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The Anticompetitive Nature of Certificate of Need and Certificate of Public Advantage Laws in the United States

Caleb Atkins

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THE ANTICOMPETITIVE NATURE OF CERTIFICATE OF NEED AND CERTIFICATE OF PUBLIC ADVANTAGE LAWS IN THE UNITED STATES

By: Caleb Atkins*

ABSTRACT

Certificate of Need (CON) laws serve as a major barrier to entry in the healthcare market, which already suffers from a high degree of market concentration. Certificate of Public Advantage (COPA) laws give healthcare providers robust antitrust immunity by allowing a merger to go through that would oftentimes be illegal. These COPAs can lead to a reduced quality of care for patients, reduced access to care in the communities where hospitals with COPAs operate, reduced wages for hospital employees in the relevant geographic market, and increased prices for patients seeking care. Given the essential nature of healthcare services, addressing the anticompetitive effects of CON and COPA laws is of the utmost importance.

In places like Northeast Tennessee, the anticompetitive effects of CON and COPA laws are particularly troubling when we consider how little economic power the citizens in the region wield. In 2018, a COPA was granted that allowed the two largest hospitals in the region, Mountain States Health Alliance (Mountain States) and Wellmont Health Systems (Wellmont Health), to form a new entity, Ballad Health Systems (Ballad Health), in a merger. Since the merger in 2018, the citizens of Northeast Tennessee have been incredibly unsatisfied with what Ballad Health has done in their region. Accordingly, the state of Tennessee should eliminate, or at least greatly restructure, their CON laws and require Ballad Health to deliver on their promises that the state and Ballad used to justify the COPA being created in the first place. Additionally, states that are considering eliminating their CON laws or whether to grant a COPA to a hospital should carefully consider the harms that CON and COPA laws can cause.

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INTRODUCTION

Certificate of Need (CON) laws serve as a major barrier to entry in the healthcare market, which already suffers from a high degree of market concentration.¹ Certificate of Public Advantage (COPA) laws give healthcare providers robust antitrust immunity by allowing a merger to go through that would oftentimes be illegal. These COPAs can lead to a reduced quality of care for patients, reduced access to care in the communities where hospitals with COPAs operate, reduced wages for hospital employees in the relevant geographic market, and increased prices for patients seeking care. Given the essential nature of healthcare services, addressing the anticompetitive effects of CON and COPA laws is of the utmost importance.

In places like Northeast Tennessee, the anticompetitive effects of CON and COPA laws are particularly troubling when we consider how little economic power the citizens in the region wield.² In 2018, a COPA was granted that allowed the two largest hospitals in the region, Mountain States Health Alliance (Mountain States) and Wellmont Health Systems (Wellmont Health), to form a new entity, Ballad Health Systems (Ballad Health), in a merger. Since the merger in 2018, the citizens of Northeast Tennessee have been incredibly unsatisfied with what Ballad Health has done in their region.³

*Caleb Atkins is a J.D. candidate at University of Tennessee College, he expects to graduate in 2025. He graduated from the Honors College at East Tennessee State University with a Bachelor of Business Administration in Economics with a concentration in Financial Economics. He would like to thank Professor Maurice Stucke for his thoughtful feedback and guidance throughout the writing and editing process of this paper.

¹ U.S. DEP'T OF TREASURY, THE STATE OF LABOR MARKET COMPETITION 41 (2022). <https://home.treasury.gov/system/files/136/State-of-Labor-Market-Competition-2022.pdf> [https://perma.cc/3647-QZL9].

² See Mandy Spears, *2021 Census Data on Income & Poverty in Tennessee*, THE SYCAMORE INSTITUTE (Dec. 12, 2022), <https://www.sycamoreinstitutetn.org/2021-income-poverty-in-tennessee/> [https://perma.cc/S7EJ-AF8K] (according to this 2021 report, Tennessee's median income level was lower than the national average. At the time of the 2021 report, the state of Tennessee had 20 counties with a population of more than 65,000; of those counties, three of those were in Northeast Tennessee. Of those three counties, Sullivan, Washington, and Greene, all three were ranked in the bottom half for median household income with Washington County being ranked 15 out of 20 and Sullivan County being the lowest of all 20. Concerning poverty rates, Washington and Sullivan County were ranked 14 and 20 respectively, out of the 20 qualifying counties).

³ See Brett Keleman and Samantha Liss, *These Appalachia hospitals made big promises to gain a monopoly. They're failing to deliver*, TENNESSEE LOOKOUT (Sept. 29, 2023, 11:29 AM), <https://tennesseelookout.com/2023/09/29/these-appalachia-hospitals-made-big->

Accordingly, the state of Tennessee should eliminate, or at least greatly restructure, their CON laws and require Ballad Health to deliver on their promises that the state and Ballad used to justify the COPA being created in the first place. Additionally, states that are considering eliminating their CON laws or whether to grant a COPA to a hospital should carefully consider the harms that CON laws can cause.⁴

Part I of this paper will provide a general overview of what CON and COPA laws are and the justifications that states give for their usage. Part I will also explain the anticompetitive harm that CON and COPA laws contribute to for both workers and consumers. Part II will then apply what is discussed in Part I to Ballad Health and explore why market forces have not been an effective way to combat CON and COPA law harms. Part III of this paper explores the legal theories, like the state action doctrine, that exempt hospitals from antitrust scrutiny through CON and COPA laws. Part III will also analyze cases where CON and COPA laws have been challenged under existing antitrust laws. Part IV discusses why political forces have not prevented the harm caused by CON and COPA laws. Part V will propose using the active supervision prong of the state action doctrine to address the harms caused by CON and COPA laws.

I. CON AND COPA LAWS BACKGROUND AND ANTICOMPETITIVE CONCERNS

Healthcare costs have been increasing rapidly in the United States for the last few decades, even when inflation is considered. Adjusted to inflation (2021 dollars), according to the Peterson-KFF Health System Trackers interpretation of the National Health Expenditure (NHE) data, health spending increased from \$1,951 per person in 1970 to \$12,914 per person in 2021.⁵ While numerous

promises-to-gain-a-monopoly-theyre-failing-to-deliver/ [https://perma.cc/MP7M-P5DE] (following the closure of the neonatal ICU at the Ballad owned Holston Valley hospital, “protesters gathered outside Holston Valley for eight months.”).

⁴ See generally FED. TRADE COMM’N & DEP’T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 8 (2004), <https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-reportfederal-trade-commission-and-department-justice/040723healthcarerpt.pdf> [hereinafter DOSE OF COMPETITION] [https://perma.cc/2JCV-7SK8].

⁵ See Matthew McGough, Aubrey Winger, Shameek Rakshit & Krutika Amin, *How has U.S. spending on healthcare changed over time?*, Peterson-KFF Health System Tracker (Dec. 15, 2023), <https://www.healthsystemtracker.org/chart-collection/u-s-spending->

factors have contributed to the increasing costs of healthcare in the US, this Part will explain how CON and COPA laws may have played a major role.

A. What is a Certificate of Need Law?

Certificate of Need (CON) laws serve as “state regulatory mechanisms for approving major capital expenditures and projects for certain health care facilities,” and 35 states plus Washington D.C. currently have them in place.⁶ CON laws in most states require, “a health planning agency or other entity [to] approve the creation of new health care facilities or the expansion of an existing facility’s services in a specified area.”⁷

For instance, in a state with a CON program, a hospital that wants to open a new facility must demonstrate that the new hospital would serve a community need that existing hospitals in the relevant geographic area are not adequately meeting. The demonstration will usually be a part of the hospital’s CON application to the state.⁸ Additionally, when applicants seek a CON, their potential future competitors, other healthcare companies and hospitals in that region, have the ability to argue that the need the applicant is seeking to demonstrate in that market is already met by the services they provide by filing comments and challenges to potential new competitors CON applications.⁹

CON laws vary by state, but most CON laws tend to “regulate hospitals, outpatient facilities and long-term care facilities.”¹⁰ Many states have been adjusting their CON laws recently, most of these changes have been geared towards limited their breadth by making changes like exempting certain types of facilities from CON review.¹¹ For instance, Tennessee made some major changes to its CON law in

healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20\$%20per%20capita,%201970-2021 [https://perma.cc/RPY5-38GW] (analyzing “National Health Expenditure (NHE) data from the Centers for Medicare and Medicaid Services.”).

⁶ *Certificate of Need State Laws*, NATIONAL CONFERENCE OF STATE LEGISLATURES, (Feb. 26, 2024) <https://www.ncsl.org/health/certificate-of-need-state-laws> [https://perma.cc/5A93-MJD3].

⁷ *Id.*

⁸ *Id.*

⁹ JOINT STATEMENT OF THE FEDERAL TRADE COMMISSION AND THE ANTITRUST DIVISION OF THE U.S. DEPARTMENT OF JUSTICE TO THE VIRGINIA CERTIFICATE OF PUBLIC NEED WORK GROUP 6 (2015) [hereinafter *Joint Statement of FTC and DOJ*].

¹⁰ *Certificate of Need State Laws*, *supra* note 6.

¹¹ *Id.*

2021, including exempting mental health facilities and any activity in an economically distressed county from CON review.¹² Considering the fact that many states have been repealing and majorly limiting the scope of their CON laws in recent years,¹³ we can reasonably deduce that states are acknowledging some of the anticompetitive issues that accompany CON laws. So the question is, why were CON laws created in the first place?

B. History and Justification of Certificate of Need Laws

In 1964, New York became the first state to enact a CON law, many other states soon followed; then, in 1974 Congress passed a law that required all states to adopt some form of CON law if they wanted to receive federal funding associated with the 1974 federal law.¹⁴ As a result, every state, except Louisiana, adopted some form of CON law by 1984.¹⁵ Several states later got rid of or changed their CON laws after the federal law and the associated funding was repealed in 1987.¹⁶ According to the National Conference of State Legislatures, CON laws “primarily aim to control health care costs by restricting duplicative services and determining whether new capital expenditures meet a community need.”¹⁷

“A primary objective of state CON laws is to control health care costs by avoiding unnecessary expansion or duplicative services within an area.”¹⁸ Those who support CON laws assert that they help ensure that new, underused hospital services do not form, which might lead to price inflation.¹⁹ “Beyond cost containment efforts, CON laws aim to ensure access to services for historically underserved communities, such as rural areas, and meet the health care needs of indigent patients.”²⁰ However, “many opponents argue CON laws have the opposite effect on health care costs and access to quality health services.”²¹

¹² *Id.*

¹³ *Id.* (as of 2022, 12 states either completely eliminated their CON laws or allowed them to expire. In 2021, Montana passed legislation that exempted all but long-term care facilities from their CON review).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

C. What is Wrong with Certificate of Need Laws?

CON laws are problematic because of the barriers that they artificially create for healthcare companies who attempt to enter the market,²² which naturally leads to less competition in the healthcare market.²³ The evidence shows that CON laws tend to increase costs rather than lower them.²⁴ Concerning the quality of care that hospitals in states with CON laws provide, empirical evidence shows that CON laws “lead to lower-quality care for some quality measures and have little or no effect on other quality standards.”²⁵

In 2015, the FTC and the United States Department of Justice (DOJ) both expressed that “CON laws raise considerable competitive concerns and generally do not appear to have achieved their intended benefits for health care consumers”²⁶ and that states should “consider repeal or retrenchment of their CON laws.”²⁷ The justification behind the creation of CON laws was to expand access to care and reduce the cost of healthcare; however, CON laws seemingly have the opposite of their intended effect.²⁸ The concerns about CON laws expressed by the FTC and DOJ (the agencies) are not new concerns. As early as 2004, the agencies released an extensive report about improving healthcare in the United States; throughout the over 300 page report, the agencies repeatedly expressed concerns about CON laws.²⁹ The 2004 report had an entire CON law section where the agencies concluded that “CON programs risk entrenching oligopolists and eroding consumer welfare.”³⁰

CON laws curtail innovation, cause consumers to have less choices, make it more difficult for new hospitals to enter the market, and make it more difficult for existing hospitals to expand their

²² DOSE OF COMPETITION, *supra* note 4, at Ch. 8 at 5 (showing that the empirical literature tends to show that CONs have not controlled hospital costs and may have even raised costs while also restricting entry).

²³ JOINT STATEMENT OF FTC AND DOJ, *supra* note 9, at 2.

²⁴ See *supra* text accompanying note 22.

²⁵ Thomas Stratmann, *The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services*, 15 J. RISK & FIN. MGMT. (HEALTH ECON. & INS.) 272, 272 (2022).

²⁶ JOINT STATEMENT OF FTC AND DOJ, *supra* note 9, at 13.

²⁷ *Id.* at 2.

²⁸ JOINT STATEMENT OF FTC AND DOJ, *supra* note 9, at 1-2; see also DOSE OF COMPETITION, *supra* note 4, Exec. Summary at 22 (“the vast majority of single specialty hospitals – a new form of competition that may benefit consumers – have opened in states that do not have CON programs. . . [o]ther means of cost control appear to be more effective and pose less significant competitive concerns.”).

²⁹ See generally DOSE OF COMPETITION, *supra* note 4, at Ch. 8.

³⁰ *Id.* at Ch. 8, 6.

services.³¹ Healthcare entities that have been granted a CON can delay or even prevent new firms from entering their geographic market under current CON laws.³² It can be logically deduced that a rational profit seeking company, given the ability to do so, would vigorously push back against potential new entrants to their market, regardless of whether their company actually meets the needs of the community they serve. Furthermore, CON laws could be enabling tacit collusion in the healthcare industry by discouraging hospitals from attempting to enter new geographic markets or expand the services that they currently offer, especially if a competing hospital already exists in the market or offers those services.

To illustrate some of the difficulties that CON laws can impose on potential new market entrants, let us look at an instance where a CON was denied in Northeast Tennessee. In 2013, Tri-Cities Holdings attempted to open an out-patient methadone facility in Johnson City, Tennessee, but their CON application was denied.³³ On top of the barrier that the CON application posed, Tri-Cities Holdings simultaneously faced zoning issues with Johnson City.³⁴ In 2016, while Tri-Cities Holdings was in a legal battle over the denial of their CON application and the Johnson City zoning laws, a CON was granted to Mountain States (one of the companies that went on to form Ballad Health) and East Tennessee State University Research Foundation so that they could establish a new methadone clinic in Johnson City, Tennessee.³⁵ Unsurprisingly, Mountain States was one of the parties who originally opposed Tri-Cities Holdings' CON application to open a methadone clinic in 2013.³⁶

While the CON denial in Northeast Tennessee is a useful example as to why there are concerns with the structure of CON laws, we should not need to look any further than basic economic principles to understand why allowing state enabled oligopolist, and monopolist, to protest potential market entrants is concerning in any

³¹ *JOINT STATEMENT OF FTC AND DOJ*, *supra* note 9, at 2; *see also* DOSE OF COMPETITION, *supra* note 4, Exec. Summary at 22 ("Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market.").

³² *JOINT STATEMENT OF FTC AND DOJ*, *supra* note 9, at 2.

³³ *Tri-Cities Holdings LLC v. Tennessee Admin. Procedures Div.*, 726 Fed. Appx. 298, 303 (6th Cir. 2018) (unpublished).

³⁴ *Id.* at 302.

³⁵ *Id.* at 306.

³⁶ Nathan Baker, *Mountain States Sues to Stop Methadone Clinic*, JOHNSON CITY PRESS (Feb. 6, 2016), https://www.johnsoncitypress.com/mountain-states-sues-to-stop-methadone-clinic/article_780ef1e8-8607-531e-8adb-395ce64f601b.html [<https://perma.cc/KQ29-8PBB>].

market.³⁷ CON laws are even more problematic when combined with COPAs, as the next section explores.

D. What are Certificate of Public Advantage (COPA) Laws and Why Do They Exist?

COPAs are certificates created by states that provide antitrust immunity to healthcare companies attempting to merge.³⁸ According to the state of Tennessee, “[a] COPA provides state action immunity to the [merging] hospitals from state and federal antitrust laws by **replacing competition with state regulation and Active Supervision**” and “[t]he goal of the COPA process is to protect the interests of the public in the region affected and the State.”³⁹

Ordinarily, mergers and acquisitions can be subject to antitrust scrutiny. Antitrust laws can be enforced by the FTC, DOJ, and private plaintiffs; the FTC can bring actions under the Federal Trade Commission Act and the Clayton Act, and the DOJ can bring actions under Clayton Act and the Sherman Act.⁴⁰ The agencies both have the ability to challenge mergers in various industries, but “the agencies have developed expertise in particular industries or markets;” one of the industries that the FTC has developed expertise in is the healthcare industry.⁴¹ For that reason, we might expect most

³⁷ DOSE OF COMPETITION, *supra* note 4, Exec. Summary at 4 (“In the overwhelming majority of markets, the government does not decide the prices and quality at which sellers offer goods and services. Rather, rivals compete to satisfy consumer demand, and consumers make decisions about the price and quality of goods or services they will purchase. A well-functioning market maximizes consumer welfare when consumers make their own consumption decisions based on good information, clear preferences, and appropriate incentives.”).

³⁸ FTC POLICY PERSPECTIVES ON CERTIFICATES OF PUBLIC ADVANTAGE, STAFF POLICY PAPER 1 (2022) https://www.ftc.gov/system/files?file=ftc_gov/pdf/COPA_Policy_Paper.pdf [<https://perma.cc/9BWD-7NJA>] [hereinafter FTC POLICY PAPER] (“COPA laws are enacted to replace competition among healthcare providers with regulatory oversight by state agencies. In states with COPA laws, officials allow hospitals to merge if they determine the likely benefits from a particular merger outweigh any disadvantages from reduced competition and increased consolidation.”).

³⁹ *Certificate of Public Advantage (COPA)*, TN DEP’T OF HEALTH <https://www.tn.gov/health/health-program-areas/health-planning/certificate-of-public-advantage.html> [<https://perma.cc/JE2R-MYAS>] (last visited Dec. 14, 2023).

⁴⁰ *The Enforcers*, FEDERAL TRADE COMMISSION <https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/enforcers> [<https://perma.cc/2UFF-CB57>] (last visited Dec. 14, 2023) (Part III of this paper will discuss what merger review normally looks like in greater detail).

⁴¹ *Id.*

antitrust actions in the healthcare industry to be carried out by the FTC.

Section 7 of the Clayton Act aims to prevent mergers when “the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.”⁴² Generally speaking, antitrust laws apply to hospital and healthcare system mergers and acquisitions just like mergers and acquisitions in any other industry.⁴³ Also similar to other industries, the anticompetitive effects of a hospital merger or acquisition are the focus of antitrust actions against hospitals.⁴⁴ “To establish a prima facie case under § 7 of the Clayton Act, after the plaintiff has defined the relevant market, the plaintiff must then establish that the proposed merger will create an appreciable danger of anticompetitive consequences;” in §7 actions, the plaintiff only needs to prove that there is a probable anticompetitive effect rather than having to prove actual restraint.⁴⁵

The FTC has successfully prevented multiple hospital and hospital system mergers through enforcing § 7 of the Clayton Act.⁴⁶ However, this has not always been the case. Between 1994 and 1999 the FTC and the DOJ lost six consecutive cases where they challenged hospital mergers, largely because of how the agencies and the courts defined relevant geographic markets.⁴⁷ As a result of these losses, the agencies did not challenge any hospital mergers for a number of years.⁴⁸ The FTC then, in 2002, started conducting post-merger reviews of hospitals and found evidence of anticompetitive effects, which ultimately led to a shift in how the courts view relevant geographic markers in 2008.⁴⁹ After 2008, the FTC started challenging hospital mergers at a rate comparable to the rate they challenge mergers in other sectors.⁵⁰ On three separate occasions in 2022, healthcare providers who were attempting to merge abandoned

⁴² 15 U.S.C.A. § 18.

⁴³ Eric C. Surette, Annotation, *Application of Clayton Act to Mergers and Acquisitions of Hospitals and Healthcare Systems* (15 U.S.C.A. §§ 12 to 27), 13 A.L.R. Fed. 3d Art. 7 (Originally published in 2016).

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ See generally *ProMedica Health Sys. Inc. v. F.T.C.*, 749 F.3d 559 (6th Cir. 2014), cert. denied; *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, 778 F.3d 775 (9th Cir. 2015); *F.T.C. v. OSF Healthcare Sys.*, 852 F. Supp. 2d 1069 (N.D. Ill. 2012).

⁴⁷ Cory Capps, Laura Kmitch, Zenon Zabinski & Slava Zayats, *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L.J. 441, 443 (2019).

⁴⁸ *Id.* at 444.

⁴⁹ *Id.* at 446-47.

⁵⁰ See *id.* at 450.

their mergers within two weeks of the FTC filing administrative complaints in opposition to proposed mergers.⁵¹

However, when hospitals or hospital systems attempting to merge are granted a COPA, they are not subject to state or federal antitrust laws. According to the FTC, “COPA laws are enacted to replace competition among healthcare providers with regulatory oversight by state agencies.”⁵² Eighteen states in the United States currently have laws that let hospitals who are wanting to merge apply for a COPA.⁵³ Generally, states that have COPAs will use them to let hospitals merge if the officials in that state “determine the likely benefits from a particular merger outweigh any disadvantages from reduced competition and increased consolidation.”⁵⁴ After a hospital is granted a COPA, they will usually be subject to numerous terms and conditions that are designed to limit the harms that normally follow from a loss in competition.⁵⁵

E. Why are COPAs bad?

The FTC found that COPAs “allow for hospital consolidation that is likely to harm patients and employees” and that “existing research shows that *COPAs’ purported benefits are simply unproven.*”⁵⁶ Local officials justify COPA laws “by claiming that federal antitrust enforcers do not properly credit the benefits of hospital mergers.”⁵⁷ However, “[t]he local politicians advocating for COPAs are often influenced by the hospitals that wish to merge without the scrutiny of anti-trust enforcement.”⁵⁸

The FTC provides numerous reasons for state law makers to be highly skeptical of COPAs by explaining how hospital consolidation can cause “higher prices for patients without improvements in quality of care, reduced patient access to healthcare services, hospital resistance to value based delivery and payment models intended to help reduce costs, and lower wages for hospital employees as a result

⁵¹ FEDERAL TRADE COMMISSION, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, 52-54 (2024) https://www.ftc.gov/system/files/ftc_gov/pdf/Overview-Healthcare.pdf [<https://perma.cc/YCF3-5BU8>].

⁵² FTC POLICY PAPER, *supra* note 38, at 1.

⁵³ Christopher Garmon & Kishan Bhatt, *Certificates of Public Advantage and Hospital Mergers*, 65 J. LAW ECON 465, 466 (2022).

⁵⁴ FTC POLICY PAPER, *supra* note 38, at 1.

⁵⁵ *Id.*

⁵⁶ *Id.* (emphasis added).

⁵⁷ Garmon, *supra* note 53, at 466.

⁵⁸ *Id.*

of fewer employment options.”⁵⁹ Based on FTC findings, “COPA oversight is an inadequate substitute for competition among hospitals, and a burden on the states that must conduct it.”⁶⁰ Additionally, the FTC asserts that “[a]ntitrust enforcers have successfully challenged anticompetitive hospital mergers likely to cause such harms, and COPAs undermine these efforts.”⁶¹

The data surrounding quality of care is limited due to the difficulty of measuring quality and the price data is limited due to relatively few COPAs being created. But in 2022, Christopher Garmon and Kishan Bhatt published “the first comprehensive analysis of the long-run effects of hospital mergers shielded from antitrust enforcement with COPAs”.⁶² While COPAs do have the ability to control pricing for the hospital created under the COPA agreement, after a COPA expires or is repealed the effected communities are left with much higher prices that are significantly higher than they would have been had the COPA never been granted.⁶³ One COPA in North Carolina, Mission Health, is estimated to have increased prices by more than 38% than if the COPA were never granted.⁶⁴ The price data indicates that after a COPA period ends, prices increase from 39% to 51%.⁶⁵ This is especially problematic when we consider that nearly every COPA created after 2015 expired or was repealed by 2022.⁶⁶ It should be noted that these major price increases do not just indicate that the COPA was ineffective at regulating price jumps in the long run, one would think that these COPA enabled hospitals might not have the market power to get away with these kinds of price increases had a COPA never given them the opportunity to merge in the first place.

Because there is little information about the long-run effects of COPAs, looking at hospital consolidation data is helpful when considering the potential effects of a COPA because a COPA, by its nature, is the consolidation of hospitals or healthcare systems. The Department of the US Treasury reported that even though the US

⁵⁹ *Key COPA Facts*, FEDERAL TRADE COMMISSION
https://www.ftc.gov/system/files/ftc_gov/pdf/Key_COPA_Facts.pdf
 [https://perma.cc/B8CP-K4TA].

⁶⁰ See generally FTC POLICY PAPER, *supra* note 38.

⁶¹ *Key COPA Facts*, *supra* note 59.

⁶² Garmon, *supra* note 53, at 467 (providing that “[d]espite a large literature that studies the price and quality effects of hospital mergers, little is known about the long-term effects of hospital mergers shielded from antitrust enforcement with COPAs.)

⁶³ *Id.* at 482.

⁶⁴ *Id.* at 478.

⁶⁵ *Id.* at 482.

⁶⁶ *Id.*

population has grown, “the number of hospitals decreased from 7,156 hospitals in 1975 to only 6,093 hospitals in 2021.”⁶⁷ Empirical evidence shows that hospital consolidation is “associated with modestly worse patient experiences and no significant changes in readmission or mortality rates.”⁶⁸ One study in the United Kingdom found that the introduction of a particular pro-competitive policy significantly reduced mortality rates within just two years of its implementation.⁶⁹ That same study demonstrated “that the introduction of competition can be an important mechanism for enhancing the quality of care patients receive even in a set up where hospitals are not profit maximizers.”⁷⁰

Regarding pricing, one empirical study found that “[m]onopoly hospitals are associated with 12% higher prices.”⁷¹ That same study found that when hospitals within five miles of each other merged, prices at the merging hospitals increased by over 6%, but as the distance between merging hospitals increased, the effect on prices became less significant.⁷²

The concerns with COPAs are not limited to the harms that consumers might experience. Hospital mergers can also harm hospital workers.⁷³ Consolidation of hospitals, through mergers that lead to few remaining hospital employers, causes employees whose jobs are typically connected to hospitals to experience slowed wage growth.⁷⁴ One study showed that four years after mergers that lead to few remaining hospitals in a local area took place, “nominal wages were 6.8% lower for nurses and pharmacy workers and 4.0% lower for non-medical skilled workers than they would have been without the merger.”⁷⁵

If some of the largest healthcare companies in a geographic area merge, it logically follows that a monopsony in the healthcare labor market might emerge in that geographic area, particularly when the

⁶⁷ THE STATE OF LABOR MARKET COMPETITION, *supra* note 1, at 41.

⁶⁸ Nancy D. Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions*, 382 NEW ENGL. J. MED. 51, 51 (2020).

⁶⁹ Martin Gaynor, Moreno-Serra Rodrigo & Carol Propper, *Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL’Y 134, 163 (2013).

⁷⁰ *Id.*

⁷¹ Zack Cooper et al., *The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51, 103 (2019).

⁷² *Id.*

⁷³ FTC POLICY PAPER, *supra* note 38 at 2.

⁷⁴ *Id.*

⁷⁵ *Id.* (citing Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, 111 AM. ECON. REV. 397 (2021)).

merger happens in a state where CON laws serve as a barrier to entry. In the case of Ballad Health, the merger did not just make them the largest healthcare company in the region, it made them the largest employer in the region with almost three times the number of employees of the next largest.⁷⁶

Non-hospital businesses and non-hospital employees are also greatly impacted by hospital consolidation because of insurance companies losing the ability to negotiate rates as effectively with hospitals.⁷⁷ The inability for insurance companies to negotiate with hospitals can lead to businesses providing insurance that covers less services to their employees or could lead to some employers getting rid of insurance coverage for their employees altogether.⁷⁸

When insurance companies are unable to effectively negotiate with hospitals, the extra cost will be “passed on to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses.”⁷⁹ Additionally, reducing or eliminating competition among hospitals could get rid of incentives for hospitals to expand access to care for patients and to improve or maintain their current quality of care.⁸⁰ The FTC policy paper about COPAs provided that based on their observations of the available evidence, they “cannot presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.”⁸¹

A lack of competition in the hospital industry is particularly concerning in the context of emergency services because of the extreme inelasticity of demand for those services.⁸² This lack of competition is supposed to be offset by the terms and conditions that come along with a COPA through regulations on things like pricing.⁸³ However, when we consider the fact that “[a]lmost all COPAs established prior to 2015 expired or were repealed, which left

⁷⁶ Richard Cowart, FTC Workshop Remarks Transcript: A Health Check on COPAs at 8 (Jun. 18, 2019).

⁷⁷ FTC POLICY PAPER, *supra* note 38 at 2.

⁷⁸ *Id.* (“Studies show that rising healthcare costs caused by hospital consolidation are often passed through to employees in the form of lower wages and less generous benefits.”).

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² See Randall P. Ellis et al., *Health care demand elasticities by type of service*, J. OF HEALTH ECON., 232 vol. 55, 243, 233 (2017) (finding that emergency room spending has an elasticity of -0.04 and ambulance services have an elasticity of -0.02).

⁸³ See Garmon, *supra* note 53, at 467 (providing that after granting COPAs, some “states justified their decision by concluding that a combined regulated system could better serve the health care needs of the local region than two competing systems.”).

the affected communities with unregulated hospital monopolists, higher prices, and likely reduced quality,” hospitals seem to be incredibly successful at dodging the regulatory scheme designed to protect communities from the anticompetitive effects that the COPAs ultimately enable.⁸⁴

COPA laws essentially create oligopolies or monopolies in particular geographic markets. Therefore, it would be incredibly difficult for a healthcare provider to compete with the resources of a COPA formed hospital. While trying to compete with a hospital that formed because of a COPA, the market player may not just be battling the COPA formed hospital through competition, they may also be fighting to receive a CON in order to even begin competing with that hospital. Considering that, COPAs appear especially problematic when paired with CON laws because the CON laws create a major barrier to entry for potential competitors to enter the market that COPA created hospitals ultimately dominate.⁸⁵

II. BALLAD HEALTH

One instance of a hospital system being formed through a COPA and existing in states with CON laws is Ballad Health. In the states of Tennessee and Virginia, a COPA was granted that led to the formation of Ballad Health Systems by providing antitrust immunity to the merger of Mountain States Health Alliance and Wellmont Health Systems.⁸⁶ The COPA application that formed Ballad Health was granted despite multiple public comments from the FTC that objected to the COPA formation.⁸⁷ In its third and final public comment, the FTC, said “the proposed merger will eliminate competition and likely lead to higher prices, lower quality, and reduced availability of healthcare services in Northeast Tennessee

⁸⁴ *Id.* at 482.

⁸⁵ See John Seyer, FTC Workshop Remarks: A Health Check on COPAs, at 16 (Jun. 18, 2019) (stating “the compounding effect of certificate of need in conjunction with COPA. That’s such a challenge. I mean, COPA grants, essentially, a geomonopoly. And then you have COPN on top of that, which restricts more barriers to entry. It restricts others coming into that market to help alleviate that competitive environment.”).

⁸⁶ FTC POLICY PAPER, *supra* note 38, at 11.

⁸⁷ See generally *Wellmont Health System/Mountain States Health Alliance*, FEDERAL TRADE COMMISSION <https://www.ftc.gov/legal-library/browse/cases-proceedings/151-0115-wellmont-health-systemmountain-states-health-alliance> [https://perma.cc/773W-6Z5T] (last visited Dec. 14, 2023).

and Southwest Virginia.”⁸⁸ In that public comment, the FTC clearly expressed that giving Mountain States and Wellmont Health a COPA appeared to be a bad idea by concluding that it was “deeply concerned that this proposed merger will cause significant and irreversible harm to competition and consumers in the region.”⁸⁹ The FTC’s public comment was released on July 18, 2017, and just two months later, on September 19, 2017, the Tennessee Department of Health Commissioner announced that the COPA was granted and would be effective at the start of 2018.⁹⁰ Ballad Health is now essentially serving as a monopolistic actor in the Northeast Tennessee region.⁹¹

While experience with COPAs seems to be overwhelmingly negative, the Ballad Health COPA is apparently too young to know its long-run effects. Considering that the COVID-19 pandemic started two years after Ballad Health’s COPA took effect, there might be difficulties interpreting price and quality of healthcare data when studying the impact of the Ballad Health COPA. But, in October 2019 the FTC announced that it will “study effects on prices, quality, access, and innovation of healthcare services, as well as the impact of hospital consolidation on employee wages.”⁹² The FTC study plans “to collect information over several years” so that they can perform a retrospective analysis of the Ballad Health COPA.⁹³ Because of the lack of empirical data about the effects of the Ballad Health COPA, it is difficult to demonstrate particular anticompetitive effects that have resulted from Mountain States and Wellmont Health merging. However, when we consider the harms of hospital consolidation generally, the dramatic price increases realized when COPAs are

⁸⁸ *Federal Trade Commission Staff’s Third Submission to the Tennessee Department of Health Regarding the Certificate of Public Advantage Application of Mountain States Health Alliance and Wellmont Health System*, FEDERAL TRADE COMMISSION 9-10 [hereinafter Third FTC Comment] https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staffs-third-submission-tennessee-department-health-regarding-certificate-public-advantage/ftc_-_third_comment_to_tennessee_-_final_public_version.pdf [<https://perma.cc/LBL7-XHRR>]

⁸⁹ *Id.* at 10.

⁹⁰ *Id.*; *COPA History*, TN DEP’T OF HEALTH <https://www.tn.gov/health/health-program-areas/health-planning/certificate-of-public-advantage/redir-copa/granting-the-copa.html> [<https://perma.cc/K8QR-D62P>] (last visited Dec. 14, 2023).

⁹¹ See John Seyer, FTC Workshop Remarks: A Health Check on COPAs, at 15 (Jun. 18, 2019) (while speaking about the Ballad Health’s service area, “[t]here were seven counties and one city in the state of Virginia that there would be no other alternative. . . this geography is 14,000 square miles without an alternative.”).

⁹² FTC POLICY PAPER, *supra* note 38, at 11.

⁹³ *Id.*

repealed or eliminated⁹⁴, and the problems that accompany CON laws in the context of the information we can gather about Ballad Health, we can make reasonable inferences about anticompetitive harms that the Ballad Health COPA might cause.

In places like Northeast Tennessee, a COPA can give a hospital a monopsony in the healthcare labor market and a significant market share in the regional labor market. Ballad Health covers 21 counties, primarily in Northeastern Tennessee and Southwestern Virginia.⁹⁵ As of 2019, they were the largest employer in the region with 15,000 employees, that is nearly three times the number of employees than the region's next largest employer, Eastman Chemical (with 6,000 employees).⁹⁶

In October 2023, the MIT Sloan Management Review released a Nursing Satisfaction Index which "shows how nurses evaluate the employee experience at 200 of the largest U.S. health care employers ... from the beginning of the pandemic through June 2023."⁹⁷ In this Nursing Satisfaction Index, Ballad Health received the lowest overall rating, which was 2.7 standard deviations below the average rating of all of the 200 largest US health care employers.⁹⁸ Anecdotally, I know many nurses who lived in Johnson City, Tennessee that moved out of the region specifically because they did not want to work for Ballad Health. In a competitive market, one might expect nurses to be able to work for rivals in the region if they do not like their working conditions; however, in the case of Ballad Health, they will likely have to move outside of that region if they want to work for another hospital.

Ballad Health seems to have led to many hospital closures and less ability for consumers to be able to negotiate their pricing.⁹⁹ Within one year of the creation of Ballad Health, a trauma center and a neonatal intensive care unit (NICU) were closed in Kingsport, Tennessee, one of the largest cities in Ballad Health's service area.¹⁰⁰ While Ballad Health has not closed any of their hospitals thus far,

⁹⁴ Garmon, *supra* note 53, at 482.

⁹⁵ See Richard Cowart, FTC Workshop Remarks: A Health Check for COPAs, at 8 (Jun. 18, 2019).

⁹⁶ *Id.*

⁹⁷ Donald Sull & Charles Sull, *Nursing Satisfaction Index*, MIT SLOAN SCHOOL OF MANAGEMENT (Oct. 18, 2023), <https://sloanreview.mit.edu/article/nursing-satisfaction-index/#interactive-launcher> [<https://perma.cc/K59H-PT7W>] (after going to index, click on the "overall rating" category to have it sorted in order from worst to best).

⁹⁸ *Id.*

⁹⁹ FTC POLICY PAPER, *supra* note 38, at 11-12.

¹⁰⁰ See Scott Fowler, FTC Workshop Remarks: A Health Check for COPAs, at 14 (Jun. 18, 2019).

Ballad Health has closed an intensive care unit (ICU) at one hospital and closed the neonatal ICU at another hospital that they operate.¹⁰¹ Additionally, Ballad Health has downgraded the capabilities of trauma centers at two of their hospitals, one of which was the same hospital where the NICU was closed.¹⁰² According to the *Tennessee Lookout*, Ballad Health explained that the downgrades and closures were the result of redundancy with other hospitals that they operate.¹⁰³

Under the original terms of the Ballad COPA, they were not allowed to oppose a CON application of a provider in their service area “unless such applicant for the certificate of need does not consistently accept inpatient Medicaid patients or uninsured patients.”¹⁰⁴ The existence of this term in Ballad Health’s COPA, in and of itself, is an apparent admission from the state of Tennessee that Ballad Health opposing a CON application would be burdensome to potential competitors, otherwise that term would not be necessary to include. However, in 2022 the state of Tennessee amended Ballad Health’s COPA terms so that they would be allowed to support or oppose *any* CON applications that compete with the services Ballad Health provides.¹⁰⁵ As far as market forces in the context of competing hospitals are concerned, they appear to be nearly powerless when it comes to eliminating CON and COPA laws. Market forces that might normally keep companies like Ballad Health in check are limited because CON laws serve as a major barrier to entry in the healthcare market.

Outside of opposing CON applications, Ballad Health may be able to restrict competition through other means. For instance, consider the proposed methadone clinic previously discussed in the CON section where Mountain States opposed the CON application of Tri-Cities Holdings. In 2016, Mountain States, before it became Ballad Health, sold a piece of property to a real estate company and

¹⁰¹ Keleman, *supra* note 3.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health* 34 (Sept. 18, 2017), https://www.tn.gov/content/dam/tn/health/documents/Ballad_Health_-_Terms_of_Certification_Governing_the_COPA_-_September_18_2017_-_approved_by_MSHA_Board.pdf [https://perma.cc/A8G9-YW9X].

¹⁰⁵ *Third Amended and Restated Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health* 36 (July 1, 2022), <https://www.tn.gov/content/dam/tn/health/documents/copa/2022-07-01-FINAL-EXECUTED-Third-Amended-and-Restated-Terms-of-Certification-Governing-the-COPA.pdf> [https://perma.cc/8HU4-4XKF].

a company called Crossroads; after the sale of this land, Mountain States sued the companies upon learning that it was Crossroads' intention to open a methadone clinic on that piece of property.¹⁰⁶ The lawsuit ultimately settled and Crossroads agreed to purchase a different piece of land.¹⁰⁷ If only a limited amount of land is zoned for healthcare services, it is possible that Ballad Health could acquire most or all of that land in their geographic market, then refrain from selling it to potential competitors. Something like this would effectively prevent competitors from entering Ballad Health's geographic market. Considering the behavior of Mountain States, one of the two companies that formed Ballad Health, one could reasonably anticipate that Ballad Health might do something similar.

We have just discussed how the Ballad Health COPA might be tampering market forces in the labor market for nurses and in the market for new entrants, but how might the Ballad Health COPA interfere with market forces in the consumer market? In something that represents a free market, one might expect consumers to patronize other businesses if they are unhappy with the prices they are charged or the quality of the services they receive. However, consumers seem to be relatively powerless when it comes to asserting their market power to combat CON and COPA laws.

Logically speaking, it is hard to understand how a consumer is supposed to use their market influence against a COPA enabled hospital system like Ballad Health. If a consumer is unhappy with Ballad Health's prices or quality of care, then they would need to either forego healthcare services entirely or travel outside of the region since Ballad Health essentially has a geographic monopoly.¹⁰⁸ Even if a particular consumer has abundant resources, what options does that consumer have in an emergency situation? If the entire region they live in is dominated by Ballad Health and they break their leg, then Ballad Health is likely to be their only option, regardless of the quality of care they provide. Additionally, because the Ballad Health COPA effectively eliminated existing competition in their geographic market,¹⁰⁹ Ballad Health has little economic incentive to increase their quality of care, nor can insurance

¹⁰⁶ Nate Morabito, *Crossroads, MSHA Settle Lawsuit, ditch plans to build methadone clinic at Princeton Road site*, WJHL (Apr. 1, 2016), <https://www.wjhl.com/news/crossroads-msha-settle-lawsuit-ditch-plans-to-build-methadone-clinic-at-princeton-road-site/> [<https://perma.cc/45NX-JJUP>].

¹⁰⁷ *Id.*

¹⁰⁸ See John Seyer, *FTC Workshop Remarks: A Health Check on COPAs*, at 15 (Jun. 18, 2019).

¹⁰⁹ *Id.*

companies constrain the prices Ballad Health charges.¹¹⁰ It logically follows that insurance companies might have little, if any, leverage in negotiating prices when Ballad Health is the only hospital system in an entire geographic market. If Ballad Health can successfully get insurers to pay unreasonable prices, then people who have employer-based insurance coverage are likely to be adversely affected by the COPA given to Ballad Health, even if they never have to use Ballad Health's services.¹¹¹

Now that some of the anticompetitive harms and concerns surrounding CON and COPA laws have been discussed, we will examine how CON and COPA laws are protected from actions that the FTC and others have taken.

III. HOW CON AND COPA LAWS SHIELD HOSPITALS FROM FEDERAL ANTITRUST LAWS

The Sherman Act prevents unreasonable restraints on trade.¹¹² Some actions like price fixing and market division among competitors are *per se* illegal under the Sherman Act, meaning that no defense or justification will make the action permissible.¹¹³ We know that part of the justification for the existence of CON laws is to "restricting duplicative services."¹¹⁴ On their face CON laws seemingly violate the Sherman Act because CON laws, by their nature, are allocating markets and limit entry. Thus, one might think that antitrust laws would prevent CON laws from being enacted. But, in *Parker*, the Supreme Court created the state action doctrine, which effectively allows states to implement their own restraints on trade, even if they violate the Sherman Act.¹¹⁵ In *Parker*, the Court

¹¹⁰ See FTC POLICY PAPER, *supra* note 38, at 2 (explaining that "[h]ospitals compete for inclusion in insurance plans, and insurers rely on that competition to negotiate better prices and higher quality of care commitments for plan members. When hospitals have substantial market power, their negotiating leverage with health insurers increases and they often are able to demand higher rates.").

¹¹¹ See *id.* (providing that in instances of hospital consolidation "employers facing higher costs may limit insurance coverage for their employees or eliminate insurance coverage altogether. Studies show that rising healthcare costs caused by hospital consolidation are often passed through to employees in the form of lower wages and less generous benefits.").

¹¹² *The Antitrust Laws*, FEDERAL TRADE COMMISSION <https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/antitrust-laws> [<https://perma.cc/VC6B-JKUN>] (last visited Dec. 14 2023).

¹¹³ *Id.*

¹¹⁴ *Certificate of Need State Laws*, *supra* note 6.

¹¹⁵ *Parker v. Brown*, 317 U.S. 341, 351 (1943).

provided that the Sherman Act “gives no hint that it was intended to restrain state action or official action directed by a state.”¹¹⁶

In the COPA section of Part I, we established that the FTC is the group who typically challenges a hospital merger under Section 7 of the Clayton Act.¹¹⁷ While a merger may violate § 1 or 2 of the Sherman Act or § 5 of the FTC Act, § 7 of the Clayton Act “is the antitrust law that most directly addresses mergers and acquisitions.”¹¹⁸ Section 7 aims to prevent a merger when “the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.”¹¹⁹ Additionally, “[t]he Hart-Scott-Rodino Act established the federal premerger notification program, which provides the FTC and the Department of Justice with information about large mergers and acquisitions before they occur.”¹²⁰

This premerger notification program usually starts with filling out an HSR form that has information about each company.¹²¹ The parties have to wait a specified period, usually 30 days, before they are allowed to consummate the transaction.¹²² During the waiting period, the reviewing agency (either the FTC or DOJ) has the authority to issue an additional request for more information, if they determine that is necessary.¹²³ This additional request extends the waiting period, usually by 30 days, so that the reviewing agency can have more time to review the proposed merger.¹²⁴ If the reviewing agency determines that the proposed merger might violate antitrust laws, the agency “may seek an injunction in federal district court to prohibit consummation of the transaction.”¹²⁵ The state action doctrine effectively prevents the FTC and DOJ from challenging

¹¹⁶ *Id.*

¹¹⁷ *The Enforcers*, *supra* note 40.

¹¹⁸ *Draft Merger Guidelines*, U.S. DEPARTMENT OF JUSTICE & FEDERAL TRADE COMMISSION 1 (2023), https://www.ftc.gov/system/files/ftc_gov/pdf/p859910draftmergerguidelines2023.pdf [https://perma.cc/XZA9-VF59].

¹¹⁹ 15 U.S.C.A. § 18.

¹²⁰ *Premerger Notification Program*, FEDERAL TRADE COMMISSION <https://www.ftc.gov/enforcement/premerger-notification-program> [https://perma.cc/7C44-TZRX] (last visited Dec. 14, 2023).

¹²¹ *Id.*

¹²² FEDERAL TRADE COMMISSION, WHAT IS THE PREMERGER NOTIFICATION PROGRAM? 1 (2009), <https://www.ftc.gov/sites/default/files/attachments/premerger-introductory-guides/guide1.pdf> [https://perma.cc/8VBX-R9QL].

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ *Id.*

hospital mergers that might otherwise be subject to antitrust scrutiny if not for a state granting the merging hospitals a COPA.¹²⁶

A. State Action Doctrine

As provided by the United States Supreme Court in *Phoebe Putney*, the state action doctrine exempts local government entities from federal antitrust law “when a local governmental entity acts pursuant to a clearly articulated and affirmatively expressed state policy to displace competition.”¹²⁷ The Court in *Phoebe Putney* also provided, “that a state policy to displace federal antitrust law was sufficiently expressed where the displacement of competition was the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature.”¹²⁸

Furthermore, a private party (such as hospitals and healthcare companies) can also be protected by the state action doctrine by the same clear articulation rule that applies to a local government entity, but that private party will also be subject to active state supervision to receive protection under the state action doctrine.¹²⁹

In *Phoebe Putney*, the FTC brought action against a Georgia hospital for creating an effective monopoly with an attempted merger in Albany, Georgia; the hospital asserted an immunity defense under the state action doctrine but was ultimately unsuccessful in their defense because “Georgia [did] not clearly articulate[] and affirmatively express[] a policy to allow hospital authorities to make acquisitions that substantially lessen competition.”¹³⁰ Despite the FTC successfully overcoming the hospitals’ asserted state action doctrine immunity, the hospital was able to consummate their merger during the appeal process.¹³¹ The FTC was unable to require divestiture because of Georgia’s CON requirements and entered into a consent agreement with the hospital

¹²⁶ FTC POLICY PAPER, *supra* note 38, at 1.

¹²⁷ F.T.C. v. *Phoebe Putney Health System, Inc.*, 568 U.S. 216, 219 (2013).

¹²⁸ *Id.* at 229.

¹²⁹ *Id.* at 226 (while the Court addressed that the active state supervision requirement is a part of the state action doctrine test, the Court did not go into the active supervision requirement in their analysis).

¹³⁰ *Id.* at 236.

¹³¹ *Phoebe Putney Health System, Inc., Hospital Authority of Albany-Dougherty County, and HCA Inc. Settle FTC Charges that Acquisition of Palmyra Park Hospital Violated U.S. Antitrust Laws*, FEDERAL TRADE COMMISSION [hereinafter FTC Press Release] (Mar. 31, 2015). <https://www.ftc.gov/news-events/news/press-releases/2015/03/phoebe-putney-health-system-inc-hospital-authority-albany-dougherty-county-hca-inc-settle-ftc> [<https://perma.cc/2K9Y-B4HA>].

that imposed numerous regulations on the hospital, like prohibiting the hospital from opposing CON applications for general acute-care hospitals in Albany, Georgia.¹³²

As to the reasoning of the Supreme Court when rejecting the state action defense in *Phobe Putney*, it provided:

that Georgia, particularly through its certificate of need requirement, does limit competition in the market for hospital services in some respects. But regulation of an industry, and even the authorization of discrete forms of anticompetitive conduct pursuant to a regulatory structure, does not establish that the State has affirmatively contemplated other forms of anticompetitive conduct that are only tangentially related.¹³³

This line of reasoning could provide some room for the FTC or others to challenge anticompetitive mergers in states with only CON laws; however, if the merger has already been consummated, then relief may be limited. Additionally, when a state does clearly articulate an intention to provide healthcare companies with antitrust immunity, a plaintiff may have great difficulty even moving past the motion to dismiss stage of a case.¹³⁴

When a state gives a hospital a CON, that state is essentially giving a hospital a license to operate in a particular geographic region – this does not allow a hospital to take any particular anticompetitive action.¹³⁵ Because the granting of a CON is a unilateral action by a state, CON laws create barriers to entry for potential competing hospitals and any anticompetitive effect that results from the application (or lack thereof) of CONs is just the way a particular state decides to license hospitals.¹³⁶

Unless there is a form of hybrid restraint on trade or a separate per se violation of antitrust laws, then states are allowed to have

¹³² *Id.*

¹³³ *F.T.C. v. Phoebe Putney Health System, Inc.*, 568 U.S. 216, 235 (2013).

¹³⁴ *See generally* Jackson, Tennessee Hosp. Co., LLC v. W. Tennessee Healthcare, Inc., 414 F.3d 608 (6th Cir. 2005) (a hospital district in Tennessee successfully asserted a state action immunity defense and got their Fed.R.Civ.P 12(b)(6) motion to dismiss under the state action doctrine defense because a Tennessee law clearly expressed antitrust immunity for hospital authorities by granting a list of broad powers to them “regardless of competitive consequences.”).

¹³⁵ *Yakima Valley Meml. Hosp. v. Washington State Dept. of Health*, 654 F.3d 919, 929 (9th Cir. 2011).

¹³⁶ *Id.* at 931.

CON laws.¹³⁷ When considering the difference between unilateral state action and hybrid restraints on trade, “[t]he key distinction is that the regulation leaves a gap in the restraint of trade for private parties to fill at their discretion.”¹³⁸ Hybrid restraints tend to grant some amount of regulatory authority to a private party or multiple private parties.¹³⁹ In *Yakima Valley*, even though the Washington State Department of Health considered whether current CON holders were meeting the need of the area they operated in, the court ruled “that responsiveness to private activity does not amount to a hybrid restraint” because the state did “not delegate any aspect of need calculation to private parties.”¹⁴⁰ Considering that courts seem to view CON laws as little more than state regulatory schemes,¹⁴¹ it is not surprising that the FTC has avoided attacking CON laws in the system.¹⁴²

When a state grants a COPA to a hospital, the FTC seems to have little recourse because of the state action doctrine.¹⁴³ Recently, in *Louisiana Children’s Medical Center*, the FTC challenged an acquisition between hospital systems that was permitted by a Louisiana COPA.¹⁴⁴ In *Louisiana Children’s Medical Center*, the FTC was not challenging the COPA enabled acquisition itself, rather the FTC brought action against the hospitals because they failed to comply with the premerger notification required under the HSR Act.¹⁴⁵ In September 2023, the district court ruled that the acquisition was not subject to the HSR filing requirement because of the state action doctrine.¹⁴⁶ According to the district court, the statute that makes COPAs possible in Louisiana “easily satisfies” the clear articulation requirement of the state action doctrine.¹⁴⁷

In *Louisiana Children’s Medical Center*, the court did not go into a detailed analysis of the active supervision requirement of the state

¹³⁷ *Id.*

¹³⁸ *Id.* at 927.

¹³⁹ *Id.*

¹⁴⁰ *Id.* at 929.

¹⁴¹ *Id.* at 923.

¹⁴² See generally FEDERAL TRADE COMMISSION, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2024).

¹⁴³ See generally *Louisiana Children’s Med. Ctr. v. Att’y Gen. of U.S.*, No. CV 23-1305, 2023 WL 6293887 (E.D. La. Sept. 27, 2023) (explaining (or some other present participle) that the hospital and the FTC filed dueling motions to dismiss, and the court here granted the hospitals’ motion, with prejudice).

¹⁴⁴ *Id.* at *3.

¹⁴⁵ See *id.*

¹⁴⁶ *Id.* at *11-12.

¹⁴⁷ *Id.* at *7 (providing that the language of the statute “plainly indicates the state’s policy in favor of COPA-approved mergers regardless of their anticompetitive effects.”).

action doctrine.¹⁴⁸ In the active supervision prong of the state action doctrine analysis, the court rebutted the FTC's assertions by mentioning how the Louisiana Department of Justice (LADOJ) did an extensive review of the hospitals' COPA application and how the LADOJ has the ability to actively supervise the acquisition and the new entity on an ongoing basis under the terms and conditions of the COPA.¹⁴⁹ This ruling is particularly troubling if applied in future cases because this application of the state action doctrine would mean that hospitals who are granted COPAs will not even have to give the FTC an opportunity to investigate what is likely a massive acquisition through an HSR filing and to determine if the state action doctrine would apply to this merger.

If the ruling in *Louisiana Children's* remains good law, it will provide incredibly robust immunity to hospitals who are granted COPAs. This could cause many more hospitals who want to merge or acquire other hospitals to seek COPAs in order to dodge transactional oversight from federal agencies.

A key distinction between the *Phoebe Putney* case and the *Louisiana Children's Medical Center* case is that the merger in *Phoebe Putney* was not authorized by a COPA, whereas in *Louisiana Children's Medical Center*, the acquisition was permissible because of a COPA.¹⁵⁰ The COPA statute in *Louisiana Children's Medical Center* was used by the court to make a conclusory analysis of both the clear articulation test and the active state supervision test provided by the state action doctrine.¹⁵¹ However, in both *Phoebe Putney* and *Louisiana Children's Medical Center*, we did not receive a detailed analysis of the active state supervision test under the state action doctrine, this leads us to examine other cases that do not touch on CON or COPA laws to see what a strong active supervision argument may look like.¹⁵²

In *North Carolina State Board of Dental Examiners*, the Supreme Court further explained the active supervision requirement of the state action doctrine by providing that "the inquiry regarding active supervision is flexible and context dependent" and that the state

¹⁴⁸ *Id.* at *8-9.

¹⁴⁹ *Id.*

¹⁵⁰ F.T.C. v. Phoebe Putney Health Sys., Inc., 568 U.S. 216, 235 (2013); Louisiana Children's Med. Ctr. v. Att'y Gen. of U.S., No. CV 23-1305, 2023 WL 6293887, at *2 (E.D. La. Sept. 27, 2023).

¹⁵¹ Louisiana Children's Med. Ctr. v. Att'y Gen. of U.S., No. CV 23-1305, 2023 WL 6293887, at *7-9 (E.D. La. Sept. 27, 2023).

¹⁵² See generally F.T.C. v. Phoebe Putney Health Sys., Inc., 568 U.S. 216 (2013); Louisiana Children's Med. Ctr. v. Atty. Gen. of U.S., No. CV 23-1305, 2023 WL 6293887 (E.D. La. Sept. 27, 2023).

does not need to carefully review every decision, instead “the question is whether the State’s review mechanisms provide ‘realistic assurance’ that a nonsovereign actor’s anticompetitive conduct ‘promotes state policy, rather than merely the party’s individual interests.’”¹⁵³ It is worth noting that the *North Carolina State Board of Dental Examiners* might be an extreme case because it was about whether “active market participants” could serve as unsupervised regulators of a market.¹⁵⁴ The Court has been fairly unclear about the definition of the active supervision aspect of the state action doctrine.¹⁵⁵ This lack of clarity could be beneficial for antitrust actions against hospitals who have been granted COPAs and against the CON laws in some states, but we will discuss this possibility more in Part V of this paper.

The state action doctrine seemingly bars the FTC from preventing hospital mergers when a state has granted a COPA that allows the merger to happen.¹⁵⁶ CON laws are hurdles for the development of new hospitals in particular geographic areas, and COPA laws are shields that a state can give to a proposed hospital merger; then, the state action doctrine is a sword that a hospital who was granted a COPA can use as an affirmative defense to attack any potential entrant post-merger.

Because of the difficulty that the state action doctrine poses to plaintiffs when bringing antitrust claims in states with CON and COPA laws, we now turn to non-antitrust actions that have attempted to challenge CON laws to analyze some alternative courses of action that may bring about the same effect as an antitrust action.

B. Due Process

In *Tiwari*, the plaintiffs attempted to start a home healthcare company in the Louisville, Kentucky area that would focus on

¹⁵³ *N. Carolina State Bd. of Dental Examiners v. F.T.C.*, 574 U.S. 494, 515 (2015) (citations omitted).

¹⁵⁴ *Id.*

¹⁵⁵ See Rebecca Haw Allensworth, *The New Antitrust Federalism*, 102, VA. L. REV. 1387, 1434 (2016).

¹⁵⁶ See *Louisiana Children’s Med. Ctr. v. Att’y Gen. of U.S.*, No. CV 23-1305, 2023 WL 6293887, at *12 (E.D. La. Sept. 27, 2023) (“the Court appreciates that this holding may make enforcement more difficult for the FTC in the narrow context of transactions that close pursuant to state COPAs”); see also FEDERAL TRADE COMMISSION, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS 52,56, 77 (2024) (noting that the only FTC enforcement mechanism appears to be issuing statements that oppose the granting of COPAs to states).

attending to people who speak Nepali.¹⁵⁷ Kentucky has CON laws in place, and the plaintiffs were denied a CON, which prevented them from having the ability to start their home healthcare company.¹⁵⁸ Instead of challenging the denial of the CON through Kentucky courts, the plaintiffs adequately stated a claim for relief against the various agencies and officials in the state of Kentucky under the constitution's Fourteenth Amendments Due Process and Equal Protection clauses; more specifically, that the Kentucky CON law put a substantive restriction on their ability to engage in a particular occupation.¹⁵⁹ Because Kentucky's CON law was challenged on an economic basis, the plaintiffs had to invalidate the law by meeting the high threshold of review under the rational-basis test.¹⁶⁰

The court in *Tiwari* ultimately found that Kentucky's CON law could be justified as lawful against a Due Process claim under the rational-basis test; however, the court was far from defensive as to whether the law is a good thing for the community or as to whether the rational-basis test is the best test to deal with issues such as the one at issue in this case.¹⁶¹ While discussing the issues with CON laws, the *Tiwari* court provided that "[t]he real problem, and the most potent explanation for criticizing them, is that the costs of these laws—needless barriers to entry, protectionism for incumbents, the improbability of lowering prices by decreasing supply—*outweigh* their modest regulatory benefits."¹⁶² Although, the court in *Tiwari* was obviously skeptical of Kentucky's CON law, the court ultimately decided that the issues with the CON laws are for the Kentucky state legislature, or perhaps even the Kentucky state courts to resolve.¹⁶³

¹⁵⁷ *Tiwari v. Friedlander*, 26 F.4th 355, 358 (6th Cir. 2022), *cert. denied*, 143 S. Ct. 444 (2022).

¹⁵⁸ *Id.* at 359.

¹⁵⁹ *Id.* at 359-60 (although the plaintiffs sued various state agencies and officials, "[t]he Kentucky Hospital Association successfully moved to intervene as a defendant").

¹⁶⁰ *Id.* at 361 (for the purposes of this paper, we will not go through a detailed account of what rational-basis review is, but the court here succinctly explained the burden of rational-basis scrutiny by providing that "[s]o long as some 'plausible' reason exists for the law—any plausible reason, even one that did not inspire the enacting legislators—the law must stand, no matter how unfair, unjust, or unwise the judges may see it as citizens") (citations omitted).

¹⁶¹ *See id.* at 368 - 69 ("[M]any thoughtful commentators, scholars, and judges have shown that the current deferential approach to economic regulations may amount to an overcorrection in response to the *Lochner* era at the expense of otherwise constitutionally secured rights. . . . Is it worth considering whether a similar form of protectionism should receive more rigorous review under the dormant Commerce Clause solely when the entrant happens to be from another State? Put more specifically, should *Tiwari* and *Sapkota's* challenge have a better chance of success if they move to Indiana?").

¹⁶² *Id.* at 366.

¹⁶³ *Id.* at 370-71.

Despite the Fourteenth Amendment claims being unsuccessful in *Tiwari*, the court did leave us with an interesting question to consider when challenging a CON law: “[i]s it worth considering whether a similar form of protectionism should receive more rigorous review under the dormant Commerce Clause solely when the entrant happens to be from another State?”¹⁶⁴

While the question that the *Tiwari* court raised has to do with reconsidering how courts review Fourteenth Amendment claims that rely on an economic basis, the question should also cause us to consider whether an out-of-state plaintiff may have more luck challenging a CON law in a particular state.¹⁶⁵ However, the question about whether a CON law could survive a Fourteenth Amendment claim from an out-of-state plaintiff does not need to be an abstract thought experiment, because the Sixth Circuit addressed that very question as recently as September 2023.¹⁶⁶

C. Dormant Commerce Clause

In *Truesdell*, an ambulance provider (Legacy) based out of Ohio challenged Kentucky’s CON law under the dormant Commerce Clause.¹⁶⁷ Legacy was located just seven miles from the Kentucky-Ohio border and had no issues operating in Ohio, but Legacy had growing demand for their services in Kentucky.¹⁶⁸ Under the Kentucky CON law, Legacy was able to transport *to* Kentucky but was not allowed to transport *from* Kentucky unless they were granted a CON from the state of Kentucky.¹⁶⁹ The court in *Truesdell* ultimately “split the baby” in their holding; the court ruled that despite Legacy demonstrating that the CON law may harm Kentucky residents, Legacy did not show that the CON law provided a substantial harm to interstate commerce.¹⁷⁰ However, the court did rule that Kentucky’s law violated the dormant Commerce Clause by barring Legacy from offering “*interstate* ambulance transportation between Kentucky and Ohio.”¹⁷¹

The main takeaway from the *Truesdell* decision is that Kentucky is allowed to regulate *intrastate* commerce through their CON law,

¹⁶⁴ See *id.* at 369.

¹⁶⁵ See *id.*

¹⁶⁶ *Truesdell v. Friedlander*, 80 F.4th 762, 762 (6th Cir. 2023).

¹⁶⁷ *Id.* at 764.

¹⁶⁸ *Id.* at 765-67.

¹⁶⁹ *Id.* at 767.

¹⁷⁰ *Id.* at 764-65.

¹⁷¹ *Id.* at 765.

but they cannot regulate *interstate* commerce through their CON law because of the dormant Commerce Clause.¹⁷² *Truesdell* was nothing more than a small win against challenges to CON laws, if it can be considered a win at all, since the court ruled that Kentucky's CON law did not violate the dormant Commerce Clause because it was not discriminatory against out-of-state economic interests and did not substantially harm interstate commerce.¹⁷³

Now, let's sum up what we have discussed about challenging CON and COPA laws under the antitrust laws, given the Supreme Court's limitations imposed by its state action doctrine, the Due Process clause, and dormant Commerce clause.

The Court's state action doctrine effectively prevents the FTC and private parties from enforcing antitrust laws against mergers that have been given immunity under COPAs, such as the merger that led to Ballad. The FTC strongly discouraged the state of Tennessee from granting a COPA to Ballad but given the immunity that the state action doctrine defense can afford to merging hospitals through a COPA, it did not appear that the FTC could do anything more than release comments to Tennessee expressing their concerns.¹⁷⁴

The state action doctrine also permits CON laws to exist if the CONs are granted through unilateral state actions. Thus, under Tennessee's CON law, Ballad can oppose CON applications and the state of Tennessee is allowed to factor that opposition into the decision about whether they ultimately grant a potential competitors' CON application so long as the state does not delegate any part of the ultimate decision to Ballad or another active market participant.¹⁷⁵ CON laws are viewed as more of a regulatory scheme than anything else.¹⁷⁶

Due Process claims challenging CON laws are likely to fail because of the CON laws being economic in nature and therefore subject to the Court's rational-basis test. This means that if Tennessee's CON law were challenged under the Due Process

¹⁷² *Id.* at 777-778.

¹⁷³ *See generally id.*

¹⁷⁴ *See generally Third FTC Comment, supra* note 88.

¹⁷⁵ *Yakima Valley Mem'l. Hosp. v. Washington State Dept. of Health*, 654 F.3d 919, 929 (9th Cir. 2011); *N. Carolina State Bd. of Dental Examiners v. F.T.C.*, 574 U.S. 494, 515 (2015).

¹⁷⁶ *See generally Yakima Valley Mem'l Hosp.*, 654 F.3d 919.

Clause of the Fourteenth Amendment that *any plausible reason* could justify the existence of the CON law, legally speaking.¹⁷⁷

Finally, dormant Commerce Clause challenges to CON laws will likely be unsuccessful unless they are specifically regulating something like *interstate* transportation; however, a CON law that regulates *intrastate* transportation will likely stand if challenged under the dormant Commerce Clause.¹⁷⁸ Practically speaking, this means that to bring a successful dormant Commerce Clause claim against Tennessee's CON law, that the CON law would need to be doing something like barring ambulance services from bringing customers to and from hospitals in Virginia or North Carolina. The dormant Commerce Clause challenges seem like they might only apply to limited services and under a specific set of circumstances.

In Part III, we addressed how antitrust laws can do little to alleviate the harms that CON and COPA laws cause. Next, in Part IV we will discuss more shortcomings associated with CON and COPA laws and why political forces have been ineffective at eliminating them, despite their anticompetitive consequences.

IV. POLITICAL FORCES

Hospitals that operate in states with CON laws benefit from their existence by becoming state-enabled oligopolies and monopolies. For example, in *Tiwari*, the Kentucky Hospital Association successfully intervened as a defendant when the plaintiffs were challenging the constitutionality of Kentucky's CON law.¹⁷⁹ Presumably, hospitals that operate in states with CON laws have significant market power because of competition being intentionally restricted by the state in their relevant market. A company with a large degree of market power is likely to be interested in keeping, or even expanding, that market power; thus, it would not be a logical leap for us to assume that hospitals in states with CON laws might be funding some or many political campaigns in hopes of keeping the CON laws of their respective states alive.¹⁸⁰ For instance, Google and Facebook are now advocating for regulations on big tech

¹⁷⁷ *Tiwari v. Friedlander*, 26 F.4th 355, 361 (6th Cir. 2022), *cert. denied*, 143 S. Ct. 444 (2022).

¹⁷⁸ *Truesdell v. Friedlander*, 80 F.4th 762, 777-78 (6th Cir. 2023).

¹⁷⁹ See *supra* text accompanying note 159.

¹⁸⁰ See generally Thomas Ferguson, Paul Jorgensen, & Jie Chen, *How money drives US congressional elections: Linear models of money and outcomes*, 61 *STRUCTURAL CHANGE AND ECON. DYNAMICS* 527, 530 (2002). (using empirical data to find that “[a]ll regressions indicate that money has significant effects on electoral outcomes”).

companies because those regulations are difficult to comply with and they have the resources to do it, whereas potential new entrants might be less able to comply.¹⁸¹

Despite one's obvious skepticism of the ability and/or willingness of a legislature to repeal their CON laws, some states have repealed their CON laws; therefore, the political forces are obviously not powerless when it comes to CON law repeal since they have acted in some states.¹⁸² However, in states like Tennessee, the political forces are unlikely to work towards repealing CON and COPA laws because that would probably go against their own self-interest.

To provide an example of local politicians who may be influenced by hospitals seeking a COPA, Tennessee State Senator Rusty Crowe was a co-sponsor of the COPA bill that allowed for Ballad Health to form by creating a way for Wellmont Health and Mountain States Health to merge; coincidentally, Senator Crowe worked as a contractor for Mountain States when he introduced the bill in 2015 and has been a contractor for Ballad Health since its formation.¹⁸³

Additionally, Senator Crowe has been the chairman of the Senate Health and Welfare Committee since 2007.¹⁸⁴ The Senate Health and Welfare Committee in Tennessee "is responsible for legislation dealing with all aspects of health and public welfare," and some of the agencies and departments that report to that same committee include the Department of Health as well as the Health Facilities Commission (who approves CON applications in the state of Tennessee).¹⁸⁵ In Tennessee, the Department of Health is the

¹⁸¹ Thomas Lambert, *Rent-Seeking and Public Choice in Digital Markets*, in GLOBAL ANTITRUST INSTITUTE'S REPORT ON THE DIGITAL ECONOMY 1, 36 (2020).

¹⁸² NATIONAL CONFERENCE OF STATE LEGISLATURES, *supra* note 6 (noting that 35 states have CON laws in place right, but it used to be almost every state in the US).

¹⁸³ See *Statements of Disclosure of Interests*, TENNESSEE ETHICS COMMISSION, <https://conflict.app.tn.gov/conflict/dashboard.htm> (last visited April 20, 2024) (view Statement of Disclosure of Interests that Rusty Crowe filed with the Tennessee Ethics Commission; Ballad Health is listed in the Sources of Income section from years 2018-2023 and Mountain States Health Alliance is listed in the same section in the years prior to 2018. To view source, click on link then once on login screen just click on "Search Statements" below the login area – 2016 and 2023 are on file with author).

¹⁸⁴ Tamas Mondovics, *Senator [sic] Rusty Crowe re-appointed chairman of Senate Health and Welfare Committee*, The Tomahawk (Jan. 21, 2023), https://www.thetomahawk.com/news/statewide/article_a0f6ea9c-967e-11ed-93eb-2763154f44c8.html [<https://perma.cc/WQ9P-5FQL>].

¹⁸⁵ *Id.*; *Certificate of Need*, HEALTH FACILITIES COMMISSION <https://www.tn.gov/hfc/certificate-of-need-information.html> [<https://perma.cc/2DBQ-PR6P>] (last visited Dec. 14, 2023).

department who a hospital has to apply for a COPA application through, the department that will issue a COPA to a hospital, and the department that will review and possibly modify a hospital's COPAs annually.¹⁸⁶

While much of Senator Crowe's business dealings or political motivations are not publicly known, creating the COPA legislation that allowed Ballad Health to form and then serving as the chair for the committee that oversees the department who has the power to review compliance with that COPA, as well as the power to grant or deny a CON for a potential competitor, all the while being a contractor for Ballad Health, appears to be a major conflict of interest.

Senator Crowe has stated that if Ballad Health's COPA gets to the point where it is not advantageous to consumers, then the Department of Health will get rid of the COPA.¹⁸⁷ Taken at face value, that sounds like a good way to keep Ballad Health in check; however, if the COPA agreement is terminated then the people of Northeast Tennessee and Southwest Virginia would be left with an unregulated monopoly that the states enabled.¹⁸⁸

A particularly concerning aspect of the power that Ballad Health yields is its ability to pull funding or reduce resources to a community who may be expressing discontent with the company. According to the *Tennessee Lookout*, one county commissioner in Carter County, Tennessee voiced concerns about speaking out against Ballad Health after it threatened to pull funding for ambulatory services after community members and county commissioners had previously expressed frustrations with Ballad Health.¹⁸⁹

Finally, outside of the legislature, the next question is why the terms and conditions that normally come along with receiving a COPA, have not offset the anticompetitive harms that accompany market consolidation of hospitals.¹⁹⁰ One explanation could be that the state agencies tasked with monitoring a hospital's compliance

¹⁸⁶ TENN. CODE ANN. § 68-11-1303 (West 2015).

¹⁸⁷ Sam Stockard, *Tenn. Attorney General urges look at Ballad Health amid community concerns over monopoly deal*, TENN. LOOKOUT (Nov. 26, 2023), <https://tennesseelookout.com/2023/11/06/tenn-attorney-general-urges-close-look-at-ballad-health-operations-amid-community-concerns-over-monopoly-deal/> [<https://perma.cc/BDB6-X7XB>].

¹⁸⁸ See generally Garmon, *supra* note 53.

¹⁸⁹ Adam Friedman, *East Tennessee official says Ballad Health issued threat to care after community protest*, TENN. LOOKOUT (October 11, 2023), <https://tennesseelookout.com/2023/10/11/east-tennessee-official-says-ballad-health-issued-threats-to-care-after-community-protest/> [<https://perma.cc/64RD-SQ6U>].

¹⁹⁰ See FTC POLICY PAPER, *supra* note 38, at 1-2.

have not been effective at requiring compliance. Some of the terms and conditions of Ballad Health's COPA include "a price increase cap, quality of care commitments, a prohibition of certain contractual provisions, and a commitment to return cost savings to the local community."¹⁹¹ However, the terms in the COPA have been amended three times in the five years that they have been in effect, one of those amendments allowed for Ballad Health to start opposing CON applications, as previously discussed in Part II of this paper. Ballad Health also appears to be falling short of meeting many terms and conditions that the COPA imposed on them, according to the *Tennessee Lookout*, documents released from the Tennessee Department of Health showed that Ballad Health "failed to meet about 80% of benchmarks designed to monitor and improve its quality of care — including rates of infection and death — in the most recent year for which data is available."¹⁹²

One of the terms of the COPA that Ballad Health was granted in 2018 was a charity care requirement, Ballad Health has failed to meet the charity care requirement for every year that data is available (2018, 2019, 2020, 2021, and 2022) and was subsequently granted a waiver of that same charity care requirement by the state of Tennessee.¹⁹³ The charity care requirement of Ballad Health's COPA provides that Ballad Health must provide a certain amount of free care to low income patients who are uninsured each year.¹⁹⁴ The reasoning provided for these waivers was that Tennessee and Virginia both provided more Medicaid reimbursement and Virginia expanded Medicaid to more people, meaning that there were less people in their service area in need of charity care than when the COPA terms were created.¹⁹⁵ However, it should be noted that Tennessee has not expanded Medicaid.¹⁹⁶

¹⁹¹ *Id.* at 11.

¹⁹² See Keleman, *supra* note 3.

¹⁹³ See *COPA Reports*, TN DEP'T OF HEALTH, <https://www.tn.gov/health/health-program-areas/health-planning/certificate-of-public-advantage/redir-copa/copa-reports.html> [<https://perma.cc/FTM2-N3WW>] (last visited Dec. 14, 2023) (view charity sections in the COPA Compliance Annual Reports and Department Reports sections).

¹⁹⁴ *Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health* 1, 29 (Sept. 18, 2017), https://www.tn.gov/content/dam/tn/health/documents/Ballad_Health_-_Terms_of_Certification_Governing_the_COPA_-_September_18_2017_-_approved_by_MSHA_Board.pdf [<https://perma.cc/HYZ2-V33H>]; see also Keleman, *supra* note 3 ("Charity care comes in two forms: free or discounted care for low-income patients, or the amount left over when Medicaid patients are treated but their entire cost is not covered.").

¹⁹⁵ Keleman, *supra* note 3.

¹⁹⁶ *Id.*

The justification for giving Ballad Health a COPA was that active state supervision of Ballad Health could offset the anticompetitive harms that would be associated with hospital consolidation.¹⁹⁷ Yet, the terms of this COPA are not being enforced. The terms of Ballad Health's COPA provide that they can be fined up to \$1,000,000 for noncompliance, but to date there does not seem to be any penalties imposed on Ballad for falling short of any compliance requirements.¹⁹⁸ Specifically, the terms Ballad Health's COPA provide that they can be fined up to \$1,000,000 for not complying with their charitable care requirements.¹⁹⁹

The suspect motivations of the political body involved in the creation and oversight of the Ballad Health COPA combined with the apparent lack of compliance and enforcement of the COPA terms should be cause for concern. The lack of compliance and enforcement should also lead us to question if the state of Tennessee is actually actively supervising Ballad Health, as they claim they are and as the state action doctrine requires. However, in November 2023, the Tennessee Attorney General, Johnathan Skrmetti, expressed that the state should listen to the concerns of the people who live in Northeast Tennessee and that if the COPA arrangement is making healthcare in the region worse, then everyone involved should work to make the situation better.²⁰⁰ It is too early to know whether Tennessee's Attorney General looking into Ballad Health's COPA will lead to greater compliance with the COPA, or any change in behavior on the part of Ballad Health or the Tennessee Department of Health, but publicly acknowledging the concerns of the people who the COPA affects feels like it could be a step in the right direction for the state of Tennessee.

V. SOLUTIONS

There is no simple solution here, but there are a few options that exist which could help cure some of the anticompetitive effects of CON and COPA laws. The first solution could come from state legislation. Some states have already started to repeal their COPA

¹⁹⁷ See *Certificate of Public Advantage (COPA)*, *supra* note 39.

¹⁹⁸ *Third Amended and Restated Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health 1*, Exhibit H – Page 2 (July 1, 2022), <https://www.tn.gov/content/dam/tn/health/documents/copa/2022-07-01-FINAL-EXECUTED-Third-Amended-and-Restated-Terms-of-Certification-Governing-the-COPA.pdf> [<https://perma.cc/N37N-879N>].

¹⁹⁹ *Id.*

²⁰⁰ Stockard, *supra* note 186.

laws and many states have limited the scope of or eliminated their CON laws.²⁰¹ However, in states like Tennessee, where the legislature appears to be incredibly self-interested regarding their CON and COPA laws, this solution may not be feasible politically, even if democratically popular.

It is important to note that the Supreme Court created this antitrust immunity, not Congress. Therefore, another solution could be to argue that courts should expand upon the active supervision prong of the antitrust state action doctrine. Expanding upon what active supervision means regarding the protection that COPAs receive under the state action doctrine could either force hospitals to stick to the terms of their COPAs or force the state who approved the COPA to take their enforcement role more seriously. Justice Kennedy's opinion in *North Carolina State Board of Dental Examiners* expanded the active supervision requirement by explaining how a supervisor should not be an "active market participant."²⁰² Although, fighting COPA laws through an "active market participant" lens would not make much sense because in COPA arrangements, the state does tend to be the supervisor. However, there might be an argument that this supervision is effectively illusory if the COPA laws are constantly being repealed and the terms are ineffectively enforced wherever they have been implemented thus far.

A Due Process challenge and the dormant Commerce Clause challenge do not seem like strong arguments against COPA and CON laws, but the active supervision prong of the antitrust state action doctrine might provide a significant challenge to COPA laws if it can be established that COPA laws are almost never effectively supervised and enforced by the states that enact them. Arguing that courts should expand the active supervision prong appears to be the strongest strategy when it comes to attacking COPA laws. Congress could also limit the scope of the state action doctrine through legislation, but expecting Congress to limit state action immunity could be subject to the same issues discussed in Part IV of this paper.

A major issue with challenging COPA laws is that if a hospital has already implemented a state enabled COPA, finding a remedy to undue the harm that the newly formed hospital can cause would be difficult. In *Phoebe Putney*, the merged hospital was not enabled by a COPA, but we saw the difficulties associated with obtaining a

²⁰¹ *Certificate of Need State Laws*, *supra* note 6.

²⁰² *N. Carolina State Bd. of Dental Examiners v. F.T.C.*, 574 U.S. 494, 515 (2015).

remedy just because of the restrictive nature of the state of Georgia's CON law.²⁰³ This is one of many reasons that a state with a CON law should seriously consider repealing or majorly limiting the scope of their CON law.

Relating to CON laws, the "active market participant" argument might be a strong attack, albeit a narrow one. In Tennessee, the Health Facilities Commission (HFS) reviews CON applications and ultimately decides whether to grant or deny them.²⁰⁴ The HFS has a CON board that consists of eleven members, at any given time at least five of those members are representatives of the healthcare industry, including one seat that represents hospitals and another that represents nursing homes.²⁰⁵ Under a *North Carolina State Board of Dental Examiners* analysis, there could be a legitimate claim that the state of Tennessee has delegated their CON granting authority to active market participants.²⁰⁶

The HFS board could be made up of only five active market participants of the eleven total board members. Although, according to Justice Kennedy, the active market participant standard will generally "depend on all the circumstances of a case."²⁰⁷ The HFS board in Tennessee also consists of at least two consumer representatives at any given time, so this means an inquiry into who those representatives are and whether they participate in the market could be incredibly relevant in an argument against a state action doctrine defense of Tennessee's CON law. Additionally, a circumstance in the case of Tennessee's CON law that could be relevant is the fact that in Ballad Health's COPA terms they were initially not allowed to oppose a CON application.²⁰⁸ This term by itself appears to indicate that current CON holders have a significant role in the ultimate determination about whether a CON is granted to an applicant.

²⁰³ See generally FTC Press Release, *supra* note 131.

²⁰⁴ *Certificate of Need Basics*, TENN. HEALTH FACILITIES COMM'N., <https://www.tn.gov/hfc/certificate-of-need-information/certificate-of-need-basics.html> [<https://perma.cc/S3L3-UZBJ>] (last visited Dec. 14, 2023).

²⁰⁵ *Id.*

²⁰⁶ *N. Carolina State Bd. of Dental Examiners v. F.T.C.*, 574 U.S. 494, 515 (2015).

²⁰⁷ *Id.*

²⁰⁸ *Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health* 1, 34 (Sept. 18, 2017), https://www.tn.gov/content/dam/tn/health/documents/Ballad_Health_-_Terms_of_Certification_Governing_the_COPA_-_September_18_2017_-_approved_by_MSHA_Board.pdf [<https://perma.cc/AG3C-V6BW>].

CONCLUSION

CON and COPA laws appear to contribute to many poor outcomes for consumers and the legal protections for them are robust. Any state who has CON laws should consider repealing or greatly limiting their scope. Any state with a COPA law should consider repealing it if they do not have an existing COPA enabled hospital or healthcare system. If they do have a COPA enabled hospital, then that state should take their role as supervisors seriously and do everything they can to ensure that the hospital complies with the terms. Otherwise, the state with the COPA enabled hospital puts the citizens in the region that the hospital serves at a serious risk of receiving a lower quality of care, increased costs, and reduced wages.