

RESEARCH REPORT

Certificates of Public Advantage

Can They Address Provider Market Power?

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Executive Summary

US health care policy needs better tools for addressing the high provider prices that are a main driver of high and increasing health care spending. A key problem is provider pricing power in increasingly concentrated health delivery markets. The growth of pricing power follows recent waves of hospital mergers, the emergence of “must-have” hospitals, and increasing integration with physicians. Antitrust law alone has done little to maintain competitive pricing. One alternative is the use of Certificates of Public Advantage (COPAs) to oversee merged hospitals. COPAs are seldom used, but one has operated in Western North Carolina for nearly 20 years. This COPA’s experience merits policy attention because of the model’s potentially broad applicability.

This case study describes the COPA’s quasi-regulatory approach to ongoing oversight of the Mission Health merger in Asheville, North Carolina; examines available performance data; and illustrates the policy challenges of combining regulatory and antitrust approaches into a workable regime of fiscal oversight. We reviewed available literature on this COPA’s design, operations, and records (as available) and complemented our review with interviews with senior executives at Mission Health and insurers in North Carolina, state officials, and expert observers of the COPA’s effect on health delivery and prices. Interviews were all conducted with a promise of nonattribution. We conclude that this application of the COPA model has some successes, and with modifications a COPA-like approach could provide a useful complement to antitrust enforcement in addressing market power.

The Structure and Operations of the 1995 COPA

North Carolina’s 1993 COPA-enabling act allowed providers to apply for state approval and ongoing oversight of provider collaborations; the act was amended in 1995 to include hospital mergers. Such COPAs block antitrust enforcement under a judicially created “state action” exemption. We reviewed the only COPA ever agreed to in North Carolina, which permitted the merger of the only two general hospitals in Asheville, North Carolina, into Mission Health (Mission), thereby staving off a federal antitrust inquiry. This antitrust exemption, however, came subject to many conditions that created a quasi-regulatory regime. Most important were three “caps.” Two controlled Mission’s overall profit margins and its average inpatient and outpatient costs; a third limited the share of primary physicians that it could employ. Other provisions sought to assure public benefit from the merger and fair dealings with insurers and physicians. Mission agreed to document its compliance in annual reports.

The COPA operated for years with little controversy. Regular reports were reviewed by the two state oversight agencies, the North Carolina Department of Health and Human Services (DHHS) and the attorney general's office, with help from expert outside accountants paid for by financial assessments on Mission. Over time, the COPA underwent slight modifications while Mission evolved into a multihospital system that includes many physicians, clinics, and other components. From two midsized competing Asheville hospitals, Mission became the dominant hospital system throughout Western North Carolina, a must-have institution for health insurers.

In 2010, some of Mission's competitors expressed concern about Mission's growth, arguing that the COPA had given it an unfair advantage, and requested substantial changes to state oversight. In response, the state agencies sought input from a national economic expert. Additional expert reports for the competitors and for Mission itself followed, as did legislative hearings, all of which generated more information than had been made available by the existing, informal oversight process. Ultimately the COPA continued with modest changes to the physician employment cap.

Assessment

This COPA has operated in quasi-regulatory fashion and has included antitrust-style provisions seeking fair competition. It has applied only to one merger and largely by application of an agreement with the "regulatee." The oversight process is quite informal; no extra state hiring and only modest new state data collection has been needed, and overall costs to the agencies seem low. Mission's COPA has never been challenged in court and has won political acceptance. In contrast, state hospital rate regulation has lost political support since its peak in the 1970s and '80s, except in Maryland and West Virginia. Rate-setting was mandatory, statewide, and required substantial expertise and commitment of resources. The Mission COPA is ongoing: no formal provisions limit its duration. Mission has indicated that sometime soon it may seek to terminate the COPA.

Definitive evidence on the COPA's performance is lacking. Both Medicare and private payer per-person costs have been found to be low in Asheville, though quality is good, according to independent findings using different data. Indeed, well-recognized policy experts have held up Asheville as one of the best communities for providing high-value hospital care. COPA administration has developed some evidence of control over spending increases and margins, although the COPA process does not generate and make public much data for outside verification. Insurance sources, however, say their challenges in contracting and pricing in Western North Carolina are similar to those throughout the rest of the state.

because consolidated hospitals have increased negotiating leverage in most other regions, evidently without involving antitrust enforcement or other COPAs.

Policymakers should consider quasi-regulatory oversight of provider consolidation like that of the Mission COPA because antitrust oversight has done little to prevent, roll back, or continually discipline consolidation and its high prices for consumers. Our understanding of this COPA's dynamics and accomplishments remains incomplete. Yet our case study suggests several important policy choices and challenges in addressing provider consolidation and pricing power:

- Competition and regulation are not mutually exclusive choices for policy intervention. The COPA has aspects of conventional regulation and of procompetitive antitrust strictures.
- The nature of cost or price oversight can vary. The focus can be prices or, as for this COPA, margins and costs. Different units of value are possible. This COPA monitors all costs through one metric, combining inpatient and outpatient costs into a single average in a way that has raised some concern. The benchmarks for comparison can also be challenging to choose and maintain over time. Also challenging is the decision of whether to focus on the level of prices (or costs or margins) or instead on their rate of change in those measures; the Mission COPA uses both approaches. Though not as difficult to operate as statewide rate-setting, the technical challenges in COPA oversight seem to require specialized expertise and adequate funding.
- Information needs are challenging for any public oversight or market assessment. It can be hard and expensive to obtain information other than from the regulatee. Monitoring for this COPA relies greatly upon Mission's self-reporting and review by consulting accountants.
- Both the beginning and end of COPA-style public oversight need attention if a similar mechanism is to have broader policy usefulness. Current COPAs, including the one in North Carolina, are only triggered by providers' application to state authorities. Hospitals accept state oversight of their pricing power only as a means to avoid federal antitrust review. States cannot themselves initiate COPA oversight to constrain provider market power, so such oversight would require new authority. When and how to end state oversight is another issue, one not yet to be explicitly addressed under the ongoing North Carolina COPA. It would be shortsighted to simply cease COPA oversight and return to antitrust review alone once consolidated providers have built market power, because the window for antitrust review to address a merger is time-limited under current law. (Antitrust reviewers are unwilling to "unscramble the eggs" of a settled merger.) A more promising approach is to terminate COPA

oversight only if effective new price competition has emerged, as Mission's economic consultant reported had been done elsewhere.

- Accountability for public agencies typically relies upon open administrative processes, clashes of private interests, and judicial and political review. This COPA has operated informally, relying heavily on negotiation and agreement with Mission. This process may well have achieved some success and has kept down judicial challenges and costs, but perhaps without needed transparency.

Across the nation, public policy will likely proceed without fully adopting either strong regulatory measures or unbridled competition. Accordingly, COPA-like oversight, if fully examined and improved, could usefully complement any mix of regulatory or market-oriented approaches to providers' market power.

Certificates of Public Advantage: Can They Address Provider Market Power?

Background and Importance of This Case Study

A little-known experiment in health care competition and regulation has operated for nearly two decades amid the mountains of North Carolina. Asheville's only two general hospitals merged in the 1990s. A state-issued Certificate of Public Advantage (COPA) sheltered the merger from antitrust scrutiny at the time but also sought to preserve the consumer benefits of competition by imposing ongoing state oversight, notably of hospital costs, margins, and physician employment. Some evidence suggests that the COPA has supported good-value care: accessible and high-quality services at reasonable cost. Costs of administration have also been low, and the COPA has won continuing political support while drawing relatively little criticism from employers, insurers, or consumers. However, some competitors and economic consultants have criticized it for insufficiently disciplining the market power unleashed by the merger, echoing familiar critiques of regulation.

The COPA's blend of light-handed, targeted regulation and market forces resembles the "conduct remedies" imposed on merging hospitals in some recent antitrust settlements. Such interventions address the increased pricing power of consolidating hospitals, which has developed in many markets nationally. Understanding the strengths and weaknesses of such interventions is important given the paucity of practical alternatives for promoting fully effective competition in health care delivery.

Furthermore, given the broad-based reality that consolidation in the delivery system in many markets has produced health care monopolies or near-monopolies, how this North Carolina COPA has dealt with one for almost two decades is of substantial policy interest. Such oversight may constitute a viable intermediate policy between fully competitive and fully regulatory approaches to hospital consolidation. The policy does not need the elaborate statewide apparatus of full rate-setting; rather, it targets particular institutions and specific geographic areas. Further, only modest administrative resources are needed. The North Carolina COPA also created behavioral remedies that are similar to those sometimes used in antitrust cases, but potentially stronger in that the COPA's remedies have been longer lasting

and have adapted to changing circumstances. There are also some indications that the oversight may have provided good value to local residents despite the reduction of competition.

In this case study, we first examine why many states enacted COPA legislation in the 1990s and then examine the reasons behind the North Carolina COPA as applied to Asheville's hospital merger. We next examine the Mission Health COPA in detail and how it has evolved. We explore the limited evidence available on its effectiveness and then conclude by discussing the potential lessons and challenges for using COPA or COPA-like mechanisms for addressing health care consolidation and pricing problems.

We interviewed stakeholders (including senior executives at Mission Health and insurers in North Carolina), state officials, and expert observers of the COPA's effect on health delivery and prices. These interviews were all conducted with a promise of nonattribution. We also reviewed available public documents and cite these as appropriate.

Rising Health Costs and Declining Competition

High prices are the dominant reason that US health care costs so much. "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," explains a classic *Health Affairs* paper (Anderson et al. 2003). By one estimate, the United States spent \$650 billion more on health care in 2006 than developed-world norms, mostly because of uniquely high health care prices, high salaries and staffing ratios, expensive drugs and other medical supplies, and the profits of private participants in the system (Farrell et al. 2008). Price increases were also the leading cause of overall health care spending increases for the first decade of this century (Martin et al. 2014).

Hospital care is the single largest category of spending. Hospital care as well as physician services and other professional services compose nearly two-thirds of 2012 national health spending for personal health care services (Martin et al. 2014). Over the past few years the issue of high and variable provider prices has emerged as an important policy issue; many reports and papers document the extent of the problem and seek explanations. The main explanation seems to be an imbalance in negotiating leverage between providers and consumers, specifically insurers that negotiate prices on behalf of their enrollees or for the self-funded employers that hire insurers to provide administrative services.

Provider Consolidation, Pricing Power, and Antitrust Law

A major reason for the power shift in negotiating prices has been the continuing consolidation of health providers across the country, which has gone through two eras. A wave of hospital mergers reduced competition in the 1990s (Fuchs 1997). After a lull, another wave, described by one health economist as a “frenzy” of mergers and acquisitions, is now underway (Dafny 2014). Many or most hospital markets have become highly concentrated as benchmarked against antitrust merger guidelines.¹ Having larger hospital systems arguably produces greater efficiency through economies of scale and scope, easier access to capital to support care improvements, and reduction in redundant services (Morrissey 2012). Hospitals in both eras have also acquired physician practices, and independent physician practices themselves have “bulked up.” One motivation in each era has been to better integrate delivery of care, clarify responsibility for the appropriateness of care, and achieve high-quality and good results. To these ends, thought leaders in the 1990s promoted more integration, and the Affordable Care Act explicitly promotes integrated accountable care organizations (ACOs; Luft 2010; Shortell, Gillies, and Anderson 1994). Some observers even expect horizontally and vertically consolidated “super-regional health care systems” to dominate service delivery by consolidating services across state lines, perhaps for the better.²

However, these alleged advantages of consolidation are disputed. Despite such laudable intentions for consolidation, the expected savings from mergers are often not achieved in practice (Saxena, Sharma, and Wong 2013), and much of any savings achieved may be retained by providers rather than passed through to consumers as price cuts. Moreover, providers in both eras have sought consolidation to boost prices by increasing their bargaining power with ever-larger insurers. Reduced consumer choice and increased provider market power threaten to allow hospitals to raise prices above competitive levels for both patients seeking care and insurers contracting to form provider networks.³ Economic theory and common sense both support this fear, and empirical proof is now accumulating that provider consolidation increases prices, largely by enhancing the bargaining position of the consolidated entity in their contract negotiations with payers (Gaynor and Town 2012; Massachusetts Attorney General 2010a, 2010b; Vogt and Town 2006). There is little dispute that horizontal consolidation, such as a merger of two competing hospitals, substantially raises prices to nongovernmental payers. Vertical mergers, including hospital acquisition of physician practices, whether or not they create ACOs, raise additional concerns (Berenson, Ginsburg, and Kemper 2010).

Federal antitrust law, starting with the Sherman Antitrust Act of 1890, has established the fundamental national policy of promoting consumer welfare by relying on competition to guide and constrain private commercial activity (codified at 15 US Code §§ 1–7). Federal and state antitrust laws both seek to protect competition against unreasonable private restraints

on trade that would otherwise benefit consumers. Restraints include private price-fixing, market-division agreements, and mergers. Antitrust law is phrased generally for the entire economy but also applies to health care (Federal Trade Commission and Department of Justice 2004; Hovenkamp 2011).

During a century of antitrust enforcement litigation, case-by-case judicial decisions have created specific doctrines that define misconduct, its proof, and exceptions to general principles. Enforcement power is shared by the US Department of Justice; the Federal Trade Commission (FTC), an independent agency; and state attorneys general (Feinstein 2014). Competing providers may also bring private antitrust suits. Competitors can prevail, however, only if they show harm to consumers rather than just to themselves. “Antitrust law protects competition, not competitors” is the legal catchphrase.⁴

State Regulation, Including Certificates of Public Advantage

States’ traditional legal authority includes the ability to regulate health care delivery, for example, by requiring licensure or certificates of need rather than allowing unfettered competition. Such state regulatory action is not preempted by procompetitive federal antitrust law, because courts have held that federal legislation does not intend to limit the states’ sovereign authority over such traditional matters (Havighurst 2006; *Parker v. Brown*, 317 US 341 [1943]). Instead, states may authorize anticompetitive actions if they meet a judicially created standard.

The US Supreme Court has laid out a two-pronged test for allowing such “state action immunity” from antitrust law (*California Liquor Dealers v. Midcal Aluminum, Inc.*, 445 US 97 [1980]). Under the “Midcal test,” a state or local policy choice against competition will be respected if the state has both (1) “clearly articulated” its alternative policy, including its intention to reject competition as a policy instrument and (2) provided for “active supervision” of private actions pursuant to the articulated policy. The state has to be acting as a sovereign rather than, for example, an operator of hospitals.

During the late 1970s and early 1980s, many states took action against high hospital spending through state rate-setting, a clear alternative to competitive pricing (Atkinson 2009; Sommers, White, and Ginsburg 2012). Federal policy provided some encouragement and by waiver allowed some “all-payer” states to govern Medicare in addition to commercial insurance and Medicaid. Rate-setting waned with the emergence of hospital price discounting and growing antigovernment sentiment. Only Maryland retains an all-payer program.

A much narrower state regulatory approach to hospital pricing power emerged in the 1990s, also under state action immunity. Laws allowing state-issued COPAs, also called

provider cooperation laws, were enacted after the American Hospital Association endorsed sheltering certain hospital mergers or other cooperative activities believed to promote efficiency from antitrust challenge (Blumstein 1994; US General Accounting Office 1994). The rationale was that in particular circumstances, provider cooperation is a better route to good value than is competition. To meet the Midcal test requirement of “active supervision,” COPA laws called for ongoing quasi-regulatory oversight of COPAs once issued. Hospital actions outside a COPA’s scope remained subject to antitrust law and enforcement.

Between 1992 and 1995, at least 19 states, including North Carolina, passed such legislation (Blumstein 1996). Few states have passed such laws since then. One exception is New York, which authorized COPAs as a response to federal health reform in 2011.⁵ North Carolina issued its first and only COPA in 1995 as two competing Asheville hospitals combined into a larger health system.

North Carolina’s 1993 COPA Statute

In North Carolina, COPAs were authorized by the Hospital Cooperation Act of 1993, part of legislation devoted to planning for state health care reform and insurance coverage expansion.⁶ The legislature authorized certain “cooperative agreements” among providers (amended in 1995 to include mergers) on the grounds that they can improve quality, moderate cost increases, improve rural access, and help keep smaller hospitals open. Accordingly, competition as overseen by antitrust “should be supplanted by a regulatory program” where justified.

Parties to a cooperative agreement can ask the North Carolina Department of Health and Human Services (DHHS)⁷ to grant a COPA to govern that agreement. The public advantage is to be shown by weighing benefits versus disadvantages (table 1). The statute’s listing includes the key positive and negative assertions from the literature about hospital mergers (Hall 2014; Morrissey 2012).

After a public hearing, DHHS is to issue a COPA if it finds “clear and convincing” evidence of net benefit⁸ and the attorney general has not stated any objection. COPAs may include conditions deemed appropriate and “shall include conditions to control prices of health care services provided under the cooperative agreement.” In North Carolina, COPAs are not limited to rural areas as in some other states, but DHHS is directed to give consideration to assuring access to care in “all areas of the State.”⁹ Any applicant or other aggrieved person may challenge the final state decision in court.

TABLE 1

Factors for the State to Weigh before Issuing a COPA

Benefits	Disadvantages
The extent to which the proposed agreement may	
1. Improve quality of hospital and hospital-related care	1. Increase costs or prices at hospital(s) involved
2. Preserve facilities' "geographical proximity" to communities traditionally served	2. Adversely affect quality, availability, and price of patient services
3. Lower costs or raising efficiency of service delivery	3. Reduce competition, and "the likely effects thereof"
4. Improve utilization of hospital resources	4. Adversely affect health care payors' ability to negotiate optimal arrangements with health care providers
5. Avoid duplication of resources.	5. Reduce competition among physicians and others providing goods or services to hospitals or in competition with them
6. Give access to medically underserved populations	6. Have an alternative that restricts competition less but achieves at least the same net benefit
7. Create any other benefit that "may be identified"	7. Create any other disadvantage that "may be identified"

Source: NC Gen. Stat. § 131E-192.4 (2013).

The statute also provided for continuing oversight. DHHS or the attorney general may "at any time" raise questions about parties' compliance with any COPA condition or the ongoing balance of benefits and disadvantages and may "request any information necessary." Parties to the underlying cooperative agreement must file regular reports every two years that include

- a description of activities conducted under the cooperative agreement,
- price and cost information,
- the nature and scope of anticipated activities in the next two years and their likely effect,
- a signed certificate by each party to the agreement that the agreement's benefits continue to outweigh its disadvantages, and
- any additional information requested by DHHS or the attorney general.

According to the statute, after each report review DHHS "shall determine whether the certificate should remain in effect" and if so, whether any changes are needed in the

conditions the COPA places on provider operations under a merger or other cooperative provider agreement.

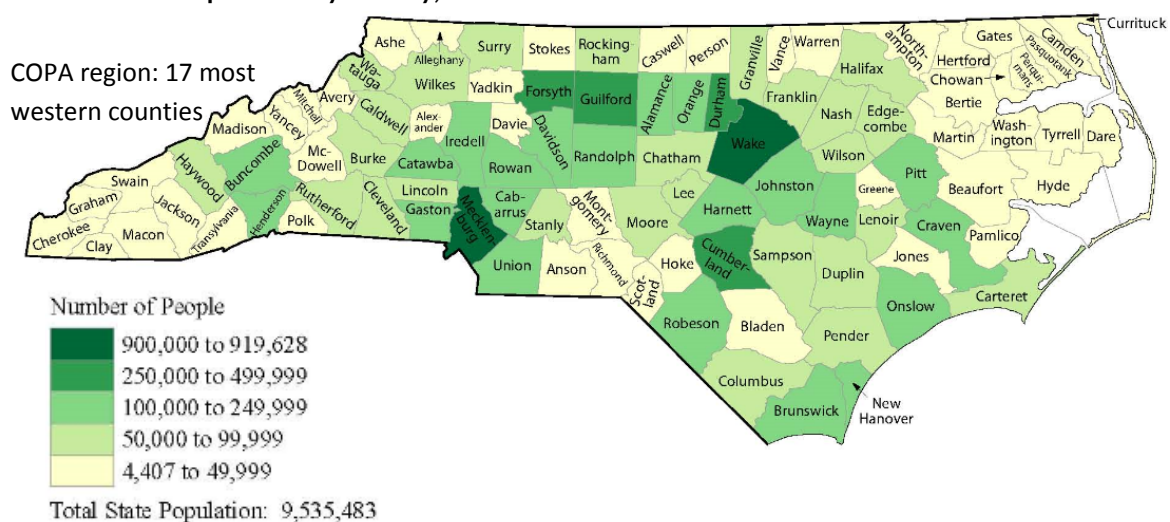
Asheville's 1995 COPA Application and Agreement

The first and only North Carolina application for a COPA came from Asheville, a small but now fast-growing city in the Blue Ridge Mountains of Western North Carolina (WNC).¹⁰ The region has low population densities and below-median incomes, though it has become a popular retirement area, often for upscale retirees. As defined in the current COPA, WNC comprises 17 counties between Tennessee and Georgia. WNC has about 850,000 residents of the state's 9.5 million (according to the 2010 census; figure 1). Asheville is the region's largest city (about 83,000 residents in 2010) and county seat of Buncombe County, the region's largest county. Neighboring Henderson County immediately to the south is the second largest. Together Buncombe and Henderson counties contain 40 percent of WNC residents.

Asheville is located within about two hours driving time of four larger metropolitan areas and their large medical centers. Interstate highways connect Asheville to Charlotte, North Carolina; Winston-Salem/Greensboro/High Point, North Carolina; Greenville-Spartanburg-Anderson, South Carolina; and Knoxville, Tennessee. The region's mountainous terrain increases travel time for most residents away from the interstates and thus increases the policy importance of maintaining access to a local hospital for most inpatient services.

FIGURE 1

North Carolina Population by County, 2010



Source: US Census Bureau, 2010.

As of the early 1990s, Asheville was served by two general hospitals, Mission Hospital and St. Joseph's Hospital, which were the two largest hospitals in WNC.¹¹ They were located on adjacent blocks and competed to provide patient care across a “substantial overlap” of their services (as found by the 1995 COPA). The town also had a veteran's hospital and a small rehabilitation facility, but those served different clienteles. Over time, Mission and St. Joseph's hospitals became more collaborative and wanted to deepen that trend. They jointly operated a laundry and a child care center to achieve efficiencies, for example, and they had substantially overlapping medical staffs. Some sources suggest that collaboration was also motivated by a desire to consolidate operations to raise low occupancy rates or to end an expensive “medical arms race” between the institutions.

By 1994, their evolving collaboration prompted a federal Department of Justice investigation. Shortly thereafter, in July 1995, the hospitals applied for a COPA to immunize their collaboration from antitrust challenge. Their application proposed an organizational partnership under which the hospitals were to be managed jointly as the Mission-St Joseph's Health System (a full merger of assets and operations occurred only in 1998). The state approved the initial COPA subject to several conditions. The COPA took effect as a signed agreement with the hospitals and was finalized in December 1995 (North Carolina Department of Health and Human Services 1995). The conditions sought to assure consumer benefits even after the two hospitals stopped competing for customers (Vistnes 2011). Key rules have continued to the present day, modified by three amendments. The most debated and arguably the most important provisions created quantitative caps on the hospitals' adjusted costs, margins, and physician employment.

Three Key Caps

The COPA does not directly regulate Mission's prices—the amounts payers actually pay—which would have been more technically challenging. Instead, the COPA attempts to achieve the same end by first capping Mission's overall margin, calculated on a system-wide basis. A second cap limits Mission's overall inpatient and outpatient cost growth, calculated only for the two Asheville hospitals that merged into what is now Mission Hospital (Capps 2011; North Carolina Department of Health and Human Services 1995). The margin cap helps prevent postmerger price increases that might otherwise occur.¹² The complementary cost cap prevents a provider with market power from complying with its margin cap by simultaneously increasing both prices and costs.¹³

A third cap, on physician employment, limits the system's employment of primary physicians to 20 percent of those practicing in its primary service area. Exclusive contracts are included along with direct employment. The primary service area is Buncombe and Madison

Counties.¹⁴ At the time of the merger there were few, if any, employed primary care physicians at either of the merged hospitals. The employment cap was raised to 30 percent in August 2011.

How the Cost Cap and Margin Caps Evolved

Mission's cost cap limited the combined hospitals' cost per case to the average cost at a set of comparable North Carolina hospitals.¹⁵ Adjustments were to be made for case mix, inpatient and outpatient costs were combined, and a formula converted outpatient care to an equivalent number of inpatient cases. Comparison hospitals were left to later selection by the state agencies, but the class was defined as other nonprofit, nonteaching facilities of 300 or more beds in the state (it was not required that comparison hospitals come only from competitive markets as opposed to concentrated ones).

Over time, the comparison group criteria were made less binding upon the agencies' choice of peer hospitals.¹⁶ Moreover, the state agencies were given discretion to use other metrics, notably including a national cost index (initially the medical consumer price index, later the producer price index for hospitals). Going over the cost cap in one year would require Mission to hold costs a similar fraction below the next year's benchmark. Overshooting the cap two years running would trigger specific corrective actions.

The margin cap limited the system's operating margin to the three-year average of a comparison group of North Carolina hospitals or 3 percent, whichever is larger. As for the cost cap, later changes called for making national comparisons to the average margin of AA-rated hospitals (Mission's bond rating).¹⁷ Any funds earned above the allowable margin were to be paid into a fund devoted to free or reduced-fee services or population services, such as immunization programs.

Other Provisions, Including Mandated Savings and Fair Competition

Additional COPA provisions addressed such goals as assuring that the public benefited from the merger and that Mission dealt fairly with insurers and physicians:

1. **Specific cost reductions** applied during the COPA's first five years. The combined hospitals had to document savings of at least \$74 million, or about \$15 million a year, just above 5 percent of their base-year revenues of some \$260 million. The savings were to be passed through to the

community through free or discounted care or in the form of public health programs, such as immunizations. Raised slightly in 1998 as a condition of approving the full merger, this specific savings target was met and accordingly ended after 2000.

2. **Maintenance of quality** provisions required that the system achieve specified minimum scores on Joint Commission measures.
3. **Maintenance of access** provisions required the new system to give Medicare and Medicaid patients the same access as other payers, to continue the merging hospitals' existing policies of providing care regardless of ability to pay, and to follow the charity rules of St. Joseph's. Unusually, Mission was to help maintain residents' access to non-Mission hospitals. That is, Mission was to periodically determine whether the survival of any general acute care hospital in WNC was in jeopardy and, if so, suggest alternatives to preserve access.
4. **Fair dealings with insurers** were addressed by requirements such as a mandate to negotiate new contracts in good faith with all insurers in WNC. Mission was also barred from (1) refusing to contract with health plans seeking to pay for care on a commercially reasonable capitated basis; (2) having health plan contracts with "most favored nation" clauses; and (3) tying physician services to hospital services—that is, requiring that health plans contract with its employed physicians to obtain hospital services.¹⁸
5. Mission's **relationships with physicians** were addressed by requiring the two hospitals to operate with an open staff, thus allowing all qualified physicians in or near Buncombe County to admit patients.
6. Mission's **organization and governance** also received attention. The hospitals were required to remain nonprofit entities, and state agencies would have to approve any sale of either hospital. As proposed by the hospitals, the COPA specified the new system's board composition: it required representation by members who reflect the interests of purchasers and the goal of low-cost services.

Data and Reporting

The COPA directed Mission to submit annual reports documenting compliance with its terms by adding off-year submissions to the statute's biannual reports. It also specified the accounting information needed to calculate cap compliance and directed submission of information on employment, utilization, and any changes in services. Additionally, it expressly noted that state agencies could ask for other information as needed, which reiterated a

statutory provision. Subsequently, Mission and the state agencies executing the COPA agreed to specific monitoring procedures for an independent accounting firm to verify annually.

The initial COPA also mentioned using other information DHHS already collected on North Carolina hospitals. It did not create a structure for new data collection on comparison hospitals. Instead, it established back-up provisions to cope with potential data shortfalls. In practice, the agencies have examined an increasing number of indicators over time, as compiled by private firms under contract (McCarthy 2011a, 2011b).

Administration and Funding

North Carolina's DHHS and the North Carolina attorney general share responsibility for administering the COPA. The enabling statute required only that the attorney general's office not object to DHHS's decisions (above), but in practice the state agencies have acted in concert throughout. DHHS acts through its Division of Health Services Regulation, which operates the state's Certificate of Need program. This shared authority combines the complementary expertise of DHHS in hospital regulation and of the attorney general's office in antitrust litigation and settlement.

The COPA oversight has been quasi-regulatory; that is, quite informal compared with typical regulatory regimes. DHHS formally published only very basic implementing rules that have gone without addition since their establishment in 1993.¹⁹ As discussed, the COPA certificate and amendments have set out detailed rules that are binding upon Mission, but with one recent exception these have been created by agreement with Mission rather than by DHHS decision and promulgation.²⁰ Since 1995 the agencies have reviewed Mission's regular reports and occasional applications for modification. Their administrative review relies heavily upon substantive evaluation and advice from expert consultants, some written comment from the various interested parties, and negotiations between Mission and the agencies. Over time, state officials and the hospital system have agreed upon amendments and changes in metrics without further hearings or rule-making.

Familiar forms of legal and political accountability apply—interested parties may seek judicial review of COPA decisions, although this has never occurred, and legislators and governors oversee the agencies. The 2010–12 controversy over Mission's expansions illustrated political accountability in operation, as is discussed further below.

This informal process appears relatively inexpensive. Small amounts of existing agency staff time seem to be supported within overall agency budgets. Mission has to pay the state various small filing and reporting fees (the largest dollar amount set by written COPA

authority seems to be the maximum of \$25,000 a year for report review set by the 2005 COPA amendment). Mission has also has to pay for reports from outside accountants and consultants selected by the state agencies.²¹

Changes over Time

Growth and Integration of the Mission Health System

After the two Asheville hospitals merged, the combined Mission-St. Joseph's system added five smaller "member" hospitals in four nearby counties.²² Although a few hospitals have rejected affiliation with Mission, the system's horizontal expansion still gave it 44 percent of the licensed general beds in WNC.²³ In 2013, Mission announced plans to build new facilities to physically integrate the two original Asheville hospitals, which were still physically separate, although on adjacent campuses, long after their merger. The system has also expanded vertically. It has contracted with hospital specialist groups and employed many physicians directly through its physician group practice, Mission Medical Associates.²⁴ Mission has also built or acquired outpatient centers with a range of capabilities, including the largest cardiology practice in WNC, and a firm offering rehabilitation and home care services.

Not surprisingly, all this activity has won Mission a high market share. Mission accounted for about 44 percent of all hospital discharges in WNC in 2010, having increased its share of admissions in every one of its 17 counties over the preceding 5 years (Vistnes 2011, 27). In volume of surgery, Mission Hospital in Asheville is high compared with any other hospital in the state. By 2011, the system was providing WNC's largest volume of emergency care, running WNC's only children's hospital and only designated Level II Trauma Center, and operating a regional ground and helicopter transport system. The expansions have also made Mission WNC's largest employer.

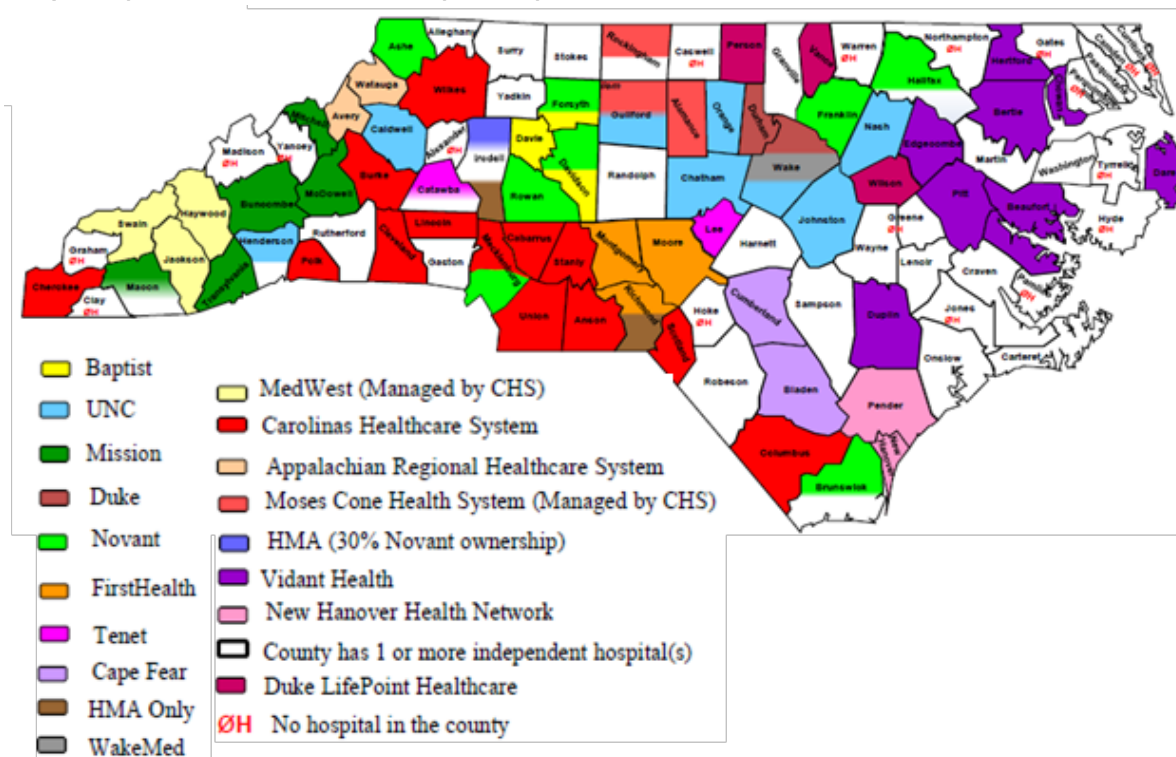
In short, two midsize competing hospitals in Asheville have become WNC's dominant hospital, a must-have institution for health insurers' networks, and "the hub of the health care system in WNC" (Blue Ridge Paper Products et al. 2004). Mission now describes itself as a regional "integrated delivery system" and has emerging capabilities to operate as an ACO.²⁵

Mission's expansions are not atypical, however. Since 1995, other North Carolina hospitals have also consolidated into larger systems (figure 2). By 2013, only 22 of the state's 120 hospitals remained independent, according to the North Carolina Hospital Association, including only one in WNC.²⁶ The others belonged to one of the state's 19 local, regional, or

national systems. Some of these other hospital systems have entered WNC, giving Mission new competitors.

FIGURE 2

Hospital Systems in North Carolina by County, 2014



Source: Blue Cross and Blue Shield of North Carolina (2014).

Notes: Multiple shadings in a county indicate a split between two or three systems. Only counties shaded white have one or more independent hospitals.

Recent Calls for COPA Changes

In 2010, Mission asked DHHS to raise the COPA's employment cap from 20 to 40 percent to allow development and expansion of integrated care throughout WNC, recruiting new physicians where necessary (Mission Health 2011; North Carolina Department of Health and Human Services 2010).²⁷ Park Ridge Health, Mission's competitor hospital, objected and argued for even stronger restraints on Mission's expansion. DHHS and the attorney general rejected both positions, instead commissioning an economist consultant's review and advice (known as the Vistnes report; North Carolina Department of Health and Human Services 2010). The public release of this review (Vistnes 2011) permitted Park Ridge Health, joined by some physicians, to again urge more active COPA oversight and additional restraints on

Mission.²⁸ Some of these competitors also disputed Mission's 2011 request for a Certificate of Need to locate a new large outpatient center near the rival hospital.

The state consultant made several key recommendations about the caps in early 2011 (Vistnes 2011):

- Shift to regulating through price caps rather than the existing cost and margin caps.
- Create separate price caps for inpatient and outpatient care. This could eliminate the potential for "regulatory evasion," or gaming a rule, created by flaws in how outpatient services are calculated as inpatient admission equivalents.
- Apply the caps uniformly to all of Mission's operations. The existing cost cap covers only the Asheville hospital though the margin cap applies to the whole Mission system, compromising the utility of the cost cap as a complement to the margin cap.
- Expand the anti-tying rules.²⁹ The COPA already prohibits Mission from requiring insurers to include its physician services together with its hospital services, whether or not the bundling adds value for consumers. The recommendation would also ban tying of other Mission services, such as outpatient and home care, to prevent anticompetitive use of the hospitals' market power.
- Discontinue the employment cap. This would further the national policy commitment to integrate physicians with hospital care as a way to lower overall costs and increase quality. The report noted that neither of the merged hospitals at the time of the merger had employed primary care physicians and that COPA regulations should focus only on the direct results of the merger, leaving other developments to other mechanisms. Also, other entities were likely to employ these physicians if Mission could not because of the restrictive cap on employment.

A second economic consultant's report (Capps 2011) was commissioned by Mission's competitors (the Capps report). This report strongly concurred with the Vistnes report's recommendations concerning payment level control mechanisms. However, it urged the state to strengthen the physician employment cap, not abandon it, by extending it beyond primary physicians and outside Mission's two home counties to all of Mission's operations. It argued that permitting the powerful Mission system to employ physicians without limit would deprive rival hospitals of critical patient referrals or the ability to employ sufficient physicians to form their own ACOs and otherwise offer consumers an effective alternative to Mission. In an accompanying submission from the competitors' attorneys, the competitors argued that Mission could also achieve the benefits of an ACO or other integration through nonemployment contracts with doctors and others (Gunter 2011b).

Mission commissioned its own consultant to respond (the McCarthy report; McCarthy 2011a). Based on that report, Mission, through its lawyers, challenged most of the recommendations in the Vistnes report except the recommendation to lift the employment cap. Mission emphasized that although the Vistnes and Capps reports had described theoretical incentives that might undermine the purpose of the COPA, neither had produced documentation that Mission had acted consistently with these incentives. The McCarthy report asserted that empirical evidence did not support any evasion or anticompetitive behavior by Mission, but rather that Mission's performance under the COPA had been exceptional for both price and quality.

Based upon the McCarthy report, Mission and its attorneys argued that (1) the COPA and the state's performance in administering it were working well and as intended, (2) Mission's behavior mirrored that of comparable hospitals in competitive markets, and (3) Mission faced growing competition from the recent market entry of large health care systems and from the presence of strong purchasers in the market. Relying on this emphasis that the market had changed significantly in the 15 years since the COPA was first initiated, Mission itself publicly discussed the possibility that "before long, Mission and the State will likely want to consider whether the COPA should be set aside in its entirety" (Mission Health 2011; Robinson Bradshaw & Hinson 2011b). Mission's CEO has repeated that it will "continue to seek a clear pathway for an eventual and appropriate termination of the 16 year old COPA."³⁰

DHHS and the attorney general thus faced a broad set of recommendations from their consultant, contentiousness among the directly involved providers, and seeming indifference among such affected parties as insurers and employers. The state agencies did not concur with most of the competing recommendations and issued a third amendment to the COPA, addressing only the employment cap (North Carolina Department of Health and Human Services 2011, 2012). The amendment increased the limit to 30 percent (midway between the prior 20 percent and Mission's requested 40 percent), kept the cap applicable only to the original two counties (rejecting the competitors' proposal), and expanded the number of specialties included (as the competitors sought). The cost and margin caps remained in place, as did all other provisions. Subsequent political and Certificate of Need attacks on Mission effected little change.³¹ The agencies recently issued a formal statement that declined to update or expand on their consultant's 2011 report as suggested by a public comment on a Mission annual report (North Carolina Department of Health and Human Services 2014). They reasoned that further assessment was premature before the effects of federal health reform are better understood.

COPA Performance: Limited Evidence and Conflicting Views

This case study found no definitive evidence about whether the COPA's state oversight has successfully replaced the former competition that was lost by permitting the collaboration and combination of the only two general hospitals in the population center of WNC. Despite the vigorous debates described, little persuasive information appears in the public record. Notably, for example, neither the parties nor outside observers have addressed to what extent Mission's prices, overall health costs, or quality have been affected by the COPA oversight. Many other factors are plausibly influential, including regional demographics, the prevailing demand for care, a relatively high ratio of primary physicians to specialists, the policies of Medicare and Medicaid (Mission's dominant payers) and federal health reform.

From our review of media reports, the administrative and legislative record including parties' submissions, and confidential interviews with important stakeholders,³² we conclude that the COPA and its effect have been mostly an "inside baseball" issue: It is important to the direct stakeholders but seldom to the state's broader policy or political communities, and even less so to national observers. This level of interest may partly explain the paucity of information provided. The voices of employers and insurers have been strikingly absent, and state agencies have not generated much data or analysis (or it has not been public). The Vistnes report is restricted in scope and addresses regulatory rules and incentives rather than performance; notably absent is information about the COPA's effects on prices. The responding Capps and McCarthy reports address more issues.

This case study did not set out to assess this particular COPA's performance, but expected some indications of good performance to help justify policymakers' attention. The following observations are not conclusive.

No one seems to dispute that Mission dominates its market. Even its own consultant termed it "the only major producer of hospital services in Western North Carolina" (McCarthy 2011a, 3). Nor has there been much dispute that Mission has helped maintain access and quality of care in WNC. The two big policy concerns are whether Mission's dominance has led to prices above competitive levels and whether COPA oversight of costs and margins has tended to moderate any such overpricing.

The state agencies have repeatedly found that Mission was in compliance with the cost and margin caps, offering suggestive and indirect indications of good value for insurers and patients. The McCarthy report generalized, saying that Mission's costs and margins have risen in step with the applicable comparison benchmarks (McCarthy 2011a, 29–30). Yet supporting information on data and methods was kept confidential in the report (Robinson Bradshaw & Hinson 2011a) and in subsequent legislative presentation (McCarthy 2011b). Moreover,

although the cost and margin cap benchmarks have changed several times, no detailed assessment explains how those changes may have affected findings of continuing compliance.³³

Separate from the COPA cap metrics, the McCarthy report also found that in 2003 Mission Hospital's "commercial pricing levels" were "18 percent lower" than those at its "COPA Benchmarking Group."³⁴ The consultants for the state and competitors, Vistnes and Capps, seem to have had less access to data than did McCarthy; the state agencies declined to generate more independent empirical information on price effects. The agencies did not commission their own consultant to do so, before or after the McCarthy report touted Mission's good performance, nor did the agencies encourage Mission's competitors to respond. In effect, Mission and its consultant had the final word.

Arguably more credible information about relative costs in WNC comes from disinterested groups' comparisons that included Asheville and other areas in the county. According to separate findings using different data, Medicare and private payer per-person costs are low and quality is good in Asheville.³⁵ Well-recognized policy experts have held up Asheville as one of the best communities for providing high value hospital care (Institute for Healthcare Improvement 2009). These data lack an earlier baseline to show change over time, but costs may have been higher in the past. A report from four sizeable Asheville employers presents limited evidence from 2002 and 2003 that insurance premiums were then higher in Asheville and WNC than elsewhere in North Carolina or in neighboring states (Blue Ridge Paper Products et al. 2004). At that time, Mission did not contest the finding but blamed a high-risk population for higher costs. Inpatient and outpatient payment rates for Mission also seemed high relative to other regional referral centers.³⁶ Furthermore, Gawande and colleagues' Medicare data show that Asheville's ranking for low per capita cost improved markedly between 1992 (pre-COPA) and 2006 (post-COPA; Institute for Healthcare Improvement 2009). Because Medicare controls most service prices administratively, this finding suggests successful moderation in use of services more than any effect on Medicare prices. It also does not suggest success in curbing possible differences in private payer prices.

This project's interviews with insurers and other informed observers suggested that Asheville and WNC closely resemble other parts of the state: bargaining power over prices has shifted in favor of hospitals because provider consolidation is occurring throughout North Carolina (figure 2). The unstated implication was that the COPA has made little difference. In contrast, McCarthy reported that two insurers told him it was premature to end the COPA (McCarthy 2011a, 5), which suggests that it has offered value for purchasers.

That said, the record does illuminate key issues raised by this regulatory approach, which was the main goal of this case study.

Implications for Health Policy

The Relevance of Regulation

Why should readers care about the unusual COPA regulation in North Carolina? Because so many health care markets have become concentrated, many provider organizations are now able to use their pricing power to raise prices and make market entry of competitors difficult. Antitrust enforcement has been unable to forestall this broad move toward concentration or address the resultant market power. Although courts recently have seemed more amenable to antitrust enforcement agency arguments that mergers and acquisitions may not produce the efficiencies promised, many markets have already become highly concentrated and resistant to the entry of new competitors that would restore competitive forces. In these circumstances of apparent market failure, approaches to regulating the conduct of the powerful provider systems would seem to be needed.

Yet, economists have long pointed to the difficulties of regulating monopolies. Regulation, they say, no matter how carefully crafted and implemented, can inadvertently create undesirable incentive problems and opportunities to evade the intent of the regulations (Vistnes 2011). The back-and-forth between consultants and stakeholders on whether the COPA should be modified suggests that even this form of targeted regulation is complex and requires expertise and commitment. Antiregulatory thinkers contend it is simply better to rely on marketplace competition.³⁷ Moreover, COPAs have not been widely used—once in North Carolina and perhaps only a few times nationally—even though enabling acts were passed in at least 20 states, counting New York’s recent enactment. Doesn’t lack of interest in the mechanism suggest that it doesn’t work? Perhaps not, for two reasons.

First, that regulation is often imperfect does not show that unfettered markets are always better. Such simple assumptions neglect the classic “compared to what” question. Monopolies, or at least powerful oligopolies that are must-have providers in insurers’ provider networks, are hardly the preferred mode of health care delivery, but for different reasons they have become the norm through two waves of rapid provider consolidation. In many health care service areas, the alternative to regulation is not the well-functioning, competitive market of policy hopes and rhetoric. The more realistic choice is between nonregulated monopolies and imperfectly regulated ones; COPA-like mechanisms are one possible imperfect regulation.

Second, that few COPAs exist does not prove that policymakers have found them wanting. Rather, it suggests that hospitals and other providers have not wanted them. COPA enabling acts gave hospitals a possible shelter (albeit a regulatory one) against antitrust enforcement. Plausibly, hospitals may not have sought COPAs because from the mid-1990s until recently,

antitrust enforcement failed to prevent mergers. One of our sources suggested that hospitals could deter antitrust enforcers from acting by threatening to end any challenge by getting COPA authorization to merge. In Asheville, the merging hospitals did not just threaten to seek a COPA but actually did so.

It seems that the opportune use of COPA-like mechanisms is to improve upon unregulated market power that occurs when antitrust and other promarket mechanisms do not work or come too late, or when the case for provider consolidation is strong under conventional antitrust analysis but allowing consolidation unconditionally would greatly disadvantage purchasers. “Better than nothing” seems faint praise, but small improvements on monopoly prices or other problems may accumulate over time.

Limits on the Role of Antitrust

A common misunderstanding among health care policymakers is that antitrust law alone provides a reliable counterforce to provider monopoly (Berenson, forthcoming; Greaney 2014). During the 1990s wave of consolidation, antitrust enforcers repeatedly lost in court. After restating their rationale and approach in the 2000s (Federal Trade Commission and Department of Justice 2004), federal enforcement has had more recent successes, although consolidation continues.³⁸ A key issue today is that enforcers can most readily intervene before consolidation occurs. Then, they can apply straightforward “structural” remedies, such as barring mergers, imposing divestiture of some part or parts of a merging firm, or dissolving mergers newly occurred. Thereafter, the restructured market can continue to be disciplined by competition.

However, once markets are concentrated, antitrust doctrine and enforcement policy generally have been reluctant to intervene (Havighurst and Richman 2011; Richman 2012). Dissolving a long-standing merger would be structurally difficult, akin to “unscrambling eggs,” they typically reason, and would impose new disruptions that are difficult to assess. In the landmark *Northwestern* case, the FTC intervened in an authorized merger (Federal Trade Commission 2008) but only imposed arguably minor restrictions; the newly merged hospital system viewed this as a victory (Havighurst and Richman 2011). The FTC has since undone at least one merger but acted within two years.³⁹ In general, antitrust regulation has tolerated the continuing exercise of established provider market power, leading to higher prices, reduced output and perhaps lowered quality. Enforcers typically intervene only where existing monopoly power wrongfully excludes actual or would-be competitors.

Antitrust regulation does sometimes use traditionally less favored “behavioral” or “conduct” remedies to prevent future abuse of monopoly power after a merger. Behavioral

remedies may be on the rise (Kwoka and Moss 2011). For example, in recent years the Pennsylvania Attorney General has reached a series of antitrust settlements with expanding hospital systems. The agreements imposed such behavioral remedies as mandatory contributions to charitable works, maintenance of existing insurer contracts and pricing for some time, a ban on “arbitrary” price increases, and requirement of continued separate contracting with insurers by a newly acquired hospital.⁴⁰ Still, such settlements illustrate the limits of antitrust intervention. Typically these consent decrees are triggered by providers’ proposing new mergers, not by antitrust authorities’ own oversight of prevailing prices and other behavior within already consolidated markets. Also, remedies are typically strictly time-limited rather than ongoing, in contrast to the COPA approach.

Policy Choices and Challenges in Addressing Market Consolidation

This case study of quasi-regulatory oversight of a consolidated health care market suggests insights about policies for addressing consolidation. These are less definite lessons than observations about policy choices and challenges inspired by the Mission COPA. The following subsections emphasize key choices of general oversight policy or specific operations of regulation. Many more “nuts and bolts” of regulation exist; only notable examples are sketched here. Later subsections describe important cross-cutting challenges inherent in regulatory policy-making and operations. We emphasize that although the points made have been generated by observing the Mission COPA dynamics, they are not conclusions about Mission itself, nor about the overseeing state agencies.

Competition versus regulation. A very general policy choice is whether policy interventions targeting the problems of health care market concentration should rely on competitive or regulatory strategies. This standard dichotomy, discussed in the realm of social and economic policy, oversimplifies the policy choice. Not only do regulated providers continue to compete with others, there can also be quasi-regulation, as the Mission COPA illustrates. If a COPA improves a provider’s value, it should create a competitive long-term advantage for the regulatee where it does face competition, for example, from new entrants or from consumers becoming willing to travel to more distant providers for some care.

How is the North Carolina COPA quasi-regulatory? A COPA is designed and implemented to target a specific problem area without the need to regulate the industry statewide. The Mission COPA process has also lacked the formality of standard regulation. It accordingly has low administrative costs compared with full-blown hospital rate-setting, for example. Its limited applicability also seems to make it more politically feasible than a formal rate-setting program.

Finally, a COPA is not mandatory regulation that is imposed by the state on all or particular market participants, as are licensure requirements for professionals or regulation of public utilities. A COPA comes into existence only after applicant providers request one. The applicants are free to choose between being regulated by the state under a COPA, assuming one is granted, and remaining subject to state and federal antitrust oversight. For the Mission Health COPA, even the specific findings and conditions were created only by agreement with the hospitals rather than by unilateral state imposition of the COPA, and all but one change has been negotiated. Voluntarism presumably improves political feasibility and avoids litigation, but by definition cannot apply generally wherever providers have pricing power.

The trigger for oversight. Both COPA oversight and antitrust intervention normally respond to an impending merger: a COPA at the discretion of a provider application for antitrust exemption, an antitrust action at the discretion of an oversight agency or private party affected by the merger. Neither form of intervention as now operated can readily address long-consolidated markets and entrenched pricing power. To reach them in the large share of markets of this nature, some trigger point for intervention is needed other than a merger. Some measure of market concentration or of prices relative to Medicare levels might serve as a trigger. Finding such triggers is a key challenge for future policy, whether it promotes antitrust enforcement, regulation, quasi-regulation, or some other approach.

Duration of regulation. How long should regulatory oversight apply? As noted, antitrust enforcers prefer one-time, structural remedies. Even the innovative conduct remedies sometimes adopted seem quite time-limited. In contrast, the North Carolina COPA created open-ended protection against some abuses of market power, already applicable for 18 years and counting. It could be argued that COPAs should be time-limited like the antitrust conduct remedies they resemble. However, a COPA is arguably better able than antitrust regulation to change over time. The COPA's design calls for ongoing monitoring and periodic examination of conditions. This allows for midcourse corrections in response to substantial market changes that alter the conditions that gave rise to the oversight. According to Mission's consultant's report, for example, at least one other COPA was terminated because new competitors had appeared (McCarthy 2011a). Similarly, technical change may alter the nature of service that buyers want to pay for and thereby reduce earlier market power. Market power resulting from major consolidation could well resist market entry of competitors and grow even stronger over time.

In North Carolina, state agencies have statutory authority to terminate a COPA. Also, Mission might argue that it can withdraw its agreement to COPA oversight, which ostensibly was created and has been maintained by such agreement. Termination of COPA oversight would resubject any covered merger to antitrust scrutiny. However, antitrust enforcers are highly unlikely to address a settled merger. Unless newly effective price competition or

another policy has been developed to mitigate COPA-sheltered hospital market power, good policy for COPA-like oversight calls for a better solution to any termination than simple sunset of oversight after a period.

Nature of cost or price oversight. The Mission COPA opted to address costs and margins rather than prices directly, as recommended by its economic consultant. Any COPA-like oversight would face the same policy choice. Regulating prices is difficult where so many forms of payment coexist, which in North Carolina was a rationale for using complementary cost and margin controls rather than direct price controls. Within a single hospital, some services are tracked and paid for by service, some are tracked and paid for by diagnosis related group, and some are capitated according to the population at risk. Consequently, it may be challenging to find comparable units of service in other provider entities for comparison. Moreover, current payment methods appear to be on the cusp of substantial change and the line between inpatient and ambulatory care seems to be blurring. Such developments complicate regulation and patient-based, cost-sharing strategies. Another oversight choice is whether to address the level of price or cost instead of its rate of change. The COPA oversight has used both approaches.

Choosing benchmarks of assessment. A regulatee can be held to the performance of a comparison group of similar providers, as with Mission initially. Alternatively, performance can be benchmarked against an exogenous standard, such as the increase in the producer price index, which is a standard the state agencies have applied to growth in Mission's margins. Changes in benchmarks over time can be appropriate where conditions change, but changes can also be used to mask an impending failure under prior standards (or appear to do so). Transparency about the effect of changing standards is desirable for building credibility.

Information needs. Good data are the bedrock of any policy-making on markets and prices. Yet it is hard to obtain objective information not controlled by the supplier of data, and it is expensive to audit financial data, much less perform specialized analysis once data are obtained. It is also expensive to collect the information needed on other providers to use as benchmarks. Control over data could allow a regulatee to cherry pick its public documentation and possibly even metrics of oversight; we observed only this possibility in North Carolina. Guarding against it would call for much more detailed assessment than this case study. We did observe that the paucity of relevant objective data accessible to parties and public alike made any outside assessment a challenge.

Monitoring and enforcement policy choices. In North Carolina, the specific monitoring of compliance was mainly outsourced to an accounting firm that checked to see that Mission was in compliance with required procedures and reporting.⁴¹ Any set of rules needs some way to motivate compliance or penalize any noncompliance found by monitoring. The North Carolina statutory regime relies in large part upon voluntary compliance. The COPA statute and the

Mission COPA have no built-in rewards for better performance, nor do they enact sanctions for worse performance.

The COPA statute does not threaten civil money or other penalties for failure to comply with a COPA requirement, only termination of the COPA. Enforcement tools might be found among more general powers; this is a legal issue not in the scope of our case study. Moreover, informal suasions may exist, given that hospitals are usually reluctant to anger oversight agencies from whom they may need help on other fronts. Any termination of the COPA would remove its antitrust protection for the merger and might cause reputational damage. However, antitrust regulation is unlikely to address such a settled merger, so the theoretical sanction does not look strong in practice. Indeed, Mission has often said it would like to move toward terminating the COPA.

Challenges of accountability. The Mission COPA has operated with low administrative or transactional costs, considerable flexibility to reconcile competing statutory objectives and reasonable speed of decisionmaking. The oversight agencies seem to have proceeded by minimizing formal rule making, emphasizing private negotiation with the regulated providers, laying out findings and requirements through agreement with its regulatees rather than through administrative decision and avoiding judicial challenges. COPA submissions are made available for public inspection as required by law, but very little is web-posted. In contrast, DHHS's Certificate of Need program has a dedicated webpage with much documentation,⁴² a now more familiar mode of public openness.

Instead, the COPA's process more closely resembles the decisionmaking of and actions taken by private firms, or the private negotiation that settles most litigation, even among public actors.⁴³ Private actors face market accountability for results as judged by boards of directors, market analysts, and shareholders. The Mission COPA may be achieving such results; this case study found limited though encouraging information.

Tension can exist between desired transparency and desired accomplishment, which any regime of continuing oversight needs to address.

Challenges of regulatory capture and untoward political influences. Administrative regulators can be "captured" such that they cease to represent public interests and instead become susceptible to inordinate private influence or manipulation. This observation has become a standard complaint against regulation (Stigler 1971). Superior resources from regulatees are one factor, given their highly concentrated interest in regulatory policy; this advantage is counterbalanced only by diffuse consumer interests. Related concerns include superior private party expertise, the lure of revolving-door career advancement by staff departure to the regulated industry, public reliance on private information, and untoward input into standard setting. As demonstrated in the review of divergent views on the merits of

the various COPA caps discussed earlier, the oversight issues are complex, perhaps making deference to the regulated party's perspectives more likely. In North Carolina, the COPA regulators have many responsibilities and therefore may associate less closely with their (part-time) regulatees. Consequently, perhaps they may be less amenable to capture.

When a COPA is sought, the regulator would seem to have the upper hand in dictating terms. In Asheville, the result was approval of Mission's merger and relief from potential federal antitrust investigation. However, once a merger is achieved, the incentive for the regulatee to accept terms without a political or judicial battle declines. This is especially true if there are few sanctions for noncompliance. The state agencies could refuse to continue the COPA altogether. This would have troubled the hospitals before the merger, when they were under antitrust investigation. But once the merger is established, revocation of the COPA would leave monopoly power unregulated except by antitrust action. Antitrust enforcement might have blocked the consolidation of the only two Asheville hospitals in the mid-1990s, but antitrust action is unlikely now that consolidation is well established.

Funding challenges. Building and exercising regulatory capacity costs money and political capital. Yet, operational budgets may not be sufficient to meet the expectations in the statutory responsibilities set out in the COPA, as the North Carolina oversight agencies determined in imposing modest fees on their regulated hospital system. Funding through such assessments avoids general taxation and keeps spending off legislative budgets. This likely improves political feasibility but also requires a form of ongoing negotiation with regulatees. And in cases of dueling experts, as seen in the Mission COPA, it may be a challenge to get a regulatee to support a state's expert as well its own.

Challenges of creating and maintaining expertise for oversight. Although the demands of COPA oversight are much more limited than those of an all-payer approach, the give-and-take associated with the 2011 state consultant's recommendations for the Mission COPA suggests that the issues the regulators must deal with are complex and require specialized expertise. Some question whether many states are willing to commit resources for this purpose. As North Carolina's experience shows, many technical issues can be addressed by contracted expertise, although it comes at a price.

The COPA contained many new rules, similar to the "conduct remedies" of antitrust settlements, designed to prevent Mission's exploitation of its enhanced postmerger market power in dealings with health plans and physicians. Although COPAs resemble antitrust settlements, more than in many antitrust agreements, a COPA requires a careful weighing of likely net benefits and ongoing monitoring to assure that the promised benefits occur. Operational practice also relied upon a measure of voluntary compliance. In North Carolina, detailed monitoring of compliance was outsourced to an accounting firm that checked that Mission was in compliance with required procedures and reporting.

Concluding Thoughts

Both COPA-based oversight and antitrust intervention typically respond to an impending merger. Neither of them, as now operated, can readily address already consolidated markets and entrenched pricing power. To address the large share of markets of this nature, some trigger point for intervention is needed other than a merger. The Federal Trade Commission is evidently increasingly seeking to challenge completed mergers, but it faces the daunting challenge of undoing these mergers after too much time has elapsed. The *Northwestern* case was a landmark intervention into an accomplished merger (Federal Trade Commission 2008), and even that did not undo the merger or otherwise reduce consolidation.

To avoid what would surely be highly disruptive unwinding of an already consolidated health care system, it seems much more plausible to apply conduct remedies in such situations to limit a consolidated entity's exercise of its market power. COPAs exemplify targeted but light-handed regulation, arguably a form of self-regulation, overseen by state authorities. COPAs can be derided by some as being too lenient on provider power and by others for inhibiting more innovative market-oriented responses to concentration. Nevertheless, COPAs and COPA-like oversight need not be perfect to be better than simply accepting the above-competitive prices and other effects of such consolidations, which is the current situation in many markets.

Public policy for coping with concentration will likely muddle through without full-fledged adoption of either strong regulatory measures or unbridled competition. Oversight similar to that of COPAs—fully examined, understood, and improved—could provide a useful complement to more measured regulatory or market-oriented approaches to addressing market power.

Notes

1. "Highly concentrated" markets are those with Herfindahl-Hirschmann Index values above 2500; only those scoring below 1500 are "unconcentrated" (US Department of Justice and the Federal Trade Commission 2010). The national average Herfindahl-Hirschmann Index has been above 2500 from 2000 through 2012. "Hospital Market Concentration," US Department of Health and Human Services, accessed February 4, 2015, <https://healthmeasures.aspe.hhs.gov/measure/62>. As of 2010, "half (n = 150) of hospital markets in the United States are highly concentrated, another third (n = 98) are moderately concentrated, and the remaining one-sixth (n = 58) are unconcentrated. No hospital markets are considered highly competitive" (Cutler and Morton 2013).
2. Atul Gawande, "Big Med: Restaurant Chains Have Managed to Combine Quality Control, Cost Control, and Innovation. Can Health Care?" *New Yorker*, August 13, 2012.
3. Robert Pear, "Consumer Risks Feared as Health Law Spurs Mergers," *New York Times*, November 20, 2010, www.nytimes.com/2010/11/21/health/policy/21health.html.
4. Marvin Ammori, "Monopolies: Antitrust Law Protects Consumers, Not Competitors," *Wired*, October 16, 2012, www.wired.com/2012/10/antitrust-is-supposed-to-protect-consumers-not-competitors/.
5. The state seemed about to finalize required regulations to allow applications for COPAs as of September 2014; Merlin Brittenham and Arthur Fried, "New York Certificate of Public Advantage (COPA) Program Alert: Revised Regulations Are Particularly Relevant to DSRIP Participants," *JD Supra*, August 29, 2014, www.jdsupra.com/legalnews/new-york-certificate-of-public-advantage-06454/.
6. NC Gen. Stat. § 131E 192.1–192.13 (2013), www.ncga.state.nc.us/EnactedLegislation/Statutes/pdf/ByChapter/Chapter_131E.pdf; 1993-529 NC Sess. Laws § 5.2, www.ncga.state.nc.us/EnactedLegislation/SessionLaws/PDF/1993-1994/SL1993-529.pdf; and 1995-205 NC Sess. Laws, www.ncga.state.nc.us/Sessions/1995/Bills/Senate/PDF/S886v1.pdf.
7. At the time of the COPA statute and initial COPA, the lead agency was known as the North Carolina Department of Human Resources; it later became the North Carolina Department of Health and Human Services through administrative reorganization.
8. This is a higher standard of proof than applies in private litigation about personal injuries or contracts. There, the winner must convince a judge or jury only by a "preponderance" of evidence, that is, a balance of proof even a tiny amount above an even split between the parties' positions. It is lower than the standard of reasonable doubt that governs criminal prosecutions.
9. NC Gen. Stat. § 131E-192.5.
10. "Western North Carolina" in this paper refers to the state's 17 westernmost counties, which have been the COPA area since the 2005 amendment (initially, there were 15 counties). Western North Carolina is a well-recognized term for the mountainous western region of the state. Many agencies and other organizations recognize WNC as a region, though the number of counties included varies.
11. In addition to interviews, this history draws upon Mission Health (2011); Meyer et al. (2004); Edward Martin, "Mission Possible: Asheville Medical Center Concentrates on Controlling Its Costs and Care to Create One of the State's Top Hospitals," *Business North Carolina*, March 2005, www.businessnc.com/articles/2005-03/mission-possible-category/; "About Mission Health System," Mission Health, accessed February 3, 2015, www.mission-health.org/about-us/mission-health-system.
12. Regulators often use margin caps, rather than price caps, in situations where the regulated firm's costs are likely to change over time in ways the regulator can't readily observe (Vistnes 2011). The COPA did not explain why it did not regulate prices directly.
13. Lending credence to this concern, a Medicare Payment Review Commission analysis finds that hospitals with the market power to win higher commercial insurance payment rates have higher cost structures (yet no better quality of care) and thus negative Medicare margins, whereas "leaner" hospitals negotiate lower commercial prices, thus they have lower cost structures and slightly positive Medicare margins (Vistnes 2011; Medicare Payment Advisory Commission 2014).

14. Asheville is the county seat of Buncombe County. Madison is Buncombe's sparsely populated northern neighbor and has no hospital of its own. Its residents traditionally relied almost exclusively on the two Asheville hospitals.
15. This paper's discussion of the COPA's provisions is mainly based upon the COPA certificates themselves as initially issued in 1995 and later amended (North Carolina Department of Health and Human Services 1995, 1998, 2005, 2011). Copies of all of these were supplied by state officials; only a 2012 correction is available online (North Carolina Department of Health and Human Services 2012). Other state documents also contributed (North Carolina Department of Health and Human Services 2010). Several consultants' reports were also useful for this history, as discussed in text (Vistnes 2011; Capps 2011; McCarthy 2011a, 2011b).
16. The initial 1995 COPA provided that "comparisons will be made with a selected group of non-profit, non-teaching hospitals of 300 or more licensed beds throughout the state" (North Carolina Department of Health and Human Services 1995, 26). The first amendment in 1998 gave the agencies broader discretion to select peer facilities: "Comparable hospitals *maybe* a selected group of hospitals of 300 beds or more excluding academic medical center teaching hospitals such as Duke University Health System, The North Carolina Baptist Hospitals, Inc., UNC Hospitals, and Pitt County Memorial Hospital, Inc." (emphasis added; North Carolina Department of Health and Human Services 1998, 23).
17. Initially, there was a backup provision that would have compared Mission's increase in margins over the applicable three years to the average growth in the medical consumer price index, but what was later adopted was the comparison with AA-rated hospitals nationally.
18. Most favored nation clauses guarantee one party to a contract that the other party will not enter different contracts that give more favorable terms to a third party. For example, a (prohibited) most favored nation contract might have allowed Mission to force an insurer to pay Mission any higher price being paid to another hospital. "Tying" means to sell one product or service only if the customer buys a different product or service. "Tying the Sale of Two Products, a section of an online Guide to Antitrust Laws," Federal Trade Commission, accessed February 3, 2015, www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/single-firm-conduct/tying-sale-two-products.
19. The rules provide only for filing fees and public hearings on applications. 10A NC Admin. Code § 14I.0101–14I.0104.
20. The COPA as amended has stated findings in qualitative terms and has seldom cited specific supporting evidence. In 1995, 1998, and 2005, the COPA process was begun by a request from Mission, and each COPA was made final by the signatures of all parties rather than by administrative order or promulgation of a formal rule. The "Third Amended COPA" of 2011 was also triggered by a Mission request for change, but the change was promulgated by the state without Mission's agreement. The third amendment modified only the provision defining the employment cap in the 2005 COPA. The COPAs have not been published in the *North Carolina Register* in the fashion of regulations, and very little documentation is available on state web pages.
21. Tracking actual dollar flows from all the enumerated fees is beyond this case study, but we feel confident that the annual totals are not large relative to the price of regulatory expertise.
22. This subsection draws upon not only interviews but also the following materials: "Hospitals Licensed by the State of North Carolina," North Carolina Department of Health and Human Services, accessed February 4, 2015, <http://www.ncdhhs.gov/dhsr/data/hllist.pdf>; Molly Gamble, "Reinventing a Hospital's Philosophy: Q&A with Dr. Ronald A. Paulus, President and CEO of Mission Health," *Becker's Hospital Review*, June 13, 2012, www.beckershospitalreview.com/hospital-management-administration/reinventing-a-hospitals-philosophy-qaa-with-dr-ronald-a-paulus-president-and-ceo-of-mission-health.html; Edward Martin, "Mission Possible"; Meyer et al. (2004); Mission Health (2011); Mission Health, "About Mission Health System"; John Boyle and Jon Ostendorff, "Hospital Wars: The Battle for Patients in the Asheville Area—Competition, Cooperation Alter WNC Health Care," *Asheville Citizen-Times*, October 10, 2011, <http://archive.citizen-times.com/article/20111009/NEWS/310090045/Hospital-wars-battle-patients-Asheville-area>; Becky Johnson, "Highlands-Cashiers Hospital to Jump on Mission Affiliation Train," *Waynesville (NC) Smoky Mountain News*, October 3, 2012, www.smokymountainnews.com/news/item/8921-highlands-cashiers-hospital-to-jump-on-mission-affiliation-train; Roger McCredie, "The Kingdom of Mission: Private Practice vs. Asheville's Imperial Healthcare System," *Asheville Tribune Papers*, April 21, 2013, www.thetribunepapers.com/2013/04/21/the-kingdom-of-mission-private-practice-vs-ashevilles-imperial-healthcare-system/; Angie Newsome, "Highlands-Cashiers Hospital Joins Mission Health Network," *Asheville Carolina Public Press*, February 4, 2014, www.carolinapublicpress.org/17599/highlands-cashiers-hospital-

- joins-mission-health-network; Margaret Williams, "Rescue Mission?" *Mountain Xpress*, May 17, 2011, <http://mountainx.com/news/weblog-features/051811rescue-mission/>; Margaret Williams, "Keep Patients in Mind, Some Speakers Tell Legislative Committee at Public Meeting," *Mountain Xpress*, October 20, 2011, <http://mountainx.com/article/36627/Keep-patients-in-mind-some-speakers-tell-legislative-committee-at-public-meetin>.
23. North Carolina Department of Health and Human Services, "Hospitals Licensed by the State of North Carolina."
24. Jason Sandford, "Wanted: CEO for Mission Medical Associates," *Ashvegas*, October 8, 2009, www.ashvegas.com/wanted-ceo-for-mission-medical-associates.
25. "Newly-Launched Mission Health Partners to Effectively Coordinate Health Care," *Macon County News*, June 26, 2014, www.maconnews.com/features/health-a-wellness/6843-newly-launched-mission-health-partners-to-effectively-coordinate-health-care.
26. Brenda Porter-Rockwell, "Rural Hospital Mergers Make for Improved Bottom Lines, Mixed Feelings," *N.C. Healthcare News*, August 14, 2013, <http://www.northcarolinahealthnews.org/2013/08/14/rural-hospital-mergers-make-for-improved-bottom-lines-mixed-feelings/>.
27. Boyle and Ostendorff, "Hospital Wars"; Mission Health, "About Mission Health System"; "Overview," WNC Community Health Care Initiative, accessed February 4, 2015, www.wncchoice.com/pages/overview; "Documentation," WNC Community Health Care Initiative, accessed February 4, 2015, www.wncchoice.com/pages/documentation; Jake Frankel, Margaret Williams, and David Forbes, "Living Treasures and Hospital Duels," *Mountain Xpress*, May 31, 2011, www.mountainx.com/article/2735/Living-treasures-and-hospital-duels.
28. WNC Community Health Care Initiative, "Overview."
29. As noted, "tying" means putting multiple products or services into an all-or-nothing bundle offered to buyers. The mandatory add-ons may be undesired, and tying that does not benefit consumers can be an antitrust violation. Federal Trade Commission, "Statement of FTC Chairwoman Edith Ramirez on the U.S. District Court in the District of Idaho Ruling in the Matter of the Federal Trade Commission and the State of Idaho v. St. Luke's Health System Ltd. and Saltzer Medical Group. P.A.," press release, January 24, 2014, www.ftc.gov/news-events/press-releases/2014/01/statement-ftc-chairwoman-edith-ramirez-us-district-court-district.
30. Caitlin Byrd, "Mission CEO Ron Paulus Wrote Letter to Committee about COPA on April 17," *Mountain Xpress*, April 20, 2012, www.mountainx.com/article/42230/Mission-CEO-Ron-Paulus-wrote-letter-to-committee-about-COPA-on-April-17.
31. Most notably, during 2011 and 2012, Mission and its rivals made many presentations and lobbied a special legislative committee. Rose Hoban, "Cost of Care: Legislators Ponder Hospital Regulation Update," *North Carolina Health News*, February 16, 2012, www.northcarolinahealthnews.org/2012/02/16/legislators-ponder-hospital-regulation-update/; "Mission Health and COPA," Mission Health, accessed February 4, 2014, www.missionandcopa.org. The committee seriously considered recommending substantial changes, such as regular audits, economic reports, and an extension of the employment cap (Mission Health, "Mission Health and COPA"; North Carolina House Select Committee on Certificate of Need Process and Related Hospital Issues (2012a, 2012c); North Carolina House Select Committee on the Certificate of Need Process and Related Hospital Issues (2012d). However, the committee ultimately took no action, instead directing the rivals to work out their differences privately; North Carolina House Select Committee on the Certificate of Need Process and Related Hospital Issues (2012b); Bill Moss, "Apodaca Shoots Down Mission COPA Study," *Hendersonville Lightning*, December 7, 2012, www.hendersonvilleglightning.com/business/1067-mission-park-ridge-declare-wins-in-house-panel-report.html. Both sides claimed victory. A separate North Carolina Senate bill received little local support and received no action: "Bill Targeting Mission Should Quietly Go Away," *Ashville Citizen-Times*, April 22, 2011, www.wncchoice.com/files/articles/ACT%20-%20Bill%20targeting%20Mission%20should%20quietly%20go%20away.pdf; "Senate Bill 698 Information/History (2011–2012 Session)," North Carolina General Assembly, accessed February 4, 2015, www.ncga.state.nc.us/gascripts/BillLookUp/BillLookUp.pl?Session=2011&BillID=s698&submitButton=Go. In addition, Certificate of Need objections to one Mission expansion ended in a partial win for Mission's opponents because the system was not allowed to include endoscopy screening within a substantial medical campus built near a rival hospital. Rob Kurtz, "Ambulatory Surgery Centers: State Denies NC's Mission Hospital's Request to Relocate Endoscopy Suite," *Becker's Hospital Review*, August 30, 2012,

www.beckershospitalreview.com/asc/state-denies-ncs-mission-hospitals-request-to-relocate-endoscopy-suite.html.

32. In addition to interviews, we used media sources, parties' documents, submissions from the parties' lawyers, the consultants' reports, and other documents and testimony available online or supplied by the state agencies. Media sources include Boyle and Ostendorff, "Hospital Wars"; Martin, "Mission Possible"; McCredie, "The Kingdom of Mission"; Newsome, "Highlands-Cashiers Hospital"; Williams, "Keep Patients in Mind"; Jon Boyle and John Ostendorff, "Does Mission Hospitals Constitute a Monopoly?" *Asheville Citizen-Times*, October 16, 2011, www.citizen-times.com/article/2011310160064; Johnson, "Highlands-Cashiers Hospital"; Becky Johnson, "Mission in the Crosshairs: Hospital Turf War in WNC Heats Up," *Smoky Mountain News*, May 11, 2011, www.smokymountainnews.com/news/item/3915-mission-in-the-crosshairs-hospital-turf-war-in-wnc-heats-up; Edward Martin, "Getting Group Health: Facing Mammoth Money Problems, Community Hospitals Size Things up by Becoming Part of Large Health Systems," *Business North Carolina*, July 2009, www.businessnc.com/articles/2009-07/getting-group-health-category/; Mark Schulman, "Hospital Asks for Protection: Park Ridge Accuses Mission Hospital of 'Predatory Business Practices,'" *Hendersonville Times-News*, May 25, 2011, www.blueridgenow.com/article/20110525/articles/105251005.

The parties' documents include Mission Health, "About Mission Health System"; Mission Health (2011); Mission Health, "President and CEO Ronald A. Paulus, MD, Leads Mission Health Through Challenging Payor Mix and COPA Constraints to Build a Next Generation Health System," press release, February 10, 2014, www.prnewswire.com/news-releases/president-and-ceo-ronald-a-paulus-md-leads-mission-health-through-challenging-payor-mix-and-copa-constraints-to-build-a-next-generation-health-system-244738161.html; WNC Community Health Care Initiative, "Documentation"; WNC Community Health Care Initiative, "Overview."

Submissions from the parties' lawyers include Robinson Bradshaw & Hinson (2011a, 2011b) and Gunter (2011a, 2011b).

Other testimony and additional materials were given to the North Carolina House Select Committee. See, for instance, "Comments for Meeting re: COPA, House Select Committee on Certificate of Need Process and Related Hospital Issues," North Carolina General Assembly, accessed February 4, 2015, www.ncleg.net/documentsites/committees/HSCCONPRHI/10-20-11/Park%20Ridge%20Presentation.pdf. Committee documents are retrievable at "Select Committee on Certificate of Need Process and Related Hospital Issues," North Carolina General Assembly, accessed February 4, 2015, www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=146.

The consultants' reports are Vistnes (2011); Capps (2011); McCarthy (2011a, 2011b).

33. McCarthy's report also notes that Mission was out of compliance only once, on the 2002 cost cap, but passed on reevaluation after the cost cap was revised (McCarthy 2011a, 9).
34. McCarthy cited an independent accountant firm's report using fiscal year 2003 data; the underlying report is evidently not a public document and was not reviewed by this case study. See McCarthy (2011a, 29–30).
35. Atul Gawande, Donald Berwick, Elliott Fisher, and Mark McClellan, "10 Steps to Better Health Care," *New York Times*, August 12, 2009, www.nytimes.com/2009/08/13/opinion/13gawande.html; Pyenson et al. (2010). These assessments provide little detail on Asheville and WNC but have the advantages of offering national comparisons and coming from disinterested authors.

For more on the Medicare data see John Iglehart, "Low-Cost, High-Quality Care in America," *Health Affairs* (blog), July 28, 2009, <http://healthaffairs.org/blog/2009/07/28/low-cost-high-quality-care-in-america/>; Institute for Healthcare Improvement (2009).

36. Physician fees were also high for certain Western North Carolina physician specialties, which correlated with the existence of large single-specialty medical groups. The report's hospital-specific analysis was incomplete and inconclusive. No follow up activity seems to have occurred.
37. Attacks on a quasi-regulatory proposed cap on price increases in Massachusetts antitrust settlement are good examples of this perspective (Kwoka 2014; Dafny et al. 2014).
38. For a decade, antitrust enforcers lost all but one of their lawsuits, often on the economically dubious ground that nonprofits would not exercise market power after consolidating; Greaney (2002); Gaynor (2006).

Observers have also pointed to low enforcement budgets and a growing distaste for government action during the 1990s and early 2000s. Two recent successes by the FTC include stopping a proposed hospital acquisition

of a large physician group in Idaho and the dissolution of a merger that combined two of four hospitals in a northwest Ohio market; Federal Trade Commission, “Statement of FTC Chairwoman Edith Ramirez”; Federal Trade Commission, “Federal Appeals Court Upholds FTC Order Finding Ohio Hospital Acquisition Was Anticompetitive: Commission Order Will Require ProMedica to Sell St. Luke’s Hospital to Restore Competition,” press release, April 22, 2014, www.ftc.gov/news-events/press-releases/2014/04/federal-appeals-court-upholds-ftc-order-finding-ohio-hospital.

39. Molly Gamble, “5 FTC Challenges to Hospital Mergers: Key Concepts for Today’s Antitrust Environment,” *Becker’s Hospital Review*, April 1, 2013, <http://www.beckershospitalreview.com/legal-regulatory-issues/5-ftc-challenges-to-hospital-mergers-key-concepts-for-todays-antitrust-environment.html>.
40. Pennsylvania Attorney General, “Attorney General Corbett Negotiates Two Agreements in University of Pittsburgh Medical Center’s Acquisition of Mercy Hospital,” press release, May 25, 2007, <http://gantdaily.com/2007/05/26/ag-corbett-negotiates-two-agreements-between-upmc-and-mercy/>; Heather Stauffer, “Geisinger-Lewistown Deal Approved after Antitrust Drama,” *Central Penn Business Journal*, October 29, 2013, www.cpbj.com/article/20131029/CPBJ01/131029719/Geisinger-Lewistown-deal-approved-after-antitrust-drama.
41. The accounting firm checks selected materials for compliance with the agreed metrics, although its reports typically note that it has not conducted an audit and provide no independent opinion on the records reviewed. See for example Dixon Hughes Goodman LLP (2012). The accountants also compare Mission’s costs with those of a group of peer facilities; those reviews were not available to this case study but are cited in McCarthy (2011a).
42. Certificate of Need is a much larger and more regulatory program. The department’s A–Z index does not include Certificate of Public Advantage or COPA. “A–Z Index,” North Carolina Department of Health and Human Services, accessed February 12, 2015, <http://www.ncdhhs.gov/dhsr/tableofc.htm#C>.

Such an approach also resembles the privacy accorded to attorneys’ work product for a client, which is consistent with the attorney general’s substantial role in this quasi-regulatory process.

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