific, and quality both in terms of the outcomes of various services and procedures. And those are still, of course, limited and highly debated. And there are issues associated with risk adjustment for the kinds of patients that are being evaluated. So it's complicated. Patient experience measures, though, are now really readily available and important to evaluate.

There's also access. How many points of service are there? Post-merger, will an entity decide, you know what, it's better for us to all be located in the center city? We can have our meetings together, and this is how we like it. And perhaps, when there's competition, there's more incentive to provide outposts that might be more convenient for patients. So thinking about how a transaction affects a variety of measures that consumers value would be important.

And last of what I've listed as sort of traditional effects-- and I'll distinguish those in a moment from these other effects-- are labor market implications. And we're fortunate that we're going to have an author of a recent study of these, Elena Prager, talking about that today. But the potential for a powerful post-merger health care provider to be able to depress wages and employment for health care professionals, there is some evidence that that has occurred in the marketplace, and it is an important effect to evaluate.

Now, those are traditional, I think, fairly straightforward, even if they aren't easy to measure and not even necessarily always measured. But these other factors I've listed there-- and I want you to know I was selective because I could keep going. I ran out of space on the slide and decided to stop right there. But the regulators, particularly state and local regulators, have many other concerns as they're evaluating these transactions, as those of us who followed them have seen. And some include labor market effects, so that some regulators understand that prices might be higher, but that employment may be maintained. And in their view, that's in the public interest.

Now, that is not antitrust enforcement. That is acting in the public interest under some other statute that is not Clayton Section 7. But it is present in the discussion as are discussions of what might be possible to do through a certificate of public advantage to address health disparities, to address access to the underserved. So there is a lot that gets thrown into these, as you've seen. In one of them, there was a tithe. In others, there are requirements to serve Medicaid patients and so forth. And so that can cause the regulator who's evaluating the transaction to make a decision that isn't consistent with what antitrust enforcers would do.

And now to discuss what we have learned from these studies. I recognize that this slide has too much font and probably is not readable. I am viewing it as a takeaway or a handout, which you don't have, but you could print. If you wanted a handy summary, this and the next slide would provide some sort of a summary of the four studies that we have seen. But let me then tell you what I wish you could see on the screen here and how I've divided things up.

The very first column lists the settings for these four transactions and also the change in market structure. And so something to note is that of the four studies, in three cases, we are talking about 2-to-1s. So as you think about the context of these certificates of public advantage, the ones historically are being granted in cases of mergers to monopoly primarily.

I've also listed the period for the COPA. In two cases of the three COPAs, the COPA has been subsequently repealed, as we've heard. So it summarizes that. And then I've listed the pre-period and the post-period for these studies. And the reason really is to highlight the fact that the pre-period-- that is, the period before the transaction was consummated-- in two of the cases in the Carolinas coincides with the granting of the COPA, which means that it is possible that the parties are acting differently in that control period, if you will, because they have now jointly applied for this regulation and then wait for it to be approved before the merger closes.

And I mention that because in order to have a longer and ideally unaffected pre-period, we'd need more historical data. And our research is limited by the availability of public data, which we know isn't as granular as we'd like it to be, but also doesn't go as far back given the timing of these COPAs. So that would suggest that there could be a benefit from a 6(b) study to try to get some historical data if it is available.

All right, so then I've listed the two columns. I see I'm starting to run out of time, so I won't describe them in great detail. But what is being compared with what? And in this case-- we've got, let's see-- just let me emphasize that the Montana study here is the one, Benefis, that is comparing the monopolist post-COPA with the pre-merger market structure. So that is a study that is actually comparing the pre versus post-COPA experience with what the market structure would have been absent the merger. And most of the other control groups are pooling together some different market structures probably to gain bigger control groups, but that is going to make it a little more tricky to figure out what is the effect of the COPA and the merger.

So let's see, I'll try to be hasty here. But I've listed a summary of the price effects. And the only zero, that kind of unqualified zero you'll see, is in South Carolina, and I just want to point out that that study was of the 4-to-3 market structure. It is also only considering one price measure, but it's important to note that what it might suggest-- may suggest that COPAs are either more effective or less necessary in this particular circumstance.

And I neglected to mention, and I meant to, that in my first very busy summary slide, I had a list of what the regulations and the COPAs look like, and I meant to say these are highly variable. So if you've seen one COPA, you've seen one COPA. And you can't really assume that if I say this one seemed to be effective that therefore COPAs are because there isn't a one size fits all. But in this case, that's the one situation where post-merger, consumers didn't appear to be harmed focusing on price alone.

I do want to caveat that there isn't a substantial pre-period to confirm that the treatment group and the control group have similar trends ahead of time. We don't have quality measures. So I really want to, as the authors have themselves, qualify some of the takeaways and, at the same time, recognize that we are limited in data. And so sometimes it is absolutely better to have this information and recognize the limitations than certainly not to have it. And of course, the question marks in the quality effects column really emphasize that there are few studies that are able to get the data to study the quality effects historically of these COPAs.

Okay. And let me talk about takeaways. So I'm going to focus here on this last set. Which is, as I mentioned, because we lack historical data and that it might necessitate subpoena authority to get it if it's out there, there is potential value in conducting a 6(b) study-- if not of these COPAs, then of future COPAs. In which case, it's not the lack of historical data, it's the lack of granular data that would enable researchers to really look closely and try to identify exactly what is going on with these transactions.

The results are hard to generalize because of variation in COPAs, because of variation in the market structure in the peer groups, but it doesn't mean we can't learn from what's been done here. And I would just say that the COPAs, except for in the case of Mission Health, two of them appear to have been effective. One of them was repealed, one of them seemed possibly not necessary, but fundamentally they seem quite temporary.

And we saw in the Benefis case that once the COPA was lifted, prices increased substantially. And Professor Garmon emphasized his lowest estimate of 20 percent, but there are much higher estimates presented in the paper, and that's probably because he's comparing a monopoly with duopoly, right? And we know that there can be significant price effects in those circumstances. So I'd say this substantiates enforcers' preference for structural remedies over behavioral and suggests that those interested in implementing COPAs should tread carefully.

[APPLAUSE]

AILEEN THOMPSON: Thank you, Leemore. Our next discussant is Greg Vistnes. Greg is the vice president at Charles River, and he's going to be sharing his thoughts. Thank you.

GREGORY VISTNES: Thank you. Well, thank you very much for the opportunity to come here. Thanks very much for the opportunity to see some of the early empirical work, which is just really interesting. And you certainly don't need me to be here to tell you how important all this work is and how important this discussion is. What I want to do is offer my own perspective on what these papers are telling us on really two issues. One is how well have COPAs been performing? And secondly, equally important, is are the COPAs better than the alternative? In a lot of the discussion so far, the alternative has been assumed to be the status quo, and that may or may not be the appropriate but-for world to be comparing to.

And where these questions are going to take us to ultimately are, should we, should the states still be relying on COPAs? Is it a good idea or not? And to a little bit furthering what Joe Simons was saying at the outset, is it a good idea for these COPA laws or policies to be displacing antitrust laws? Should they take precedence over them? How are we going to be ultimately better off with them?

So I want to start out with a really pretty simple summary slide. I'm an economist. I like to have pictures. And what this is all based on is the predicate that we're looking at a merger that would be considered anti-competitive. So we're not talking about a questionable one, we're talking about sort of a 2-to-1 merger that we would normally have concerns with.

What we have in the left-hand part of the panel is, say, well, gee whiz, what if the merger goes through? What if it's an unregulated merger and no one does anything? What's the result going to be? And it highlights that there really can be sort of three issues going on. There can be a price effect, and I'm using the kind of complicated coding system of red is bad, green is good.

Well, we normally think for this problematic merger that the price effect is going to be a bad result, and it may be relatively significant.

We see also the quality effect is there are concerns that the quality effect of this unregulated merger can also be bad. And what's ultimately the most important is, well, what's the net effect of the quality and the price effect? Well, if both those other bars are red, the net effect for this unregulated merger, that's a bad outcome, too. So that's pretty simple and obvious.

But now we get to the question, well, what about a COPA? What is the outcome of a COPA going to be, at least relative to the status quo of with there being no merger? And what I do is I distinguish between two possible outcomes-- what I'll call the strong COPA, what I think the legislators would like to believe that a COPA will achieve, versus what I'll call a weak COPA, and that's what sort of the skeptics may believe a COPA may result in.

And so for the strong COPA, the belief is that there'll be basically no price effect. Eh, maybe a little bit of a bad price effect, but not really too bad. But the real motivation for these COPAs, in my experience, has been that there is a real belief that there is going to be some real good coming out of allowing the merger to go through, but to regulate the price. So there is a real belief that the quality effect may, in fact, be pretty significant, leading to the net effect of a good merger, a good outcome.

If, however, we don't get that strong effect, the good outcome, we're in the world of the weak COPA. And again, we may have some bad price effects. Unclear what the quality effect is going to be. Maybe we just aren't going to get as good a quality effect, as could be the case under the strong COPA. But worst case scenario, maybe the quality effect is going to be bad.

And so under the weak COPA, the net effect is going to be maybe good, maybe bad. Who really knows what the answer is? And then there's also another bar that I put in there called the out-of-market effects. That's a little bit what Lien was referring to in the Mission Health, and that may be, well, we may have some price effects or quality effects in other markets than where the merger is occurring.

Okay. And so the question with that previous slide is, well, which world are we in, the world of weak COPAs or strong COPAs? That's a pretty doggone important thing, and that's really what a lot of this research that we've been talking about is going to. If you're then trying to say, are we in a good world or bad world, especially if we're in the world of weak COPAs, if we're in a world of weak COPAs, and this is now on the left-hand side of that chart, it suggests-- oh, there's a clock there-- it suggests that the weak COPA world might not be a very good outcome.

But if we're in a world with a different but-for world, what if we can't block the merger, this bad merger? What if but for the COPA, the merger is going to go through? If we compare the but-for world to a world of unregulated merger, then, in fact, even the weak COPA can give us a better outcome than letting the whole doggone thing going through. So it's pretty important to figure out what is the alternative world going to be. And if we can't block the merger, maybe a weak COPA is better than nothing.

Where that takes us to is we can really then talk about ranking the outcomes and trying to choose the policies. If we really believe the world is one in which we will have a strong COPA, sort of the world that the COPA folks would like to believe is true, that's the best possible world. We get the quality effects, we get no price effect, what a great world. We should all

embrace a really strong COPA. It goes to the empirical research. Are we in a world of strong COPAs? And we'll get to that in just a second.

If, though, we anticipate that it's going to be a world of weak COPAs, then we would prefer the status quo. But the question is, is antitrust enforcement going to be able to ensure us of that status quo? Because if the antitrust enforcers go out and they try to block the merger and they fail, well, then we end up not in the world in the status quo, but in the world of the unregulated merger. And in fact, even the weak COPA probably would have been a little bit better.

And it has a little bit of a policy implication-- is that absent having any confidence in the world of a strong COPA, then COPA policy, in a sense, the ideal world would be not one in which COPA policy displaces antitrust enforcement, but it should be used as a backdrop. Give the antitrust enforcers first crack at trying to block that merger. And then if-- and only if-- they fail, then bring in the I'll call it the weak regulatory outcome as the stopgap.

So with that, we get to where do all these papers really fit in? And some of the question marks are common to some of the question marks that you were seeing with Leemore's paper. With respect to price effects, I was actually a little bit surprised at some of the outcomes. I'm a little bit of a skeptic, I will confess. And I found it very interesting that in three of the four papers, I'm going to characterize the price effects as being actually fairly favorable. There was really not much of a price effect that was being found. It was only in Lien's paper, in the Mission Health, where there seemed to be strong indication that there was a strong continuing price effect.

But we see that three of the four papers were unable to get to the issue of quality effects. And when you think of the first slides, that quality effect is critical. That's what COPAs are all about. If we don't know what the quality of effect from a COPA is, we're kind of ignoring what is, I would say, one of the principal motivations of a COPA. And I don't mean to be critical of these studies because measuring quality effects is tough. It really is. The data is hard to do.

But it emphasizes that we really need to understand a little bit better what the quality effect is, particularly in light of the Phoebe Putney study that actually is rejecting, or at least strongly questioning, this premise of COPAs resulting in higher quality-- that study coming out and saying, hey, in fact, the quality effect seems to be a little bit lower.

I think I just want to finish up this little part, though, by saying some of what you see on this slide may seem to be a little bit critical of COPAs, especially if you take away from that one study that the quality effect is going to be negative. But at the same time, putting back into the context of what is really the but-for world, note that three of those four studies were done in the period where antitrust enforcers had their hearts in the right place, but they weren't all that effective. That was really in the world where the but-for world might appropriately had been viewed as unregulated mergers because antitrust enforcement was having a really tough time blocking those mergers.

So for three of those four, even the weak COPA may have actually led to a better outcome than would have been the case. But I think, at least to me, what a lot of this suggests is that now that antitrust enforcement and the FTC has gotten a little bit better at blocking some of those problematic hospital mergers, is that may be really the world where-- unless we really believe it's a world of strong COPAs-- let antitrust enforcement have the first crack at it. Thank you very much.

[APPLAUSE]

AILEEN THOMPSON: Thank you, Greg. So one theme that has emerged throughout the session is that, particularly with respect to the COPAs that took place in the 1990s, we are limited in our ability by the data that are available. And as part of the broader COPA project here at the FTC, we're considering ways in which we can analyze the more recent COPAs, and in particular, we're thinking about what types of information and data we should begin collecting now so that we can eventually do a retrospective study of the recent COPAs.

So with that in mind, I think, Greg, I'd like to start with you. In your Mission Health study in 2011, you highlighted ways in which the COPA may provide incentives for regulatory evasion. So my first part of my question is, could you elaborate a little bit on what regulatory evasion is, or at least in that context? And then I was curious, if you were to design a study to try to detect regulatory evasion, what types of factors should be taken into account?

GREGORY VISTNES: Sure. So the regulatory evasion is a little bit what Lien was talking about, and there are a number of ways. And this is really coming not from health care economics, but economics since the 1960s, that regulation is tough to make work. And regulatory evasion, especially in the context of Mission Health, but in other cases, as well-- if you've got a hospital with market power, it's going to try to use it somewhere. And if it can't use it in the market in which the price regulation exists, maybe what it will do is try to engage in some sort of tying in a different market and try to raise that price in the otherwise competitive market. And say, well, you've got to pay the higher price in this other market if you want my monopoly product in the other case.

The other things that were flagged in the Mission Health is just price regulation by its very nature is messy. And no matter what type of a price cap you try to do, whether it's a margin cap, whether it's a price cap, there are different ways of gaming the system. And again, this is nothing that's new to health care economics. People have known this ever since the '60s with regulatory regulation, giving rise to the whole vein of incentive regulation. So they're just all different ways in which-- every single rule you try to put in place to try to regulate the prices creates an opportunity for mischief. And those were some of the incentives that were flagged in the Mission Health.

Now, how would you study it? That, again, is really difficult. If you have your monopolist in a single market, then you can probably do it relatively well just by looking at the overall price in that one market. Mission Health had some of the problems of it had tentacles in other markets. And so the issue is, well, which one of these other markets is it going to try to raise its price in? Which of the markets do we try to study?

Do we look at hospital markets? Do we look at physician markets? Do we look at outpatient service markets? In which geographic region? Is it just a single region? What if they spread this effect across six? That makes it a whole lot tougher to measure. So it's a challenging empirical project. Again, I'm a bit of a skeptic that you can do a good job because there's so much noise in all of these studies.

AILEEN THOMPSON: Great. Thank you. And then, Leemore, a similar related question for you. In one of your initial slides, you listed all the important questions we should be looking at. I wanted to focus in on the total spending. So if we were to look at total spending of a COPA,

what types of information do we need? And how should we measure total spending? What should we include? What services should be included?

LEEMORE DAFNY: Okay. So great question and a great follow-up to what Greg was just talking about, the limitations of just studying price. And I would just add one comment to that, which is with the rise of what are called-- there's another health care acronym, APMs, Alternative Payment Models, where providers are compensated outside of the fee-for-service structure for meeting certain quality targets and/or for risk sharing. Those sums often don't get incorporated or necessarily allocated appropriately to price. So price regulation even trickier than it was.

So to your question about what could we do to study spending, and I can think of kind of two basic ways to do it. The one that is pursued in Massachusetts by the Health Policy Commission is regular monitoring of total medical expenditures, and that is a measure of what it sounds like-- per person per time period. So, say, you could do it annualized. And a challenge there is you have to attribute patients to certain providers and/or possibly get data from insurers so that you have the whole picture of their care. So that's something that might require access to special data.

But it is tracked in Massachusetts. Total medical expenditure. It's doable with an all-payer claims database, which exists in some states, and it can be risk adjusted. And you can measure how much is it costing us fundamentally to take care of patients, and how much is it costing differently for patients that are primarily attributed to one provider versus another. And if it's a merger-to-monopoly, you don't even need the insurers because they are providing all of the care.

The second option is to measure episode-specific spending. And there are these programs out there that group different sets of claims together, and you can have a trigger start for an episode, which could be something like a hip fracture or admission to hospital for hip replacement, track that out for a certain period of months, admission for heart attack, et cetera.

And again, grouping claims, risk adjusting, ideally these can be matched with quality measures. But what patients care about is how much it-- or ultimately their payers, but I think they do as well since they pay their premiums-- is the quality that they're getting and the total cost and less the cost per cog that goes into it.

AILEEN THOMPSON: Great. Thank you. So I'd like to give the other panelists an opportunity to weigh in on these questions in terms of-- well, two things. Number one, I'd like to give the presenters an opportunity to respond to some of the discussant comments. And also, we'd be interested in hearing your views about what we might want to do going forward to look at more recent COPAs.

CHRISTOPHER GARMON: Sure. I just want to thank the discussants for the comments, and I agree about I think this highlights the need for an all-payer claims database. I'll put a shout-out, there are proposals in Congress right now for a national all-payers claims database. I think that would be a wonderful thing to do to help us study these drivers of health care costs, like situations like mergers.

I think total expenditures-- I think it's also important to think about quality. Now we have more data that's available. So we, with Hospital Compare, might be able to look at, for the most

recent West Virginia and Tri-Cities COPAs, what were the effects and quality using public data? That might be feasible. But as Leemore mentioned, access to care, that's something that really hasn't been studied, not just which services are available, but also what is the effects on the local community in terms of inequality? What is the effects in the local community in terms of health equity? I think those are things that we should look at more.

AILEEN THOMPSON: Lien.

LIEN TRAN: Yeah, hi. Thank you, Greg. Thank you, Leemore. To the question about the importance of looking at quality overall expenditures, there are a couple things here that we haven't discussed today, and that is the differences in the regulation regime across the COPAs. In the Benefis case, the regulation is based on a price cap. It was a form of a price cap. And in the Mission Health COPA, the cost of service regulation is involved, looking at the costs and allowing the regulated entity to earn a reasonable rate of return. So those are the two different types of regulations, and they may have implications for overall health expenditures.

So you could imagine in a world where prices are fixed or price growths are fixed, that might give hospitals an incentive to increase revenues by increasing the number of procedures they can perform. In other words, by providing a greater number of procedures and volumes, and that increases utilization. And so, yes, monitoring overexpenditures could help get at that problem. When you have fixed P, providers could very well increase Q. So in that case, monitoring overexpenditures really makes a lot of sense.

In the case of regulation that's based on a type of cost of service regulation, which is usually good at limiting the rent that the regulated entity could earn, the problem there, more often than not, is that the incentives for managers to do a good job is not there. So that's a common problem for cost of service regulation, and there you might think of opportunities that managers or the lack of effort on the part of managers to, let's say, minimize cost. That's one form of a lack of incentive for managers to do a good job.

So in the Mission Health, you can imagine that if the margin is regulated, but managers did not have the incentives to minimize costs, and so, yes, cost could still increase and you observed a reasonable rate of return because of the margin cap. But then if costs increase to uncertain points and if there are opportunities to expand services or acquire new facilities, you could have an expansion overall, cost overall, and then that would push up the prices on the other end. And so I could imagine that when we look at COPAs and thinking about ways in which the regulation, the type of regulation, could have an effect on quality or overexpenditures, this is the kind of level of details that we might want to pay more attention to.

AILEEN THOMPSON: Great, thank you. And any other comments on this question? Okay, so I have a couple of questions from the audience. One is a question for Leemore. It asks, how can price be determined from the Medicare cost report data? The cost reports have charges, but do not report actual prices net of contracted allowances.

LEEMORE DAFNY: True enough. They report charges, but they also report the total amounts of the discounts that are given to payers, so you have a measure of net revenues. So that measure of net revenues, there's some complication with what you do for ancillaries that everybody on this panel has seen the formula. But effectively, it's going to be net revenue per case mix adjusted non-Medicare admission, and from net revenue, you subtract Medicare. It is just difficult to exclude Medicaid because it is so non-uniformly reported and the data is so noisy,

and so that's the reason that you've heard some discussion about how the measure seems to work pretty well if Medicaid shares aren't moving around too much.

AILEEN THOMPSON: And, Chris, did you want to-- because I was just wondering, I guess you had mentioned in your presentation that you've done some work.

CHRISTOPHER GARMON: Yes, in a previous paper, I compared the post-merger price changes using Professor Dafny's method with the price changes you would get from claims data, the actual prices. And it does a very good job, in most cases, of giving an unbiased price increase, price change estimate.

AILEEN THOMPSON: Okay, so I have another question here. How could we study effects of a COPA on access? What types of measures should we use for that?

CHRISTOPHER GARMON: I think services. How long does it take to see a doctor when you go to the ER? Are beds available when you need a surgery? How long do you have to wait to get a surgery? Those would be measures of access. Do people get the procedures and surgeries that they need when they need them, I think, generally.

AILEEN THOMPSON: Great. All right. Any other thoughts on access?

LEEMORE DAFNY: Well, just that state departments of health have really large groups that focus on measuring this sort of thing and that we would want to tap into their expertise. And I agree absolutely that wait times-- they have secret shoppers, that is how the Medicaid program assesses access for a variety of services. Composition of network and how many providers per individual are also measures.

AILEEN THOMPSON: Thank you. Another question. All regulatory regimes are susceptible to evasion, but they are not all equally susceptible to evasion. Do the COPAs you have studied appear to really try to prevent or limit evasion, or do they appear to be the product of regulatory capture? What about the more recent COPAs?

Now, some of these issues, I think, we will discuss later on in the sessions this afternoon. But I think I'll turn it to the panelists. In terms of your experience looking through the materials, I don't know if you have any comments on the question.

GREGORY VISTNES: I'll weigh in a little bit. I think from my experience, a lot of the regulation-- and I'm going to expand it not just from COPA regulation but also some state regulation that's been imposed as a condition for post-mergers-- is the complexity of that regulation can vary dramatically. I think many of the COPAs, many of the price regulations, will be very focused on just trying to keep price down in that market.

The other ones, typically with the regulators who end up pulling out most of their hair, they really do try to avoid a lot of the evasion, a lot of the ways of trying to game the system, and they're really tough to do. Here I'd point probably explicitly to some of the regulation that was either imposed or contemplated up in the state of Massachusetts with respect to some of its hospital mergers. They did a really good job of trying to anticipate the evasion that might occur, but it's really, really tough to do.

AILEEN THOMPSON: Thank you. So it looks like we are out of time, actually a little bit over time. So I'd like to thank all the panels for their participation. This has been really helpful and interesting, and I think it'll really help us going forward in terms of designing our studies. I also want to take the opportunity to thank Dave Balan from the Bureau of Economics, who also helped put together the agenda, and thank everybody for coming. Thanks very much.

[APPLAUSE]

[BREAK: MUSIC PLAYING FOR 7:23 MINUTES, PROGRAM RESUMES AT 2:16:59]

## PANEL 2 - COMPLETED COPAS: REVIEWING THE MISSION HEALTH AND BENEFIS HEALTH COPAS

STEPHANIE WILKINSON: If everybody could please be seated and if the panelists could make their way to the stage, we're going to begin shortly.

[SIDE CONVERSATION]

STEPHANIE WILKINSON: Okay. Welcome back for our second panel. As we heard during the first panel, we learned about some new empirical research presented on the Mission Health and Benefis Health COPAs. And now we're going to hear from an impressive line-up of panelists, who will reflect on their experiences with these COPAs. We're going to start off our panel with some directed questions for each panelist, and then we will move into a moderated discussion. During this time, FTC staff will be walking around with comment cards. And so if anybody would like to pose questions to the panel, please fill those out and they'll get delivered to me. And time permitting, I will try to get into some of the audience questions.

Okay, so I'm going to start off with a question for Kip Sturgis. Kip, in your role as the Special Deputy Attorney General for the North Carolina Department of Justice, you were responsible for overseeing the Mission Health COPA for its entire duration, which was from 1995 to 2016. Can you please describe this experience for us from the state's perspective, particularly in terms of the resources required to implement and monitor the COPA and the kinds of challenges you faced along the way?

KIP STURGIS: Sure. Am I audible here? It sounds like it. I have to give the disclaimer. Whatever I say is not attributable to my department or my attorney general.

The overall experience, we thought we had done a pretty good job, until I saw Lien's work and we realized we missed a few things. To me, administering a COPA is like raising a child. Once you've done it, then you're ready to actually start. And so I hope I can pass along some of the things that we learned not only just from being here today, but over the course of administering the COPA.

I can happily report that third-party quality reviewers, such as Truven and Leapfrog, have given Mission pretty consistently very high ratings. We cannot attribute that to the COPA. I attribute it more to the Mission folks' dedication to high quality. Our COPAs set minimum standards of maintaining your license, meeting Joint Commission certification, those sorts of things. So if there was a happy piece of the COPA, I think the quality story is pointing in that direction. And I hope the economists will consider those third-party reviewers as measures of quality.

Had I known at the start in 1995 about quality metrics-- length of stay, mortality, morbidity, pneumonia, sepsis, falls, my favorite quality metric is foreign objects left in body-- but had I known about these metrics, we would have put them in the COPA and called on the company or the hospital to give us detailed reports and keep records and have incentives and disincentives.

Same thing on cost control. With hindsight, I would have management financially incentivized to control costs so that management personally got paid more if the hospital's costs went down. And that's not the usual business model for a for-profit business, but those are a couple of things

that I would emphasize for the people who are experiencing COPAs now and for those who may be dealing with them in the future.

STEPHANIE WILKINSON: Okay, thank you. Moving on to Cory Capps. Cory, in 2011, you were retained by Park Ridge Hospital to evaluate the regulatory incentives created by the Mission Health COPA. Can you please describe this work for us, and in particular, perhaps some of the ways that COPA regulations may affect hospital behavior and incentives when they're making business decisions?

CORY CAPPS: Sure. I'll give a brief overview of what I did, and I think it's important to make clear at the outset what I did not do. I looked at the structure of the COPA and the high-level market landscape using public data. I did not actually use data on prices or quality to evaluate the actual effect. So at the time, which was 2011, it was a theoretical exercise in the efficacy from a theoretical perspective of a COPA regulation system.

In doing this, I was building on work by Greg Vistnes, who was retained by the state to also provide input on the structure of the COPA and whether it should continue and other things like that. I'll get into some of the details of factors that Greg and I considered. But before I do that, I'd like to make a few high-level points.

The first one is that it's actually hard to design a regulatory scheme that is hard to evade because there are a lot of moving pieces in the health care industry. It's not widgets. If it were widgets, you could say a widget is $10 and it must have these attributes, and you could look at it and say it either does or doesn't have those attributes and you can look at the price and say it either is or is not $10. Much harder when it comes to health care. But if you're give enough economists enough data and the payment mechanism is basically simple, like fee-for-service, we can probably do it. And maybe you don't have to have economists. Accountants or other people with expertise could do it. But it is hard to design a system that doesn't leave scope for evasion.

The second thing is, suppose you design a really, really good system, and it's 1996 or 1998. Now you want that system to work over the entire life of the COPA, which may be 10 or 20 or indefinite number of years. The industry is going to change. The scope of activities that the COPA-regulated entities are undertaking are going to change. And there's a good risk that the COPA system that you built at the outset is going to become less and less effective over time or that it could distort incentives in ways that are required for the entity to sustain compliance with the COPA regulations, but somehow not jump on board with the industry trends. So if somehow COPA compliance requires fee-for-service-based metrics, maybe the COPA regulated entity will be later to join the risk-based or value-based movement insofar as hospitals are joining that.

So a regulatory system that is actually well-functioning at the outset could become less so over time. And then you rely, I guess, on the legislatures to amend and adapt and update the COPA, and that might not be a fast or efficient process in all cases. In fact, I think there's probably a trade-off. If I write a regulatory scheme that is really hard to evade, it's going to have a long list of details. It's going to be highly prescriptive. It's going to have "thou shalts" and "thou shalt nots" and you must do this and you can't do that and this will be the measure. The more stringent you make a regulatory system over prices in that respect and harder to evade, I think inherently the less flexible it's going to be over time.

So there's almost no good solution. If you make it really hard to evade in the first couple of years, it may be a bigger mismatch to the marketplace some years down the road. And examples of where this can arise are that in the late '90s, outpatient was a minority of most hospitals' revenue-- on the order of, say, 20 to 30 percent-- and now it's around half, sometimes more for hospitals. And so an inpatient focused regulatory system is going to come into challenges as outpatient grows. A single hospital focused regulatory system is going to come under challenge as a hospital system adds additional hospitals. One that's designed for a hospital system that didn't own physicians is going to struggle as a hospital adds physicians. Fast forward 10 more years from 2000 and you'd say, there's nothing in a COPA regulation about an accountable care organization, so how do we regulate that? Or do we just say no because it would be too hard? And that's bad in itself.

So there's an inherent trade-off between rigidity and efficacy of price regulation and flexibility and adaptability. And I think that is one example at least of why regulation is challenging and why we generally rely on competition to drive good outcomes for the efficient operation of firms and good outcomes for consumers.

If I turn to the specific limitations that Greg and I identified in the Mission Health COPA, it relied on margin regulation, which is to say let's regulate the difference between price and cost. Okay, well that's easy to avoid. Make your costs really high, price a little bit above that, and you can have a large dollar margin, even if the percentage margin is compliant. Obviously, North Carolina is not populated with fools, so they went on top of that and said, let's also impose a cost growth cap so that you can't inflate cost too much, and then the margin will be the margin on top of a reasonable level of costs. It is a little bit circuitous. If you want to regulate prices, you could also just say, the price must match this benchmark, whatever it may be.

In practice, the cost growth cap was tied to cost per case mix adjusted discharge, which sort of took inpatient and outpatient services and threw them into a bucket with a weighting formula that led to the total number of adjusted discharges, which formed the denominator, costs went in the numerator, and that was your metric. However, because it was that weighted average, what it meant was strategic differences in how Mission raised its charges or its costs for outpatient relative to inpatient could allow it to change the adjusted measure of discharges, and thus raise or lower its costs as it really wanted to as a matter of accounting. Again, I didn't look at whether they did do this. This was just the regulatory possibility, and I agreed with Dr. Vistnes that that possibility exists.

The second shortcoming was that the margin regulation applied system-wide, but the cost growth cap was specific to Mission Hospital, the anchor hospital formed by the COPA merger. So if you could push your costs outside of Mission Hospital as an accounting measure or maybe by actually making specific investments outside of the hospital, you would lower the system-wide margin because you're incurring those costs, but you wouldn't trigger the cost growth because that's targeted to Mission Hospital. So that's an example where I think it was an oversight or a failure to predict the growth of systems or something to that effect, and the COPA scheme didn't adapt over time.

So I raised a concern in 2011 that Mission had the ability, despite the COPA, to raise prices to commercial insurers. That was basically Greg's main conclusion as well. Only this morning-- actually, a little bit before when I read early drafts, but only roughly in 2019 did I learn that I

was right about the possibility, and so I guess I can take comfort in that. But I guess it's bad if you're paying the prices.

The final thing that I address that Greg and I differed a little bit on was whether a physician employment cap made sense in the context of Mission. Greg sort of said there didn't seem to be any evidence of a problem in that area, which I agreed. Of course, maybe if you don't have a building on fire, it doesn't mean you don't need fire protection, something to that effect. So it was hard to observe from the fact that there were no problems to date with physician ownership whether that was actually an impact of the COPA, which had a low level of-- they could employ up to 20 percent of primary care physicians. So either it was working well and that was effective or it was unnecessary, and it was kind of hard to distinguish the two.

The basic point I advanced-- and I actually piggybacked off of what was then the new DOJ-FTC ACO guidelines-- and said, there's trade-offs for the state, but somewhere in the 30 to 50 percent range would be a reasonable cap to deploy. And what I had in mind there was that it would be roughly proportional or not too far behind the hospital scale and the inpatient side of things, which is also pretty close to its outpatient scale.

So therefore, they could have enough doctors employed if they wanted to try to integrate the care that they were delivering, but it would be a restriction that would keep them from going well beyond that in a way that could basically deprive actual-- and there were some, but they were smaller-- actual rivals and maybe would-be rivals or physician-led ACOs from having access to the physicians they would need to increase competition with Mission Health over time. So that was what I did back in 2011, and now Mission Health, of course, is part of HCA.

STEPHANIE WILKINSON: Okay, thank you. I'm going to shift gears a little bit now and move from discussing the Mission Health COPA to talking about the Benefis Health COPA in Montana, and I'm going to start with Mark Callister. Mark, as the former Special Assistant Attorney General for the Montana Department of Justice, you were involved in the preliminary evaluation and approval of the Benefis Health COPA as well as the oversight of the COPA for its entire duration, which was from 1996 to 2007. Can you please describe this experience for us from the state's perspective, again, I think in terms of the resources required to implement and monitor the COPA and the kinds of challenges you faced along the way?

MARK CALLISTER: Certainly. And thank you, Stephanie, for this opportunity. I agree with Kip. I wish I had been able to attend a workshop like this in 1995 before we had to come up with regulation under these COPA statutes. It was kind of a new thing that was happening back then. The legislature passed the COPA statute in 1995, and it authorized the merger of health care facilities if the Montana Department of Justice, which was the AG, found that the merger was likely to result in lower health care costs without negatively impacting quality and access to health care. And that was all that the statute said.

I was in private practice in Salt Lake at the time. Also, the Montana Attorney General had no attorneys with antitrust experience or health care experience at that time, so they solicited bids for someone who could provide them advice. I prevailed on the bid and immediately hired Dr. Tom McCarthy, who's a prominent health care economist. And while both Dr. McCarthy and I come from antitrust backgrounds and probably, if we were king, would not have enacted a COPA statute because we foresaw all of the issues that come with regulation, the state action immunity doctrine is the law of the land and we felt that we had to apply that statute, and that's what we did.

The Montana COPA statute was clear in its intent to invoke the state-action immunity doctrine to replace competition with regulation by allowing for health care consolidations that would otherwise not be permitted or arguably not permitted under the federal antitrust law unless the state actively supervised that. The statute, however, was silent on the type of regulation that was required.

So following the application, we conducted extensive interviews, we requested documents, written public comments, public hearings. The proposal was hotly contested by many, including medical professionals and other citizens of Great Falls. It was supported, however, by all the major third party payers in the state, including Blue Cross Blue Shield, which is by far the largest third-party payer.

Dr. McCarthy concluded that the proposed merger was likely to result in substantial merger-specific annual operating savings of nearly $10 million a year. And the question then became, how could this savings be passed on in the form of price reductions? And Dr. McCarthy created a revenue cap, which was described earlier by Professor Garmon.

We also implemented quality regulation to the Department of Health and sort of just turned that over to the Department of Health, and I perceived that they did a good job. There were some problems identified during the course of the COPA that seemed to be Benefis responded rapidly, and that seemed to work well. But it would be very nice to have a greater way to measure that, as was discussed in the prior panel.

As previously discussed, the COPA statute required a review after 10 years to determine whether ongoing regulation was necessary. And we concluded, the attorney general, that while competition had increased, there was still a need for continuing regulation, and Benefis disagreed with that conclusion and took the matter to the legislature, which then passed an amendment to the COPA statute and effectively ended the state's supervision and my involvement.

But let me at the outset just share with you a few of the major observations I have looking back-- and it was a while ago, I'm retired now from the practice of law-- at my experience as a COPA regulator. Dr. McCarthy and I were frankly surprised that the revenue cap regulation worked as well as it did. It certainly was not perfect, and it was frequently modified and adjusted.

And I wish we'd had the data from Professor Garmon to have gone back further because I'd be very interested in seeing if our assessment was correct. But we believed, using the best data available at the time-- trying to get data from Blue Cross, which was not easy-- that in the first full year after the COPA, Benefis inpatient prices were 12.6 percent lower than the pre-merger prices and 17.4 percent lower on the outpatient side. So for approximately five years after the COPA was implemented, Benefis's prices were less than they were in the 1995 pre-merger year, and it was about seven years on the outpatient side. And again, I don't know that our measurements were of the type that we heard about earlier today, but we did hear from the major third-party payers, like Blue Cross, that the prices were substantially lower during the COPA. Substantially may be too strong a word, but significantly lower than the other Montana hospitals. And that's what we believed at the time.

Now, on the negative side, when you displace competition with regulation, the state becomes the referee for all disputes between the hospital and other market participants, like doctors,

third-party payers, health plans, and competing service providers like home health care providers that competed with the hospital for home health services. So it would seem like anytime one of those players didn't think it was getting what it wanted in its negotiations with the hospital, they called us. We became the referee, and I found that very difficult to do as a regulator. And I think it was a big advantage to Benefis because, I mean, they had the right under the regulation to compete vigorously, and it seemed like their conduct was being scrutinized every time someone didn't like a negotiated outcome. So that, to me, was a problem.

Another problem was politics. There was tremendous political pressure on the Montana Attorney General throughout the entire process. Ultimately, Benefis resorted to politics to get the COPA regulation terminated, but they were not the only person that used politics. All of the market players went to the political arena to try to get things done, and that's a real problem, in my view, with the COPAs. The pressure was intense. The attorney general at the time was Joe Mazurek, and he's no longer with us. He passed away. But he, I think, deserves a footnote in the book Profiles in Courage because he applied this COPA. Some in Montana say it cost him the governorship later, but he believed he had-- whether he agreed with it or not-- he had an obligation to follow the law and probably paid a price for it. So politics, especially in a smaller state, is problematic.

And finally, the duration of COPAs is a big issue. In Montana, we went 10 years, and it was terminated. But there is an interesting issue here that Dr. Vistnes made earlier about the but-for world. Great Falls may be a very unique market. There were two hospitals at the time, but the population in Great Falls today is the same as it was in 1970. It has not grown for 50 years. And I think 76 percent of the payers is government. It's Medicare, Medicaid. An Indian reservation is close by. The Air Force base is close by. So their payer mix is different, and so it is very possible that the but-for world would have been a single hospital. And you can make the argument that because of this unique market, it may be that it was headed for a single hospital and the COPA allowed a more efficient transition with cost savings that were passed on to the consumers. And I think that argument has already been made.

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

STEPHANIE WILKINSON: Okay, thank you. Now I'd like to turn to John Goodnow. John, you joined Benefis as the CEO in 2002 after the COPA was already in place. You operated the hospital under the state's COPA regulatory oversight until 2007, when the COPA was repealed. Can you please describe this experience for us from the hospital perspective, including some of the challenges associated with being monitored by the state under a COPA?

JOHN GOODNOW: Sure. Let me start with just a couple things that I think tie into both what Cory and Mark said previously on this, is Montana is a pretty unique state. And there's certainly a problem with regulation when you're talking regulation in the whole country because all of these health care markets vary so dramatically. While we have cities in Montana, not really. I mean, our biggest city is Billings, Montana, and it's barely 100,000 people. Montana is a gigantic state with no people. The whole state's a million people.

And most of the hospitals in the state of Montana are not larger hospitals. They're critical access hospitals, which are separately regulated and really difficult. And that's where a lot of health care failures are occurring all across the United States is in these critical access hospitals. So it's a very unique market, as Mark mentioned. I mean, it's kind of amazing really that Great Falls is just a few people less today than it was in 1970. So it's not a growing market, and there's no real particular signs of that changing any time soon, either.

The other thing, too, that's interesting to note from the presentations earlier this morning is we're constantly talking about inpatient because that's the data that exist. And when I joined Benefis, or particularly when Benefis would have been first regulated by COPA, it was primarily inpatient organizations. That's not even vaguely true today. Today, 63 percent of all of our revenue comes from outpatient services, not inpatient. So when you only look at inpatient data, you're really missing the bigger part of the picture. And what we want health care to do in the United States is really transition from inpatient to outpatient, much more cost effective care.

So another thing, too, in health care is how goofy health care pricing is. First, as Mark mentioned-- and this is accurate-- we're 76 percent governmental payers. Medicare, Medicaid traditional, Medicaid expansion, Indian Health Service-- and there's a bunch of reservations in the state of Montana-- and TRICARE because of the military base. So in that 76 percent, you can charge anything you want. It doesn't matter. The government's going to pay what the government's going to pay, and pricing is more or less immaterial.

So where pricing truly matters are to those that do not have governmental insurance, and that's commercial insurance. And a big problem with American health care-- and every hospital in the country does this-- is they charge commercial insured patients, most of you in this room that probably are covered by commercial insurance, your commercial insurance is paying anywhere from 200 to 500 percent more than Medicare is.

And so when you're looking at pricing, it only applies to that slice of the market that's covered by commercial insurance. And in our case, that's 20 percent of our market. Seventy-six percent of our market's governmental, 4 percent are still uninsured even though we have Medicaid expansion, and the other 20 percent pay more because they have commercial insurance.

So price, while goofy, doesn't really show anything much about an organization except to that slice of the commercial market, and even then published prices don't mean a lot because within our 20 percent of commercial payers, everybody has negotiated discounts. So unless you can actually get to what a commercial insurer is paying, which they're usually unwilling to share because they don't want their competitors to know, you really don't have a handle on price.

And the other thing I will say about American health care is-- let me tell you, I am the biggest, I talk about this more than anybody I know-- American health care is broken, and the big problem with American health care is the cost of American health care and the horrid lack of affordability for those primarily with commercial coverage. Right now, you're way better off being on Medicare or Medicaid from an affordability perspective than you are on commercial insurance.

And most commercial insurance in the United States has went to real high deductibles and have high co-pays. People can't afford their own commercial insurance. So we, as a country, have to do something. And unfortunately, most of the mergers, including the big mega-mergers that

get approved that aren't regulated by COPAs-- COPA is a tiny little share of the health care market-- have tended to not address the cost problem in the United States. And the cost problem in the United States just gets worse and worse.

So was the Montana COPA effective? Yeah, I think it was. Does our data that we look at match with the data earlier shared that showed prices went up to the degree they went? No. Frankly, it doesn't. We look at a data source that, number one, is way more current, and that is data gathered by the Montana Hospital Association, and that comes out every 90 days.

It's provided directly from the hospitals, and our prices are lower than the other large hospitals in the state by about 6 percent. During the COPA, our prices were lower than the rest of the state by about 20 percent. So after COPA, there's been some price erosion, but Montana Hospital Association data shows that we still do have a price advantage. So I think COPAs are effective maybe, depending on how they're set up, but probably only during their duration.

And frankly, I don't think they get to the biggest problem in American health care, which is the cost of health care, particularly at all. And I think that's going to be the number one issue in the 2020 elections and will really kind of shape what happens in the elections. And frankly, I do think we need some level of at least base national coverage for the American population.

But let me tell you, I am the outlier within my own field. And so far, American Hospital Association, AMA, all these organizations have came out against single payer or Medicare-for-All before there's any discussion of even maybe what that would look like, which is pretty telling when you come out against something before it's even described. But that's what they've done. So anyway-- but I think it worked during the time it was in place.

STEPHANIE WILKINSON: Okay. So now I'm going to turn to Kendall Cotton. Kendall, as a policy advisor in the Office of the Montana State Auditor, you were involved in a recent effort to repeal Montana's COPA statute. Can you please describe the role that your office played in this process and the reasons why the COPA statute was ultimately repealed?

KENDALL COTTON: Sure. Thanks, Stephanie. And I'll just clarify for the audience, too-- I work for the Montana State Auditor, but we are the insurance commissioner in the state. So we regulate insurance and securities. We don't audit things except for within that purview. So with that being said, we don't normally regulate providers. That's not the insurance commissioner's role.

But post the last legislative session-- which we meet biannually, so every two years-- the last legislative session got done, and according to the commissioner's order, he wanted us to look at how to make a more competitive insurance marketplace in Montana. And through extensive research, all roads led to us looking very closely at provider contracting. And then from there, we were looking at provider relations and the market for health care providers and facilities in Montana. We believe that a more competitive marketplace for providers and health care facilities leads to stronger insurer networks, leads to lower premiums, and lower costs for consumers in the end.

So based on the data and the research, we think it's crystal clear that hospital consolidation leads to poor outcomes for both quality and costs. I mean, we think the data is in. We believe that Montana, as John mentioned, is an at-risk state for consolidation based on our geographic

and population properties. I mean, we are so spread out. We have large concentrations of population, so we have large regional actors and then a whole lot of nothing in between.

So based on that risk, we put forward legislation to repeal the certificate of public advantage law in Montana, which we viewed as a regulatory incentive for consolidation. So to be clear, Montana statute says that merging hospitals may apply for a certificate under this statute, but hospitals are free to merge without one.

From our perspective, merging hospitals would only likely apply for this COPA because they worry that their merger is going to run afoul of federal antitrust scrutiny or loss, and they're seeking a public interest exemption. And we saw that with the Benefis COPA. The FTC dropped their objections to the merger once the COPA was put in place.

With the later 10-year sunset that was put in place on the COPA statute, we saw this perverse incentive for mergers become even worse, in our perspective. Now not only could mergers who were worried about federal antitrust scrutiny escape it under a COPA, but they could also continue to act as a monopolistic power after its expiration.

And we've seen this idea of a monopolistic exertion of power in the marketplace with Benefis today, so we see very key examples that indicate monopolistic or uncompetitive market practices. Cost has been mentioned. Costs increased dramatically after the repeal of the COPA or the expiration. In addition to that, I believe all those costs were focused on inpatient.

According to a 2017 study by the Rand Corporation that we were looking at that dealt with actually outpatient costs as well, Benefis maintains that they're one of the highest cost hospitals in the state. They have some of the highest charges compared to their reimbursed costs. They're number three compared to all of the hospitals in the study. And so they've been cited numerous times by the media, by the legislatures, by citizens that say that they are one of the higher cost institutions.

In addition to that, their market power has played out in several different high-profile circumstances. Because of their regional monopoly status post-COPA, Benefis was able to be the last holdout of the Montana employee state health plans reference pricing initiative to lower health costs. They exert significant market power. In addition to that, we saw that the year directly after the COPA reporting periods expired, Benefis executives received multimillion dollar bonuses in their compensation.

JOHN GOODNOW: Damn, I missed that. You got to go back and look at that and help me find what happened to mine.

KENDALL COTTON: Sure. But that is completely backed up in the data, where it shows that monopolies and uncompetitive markets have a greater disparity between executive pay and other hospital employees, and so we're seeing that play out with Benefis. So with that being said, we decide in the best interests of Montana consumers to repeal this incentive for hospital consolidation entirely.

STEPHANIE WILKINSON: Okay, thank you. So thank you for these opening remarks. I think there's a lot to dig into here, and I'd like to get into that. I'd first just ask if there's anybody on the panel who'd like to respond briefly to anything that they heard during opening remarks before we move into our moderated questions.

KIP STURGIS: Stephanie, I mentioned to you before the conference I thought I was going to be the piñata of the day. I'm really glad you invited John here.

[LAUGHTER]

JOHN GOODNOW: Well, I found a lot of what Kendall said silly, frankly. I mean, we'll share our data with you anytime. But some of that's ridiculous.

STEPHANIE WILKINSON: And I would just like to say, Kip did offer to commission a mariachi band to come and play in case that ended up being the case. But no, nobody should be feel that.

Okay, so I think first I'd like to move into some of the remarks that Cory made regarding regulatory incentives under a COPA. And in particular, Cory mentioned that he was looking at concerns, but he didn't actually look at whether any of these actually played out in North Carolina. And I'm curious, the people on the panel, can we elaborate on this somewhat? Can anybody comment on how these types of regulatory incentives actually played out in North Carolina and Montana during the times that the COPAs were in effect? And were there any unanticipated consequences that resulted from the COPA regulations?

JOHN GOODNOW: Well, I think Mark mentioned some of the Montana COPA is where it became-- I mean, the poor AG's office. If anybody in that market, competitors or whatever, didn't like something Benefis was doing, they'd immediately go and complain to the AG's office. And of all the times that happened, between the AG's office and the consultant they used, I don't think they ever found any one that had any merit to it. But, I mean, it was kind of the regulators getting drawn into something that they were never intended to have to deal with when the regulation was put into place in the first place. So I think that's an unintended consequence.

And then I think the other unintended consequence of anything that goes over a long time period with how rapidly health care is changing today is what you start regulating on day one is dramatically different just by the market changes at the 10-year mark.

And something Cory mentioned, that if you have a regulation against not employing physicians-- because I'm the chair of a board of a medical school, too. Let me tell you, most kids coming out of medical school have no, zero desire to go into private practice because health care is so screwed up. They want to be employed by a health care organization. And the majority of physicians in the whole state of Montana are employed. So if you eliminate an organization's ability to employ physicians, you've crippled the organization's really ability to be able to recruit necessary health care professionals because they're sure as heck not going into private practice. So that would be another unintended consequence.

CORY CAPPS: Although just to be clear, I had proposed a cap that would be proportional to the inpatient side. So if you had a hospital with a 60 percent inpatient share, it'd be something on the order of 60 percent of the area physicians, not a ban on employing them. And in some areas, you see large independent medical groups that work alongside and with the hospitals.

JOHN GOODNOW: That's changing dramatically, though.

STEPHANIE WILKINSON: And, Cory, what are some of the reasons that a state might want to consider a physician employment cap in light of the information that John has just shared?

CORY CAPPS: I mean, I think the gist of it was at the heart of the case that wasn't litigated in St. Luke's-Saltzer, or that was litigated and then ignored. So the private plaintiffs in that case was a rival hospital concerned about the acquisition of a primary care-- or, actually a multi-specialty physician group that drove a lot of referrals to two hospital systems. And one of the hospital systems was going to buy that group, and the other hospital system was afraid that they would lose their referrals. So that was kind of a vertical case. It also entailed horizontal overlap, and so the horizontal combination of physicians was the decider. And the judge said, I don't have to worry about the vertical stuff, which is more complicated.

But the idea was, if you have a hospital system, two hospitals in a 50/50 competition, and then one of them buys up 90 percent of the physicians, pretty soon you'll have 90/10 on the hospital side as a consequence of the physician side. And so if we're going to regulate a monopoly through a COPA, you want to make sure that they can't do things that lessen competition beyond what the COPA enabled.

And then you could also add to that that buying up physicians and maybe if those prices aren't regulated, it gives you a way to evade the regulation through time because you could just charge a whole bunch for the physician services, which are perhaps outside the COPA because no one was thinking about that in 1996 when they enacted the system because they were all focused on inpatients. So those were two of the rationales there.

STEPHANIE WILKINSON: Okay, thank you.

KIP STURGIS: Yeah, Stephanie?

STEPHANIE WILKINSON: Yes?

KIP STURGIS: Can I give a 30,000-foot view of COPAs? We've heard about regulatory evasion during the course of a COPA, which is bad. But we've also heard about the ultimate regulatory evasion, which is hospitals merge to monopoly, they endure COPA for a while and then they are freed of it, and your community is stuck with a monopoly that is embedded and ain't going anywhere.

I'm an antitrust enforcer-- for those of you who don't know me-- so at the very start when the legislature was talking about this, I said, that's a bad idea. And then they said, hey, Sturgis, you get to regulate this. I said, well, that's a bad idea, too. I don't have the skill set. I didn't have the skill set. But more than that, the ultimate regulatory evasion that happens is just not a path that I can recommend.

STEPHANIE WILKINSON: Okay, thank you for that insight. John, can I follow up with you one more time? I'm just curious if you can discuss what the cost caps that were put into place with the Benefis COPA. Can you talk about how that affected incentives at Benefis Hospital?

JOHN GOODNOW: Well, I tell you what, I think one thing on the positive front and where American health care really needs to focus is on cost reduction. And when you go to national meetings and listen to the huge mega-systems, very few of them are talking about cost reduction, still even now. And so it instills that a bit. But then the other thing with cost caps

that can be a weird disincentive, too, is if you have a cost cap and you had an opportunity to reduce costs a whole bunch, I mean, the way it was set up, that kind of bites you and punishes you, too, because of the way the revenue cap worked.

So the cost reduction that really probably started during the COPA, we focused on cost reductions starting in 2008. And in 2008, Medicare covered 75 percent of our cost. And that's still fairly common in the United States. I think the national number right now is at an average organization, Medicare covers, like, 85 percent of an organization's cost. And then everything else gets cost shifted onto the commercials. And Medicaid, the number's way, way worse than that.

So we begin on cost reduction, and we're actually one of the few organizations in the United States-- and this is all outside verified-- that break even on Medicare reimbursement. And so, I mean, that's helped us to be very successful because-- and think of an organization that's 76 percent governmental. If you lose money on 76 percent of your business, even trying to cost shift to 20 percent others, you're probably not going to do very well.

And our organization has remained successful, but it's because of cost reduction and Medicare break-even. So I think COPA helped to instill that kind of original thought process and discipline. But really I think for that to be effective, it can't be really regulatory instilled. I think it's got to be inherent in the organization to want to reduce their costs.

STEPHANIE WILKINSON: Okay. I'm curious, were there efforts by the states to try to detect possible instances of regulatory evasion during the times that the COPAs were in place or perhaps modify the terms of the COPA if it was ever determined that they didn't offer adequate protection against the possibility of regulatory evasion?

MARK CALLISTER: We were looking at that constantly. We had an interesting issue. Both inpatient and outpatient were under the cap, so they were regulated to that extent. But the hospital didn't compete with anyone for inpatient, and they competed fairly vigorously in outpatient. So one of our concerns was they would lower those outpatient prices aggressively.

And I think during the seven years after the COPA, outpatient prices in the area were very competitive because Benefis was lowering that. And we were concerned obviously about was there a subsidy advantage there because they didn't compete on the inpatient, but their inpatient prices still were lower according to our measures for five years. But that was one thing that we monitored. And I just think it's hard to anticipate everything that's going to happen, and maybe there were some things we didn't discover.

STEPHANIE WILKINSON: Okay. And do we think the-- what we've been talking about with the regulatory evasion issues and the difficulty in detecting that for North Carolina and Montana, are these situations, can they be considered broadly applicable to other COPA situations? So are these types of concerns about regulatory incentives always going to be a factor when states are contemplating the use of COPAs?

KIP STURGIS: Yes.

STEPHANIE WILKINSON: Okay.

KIP STURGIS: Yeah. That's the nature of-- look at utilities regulation. You see the same thing with the power companies and water companies and all. They set about to find ways to shift costs from their shareholders to their ratepayers. That makes the stock go up, and that makes the executives happy. So I think that's inherent in a regulatory scheme that displaces competition. I think it will always be a problem, and I'm really grateful you all are looking at it.

JOHN GOODNOW: But on your point, you'd want to also look at the mega-consolidations that are happening nationally.

KIP STURGIS: Oh, yeah.

JOHN GOODNOW: And I don't think there's enough attention there. These COPAs, I mean, look at the ones we're looking at. They're in pretty rural states. North Carolina and South Carolina aren't as rural as Montana, but they're still not California and New York and some of the populous states. And what's happening nationally are these huge mega, mega-mergers, multi-state mergers, where everything in multi-states then is controlled by one huge corporation.

And the theory behind mega-mergers is economy of scale and it's going to reduce the cost to health care. Let me tell you, that is not happening so far if you look at the data. So, I mean, I think we need to look at the cost data all over the place, but not certainly just in little podunky COPAs, which are nothing in the national health care market.

KIP STURGIS: Right. But the FTC led the way in getting about 25 years of bad case law reversed with *Phoebe Putney*, and that was huge, really a brilliant case selection and case development. So that does lay the groundwork for hard scrutiny of future mergers in the health care field.

JOHN GOODNOW: Good.

KIP STURGIS: Yeah.

STEPHANIE WILKINSON: Okay, thanks. I think I'd like to move on to a question, and I've received a question from the audience-- and I think this kind of is a nice segue into the next question that I had-- is, what efforts did the states make to evaluate whether the COPAs achieved the purported benefits, cost savings and efficiencies, while mitigating the potential for anti-competitive harms? How did the states evaluate the impact of the COPAs on price, quality, access, and innovation for health care services during the time that you monitored these COPAs?

MARK CALLISTER: Like I said, I wish we had had access to some of the data that was used today. On the cost side, ours was a revenue cap. So the idea was they came to us and there were two hospitals. We took their cost in 1995 from their internal financial statements, and then we said, what do you think the savings will be? And they wanted to have a COPA, so they had fairly aggressive estimates of what their savings would be.

So we said, okay, we're going to take those '95 costs, we're going to subtract those savings out because that's why you're asking for permission to merge, and then that's going to be your base level cost. And we'll give you a rate of return every year above that. And we actually went in,

as I recall, we had an auditor who every year would-- a CPA firm that would go in and audit Benefis's documents that they gave us. And my recollection is that the cost targets were met and that they did reduce those costs.

One of the issues we had-- and Benefis raised this-- is while we believe that because of those lower costs and the lower prices it was good for the consumer, there was an issue as to whether this was getting passed on. Because at the time, I believe Blue Cross didn't rate by market, it was by state. And so one argument was, well, we're doing all this good work in Great Falls, and the Great Falls consumers are not getting the benefit of this because either Blue Cross is keeping it or it's going statewide.

So that was a frustration. The biggest frustration for me on the price side-- the costs were easy. We could see that they did through their combinations and efficiencies, their costs were considerably lower. The question was, did it get passed on in price reductions to the consumers? And that was, frankly, hard to measure.

STEPHANIE WILKINSON: Okay. Now I'd like to follow up on some of the remarks that Kendall made regarding the recent repeal of Montana's COPA statute, and I'd like to just turn to the reasons that the Mission Health and the Benefis Health COPAs ended. I'm wondering if we could start with Kip. Can you please describe the circumstances surrounding the repeal of the North Carolina COPA statute, which, as we know, effectively ended the Mission Health COPA, and what's been happening since then?

KIP STURGIS: The circumstance was the difficult situation that Mark found himself in with a political dimension that we can't control. And it was a political campaign by the hospital to get rid of the COPA, and they succeeded. So the statute was passed over my dead body, and it was repealed over my dead body. So I'm doubly dead. This is not bringing up good memories, Stephanie.

STEPHANIE WILKINSON: Sorry about that. But what do you feel like has happened since the time that it was repealed? We're aware of the recent sale of Mission Health to HCA Health Care. What has been the reaction to that situation within the community, if you can speak to that?

KIP STURGIS: Well, the first big thing that happened after the COPA statute was repealed was-- I know some information because of litigation of another matter in which Mission's CFO was deposed. But I can just say that when Mission was negotiating with the largest payer in the state, Blue Cross, it apparently did not make a very good offer. And Blue Cross just put them out-of-network, which is the nuclear bomb in managed care negotiations. So one can infer that Mission asked for a lot more than Blue Cross was willing to pay, and Blue Cross was willing to go through some pain as well as inflict some pain. So that was very disruptive to the community for people not to have Mission, the monopoly hospital in Asheville, in-network with the state's largest payer. It was very difficult.

The community reaction to Mission's sale of itself to a large for-profit entity, I think, was mixed. Mission, I think, did an effective PR job, but the sale did involve HCA paying $1.5 billion, which went into a foundation. One might guess that this foundation will do the things that Mission used to do and fill in where HCA decides to cut back in terms of access to care. Mission supported-- before the COPA was repealed-- it financially supported several of the regional hospitals that were small and struggling. Who knows what HCA will do there? And

so the foundation may be stepping in to provide that type of access issue, which is also very important.

So it's been, I'd say, in the community a mixed review. My view that, again, doesn't seem to be listened to very much is it's a bad idea, but they went ahead and did it anyway.

STEPHANIE WILKINSON: Mark, you described some of the circumstances surrounding the 2007 amendment to Montana's COPA statute, which limited the duration at the COPA to 10 years. John, I'm wondering, can you elaborate for us on what was the hospital's perspective on that amendment, which effectively ended the Benefis Health COPA and the state regulatory oversight that you were operating under?

JOHN GOODNOW: Well, I tell you, from our perspective-- so Montana has very few of these larger hospitals. Like I said before, it's mainly critical access hospitals in the state of Montana, and I forget which percent. There's only nine larger hospitals in Montana. And compared to the national large hospital, which think of Montana's large hospitals aren't large anyway, so of the nine hospitals in the state, all but four of those are monopoly markets anyway.

And now with the growth in some of those other markets, the other markets are as big or bigger than Great Falls, too. So actually from a common sense, fairness, whatever you want to call it perspective, if you're going to regulate one monopoly type city, you might as well regulate them all. And that would include, in Montana, Kalispell and Bozeman and Helena and some Butte, some of those kind of markets.

So listen, we're not the only hospital like this in the state of Montana in real similar communities. Number two, look at the data. We're doing a good job. And number three was, there's not a noticeable difference in the two-hospital markets in Montana, which are Billings and Missoula, as mentioned earlier. And actually, if you look at the state database pricing that's put together, state-specific data from Montana Hospital Association, heck, those markets are every bit as expensive as the others. So why keep COPA going?

And then on top of that, we did have competition that didn't exist at the time COPA was initiated in Great Falls. So that was our logic, and the legislature agreed. And plus, it added a little bit of extra cost at Benefis, too, because you're paying all of the regulatory expenses, which are a direct path through to the organization, at least they were in our COPA. So it actually reduced costs a little bit that way.

STEPHANIE WILKINSON: Okay. And, Mark, is there anything else you'd like to add about the 2007 amendment?

MARK CALLISTER: Yeah, we had prior to that engaged in a fairly lengthy review process with the hospital, and they hired a very capable outside counsel. And we were considering this argument that competition was increasing, and we were looking at ways to modify the COPA and were prepared to do that because competition was increasing. And this came as a surprise. I wasn't at that level. And then all of a sudden, it was no longer an issue. I mean, part of it was a relief because regulating is hard, and it gets harder when you're using a 10-year-old measuring stick. And we knew that was going to be the case, and we really didn't know how long that would last and be effective.

One interesting point, as Kendall was talking, they repealed the COPA statute, and that probably makes sense to me. But to my knowledge-- and this is an interesting fact about Montana-- in 1996 when they enacted it, I think four or five hospitals were looking at doing this. And then Benefis went first, we're going to have the COPA, and then nobody else wanted to do it. And I don't think anyone else did it. Is that correct? So it may be good to get it off the books, but it was really not being used at all after the Benefis.

STEPHANIE WILKINSON: Okay. Kendall, I'd like to pose a question to you. As we've heard, unlike in North Carolina, there was no active COPA at the time that the Montana COPA statute was repealed recently. It seems that the circumstances surrounding the repeal of these statutes can vary. So you had in North Carolina, you had the lifting of the active supervision that regulates the monopoly, to the situation that you recently went through in Montana, which it seemed the goal was to try to enhance competition and ensure that no additional COPAs are sought in the future. And my question is, do these circumstances matter when you're talking about the repeal of COPA statutes? Should states with active COPAs refrain from repealing their COPA statutes if it would result in a hospital monopoly operating without any regulatory oversight? And I'll pose this question to you, but then invite others to weigh in on this question if they'd like to.

KENDALL COTTON: Yeah, absolutely. I mean, as the other participants have noted, Montana is a unique state. We didn't have an active COPA when we went forward and repealed the legislation in the statute, so we weren't dealing with an active COPA situation. However, from our office's perspective, even if there was an active COPA in place, you have got to remove this bad legislation. This is just bad policy. And the mergers can still happen regardless of if a COPA statute is in place. So our view is, if mergers are happening, at least they aren't immune from antitrust oversight at the federal level.

And then what I would say is if there is a concern of dropping COPA regulation during an active COPA period with the repeal of legislation, that just means that state regulators need to do their job. We have taken an active look at really our antitrust oversight as the insurance regulator for our part. We have direct authority to look at anti-competitive unfair trade practices in the marketplace, and we're stepping up to the plate to look deeper into those circumstances. We think that state attorney generals need to do the same thing in coordination with federal authorities.

So no, I don't think in the case of an active COPA situation that a state should refrain from repealing this incentive for mergers. The history has just shown that COPA oversight is a challenge. And then the potential still exists for not only regulatory capture, but in Montana's case, a legislative capture-- where you have these big prominent institutions and communities that obviously capture a lot of public attention, a lot of political attention. And that lends itself to a situation where you have legislation passed that allows for a sunset and for these entities under the COPA to escape that regulation.

STEPHANIE WILKINSON: Would anyone else like to weigh in on this issue of when is it appropriate to repeal a COPA statute. If there is an active COPA that exists in the state, is it a good idea to repeal that statute and thereby lose that regulatory oversight? What do we think on that?

CORY CAPPS: I have more of a question than a comment, but whether it has to be either/or. So can you repeal a COPA forward looking without deregulating existing COPA hospital

systems that have come about in the past? It seems like at least in principle you could do that. Because the COPA legislation, I mean, I think the research we saw this morning shows that COPAs may have some mitigating effect on prices, and that's probably a good thing, but that doesn't mean that the COPAs were a good idea in the first place because then you get mergers that wouldn't otherwise happen.

So it's kind of like saying, well, gee, if I'm sick, I'd like to take some medicine because it might help. It's not going to make me perfect, but it will help. That doesn't mean I should go out and get sick. So they're two different but related questions. So I guess right now, there's a certain logic to repealing them so that you remove one artificial incentive to merge, but that doesn't necessarily mean that in every market where you've had the mergers already, you have to say, okay, well, do what you will now.

KENDALL COTTON: Yeah. And I'll add to that, Cory. From our office's perspective, when we were evaluating this statute and looking at legislation, we looked primarily at the before and after of the circumstances. I think it's debatable and there's data that shows there is potential effects of the COPA while in place, but I think that the evidence is very clear that post-COPA you see very negative effects.

STEPHANIE WILKINSON: Okay. So moving on, I'd like to discuss, just so that we can understand better this COPA process, what factors are persuasive to state legislators when enacting or repealing COPA laws? And for that matter, what factors are persuasive to state agencies when determining whether to grant COPA applications or modify COPA terms and conditions?

KENDALL COTTON: I'll answer that. I dealt with the legislature directly in this. And I'll just say there is a lot of interest in the legislature-- at least in our legislature, but from our experience across the nation-- in cracking down on monopoly activity and anticompetitive activity in the marketplace. In our experience, we've dealt with that in the pharmaceutical sphere. We're looking at this legislation in the hospital and facility sphere.

But there is a lot of enthusiasm from legislators and lawmakers to crack down on these issues, and it's obviously of public importance. And we heard a lot of support from legislators for this legislation. The Hospital Association, we actually didn't have any official opponents, although we had some kind of informal opposition. And like I mentioned earlier, hospitals, especially in Montana, are very prominent entities in the communities, and so these are very important decisions for lawmakers to consider when they're repealing these statutes.

MARK CALLISTER: I think it's a very complex issue, and it's very hard to give factors that would apply in all situations. I mean, I think there is an argument that Great Falls was headed to be a one hospital town because it was a lot of capacity, two historic hospitals, a lot of it was going to outpatient. And so it is very possible-- and it'd be interesting to have someone with the tool they have now to study this-- would you have ended up with a one hospital town, i.e. a monopolist, and not gotten what I think were pretty considerable benefits?

It wasn't just the price reductions. Montana had no antitrust enforcement at the time. And so I had had some experience in antitrust, and Benefis was not the only actor up there. There were doctor groups. There were interesting practices going on that because we were there, we were able to advise some of the other providers. Well, you really can't do that. You can't discuss your prices with the other group. And that was one advantage, and I think there were others.

So again, I'm not a proponent of COPAs, but just to summarily dismiss this as not a good thing, I don't think the evidence is there yet. And it was an experiment. I mean, Montana went and they took a shot at this, one of the first ones to take a look at it, evaluate it. I could see someone making the argument-- I mean, I don't want to be the cheerleader for this, but there might be markets where because of a lack of growth or quality issues, where you could come up with a COPA that would make some sense. It might not be a popular position to take, but I think the argument's there.

CORY CAPPS: So that sort of bridges a gap in sort of the merger guideline. So there is a failing firm argument that would address the situation where you can only sustain one hospital, but you have two, but you would have to meet a pretty high bar for failing this for the FTC, I think, to find it credible in general. And you're saying, well, maybe a few years earlier than that, we can make it a more orderly departure and get some concessions along the way, which is really saying we're in natural monopolies, and this is an indirect way of getting to regulation of natural monopolies.

MARK CALLISTER: Yeah. And that was an argument the hospital-- they made that argument back in '96.

STEPHANIE WILKINSON: Okay. I'm curious to what extent does-- I think somebody mentioned that one of the COPAs was hotly contested at the time when it was being put into place. How does the public's reaction to COPAs factor into the decisions of whether to enact these statutes or the decisions that the state agencies must make when deciding whether to approve a COPA application? How does the public's reaction factor in?

MARK CALLISTER: It was a surreal experience. I went up to Great Falls in the wintertime. The auditorium is full. Joe Mazurek, the AG, is sitting at a table just like this. It's packed. And he walks into chants like, "we will remember in November," and it was a very, very hotly contested thing, which is why I respect him so much. I believe he, on his own, would not have done the COPA. It wasn't what he thought was the best policy. But state action is the law of the land right now. The legislature gave him this standard. We thought it was met, despite our concerns about how long could it last and were there other negative effects, and I think he did what he felt was the right thing. But I'm glad I wasn't him.

KIP STURGIS: In North Carolina, our statute required us to have public hearings as part of the consideration of the COPA, and we did. And a successful health care system will be good at generating and projecting an image of being benevolent, and the community to some degree, I think, was persuaded that if these people think it's a good idea, then it was probably a good idea. So the public hearings were, in North Carolina, not very informative. At least it didn't tell us that there was a strong public opposition to it. That surprised me. But I do think it is an afterglow of a successful health care system projecting an image and maintaining an image of being good people in terms of their business practices, which may or may not be the case, as I've seen first-hand in other litigation.

KENDALL COTTON: I'll just add something real quick. Just from kind of an anecdotal experience and kind of on the political end of things, health care remains-- at least in Montana from the poll data that I reviewed-- the third highest issue of concern to voters. So, I mean, this is something that has maintained the top of voters' minds for over a decade now, and so I think it's going to continue to pick up steam. And I think we're seeing that in the political realm as well with the talking points and issue positions.

STEPHANIE WILKINSON: So I've received some interesting questions from the audience. I'm going to go ahead and pose them and see if anybody would like to respond to some of these. The first question has to do with the interplay between COPA and certificate of need regulations. And the question is, can you discuss the interplay between these two competition limiting statutes and how both of them may serve as barriers to entry?

MARK CALLISTER: I mean, we faced this directly because when Benefis was arguing that there was increasing rate competition, therefore the regulation should be pared back and eliminated, there was another hospital that was trying to get a license to get into Great Falls. And they were using not a CON statute, but one similar to oppose it, which seemed a little incongruous to me. So you do have-- perfect markets, it would be great if competition was perfect. It isn't.

On the federal side, one of the factors that made this merger somewhat more viable economically was you had the sole provider regulation in Medicare. So if you have only one provider in a certain geographic area, you get a significant increase in your reimbursement, which was an incentive to go from two to one, kind of a perverse incentive. So the federal government on the one hand, the FTC is concerned about competition, but then you have this Medicare regulation that is kind of the reverse of that. So yeah, there are CON statutes and regulations of all kind that seem to butt heads as you're trying to do these things.

CORY CAPPS: I mean, some of the more recent COPA grants, you can see in some of the public documents that there was an articulation of saying, we're spending too much competing with each other, which is basically the founding rationale for a certificate of need that will drive hospitals to invest in duplicative ways. Side note, for two firms to compete, they have to have some amount of duplication in order to offer different variations of the same thing to their customers.

But putting that aside, the rationale for eliminating excess investment driven by competition is the rationale for CONs. The empirical literature on that is longer than the literature on COPA, and it's not very favorable. They don't actually tend to drive savings. So insofar as that rationale for CONs carries over to one of the rationales for COPAs, it's not very promising.

The other thing about competition is in one that I looked at, I remember the system saying, look, we both have 3D mammography. Look at how bad that proves that things are because we don't need two. On the other hand, if you're a monopoly and no one is competing, maybe you don't have any. So some of these things play out in two directions.

KIP STURGIS: Yeah, I think CON just further embeds a monopoly or a certain market structure. It makes the market more rigid and less susceptible to change and innovation because why should they? It's a compounding effect on the negative side of a COPA.

JOHN GOODNOW: And most states have went away from CON. In Montana, I mean, the CON we still have is kind of goofy in Montana because we regulate the part of health care nobody wants to get into anyway-- nursing homes. Nursing home business is a terrible business, and we could actually use some more nursing homes. So let's put a CON on that and make it impossible to get into, and then leave hospitals completely unregulated. So that's Montana.

KENDALL COTTON: Yeah. I'll add to that, too. It was funny, in addition to the certificate of public advantage repeal that our office introduced, we introduced legislation to repeal our certificate of need laws as well. And it was kind of confusing with legislators sometimes because they had such similar acronyms, it was kind of funny. But in Montana-- just to clarify, too-- our certificate of need regulations don't apply to hospitals. It applies, like you said, John, really specifically to nursing homes and outpatient surgery centers and developmental centers and things like that. So it's been pared back over the years.

But what I would say is that I think an historical analysis shows that those two sets of regulations are done in the same vein, from the same line of thought. Like you said, Cory, it's from this idea that duplication of services is bad and that this idea that market competition can lead to entities going away and that that's bad for the consumer. So I think that that line of reasoning has been debunked thoroughly, and so I think that certificate of need definitely goes hand-in-hand with a certificate of public advantage repeal.

CORY CAPPS: Yeah. There's another little anecdote that shows how hard regulation can be, which is if you look at the Cabell/St. Mary's case, one of their main arguments to the FTC is we're not really competitors because one of us doesn't do much more than basic cardiac, and the other one doesn't do much more than basic pediatric. You know why they didn't do it? Certificate of need, and each one had challenged vigorously the other's efforts to enter into that home turf. So because of that artificial restriction, then fast forward however many years, they were able to say-- or try to argue, I don't think they convinced the FTC-- but argued that they were not really substitutes for health insurers anyway because they were differentiated, which had its roots in regulation in itself.

KIP STURGIS: They had already allocated the markets.

CORY CAPPS: Or the state had, I guess.

KIP STURGIS: Yeah.

STEPHANIE WILKINSON: So there's another question that we received from the audience. And this may be directed primarily to Kip and Mark, but I'd invite anybody to weigh in on this if you want to respond. The question is-- and it's been something that I think we've been receiving a lot of questions on this leading up to the workshop is why I pose this-- is there a legal theory under antitrust law to seek divestiture if a COPA oversight is terminated? So if state action immunity is gone because of the COPA repeal, is there a practical way to challenge or unscramble the eggs? Or I guess is the challenge to trying to get a divestiture, is that just the unscrambling of the eggs problem, or is it some kind of legal barrier that actually prevents antitrust from trying to seek a divestiture?

MARK CALLISTER: And that's a very interesting question and one that I was waiting for the FTC to answer when this happened. So yeah, I don't know. It would have to-- I think certainly in Montana-- would have to come from the federal level, but it's interesting. It would be practically very different because of the unscrambling of the egg.

KIP STURGIS: Yeah, with a monopolization case or attempted monopolization case, you look at whether it's illegal at the time. If the monopoly was legally created or if it legally arose-- because there are many examples in the economy of entities that have legally acquired market

power or monopoly status-- so it's a difficult theory to come after something that was legal when it was created and then say, well, we think you have too much.

It's back to the early school of antitrust of saying size matters, and if you're too big, we're going to break you up. The Chicago School displaced that, but I think there is some circling back to look at entities that are big and maybe look at how they are maintaining their monopolies. But I don't see it as a very likely avenue for addressing a monopoly that's acquired through a COPA and then the COPA statute is repealed and you have the unregulated monopolist.

MARK CALLISTER: Yeah. I think you have Noerr-Pennington issues, too, which are interesting. The First Amendment, you can't challenge a petition of a legislature.

CORY CAPPS: I mean, the FTC did challenge a retrospective or a consummated merger about, what, four and a half years after it closed. But then three or four years later, when that finally wound up, they ended up with a conduct remedy-- maybe like something you might see come about in a COPA. So would they go through all of that to get back to where a COPA was when a COPA went out? I mean, I guess that's a question for you, Stephanie. But it's a lot of effort, I guess, to get to a regulatory fix. And that's four and a half years of egg scrambling, not 15 or 20.

STEPHANIE WILKINSON: Another question that's come in from the audience, what concerns do state enforcers or regulators have regarding the involvement of politics and legislators in the issuance and repeal of COPA laws, especially where there are situations of conflicts of interest that may exist?

MARK CALLISTER: That's politics, isn't it? I mean, I don't think there's much you can do. And the Noerr-Pennington shield is pretty broad. So you can go to the legislature and make arguments basically saying, please keep my competitor away from me, and I think that's shielded.

KENDALL COTTON: Yeah, I would just add to that, with Montana's legislature in particular, it's a volunteer legislature, they're amateurs. They're not professional politicians, so there's going to be conflicts of interest always. And that's just the dynamic of our legislature, especially when you have hospitals who employ a large number of individuals in these population centers. So that's the dynamic at play. But we view-- our efforts to repeal the COPA was obviously successful, and so it's not necessarily a big barrier, I would say. Because I think that the public interest behind cracking down on monopolistic activity is there, and I don't think goes away with conflicts of interest in the legislature.

STEPHANIE WILKINSON: Okay. So we have a few minutes left on our panel. I think I'd like to end and just give everybody a chance to give a final thought before we conclude. And I'll throw out a question you may be able to answer, or feel free to say something else if you'd like. But I guess I would ask, what would you say to state legislators who are considering whether to enact COPA laws or expand existing COPA laws? And what would you say to hospitals who are considering whether to seek COPA approvals? For that matter, would you have anything to say to state attorneys general offices and departments of health that find themselves in the position of having to implement recently enacted COPA laws or evaluate COPA applications? And maybe we'll just start with Mark and just go down the line.

MARK CALLISTER: Yeah, so after I retired, I pursued a lifelong dream to become a cop, a police officer, and that's a stressful job. But I would rather chase bad guys with guns than do another COPA.

[LAUGHTER]

CORY CAPPS: So I'm supposed to go after that?

[LAUGHTER]

I guess I would say be careful what you get into, so maybe talk to Mark about the pros and cons before going down that path. There may be circumstances where there really can only be one hospital, and identifying those may be hard. And you may want to have protections after the exit, and COPAs are one way to achieve that. But it's hard to distinguish the marginal cases from the average ones that look more like regulatory evasion.

KENDALL COTTON: Yep. I mean, I don't have much else to add. I would just say from our office's perspective, certificates of public advantage, you're playing with fire. You have the possibility of these entities that enter into this oversight to get out of it. You have problems with the enforcement of that oversight in general. So we think if a state is considering entering into a COPA statute, we think that's a bad idea.

And then as far as continued oversight of these monopolistic or duopoly situations, we firmly believe that it is the state regulator's job to actively pursue instances of anticompetitive activity and enforce the laws that are on the books. We think it just is a matter of regulators doing their job and really trying to promote a competitive marketplace.

JOHN GOODNOW: Well, I don't think anybody that's probably ever been on a COPA on either side would want to be in another one. And I think in terms of the problems facing the American health care field, COPAs are probably so far down on the list, it doesn't even bear mentioning really. And I do think health care and health care costs particularly are going to be the number one issue on the 2020 presidential race and everything surrounding it and that you're already seeing that in the polls, too. So it's good that it's going to get attention, the cost problem.

KIP STURGIS: I think most people in this room are not legislators, and therefore not in a position to say yes or no to whether you should have a COPA statute or a COPA. For those who do have them, I hope you have seen Lien Tran's good crisp analysis of what we did, and we appreciate the thought that you've put into it. And the other folks as well that we've heard from this morning, who've given insights about regulatory evasion and ways you can do better with monitoring. Closely monitoring, having standards on the quality side, having deeper insight than I did into the financial side, the money side-- there are ways to do better. And I hope for those who have COPA statutes and even COPAs, I hope this is helpful for you to find ways to do better.

STEPHANIE WILKINSON: Okay. Please join me in thanking our distinguished panel for a great discussion.

[APPLAUSE]

Okay, we will now take a one-hour break for lunch. There is a cafeteria outside of the auditorium and just down the hallway, and we just ask that everyone be back in the auditorium and seated by 1:45 for our afternoon sessions. Thank you.

[MUSIC PLAYING – END OF MORNING SESSION]