Featured Paper Review—Certificates of Public Advantage: Can They Address Provider Market Power?

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The Source would like to highlight a newly published paper by Urban Institute researchers Randall R. Bovbjerg & Source Advisory Board member Robert A. Berenson with a summary of this important work.

In "*Certificates of Public Advantage: Can They Address Provider Market Power? (Feb. 2015)*," published by the Urban Institute, the authors conducted a case study through interviews with relevant stakeholders to determine the impact of a Certificate of Public Advantage ("COPA") on healthcare delivery and prices and its utility as a policy tool. For the full report, please see the link above.

On Price Increases and Provider Leverage

The United States is spending more for healthcare with reference to other developed nations, which is variously attributed to high healthcare prices, salaries, staffing ratios, drug costs, supplies, and profit-maximizing behavior by private participants. Price increases are the leading cause of healthcare spending increases, and hospitals comprise the largest category of spending. High prices are in part attributable to the negotiating leverage held by provider

systems, which have grown precipitously since the 1990s, and the pace of acquisitions and mergers appears to have increased into modern day.

Proponents of consolidation in healthcare markets contend that integrated providers can achieve higher quality service and cost savings through economies of scale and scope, while reducing redundant services and facilities. But, empirical data suggests that the purported cost savings from consolidation are often not realized for the consumer: the enhanced bargaining position of consolidated entities in contract negotiations with payers (i.e. private insurance carriers) almost invariably results in higher charges for services.

State Action Doctrine and COPA Legislation

Under the "state action doctrine," a state may impart immunity from federal antitrust scrutiny if it clearly articulates a policy to displace competition with regulation and the state provides for active supervision of private actions under the regulatory system. A COPA is one regulatory mechanism to permit cooperative action and mergers between providers by subjecting applicants to conditions and continuing oversight.

The authors focused on North Carolina's experience with its COPA program, although approximately 20 states have enacted some form of COPA legislation since 1992. Under North Carolina's statute, merging providers may apply for a COPA and receive state action immunity if they can demonstrate by clear and convincing evidence that the benefits likely to result from the transaction outweigh the likely disadvantages. Among other factors, the Department of Health and Human Services ("Department") – subject to the input and objection of the state attorney general – must

consider the proposed transactions's likely effect on costs, quality, accessibility, competition, and the availability of other arrangements that are less restrictive to competition in its determination [N.C.G.S.A. § 131E-192.4 through 192.5].

For the COPA to remain effective, the merging entities are required to make periodic reports to the Department, including a certification by both parties that the cooperative agreement continues to accrue a net benefit to the public in relation to any reduction in competition. [N.C.G.S.A. § 131E192.9]. After each periodic report, the Department must make a determination that the agreement continues to be in the public benefit and whether any changes or additions must be made to the certificate.

North Carolina's COPA Experience

Mission and St. Joseph's Hospitals, then the two largest in the Western North Carolina, elicited an investigation from DOJ in 1994 due to evolving collaborative efforts. The entities applied for, and were granted, a COPA to jointly manage the hospital under the newly formed Mission-St Joseph's Health System. In an effort to control price-growth as a result of the state-authorized consolidation, the state imposed quantitative caps on the hospital's adjusted costs, margins, and share of primary care physician employment as a condition of the grant.

The COPA imposed additional conditions to ensure the public benefited from the merger overall: cost reductions during the COPA's first five years|maintenance of service quality according to minimum benchmarks|maintenance of access to Medicare and Medicaid patients in line with other patients|a prohibition from refusing to contract with health plans seeking to pay for care

on a commercially reasonable capitated basis|a prohibition on the use of “most favored nation” clauses (typically an agreement between a payer and a provider that stipulates that the provider give the payer the lowest rate that it contracts with any comparable payer)|a prohibition on tying physician services with hospital services|to allow all qualified physicians in or near Buncombe County to admit patients to the two merging hospitals|and to make changes to the governance structure to include representation for purchasers.

Mission (the consolidated system) grew its market share significantly, acquiring five smaller “member” hospitals in four nearly counties. It had also contracted with hospital specialist groups and added physicians to its physician group practice. By 2011, the system was providing the largest volume of emergency care in the region and accounted for 44 percent of all hospital discharges.

In 2010, Mission asked the Department to raise the COPA’s employment cap from 20 to 40 percent of the primary care physicians within its geographic area, which prompted Mission’s primary competitor to petition the state to oppose the move and to increase restrictions on Mission’s continued expansion. The Department and the A.G. commissioned an economist consultant for advice, whose reports they considered in addition to reports supplied by Mission and the competitor group, The authors’ review of those records, taken in tandem with interviews with insurers and other observers, tends to bear out the conclusion that although cost and quality in the affected area with reference to other areas of the state seems to have improved in relation to pre-COPA levels, it is difficult to state the contribution of the COPA itself towards that outcome.

COPA’s Importance as a Regulatory Tool

The authors assert that the COPA’s importance as a regulatory tool is derived from the fact that antitrust enforcement alone has been largely unsuccessful in preventing healthcare consolidation, particularly in the case of markets that are already highly concentrated where structural remedies would be difficult to implement. Although “behavioral” and “conduct” remedies appear to be on the rise, the trigger for such antitrust intervention is often limited to impending mergers or acquisitions. Unlike in a COPA program, such interventions are also “time-limited,” whereas COPA oversight is continual.

The authors note the advantages of the COPA as a “quasi-regulatory” tool, noting its low administrative cost, the fact the agreements are voluntary, and its limited applicability as compared to rate-regulation (leading to greater political palatability).

The authors also identified problems with COPA programs more generally. Consolidated entities may lose the incentive to comply or remain a party to a COPA after the merger is settled, given the low propensity and success rate of federal antitrust authorities targeting such ventures. There is also no critical consensus on the appropriate metrics to track the benefits of a COPA merger, and the authors found a lack of relevant objective information to assess the North Carolina example. The success of a COPA program also relates to the state’s ability to maintain sufficient personnel and expertise to monitor and weigh the pro- and anti-competitive benefits of a consolidated system, which may be resource intensive. A COPA program may run the risk of regulatory capture, as well.

The authors conclude that although a COPA is arguably an imperfect regulatory tool, an optimized COPA program “could

provide a useful complement to more measured regulatory or market-oriented approaches to addressing market power.”