

# To Oversee or Not to Oversee? Lessons from the Repeal of North Carolina's Certificate of Public Advantage Law

by Erin C. Fuse Brown

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## **Issue Brief Summary**

In the fall of 2018, the Milbank Memorial Fund published a paper about Virginia and Tennessee's certificate of public advantage (COPA) law. Now, in a new issue brief, the same author writes about North Carolina's COPA, which was initiated to allow a health system to merge and create a monopoly. The law was enacted in 1993 and remained in effect until its repeal in 2015.

- The terms of the approved COPA in North Carolina were considerably different from the recently approved COPA for Ballad Health in Tennessee and Virginia, with fewer resources for public oversight and population health efforts.
- The COPA's subsequent repeal in North Carolina created a regulatory void in state oversight that allowed the merged hospital system to become an unregulated monopoly and then offer itself for sale to a national health system.
- In considering policies to address provider consolidation, state officials must guard against the risk that COPAs will be used as a long-term strategy to gain an unregulated monopoly that creates the very disadvantages the state's COPA law was designed to prevent.

## Introduction

States are looking for tools to confront health care consolidation because of concerns that consolidation causes significant price increases and reduces consumers' choice of providers and access to critical health care services. One tool used by states is a certificate of public advantage (COPA), a legal mechanism by which the state approves a health care merger and shields it from antitrust enforcement in exchange for state oversight and supervision of the merged entities' prices and conduct.<sup>1</sup> A COPA allows a health care entity to obtain an otherwise presumptively anticompetitive monopoly if the state finds that benefits of the merger under state oversight—such as the public advantage—outweigh the risks from loss of competition.

States generally have few ways to guard against the risks of health care consolidation, except for premerger antitrust review, which has not always been successful at identifying and stopping mergers that were not in the public interest. In response, states are exploring COPAs as one mechanism to exercise oversight over potentially harmful effects of consolidation (e.g., the merging parties' health care prices), while promoting beneficial health care integration and maintaining access to essential health care services. With a COPA, a state permits the formation of a health care monopoly in the context of ongoing state oversight and accountability, which is intended to replace the competition that has been lost. This issue brief demonstrates what can happen when a state repeals its COPA statute, leaving a health system with an acknowledged monopoly but without the oversight or accountability previously considered necessary to assure continued public benefit.

In September 2018, the Milbank Memorial Fund published a report, [Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage](#), that looked at how two states addressed a hospital system merger that spanned their state borders, how they negotiated the terms, and how they set up mechanisms for oversight. Now, the Fund looks at North Carolina's experience with a COPA. Similar to that of Tennessee and Virginia, the North Carolina COPA was initiated to allow a health system to merge and create a monopoly. The North Carolina COPA law was enacted in 1993 and remained in effect until its repeal in 2015. The repeal created a regulatory void in state oversight that allowed the merged hospital system to become an unregulated monopoly; that system is now being acquired by a national for-profit hospital chain.

This paper describes North Carolina's experience with its COPA law. As more states, including Tennessee and Virginia, consider and pursue COPAs to address health care consolidation, North Carolina's experience with a COPA provides critical lessons about one of the risks of COPAs and consequences of the repeal of a state's COPA law years later.

As noted in our earlier report, a merged hospital system may have strong incentives to evade COPA oversight and seek repeal. If a state relinquishes its COPA oversight authority, as North Carolina did, there are few tools remaining to prevent the provider—possessing a monopoly that was previously considered worthy of ongoing state oversight—from taking actions that may harm consumers and the community, such as converting from a nonprofit

to a for-profit, terminating participation with key payers, raising prices, or reducing access for patients to key services and facilities.<sup>2</sup> While each COPA is unique to the circumstances in each state, the lessons of the COPA repeal in North Carolina could help other states that have enacted COPAs or are considering embarking on one to address the negative effects of health care consolidation over the long term.

## North Carolina's COPA Law and the Mission Health Merger

North Carolina's COPA law was enacted in 1993 and amended in 1995 to allow hospital mergers to be shielded from federal antitrust enforcement using state action immunity. Mission Health was formed in 1995, merging Mission Hospital and St. Joseph's Hospital, the sole hospital competitors in the Asheville area. Mission Health was the only hospital merger to apply for and receive a COPA under North Carolina's law, and it operated under the COPA for 20 years until North Carolina repealed its COPA law in 2015.<sup>3</sup> In 2018, Mission Health announced that it would be acquired by for-profit hospital chain, HCA, Inc., which would not have been permitted under the COPA.

North Carolina's COPA law was similar to that of other states. Under the terms of its COPA law, the merging parties could apply to the state's Department of Health and Human Services (DHHS) for a COPA, and DHHS could issue the COPA if it found "clear and convincing evidence" that the benefits of the merger outweighed its disadvantages and if the state attorney general did not object.<sup>4</sup> The DHHS (which administers the state's certificate of need program) and the state attorney general's office shared responsibility for oversight of Mission Health's COPA.<sup>5</sup> The oversight was characterized in an Urban Institute case study by Randall Bovbjerg and Robert Berenson as "quasi-regulatory" and "informal," relying mostly on the evaluations and recommendations from expert consultants, interested parties, and negotiations between Mission Health and the supervising agency staff, without further hearings or rulemaking.<sup>6</sup> Funding for the state oversight was relatively modest, with a maximum of \$25,000 in annual fees payable by Mission Health.<sup>7</sup>

A full economic assessment of the Mission Health COPA was inconclusive, particularly on the critical issue of whether the COPA was effective at constraining Mission Health's commercial prices to levels comparable to more competitive markets. Competing economic analyses were commissioned by Mission Health<sup>8</sup> and its competitors<sup>9</sup> in 2011 that relied on different data and reached different conclusions.<sup>10</sup> There was some independent evidence that Mission Health's Medicare cost growth and quality were relatively favorable, which reflects utilization more than prices, because Medicare administratively sets prices.<sup>11</sup> The state agency also concluded that Mission Health had met its margin caps and cost growth caps throughout the duration of the COPA. In addition, Mission Health met its savings targets (about 5% of base-year revenues) for the first five years under the COPA, and further savings obligations were terminated in 2000. While initially a small merged entity, Mission Health continued to grow its market share to become the dominant health system in western North Carolina, with vertical acquisitions of physician groups and affiliations with several hospitals across more rural areas of the region.<sup>12</sup>

## State COPAs: Similar Goals but Different Terms and Experiences

North Carolina's 20-year experience with a COPA offers important lessons for states that might be considering or are embarking on their own COPA. However, there are also important differences between North Carolina's COPA experience and that of other states. A look at Tennessee and Virginia, states that addressed a hospital merger that crossed state lines, as described in the recent Fund report,<sup>13</sup> stands in contrast to North Carolina's COPA. In 2017, Tennessee and Virginia both approved COPAs under their respective laws to allow Wellmont Health System and Mountain States Health Alliance to merge to form Ballad Health, a combined entity that holds a near monopoly in southwest Virginia and northeast Tennessee. In contrast to the Mission Health COPA, which involved the merger of two midsized hospitals in one geographic area that was more urban, the Ballad Health COPA involved 19 facilities across 21 counties in two states in a largely rural area with challenges related to health care access, population health, employment, and facility closures. These differences suggest that the consequences of a COPA repeal could be even higher in Tennessee and Virginia than in the case of Mission Health, because the Ballad Health COPAs involve a larger system, spillover effects across state lines, and a more vulnerable rural population.

The terms of the Mission Health COPA also differed from the Ballad Health COPA. Rather than capping price increases as did Ballad Health's COPAs, North Carolina instituted a margin cap and a cost growth cap for Mission Health.<sup>14</sup> These caps limited Mission Health's operating margins and costs per case to the average levels at comparable hospitals in North Carolina. In addition, the Mission Health COPA capped physician employment and exclusive contracting initially at 20% and later raised this cap to 30%. Tennessee imposed a similar condition in Ballad Health's COPA, prohibiting it from employing more than 35% of physicians in any specialty<sup>15</sup> and from exclusively contracting with physicians, except for certain hospital-based specialties.<sup>16</sup> The Mission Health COPA did not contain the types or levels of commitments to invest in population health initiatives or maintain rural health services seen in the Ballad Health COPA, perhaps due to the more urban footprint of the Mission Health system when the COPA was approved.

North Carolina's COPA oversight was also conducted with fewer resources than those anticipated for Ballad Health, with the Mission Health COPA agreement allocating only \$25,000 annually in fees for supervision by an outside monitor and state officials.<sup>17</sup> By comparison, both Tennessee and Virginia provide that Ballad Health can be charged for each states' expenses for overseeing the COPA, budgeted in one state to cost more than \$600,000 per year.<sup>18</sup>

Finally, Tennessee and Virginia's COPA laws require the merging parties to submit and maintain an updated plan of separation that would be initiated in the event that the COPA is terminated.<sup>19</sup> A plan of separation is a detailed plan for how the parties would unwind their merger into distinct entities that could compete with each other in the event that state oversight under the COPA is terminated.<sup>20</sup> Maintaining a viable plan of separation may protect against the outcome seen in North Carolina, where the COPA statute did not

require a plan of separation. There, Mission Health retained its monopoly without state oversight after the COPA statute was rescinded, and there was no obligation or plan to separate Mission Health to restore competition.

## COPA Repeal and Consequences

In 2015, Mission Health successfully pushed for legislative repeal of North Carolina's COPA statute. Mission Health convinced state policymakers that continued oversight was unnecessary and that the COPA had "outlived its usefulness," citing its past compliance with the COPA requirements and the need for more flexibility moving forward.<sup>21</sup> State oversight of Mission Health's COPA terminated effective September 30, 2016. Following repeal, in 2017, Mission Health canceled its contract with the state's largest payer, Blue Cross Blue Shield of North Carolina, over a dispute over Mission Health's demand for rate increases.<sup>22</sup> Although the parties eventually reached an agreement, it is unclear whether Mission Health would have terminated its contract with a dominant payer had the COPA's requirements continued, because the COPA included prohibitions on refusing to contract with health plans who sought to pay commercially reasonable rates.

In 2018, Mission Health announced that it would be acquired by the national for-profit hospital company, HCA, Inc.<sup>23</sup> Mission Health's CEO explained that the deal would provide an infusion of needed capital and improve the health system's ability to take advantage of HCA's negotiating power with suppliers.<sup>24</sup> Although the deal, which would convert Mission Health from a nonprofit to a for-profit entity, is still subject to regulatory review, there are concerns among the community that HCA could raise prices and eliminate less profitable but essential services, particularly among Mission Health's affiliated network of rural hospitals.<sup>25</sup> As a for-profit, HCA would incur additional costs not faced by its nonprofit predecessor, including \$10 million in local property taxes, federal and state income taxes, and profit distributions for HCA's shareholders.<sup>26</sup> HCA claims it will be able to pay for these additional costs through savings from streamlining procurement and administrative costs. However, with the COPA in place, Mission Health's costs were relatively constrained, indicating that there may be little inefficiency to squeeze out of the system.

North Carolina's repeal of its COPA law means that, if approved, the new hospital entity will maintain its dominant market position in the area without ongoing state oversight over its rates, physician employment, maintenance of services, or health plan contracting practices.<sup>27</sup>

The repeal of North Carolina's COPA law paved the way for Mission Health's sale to HCA. Mission Health would have been a less desirable acquisition target, particularly by a for-profit buyer, had it continued to be subject to state supervision under the COPA over its costs, margins, health plan contracting, and physician employment. Moreover, the terms of the COPA would have prevented Mission Health's sale to a for-profit buyer, instead requiring Mission Health hospitals to remain nonprofit entities.<sup>28</sup>

If HCA's acquisition of Mission Health goes through as a for-profit entity, Mission Health will also be freed from the community benefit obligations it had as a nonprofit, as well as those it had under the COPA.<sup>29</sup> It will be responsible for paying state and local taxes, and the deal calls for the establishment of a nonprofit foundation from the sale proceeds to promote the health of the community.<sup>30</sup>

## Implications of North Carolina's COPA Experience for Other States

North Carolina's COPA experience can serve as a cautionary tale for states considering COPAs to avoid the potential adverse effects of health care consolidation. If a merging health system had the political clout to seek enactment of the COPA law to enable it to proceed with a merger without state or federal antitrust review and enforcement, it could later use the same political influence to seek repeal or termination of the state's COPA oversight. Twenty years after its initial COPA was approved, Mission Health's motivation to alter, weaken, or repeal the COPA to escape the constraints of state supervision over its unfettered market power outweighed the state's commitment to maintain ongoing oversight.

When the basic terms of the COPA are met, as happened in North Carolina, it might be hard for policymakers to see the need for continued supervision. Thus, despite the state's initial intentions of supplying rigorous oversight in perpetuity, there is a risk that the COPA entity will convince policymakers that supervision is unnecessary or burdensome and eliminate oversight of the monopoly enabled by its COPA law, potentially opening the door to the very harms the COPA was intended to prevent. Analysts have noted that the only circumstance where a COPA oversight should be terminated is where effective new price competition has emerged. There is no evidence that new competitors had entered the market to compete with Mission Health.<sup>31</sup>

This North Carolina case illustrates one risk of state grants of antitrust immunity: A provider can use a COPA to acquire a state-sanctioned monopoly and later seek to be freed of state oversight, leaving the monopoly provider and its corporate successors with the potential to raise prices and eliminate essential services to the detriment of the community, patients, and purchasers. In North Carolina's case, nothing changed to eliminate the need for oversight of Mission Health's monopoly, except the state's political commitment to it. Once the COPA law was repealed, technically the immunity from antitrust enforcement was also gone because the merged entity was no longer subject to state supervision. But as a practical matter, antitrust enforcers have limited ability to break up an existing monopoly that was legally acquired, even after state oversight is gone. States must guard against the risk that COPAs will be used as a long-term strategy to gain an unregulated monopoly that creates the very disadvantages the state's COPA law was designed to prevent.

## Notes

- <sup>1</sup> Fuse Brown EC. Hospital mergers and public accountability: Tennessee and Virginia employ a certificate of public advantage. Milbank Memorial Fund. September 2018. <https://www.milbank.org/publications/hospital-mergers-and-public-accountability-tennessee-and-virginia-employ-a-certificate-of-public-advantage/>. Accessed October 22, 2018.
- <sup>2</sup> Findlay S. Can a community hospital stick to its mission when it goes for-profit? *Kaiser Health News*. July 19, 2018. <https://www.npr.org/sections/health-shots/2018/07/19/629675648/can-a-community-hospital-stick-to-its-mission-when-it-goes-for-profit>. Accessed August 29, 2018.
- <sup>3</sup> Barrett M. NC dissolves anti-monopoly rules on Mission Health. *Asheville Citizen Times*. September 29, 2015. <http://avlne.ws/1FBCEci>. Accessed August 29, 2018.
- <sup>4</sup> N.C. Gen. Stat. § 131E-192.5 (2013) (repealed 2015).
- <sup>5</sup> Bovbjerg RR, Berenson RA. *Certificates of Public Advantage: Can They Address Provider Market Power?* Washington, DC: Urban Institute; February 2015. <https://www.urban.org/sites/default/files/publication/42226/2000111-Certificates-of-Public-Advantage.pdf>. Accessed September 6, 2018.
- <sup>6</sup> Id.
- <sup>7</sup> Bovbjerg and Berenson, supra note 5.
- <sup>8</sup> McCarthy T. *Economist's Report on the Mission Health Certificate of Public Advantage (COPA)*. Los Angeles: NERA Economic Consulting; 2011; McCarthy T. The Mission Health System COPA: Presentation to the House Select Committee on the Certificate of Need Process and Related Hospital Issues. Los Angeles, CA: NERA Economic Consulting; October 20, 2011. <http://www.ncleg.net/documentsites/committees/HSCCONPRHI/10-20-11/The%20Mission%20Health%20System%20COPA%20Presentation.pdf>. Accessed September 6, 2018.
- <sup>9</sup> Capps C. *Revisiting the Certificate of Public Advantage Agreement between the State of North Carolina and Mission Health System: A Review of the Analysis of Dr. Greg Vistnes, with Additional Recommendations for Lessening Opportunities for Regulatory Evasion by Mission Health System*. Washington, DC: Bates White Economic Consulting; 2011.
- <sup>10</sup> Bovbjerg and Berenson, supra note 5.
- <sup>11</sup> Bovbjerg and Berenson, supra note 5

12. Vistnes GS. *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement between the State of North Carolina and Mission Health*. Washington, DC: Charles River Associates; February 10, 2011. <http://www.mountainx.com/files/copareport.pdf>. Accessed September 6, 2018.
13. Fuse Brown, supra note 1.
14. Bovbjerg and Berenson, supra note 5.
15. State of Tennessee, Terms of Certification Governing the Certificate of Public Advantage issued to Ballad Health, approved September 18, 2017, § 5.05(e). [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://www.tn.gov/content/dam/tn/health/documents/Ballad_Health_-_Terms_of_Certification_Governing_the_COPA_-_September_18_2017_-_approved_by_MSHA_Board.pdf). Accessed August 27, 2018.
16. Fuse Brown, supra note 1.
17. Bovbjerg and Berenson, supra note 5.
18. Fuse Brown, supra note 1.
19. Tenn. Comp. R. & Regs. 1200-38-01-.02, -1200-38-01-.06; 12 Va. Admin. Code § 5-221-110.
20. Fuse Brown, supra note 1.
21. Barrett, supra note 3.
22. Barrett M. What you need to know about the Mission-Blue Cross NC dispute. *Asheville Citizen Times*. October 1, 2017. <https://www.citizen-times.com/story/news/local/2017/10/01/what-you-need-know-mission-blue-cross-nc-dispute/716227001/>. Accessed September 6, 2018.
23. Sanborn BJ. HCA Healthcare to acquire Mission Health for \$1.5 billion under terms to keep facilities, services intact. *Healthcare Finance*. August 31, 2018. <https://www.healthcarefinancenews.com/news/hca-healthcare-acquire-mission-health-15-billion-under-terms-keep-facilities-services-intact>. Accessed September 6, 2018.
24. Id. Barrett M. Mission head: HCA deal would prevent quick closure of existing facilities, services. *Asheville Citizen Times*. May 4, 2018. <https://www.citizen-times.com/story/news/local/2018/05/04/mission-health-ceo-hca-deal-would-prevent-quick-closureservices/577354002/>. Accessed September 6, 2018.



25. Editorial Board. Editorial: Who will profit from Mission's impending merger? *Asheville Citizen Times*. March 24, 2018. <https://www.citizen-times.com/story/opinion/2018/03/24/editorial-who-profit-missions-impending-merger/451201002/>. Accessed August 29, 2018.
26. Findlay, supra note 2.
27. Editorial Board, supra note 25.
28. Bovbjerg and Berenson, supra note 5.
29. Findlay, supra note 2.
30. Barrett, supra note 24.
31. Bovbjerg and Berenson, supra note 5.

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