

**SUBMISSION OF AMERIGROUP CORPORATION
TO THE TENNESSEE DEPARTMENT OF HEALTH
ON THE PROPOSED RULES AND REGULATIONS IMPLEMENTING
SECTION 68-11-1301 – 68-11-1309 OF THE CODE OF TENNESSEE**

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Table of Contents

Section	Page
I. Introduction	4
II. Background on Antitrust Immunity and COPAs	5
III. The “Active Supervision” Requirement Under the State Action Doctrine	10
A. Who must review and supervise the COPA?	11
B. Necessary elements of “active supervision”	11
C. Special considerations in the case of mergers	13
IV. The Substantive Criteria and Process for Determining Whether a COPA Should be Approved	14
A. The statutory criteria	14
B. Specific recommendations for a process for assessing a COPA Application	19
V. Active Supervision of Health Plan Contracts	23
A. Caps on health plan rates	23
B. Non-price contract terms	31
VI. Oversight of Quality	32
A. Metrics regarding the applicants’ own quality goals	32
B. Other quality metrics	34

Submission of Amerigroup Corporation

C. Reporting results	34
D. Tying results to payment	35
E. The Advisory Group	35
VII. Amerigroup’s Specific Comments to the Proposed Regulations	36
VIII. Conclusion	39
Attachment A – Recommendations for Changes to the Tennessee Proposed Regulations in Redline	

I. Introduction

Amerigroup Corporation¹ submits the following comments to the Tennessee Department of Health (the “Department”) on the proposed regulations implementing the recently amended Hospital Cooperation Act of 1993, Tenn. Code Ann. § 68-11-1301 — § 68-11-1309.² Amerigroup is a provider of health insurance for individuals and groups eligible for coverage under Medicare Advantage (HMO) and Medicaid in Tennessee, also known as TennCare. Amerigroup contracts with hospitals and other health care providers to furnish services to Amerigroup enrollees—which total more than 408,000 members statewide. Amerigroup relies on competition among hospitals and other health care providers to ensure that it obtains the highest quality, lowest cost care for its enrollees. In the absence of competition among health care providers, there would be nothing to prevent prices from rising or quality from declining, which would have an immediate and direct impact on residents of Tennessee and Amerigroup enrollees.

The Hospital Cooperation Act of 1993 was intended to enable health care providers that are granted a “Certificate of Public Advantage” or “COPA” to obtain an exemption for certain conduct from state and federal antitrust laws under the so-called “state action doctrine,” provided their conduct is subject to adequate supervision by state authorities. Earlier this year, the Tennessee legislature expanded the reach of the COPA statute to immunize certain mergers from antitrust scrutiny. Amerigroup strongly opposes any kind of antitrust exemption under a COPA statute because, as described in greater detail below, regardless of the obligations and restrictions placed on recipients of a COPA, regulations are never an effective substitute for competition. Nevertheless, given that the Tennessee legislature has enacted COPA legislation, it is important that the COPA statute be implemented in a way that assures, to the extent possible, that Tennessee residents will be protected against anti-competitive practices that might otherwise violate the antitrust laws.

The Department has made considerable progress toward achieving this goal in the Proposed Regulations—and Amerigroup commends the Department on the hard work that

¹ Amerigroup is a wholly owned subsidiary of Anthem, Inc.

² We understand that the Emergency Rules and Regulations that went into effect on July 14, 2015 are the proposed permanent regulations that will be considered at the Department of Health hearing scheduled for September 24, 2015.

Submission of Amerigroup Corporation

went into drafting them—but there is still more that can and should be done. Even further, after the regulations are finalized and implemented, it is crucial that the Department ensure that COPAs are critically evaluated within the strict confines of the statute and regulations and, if a COPA is granted, that the Department’s oversight meets the requirements of the state action doctrine. The level of oversight imposed by the COPA agreement itself—for example through rate caps or quality metrics—will be critical to ensure that the parties’ conduct ultimately qualifies for an antitrust exemption and that Tennessee residents are protected from any disadvantages or anticompetitive harm.

To address these concerns, this submission provides an overview of Amerigroup’s recommendation for how the Department should approach its obligations in assessing COPA applications and overseeing conduct subject to a COPA, and concludes with specific comments to the Proposed Regulations. Section II provides background on antitrust immunity under the state action doctrine, including references to the few states that have previously passed COPA laws and the more limited circumstances where this type of immunity has been granted. Section III describes the legal test under which grants of state action immunity have been challenged and reviewed by courts; these illustrate the rigorous test for “active supervision” that is required for antitrust immunity. Sections IV through VI provide recommendations regarding the state’s role in actively supervising a COPA, including the process for evaluating a COPA application (Section IV), obligations for applicants related to rate-setting in health plan contracts (Section V), and obligations for applicants related to quality measures (Section VI). The submission concludes in Section VII with Amerigroup’s specific comments to the Proposed Regulations.

II. Background on Antitrust Immunity and COPAs

The recently amended Hospital Cooperation Act of 1993, Tenn. Code Ann. § 68-11-1301 — § 68-11-1309 provides that health care providers who are parties to a Cooperative Agreement can apply for a COPA which, if approved and actively supervised by the Tennessee Department of Health, would allow providers to enter into mergers and other arrangements that are anticompetitive and would otherwise violate federal and state antitrust laws. This antitrust immunity would derive from the so-called “state action” doctrine.

Such antitrust immunity for health care mergers is exceedingly rare. While a number of states have enacted legislation similar to the Hospital Cooperation Act, very few health care mergers have been approved under such legislation, and the results of these arrangements so

Submission of Amerigroup Corporation

far have been mixed at best. We are aware of only four states—North Carolina³, South Carolina⁴, Montana⁵ and Texas⁶—that have approved hospital mergers under state action immunity legislation and only two of those (South Carolina and North Carolina) currently have a COPA governing a hospital merger in effect -- and one of those is now considering revoking the COPA legislation.⁷

³ N.C. Gen. Stat. § 131E-192.1 et seq. (2015) was enacted in 1993 to allow cooperative agreements among hospitals without being subject to damages, liability, or scrutiny under federal or state antitrust law. Only one hospital system, Mission Health, has been granted a COPA pursuant to the statute and since its existence it has been subject to vigorous debate and analysis by outside experts and economists regarding the nature of the restrictions it imposes. See Randall R. Bovbjerg and Robert A. Berenson, *Certificates of Public Advantage, Can They Address Provider Market Power*, RESEARCH REPORT FOR THE URBAN INSTITUTE, February 2015, at 8; 13-17 (discussing reports prepared by three economists to analyze the COPA and the overall contentious debate that occurred while reviewing the COPA's effectiveness).

⁴ South Carolina has approved one hospital merger in 1998 pursuant to a COPA agreement. See SC Code Ann. § 44-7-505 (2015). The Palmetto Health COPA agreement has been modified at least once and continues to regulate Palmetto Health to date. See Palmetto Health COPA Annual Report, available at http://www.palmettohealth.org/documents/Community%20Health%20Initiatives/PH%20Report%20of%20the%20Tithe%202014_web.pdf.

⁵ See Mont. Code Ann. § 50-4-601-622 (2015). There has only been one hospital merger in Montana pursuant to its COPA statute that led to the creation of Benefis Health System. Montana engaged in a robust analysis of whether to grant the COPA agreement and then imposed strict regulation on Benefis Health System for at ten years. See *In the matter of the application for a certificate of public advantage by the Columbus Hospital and Montana Deaconess Medical Center*, Great Falls Montana, Amended Findings of Fact, Conclusions of Law and Certificate of Public Advantage (1996), available at <https://dojmt.gov/wp-content/uploads/2011/05/decisionamended19961.pdf>.

⁶ See Tex. Health and Safety Code Ann. Sec. 265.037(d). Texas passed state action immunity legislation in 1997 to allow the merger of two hospital systems to form United Regional Health Care System. *Id.* United Regional does not appear to have been subject to any active supervision by the state or otherwise regulated, perhaps because the two hospitals entered into a lease arrangement with the county board (an actual state entity). New York also recently passed state action immunity legislation that would apply to hospital collaborations, over objections by the New York State Attorney General. See N.Y. Public Health Law Article 29-F, available at http://www.health.ny.gov/health_care/medicaid/redesign/copa/. The legislation was designed to apply to a specific collaboration between Nassau Health Care Corporation (NuHealth) and North Shore-LIJ though it is unclear whether the health systems actually entered into such a collaboration. See generally *NY Law Gives Antitrust Immunity to State Health Care System*, Law360, October 25, 2013, available at <http://www.law360.com/articles/483429/ny-law-gives-antitrust-immunity-to-state-health-care-system>.

⁷ Montana later introduced legislation to limit the length of any COPA agreement to ten years and thereby retroactively ended the Benefis Health System COPA agreement. See Montana Department of Justice Overview of Montana's Hospitals, <https://dojmt.gov/consumer/for-consumers/montana-hospitals/>, last visited July 14, 2015. North Carolina appears to be moving in a similar direction. In June 2015, the North Carolina Senate approved a Committee substitute of the budget bill that includes language intended to repeal the COPA law effective January

Submission of Amerigroup Corporation

When statutes are repealed or revised to effectively end a COPA, regulation over the merged hospital system ends. This can result in considerable harm, as reflected in the case of United Regional Health Center (“United Regional”), which was formed under the Texas COPA legislation in 1997.⁸ It appears that in the face of little continuing state oversight of United Regional, the hospital leveraged its dominant position to obtain terms in its contracts with health plans that prevented rival hospitals from competing. This conduct was the subject of a subsequent investigation by the U.S. Department of Justice Antitrust Division (DOJ), resulting in a consent decree that, among other things, required United Regional to discontinue such exclusionary conduct.⁹

There are several reasons why so few health care mergers have received state action immunity:

- State legislation purporting to grant antitrust immunity must clearly articulate an intent to displace competition. The courts, including the Supreme Court in a recent case involving hospitals in Georgia,¹⁰ have concluded that often such intent is lacking in the state legislation.

1, 2016. See NC House Bill 97 §12G.6.(b) (February 24, 2015), available at <http://www.ncga.state.nc.us/Applications/BillLookup/LoadBillDocument.aspx?SessionCode=2015&DocNum=5338&SeqNum=0> (proposing to repeal all existing certificates of public advantage on January 1, 2016). North Carolina’s proposed decision to repeal the COPA law is significant because it would eliminate all regulatory oversight over Mission Health, a dominant provider in its service area that has for the last 20 years been subject to state supervision.

⁸ *Supra* n. 4.

⁹ Shortly after the merger that formed United Regional, another hospital opened about six miles from United Regional. In 2011 DOJ charged United Regional with unlawfully using its contracts with health plans to exclude this new rival and maintain its monopoly for hospital services in violation of Section 2 of the Sherman Act, thereby causing consumers to pay higher prices for health care services. DOJ alleged that United Regional “systematically enter[ed] into exclusionary contracts with commercial health insurers. . . all [with] the same anticompetitive feature: a significant pricing penalty if an insurer contracts with competing facilities within the region that is no larger than Wichita County.” United Regional opted to enter into a settlement with DOJ that prohibited United Regional from entering into contracts that improperly inhibited commercial health insurers from contracting with United Regional’s competitors. See *U.S. et. al. v. United Regional Health Care System*, Complaint, No. 7:11-cv-00030, (Feb. 25, 2011), available at <http://www.justice.gov/file/514171/download>.

¹⁰ *FTC v. Phoebe Putney Health System, Inc.*, 133 S.Ct. 1003, 1015 (2013) (stating that “We have no doubt that Georgia’s hospital authorities differ materially from private corporations that offer hospital services. But nothing in the law or any other provision of Georgia law clearly articulates a state policy to allow authorities to exercise their general corporate powers, including their acquisition power, without regard to negative effects on competition. The state legislature’s objective of improving access to affordable health care does not logically

Submission of Amerigroup Corporation

- The state must provide active and ongoing supervision of the conduct in question. This requirement, which we discuss further below, is rigorously applied. Many health care providers that have considered seeking state action immunity have determined that they do not wish to subject themselves to the kind of regulatory oversight that would be needed to obtain the state action exemption.
- It is impossible to provide the type of regulatory oversight that can fully substitute for competition. Health care providers compete along a myriad of dimensions, including price, quality, access, the type of services offered, amenities, patient satisfaction and innovation. Regulation—no matter how extensive – can never fully address all of these issues. Measuring these qualities requires voluminous data and extensive expertise. And even with such resources, regulation often can be gamed, or can fail to address dynamic changes in the market. Thus, for example, a Massachusetts judge recently rejected a proposed settlement with the Massachusetts Attorney General that would have allowed Partners Healthcare to make several hospital acquisitions in the Boston area. The proposed consent decree ran 90 pages and included provisions imposing price restrictions, limitations on joint contracting with commercial payors, restrictions on the health systems’ future growth, physician caps, and a variety of other remedies intended to regulate the system. The settlement required the parties to pay over \$1 million dollars in investigative costs and fund a Compliance Trust Account to cover the costs of the Compliance Monitor, including depositing \$2 million in the trust upfront and maintaining a \$250,000 balance.¹¹ Judge Janet L. Sanders reached this unusual decision to reject a proposed consent that had been negotiated at length and agreed to by the Attorney General and Partners Healthcare because she concluded that she lacked the resources and expertise to oversee the merged entity, especially at a time when the health care field is undergoing enormous change.¹² She also doubted that

suggest that the State intended that hospital authorities pursue that end through mergers that create monopolies”).

¹¹ See *Commonwealth vs. Partners Healthcare System, Inc. & Others*, Joint Motion for Entry of Final Judgment by Consent, No. SUCV2014-02033-BLS2, ¶127-130, available at <http://www.mass.gov/ago/docs/press/2014/partners-settlement-062414.pdf>.

¹² See *Commonwealth vs. Partners Healthcare System, Inc. & Others*, Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgment by Consent, No. SUCV2014-02033-BLS2, 2-3, available at <http://www.mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf> (“this Court has serious concerns as to the enforceability of the Proposed Consent Judgment. Where a consent decree contemplates

Submission of Amerigroup Corporation

the oversight, even if it could be exercised, would be effective because the “Proposed Consent Judgment, which contains temporary price caps and other so-called ‘conduct-based’ remedies, does not reasonably or adequately address the harm that is almost certain to occur as a consequence of the anticompetitive conduct by Partners.”¹³

- Once a merger has been granted under a state action immunity, it is difficult to undo. Occasionally a state establishes antitrust immunity for arrangements that provide for joint rate-setting by competitors; if the state (or a court) decides that such immunity is no longer appropriate, it is relatively easy to order the entities to no longer coordinate on rates and resume competing. This is much more difficult where competitors have merged their operations.
- Health care providers do not need to merge to achieve efficiencies, quality improvements and expanded access. The Federal Trade Commission (FTC) has repeatedly noted this, including as recently as June 2015 in a letter expressing serious concerns about proposed New York legislation that would grant broad immunity from federal and state antitrust laws to health care collaborations. The letter stated that “antitrust is not a barrier to New York health care providers who seek to form procompetitive collaborative arrangements that are likely to reduce costs and benefit health care consumers through increased efficiency and improved coordination of care.”¹⁴

ongoing judicial involvement, as it does here, and there are substantial questions regarding enforcement, this alone is sufficient to reject it. The Proposed Consent Judgment envisions a ten-year period during which this Court could be called upon to resolve disagreements among the parties in at least ten different areas, including on complicated issues related to health care prices . . . This Court is ill-equipped to keep abreast of those changes [in the health care field] as they unfold over the next decade or to predict at this point how such changes might affect the meaning and application of the Proposed Consent Judgment going forward”).

¹³ See *id.* Under the proposed settlement, the Court potentially would have had to exercise oversight in a myriad of ways including: overseeing disagreements between the parties (the Proposed Consent Judgment expressly contemplated at least ten different areas that allowed for judicial recourse); overseeing the proposed remedies, which the Court felt was “not easy, since it will be called upon to answer questions that are either highly complex or that are governed with reference to vague and sometimes ambiguous criteria and standards”; and ultimately overseeing the Compliance Monitor (the Court expressed “great[] concern” over the monitor’s ability to complete the “complex task” asked of it). *Id.* at 7-19.

¹⁴ See Letter from Marina Lao, Director Office of Policy Planning, Francine Lafontaine, Director Bureau of Economics, Deborah Feinstein, Director Bureau of Competition, Federal Trade Commission and William H. Efron,

Submission of Amerigroup Corporation

While many of these considerations likely were taken into account as the Department drafted the Proposed Regulations, it is important to keep these considerations at the forefront of discussions as the Proposed Regulations are finalized and as part of the review of an actual COPA application. A rigorous and transparent approval process, as well as strict and ongoing active supervision, is essential to assure that an antitrust exemption will be granted only in situations where the applicants have established that displacing competition will benefit Tennessee residents. Moreover, unless this is done, even if a COPA is granted, the applicants will have no assurance that the grant of immunity will be sustained if subject to a legal challenge.

III. The “Active Supervision” Requirement Under the State Action Doctrine

The state action doctrine creates antitrust immunity for private parties if the conduct meets a two-prong test: first, the conduct must be pursuant to a clearly articulated policy of the state to displace competition; and second, there must be active and ongoing supervision by the state of the exempted conduct.¹⁵ This submission focuses only on the active supervision prong of the state action doctrine.

There is a substantial body of law related to the immunity, including two recent decisions by the U.S. Supreme Court in which the Court ruled in favor of the FTC in challenges to health care providers who claimed immunity under the state action doctrine. In both of those cases — *FTC v. North Carolina Board of Dental Examiners* and *FTC v. Phoebe Putney Health Sys., Inc.* — the court upheld the FTC’s position that state action immunity is disfavored and therefore available to private parties in only very narrow circumstances.¹⁶

Director Northeast Regional Office, Federal Trade Commission, to Senator Ranzenhofer and Assemblyman Abinanti, (June 5, 2015), at 5 available at https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-new-york-state-senator-tanzenhofer-new-york-state-assemblyman-abinanti-concerning/150605nypublichealthletter.pdf; see also Blog Post by Marina Lao, Director of the Office of Policy Planning, Francine Lafontaine, Director of the Bureau of Economics, and Debbie Feinstein, Director of the Bureau of Competition, Federal Trade Commission, *Not just an opinion: competition really is the key to healthy health care markets*, July 8, 2015, available at https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/not-just-opinion-competition-really-key-healthy-health?utm_source=govdelivery (“current evidence does not support special antitrust rules for health care collaborations, including those formed via Certificates of Public Advantage”).

¹⁵ *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

¹⁶ *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, 135 S.Ct. 1101, 1114-17 (2015); *FTC v. Phoebe Putney Health System, Inc.*, 133 S.Ct. 1003, 1010 (2013) (citing *FTC v. Ticor Title Ins. Co.*, 504 U.S.

A. Who must review and supervise the COPA?

Under T.C.A. § 68-11-1303(e) and § 68-11-1 (and proposed Regulations § 1200-38-01-.05 -- .06), the Department of Health must make the decision whether to approve an application for a COPA and is also responsible for continuously monitoring the COPA once granted. The Department must consult with the Tennessee Attorney General prior to issuing a COPA. The Proposed Regulations also require the Department to consult with an Advisory Group for assistance in developing measures to assess the parties subject to a COPA. Ultimately, however, it is the Department's responsibility to issue a COPA and continuously monitor it. The Department's role in overseeing any COPA is consistent with recent Supreme Court authority holding that active supervision oversight should be by a state entity and not any group that consists of a majority of active market participants.¹⁷

B. Necessary elements of "active supervision"

Where a state has established a policy to displace competition, the state action immunity from antitrust laws is "conferred out of respect for ongoing regulation by the State."¹⁸ Notably, the Supreme Court has made clear that active supervision by the state is not merely satisfied by the language or process set out in the statute that confers the immunity, but is determined based on the activities employed by the state entity as part of the oversight.¹⁹ And the courts have denied the immunity to parties where the state supervision, as implemented, was insufficient.²⁰

621, 636 ("But given the antitrust laws' values of free enterprise and economic competition, 'state-action immunity is disfavored'").

¹⁷ North Carolina State Board of Dental Examiners, 135 S.Ct. 1114-17.

¹⁸ *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 633 (1992) ("[W]hile a State may not confer antitrust immunity on private persons by fiat, it may displace competition with active state supervision if the displacement is both intended by the State and implemented in its specific details. Actual state involvement, not deference to private [anticompetitive] arrangements under the general auspices of state law, is the precondition for immunity from federal law.")

¹⁹ See *Patrick v. Burgett*, 486 U.S. 94, 100-101 (1988), "The active supervision requirement mandates that the State exercise ultimate control over the challenged anticompetitive conduct. . . . The mere presence of some state involvement or monitoring does not suffice. . . . The active supervision prong of the *Midcal* test requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those

Submission of Amerigroup Corporation

The FTC's decision in *In the Matter of Kentucky Household Goods Carriers Association, Inc.*, Docket No. 9309 (FTC 2005), which was upheld by the Sixth Circuit, is perhaps the best articulation of factors for determining the adequacy of state supervision.²¹ In that matter, the conduct at issue related to a private body composed of competitors that set rates for residential moving services within the state, and which was purportedly actively supervised by the state. The FTC challenged the collective rate-setting activity and found that state action immunity did not exist because there was inadequate state supervision, and the state had failed to assure, as it was obligated under the state statute, that the collective rates set by the movers were "just and reasonable." The Commission cited to various cases across several jurisdictions in setting out the following factors as important considerations in whether a state has actively supervised conduct where it has supplanted competition with a rate-regulating scheme:

- Has the state collected business data (including revenues and expenses);
- Has the state conducted economic studies;
- Has the state reviewed profit levels and developed standards or measures such as operating ratios;
- Has the state disapproved rates that fail to meet the state's standards;
- Has the state conducted hearings; and
- Has the state issued a written decision.²²

The FTC observed that: "While there are a range of ways a state may undertake [a review of rates], the normal starting point for such a program of regulatory oversight is for the state to establish some methodology for evaluating the appropriateness of proposed rates. Usually, such an evaluation involves some analysis of the relevant firms' costs and revenues,

that fail to accord with state policy. Absent such a program of supervision, there is no realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests."

²⁰ *Ticor Title*, 504 US at 636. ("For States which do choose to displace the free market with regulation, our insistence on real compliance with both parts of the *Midcal* test will serve to make clear that the State is responsible for the price fixing it has sanctioned and undertaken to control.")

²¹ *Ky. Household Goods Carriers Ass'n v. FTC*, 199 Fed. Appx. 410 (6th Cir. 2006).

²² *In the Matter of Kentucky Household Goods Carriers Association, Inc.*, 2005-1 Trade Cases ¶ 74,833 (June 21, 2005) (citing *Yeager's Fuel, Inc. v. Pennsylvania Power & Light Co.*, 22 F.3d 1260, 1270-72 (3rd Cir. 1994); *Lease Lights, Inc. v. Public Service Co. of Oklahoma*, 849 F.2d 1330, 1334 (10th Cir. 1988); *DFW Metro Line Services v. Southwestern Bell Tel. Corp.*, 988 F.2d 601, 606-07 (5th Cir. 1993); *TEC Cogeneration Inc. v. Florida Power & Light Co.*, 76 F.3d 1560 (11th Cir. 1996), *modified on reh'g*, 86 F.3d 1028, 1029 (11th Cir. 1998)).

profit margins, operating ratios, or other such measures.”²³ The Commission goes on to note that Kentucky had only one employee overseeing the rate-setting process, the state did not regularly collect data and information from the association that was seeking rate increases; and the regulatory procedures in the state for monitoring the rates did not involve procedural elements including public input, hearing and written decisions.

The above discussion applies to collective rate-setting involving a large number of firms. It is intended to illustrate how the courts have applied a high bar for the active supervision prong of the state action doctrine. But as noted in the next section, the nature and extent of the active supervision in the context of a COPA involving a merger, especially one eliminating virtually all competition, would need to be substantially more sophisticated and comprehensive. The oversight over rates would need to be more extensive, and as described in Section V below, reflect that rates involving health care providers and health plans are typically set through independent negotiations between the parties and therefore any type of rate regulation must be dynamic to reflect changes that might occur in a competitive market. Moreover, the supervision also would need to extend well beyond rate regulation, into the many other critical aspects of competition that would be lost if an otherwise anticompetitive merger were allowed to proceed.

C. Special considerations in the case of mergers

Active supervision requires the state to review the anticompetitive conduct both at the outset and for as long as the conduct remains anticompetitive.²⁴ The active supervision elements of state action immunity should be particularly stringent in the case of an anticompetitive merger, and especially one that is essentially a merger to monopoly of two or more private parties (rather than state actors) that leaves no or very few other competitors in the market. This is because the opportunity and incentive for private entities that are merging to act in their own self-interest and not in support of the state’s policy is greatest.

²³ *Id.* at 15.

²⁴ *A.D. Dedell Wholesale Co., Inc. v. Philip Morris Inc.*, 263 F.3d 239 (3d Cir. 2001) (citing courts’ findings that state action immunity did not apply to state sanctioned monopolies because the state entity did not actively supervise the monopoly); *New York ex rel. Spitzer v. Saint Francis Hosp.*, 94 F. Supp. 2d 399 (S.D. N.Y. 2000) (“continuing state involvement” is necessary for exemption to apply where challenged conduct is ongoing); *State of N.C. ex. Rel. Edmisten v. P.I.A. Asheville, Inc.*, 740 F.2d 274, 277-79 (4th Cir. 1984) (holding that the owner of a private psychiatric hospital could not claim state action immunity in an antitrust action brought against it even though the certificate of need which it acquired from the state might represent a clearly articulated state policy because there was no ongoing supervision of the facility under the program).

Submission of Amerigroup Corporation

Furthermore, in a merger context (unlike in other situations in which state action immunity is granted to private parties), the ability to restore competition to its pre-merger state if state action immunity is withdrawn by the state at some future date may not be possible.

Therefore, for state action immunity to apply to a COPA that facilitates a merger, state supervision of the initial grant of immunity must be particularly rigorous and the state's ongoing supervision of the merged entity must continue in perpetuity. Although granting state action immunity to private parties for a merger is extremely unusual and there is very little precedent to support such action, in other contexts Courts have said that if a state creates or sanctions the creation of a monopoly, then the state must regulate the resulting prices from that monopoly. And while the state can and should regulate and impose restrictions on a merged entity (as discussed further below in Sections V and VI), it should recognize that it may be difficult or impossible to simply revert to conditions that existed prior to the merger if the merged entity fails to abide by these restrictions or otherwise fails to meet the requirements that justify the immunity under the statute that authorizes the COPA.

Because state action immunity by private parties in a merger context is extremely unusual, it should not be granted unless the state is capable of and has the resources to actively supervise whether the initial grant of the immunity will meet the intended state policy, and whether the ongoing conduct of the parties comports with the state's policy. And arguably, it should not be granted unless the applicants for immunity can demonstrate how they might restore competition if the immunity is subsequently withdrawn by the state.

IV. The Substantive Criteria and Process for Determining Whether a COPA Should Be Granted

A. The statutory and proposed regulations criteria

The statute and regulations, T.C.A. § 68-11-1303(e)(2)-(3) and 1200-38-01-.03(2)-(3), provide that that the Department in making its determination, shall weigh a number of benefits and disadvantages when conducting a review of an application, including for example, enhancement of quality, gains in cost containment, and any potential reduction in competition, to name a few.

After consultation with and agreement from the Attorney General (who may consult with the FTC/DOJ), the Department shall issue a Certificate of Public Advantage if it determines the Applicants have demonstrated by clear and convincing evidence that the likely benefits resulting from the Cooperative Agreement outweigh any disadvantages attributable to a

reduction in competition that may result from the Cooperative Agreement. T.C.A. § 68-11-1303(e)(1); 1200-38-01-.05(1). In Virginia, by statute, the Commissioner can condition approval of an application for a Cooperative Agreement upon the parties' commitment to achieving the improvements in population health, access to health care services, quality, and cost efficiencies identified by the parties in their application. While the Tennessee statute and Proposed Regulations do not explicitly provide for this, in Section VII and Attachment A, we recommended that the Regulations explicitly recognize that the Department has the ability to impose certain conditions on the Parties in order to approve a COPA application.

1) A framework for weighing the statutory criteria

The statute requires the Department to balance the proposed benefits and likely disadvantages of a proposed Cooperative Agreement. While this requires a difficult comparison, it is similar to the type of assessment that the antitrust agencies and the courts are frequently called on to make when they weigh the potential adverse impact on competition from a merger against the potential "efficiencies" that the parties claim will result. This experience, as reflected in the 2010 *Horizontal Merger Guidelines* issued by the DOJ and FTC (the "HMG"), provides a very helpful analytical framework for how the Department and Attorney General should undertake their review.²⁵

Assessing the potential benefits. The HMG recognize that mergers often can generate significant efficiencies, thus resulting in lower prices, improved quality, enhanced service or new products.²⁶ But the antitrust agencies, and the courts, have recognized that efficiencies are difficult to verify and quantify, and that the information to do so is often uniquely in possession of the merging parties.²⁷ Also, the agencies note that "efficiencies projected

²⁵ 2010 Horizontal Merger Guidelines §10, available at <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

²⁶ *Id.*

²⁷ See e.g., *St. Alphonsus Med. Ct. – Nampa Inc. v. St. Luke’s Health System, Ltd.*, 778 F.3d 775, 790 (9th Cir. 2015); *F.T.C. v. H.J. Heinz Co.*, 246 F.3d 708, 720-22 (C.A.D.C. 2001); *FTC v. Arch Coal, Inc.*, 327F.Supp.2d 109 (D.D.C 2004) (not crediting certain efficiency claims because defendants were not able to “quantify with precision” potential savings and because other claimed efficiencies were undercut or reduced on the basis of evidence); *FTC v. OSF Healthcare System*, 852 F.Supp.2d 1069, 1088 (N.D. IL 2012) (quoting *US v. H&R Block*, 833 F.Supp.2d 36, 89 (D.D.C. 2011) (courts only consider efficiencies that are verifiable and merger-specific, and it is incumbent upon the court to “undertake a rigorous analysis of the kinds of efficiencies being urged by the parties in order to ensure that those efficiencies represent more than mere speculation and promises about post-merger behavior”); *FTC v. Promedica Health System Inc.*, No. 3:11 CV 47, 2011 WL 1219281, *56 (March 29, 2011) (“No court in a 13(b) proceeding, or otherwise, has found efficiencies sufficient to rescue an otherwise illegal merger”).

Submission of Amerigroup Corporation

reasonably and in good faith by the merging parties may not be realized.” Thus “[e]fficiency claims will not be considered if they are vague, speculative or otherwise cannot be verified reasonable means.”²⁸

The Agencies also only recognize what they call “merger-specific” efficiencies, which are efficiencies that are “likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects.” This concept is essentially the same as that described in T.C.A. § 68-11-1303(e)(3)(D) and 1200-38-01-.03(2)(b) as a possible adverse factor to be considered in assessing an application for a COPA, i.e. “the availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition.”²⁹

The HMG also only recognize efficiencies that do not arise from anticompetitive reductions in output and service. This guidance is important in light of the fact that several of the possible benefits mentioned in the COPA statute can work at cross-purposes to each other. For example, proposals that claim they will avoid the duplication of hospital resources, preserve hospital facilities in geographical proximity to traditionally served communities, and reduce cost of care should be scrutinized closely – especially if made in conjunction with claims that the proposal will not result in layoffs or reduce employment.

Assessing the potential disadvantages. The HMG also provide useful guidance for considering possible adverse effects of a Cooperative Agreement; all of the disadvantages identified in the statute relate to reductions in competition, which is at the heart of the merger assessment described in the HMG. As the HMG describe, the likelihood of adverse competitive effects increase to the extent the merging parties have a high market share in a concentrated, relevant market or markets. Such concerns increase to the extent the merging parties are each other’s close competitors. Also crucial is the timeliness, likelihood and sufficiency of entry of new competitors. Where entry is unlikely in a concentrated market, there will be few constraints to deter the merging parties from raising prices and causing other anticompetitive effects.

²⁸ *Id.*

²⁹ HMG §10.

Submission of Amerigroup Corporation

It is important to note that adverse competitive effects can take many forms. Hospitals and other health care providers compete along many dimensions, all of which can be adversely affected by a reduction in competition. These include the following:

- Prices and contracted rates. This concern is perhaps the most obvious one, and is reflected several times in the statute.
- Innovative payment approaches. Government and private payors are looking to innovative “value-based” payment approaches to replace the fee-for-service system that has been ineffective in controlling costs and assuring quality. The willingness of providers to enter into such innovative approaches, however, often depends on whether competing providers in their market are planning to do so.³⁰
- Quality. Hospitals and other health care providers compete with each other to provide better clinical care, as reflected in lower mortality and morbidity, complications, better outcomes, and a host of other measures as discussed in greater detail in Section VI below.
- Amenities and patient satisfaction. Food, cleanliness, responsiveness to patients and visitors, and similar attributes are all dimensions which can suffer where a monopolist hospital knows that its patients have few or no other alternatives.
- New technologies and services. As with any industry that seeks to attract customers, hospitals compete by providing the latest medical technology, which is particularly important in light of the fast pace of advances in the health field.

³⁰ See generally Richard M. Sheffler, *Accountable Care Organizations: Integrated Care Meets Market Power*, JOURNAL OF HEALTH POLITICS, POLICY AND LAW, Vo. 40 No. 4 August 2015, available at <http://jhppl.dukejournals.org/content/early/2015/06/09/03616878-3149964.full.pdf+html> (finding that in California ACO growth can be attributed to two market characteristics: (1) “the degree of [market] penetration of HMOs is positively associated with ACO entry and the growth of covered lives. This suggests that ACOs might be a competitive response to HMOs” and (2) “the market power of hospitals is associated with lower ACO entry and growth”). See also Presentation by David Muhlestein, Senior Director of Research & Development Leavitt Partners, *Overview of the ACO Landscape at the Examining Health Care Competition Workshop* (February 24-25, 2015), presentation available at <https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition> (discussing how the growth in ACOs is partly attributable to providers reacting to competitors creating ACOs and similar innovative delivery systems).

Submission of Amerigroup Corporation

- Access and locations. Health care providers, when faced with competition, will open new sites, make them available for longer hours and offer for shorter wait times for appointments or emergency department visits.
- Competition to attract and retain employees. Hospitals compete with each other with respect to the wages, benefits and working environments they offer their employees. If all or most of the hospitals merge in a given market and then reduce wages below competitive levels, employees seeking alternative work situations in health care will need to leave the area thereby resulting in a loss of some of the most talented and skilled workers.
- Competition involving non-physician providers, allied health professionals and others who seek to contract with health care providers. If the only significant health care systems merge, entities that need to enter into contracts or otherwise form relationships with those systems will have no other place to turn.

The above is not intended to be a complete list, but these and other dimensions of competition, all need to be considered when assessing the potential disadvantages of a Cooperative Agreement. Moreover, these dimensions must be considered with respect to all of the products and services in which the Parties compete. For example, in large health care systems the array of affected services likely will include acute inpatient care, outpatient care, physician services, imaging, laboratory, home health care, behavioral health, durable medical equipment, rehabilitative care, physical, occupational and speech therapy, and skilled nursing care, as well as possibly others.

Balancing potential benefits and potential disadvantages. The HMG observes that in the experience of the DOJ and the FTC, “efficiencies are most likely to make a difference in a merger when the likely adverse competitive effects, absent the efficiencies, are not great. Efficiencies almost never justify a merger to monopoly or near monopoly.”³¹ The courts have expressed the same conclusion in the context of mergers to monopoly or mergers in highly concentrated markets and require “proof of ‘extraordinary efficiencies’” and “rigorous analysis”

³¹ HMG §10, at 30.

of any claimed efficiencies to ensure that those efficiencies “represent more than mere speculation and promises about post-merger behavior.”³²

As a practical matter, few parties will find it worthwhile to seek a COPA unless their proposed conduct likely raises very serious antitrust concerns and they therefore believe that, absent an antitrust exemption, it will be challenged. Accordingly, consistent with the HMG and the relevant case law, there is good reason to believe that – unless there is meaningful and extensive oversight and restrictions – the likely disadvantages of the merger will outweigh the potential benefits. The task of the Department, therefore, is to (1) first assess how much the likely disadvantages outweigh the proposed benefits, recognizing the likely disadvantages increase to the extent that competition is harmed across a variety of dimensions and that promises of proposed benefits need to be scrutinized very closely and critically; and then (2) consider whether and how restrictions can be placed and oversight exercised to address the competition concerns.

B. Specific recommendations for a process for assessing an Application for a COPA

In light of the above, we recommend at least the following steps be taken to assure appropriate consideration of an application for a COPA. Some of these are already included in the Proposed Regulations and we note that where applicable. To the extent these provisions are not currently included we have suggested them in Section VII and Attachment A.

- 1) The Applicants should put forth detailed evidence in support of their proposed Cooperative Agreement for evaluation by the Department.** As the Proposed Regulations indicate, the Applicants should be required to supply certain information as part their application for a COPA. The Proposed Regulations outline a number of important categories of information that should be included in the application. Below we highlight those categories that we think are essential and those that we suggest expanding on in the regulations. Please refer to our comments in Section VII and Attachment A for more specific recommendations.

³² *St. Alphonsus Med. Ct. – Nampa Inc. v. St. Luke’s Health System, Ltd.*, 778 F.3d 775, 790 (9th Cir. 2015) (quoting *F.T.C. v. H.J. Heinz Co.*, 246 F.3d 708, 720-22 (C.A.D.C. 2001) and the 2010 Merger Guidelines §10. See also *supra* note 26.

Submission of Amerigroup Corporation

- A detailed description of each of the benefits that the applicants propose they will achieve through the Cooperative Agreement (*currently not required in the Proposed Regulations*);
- For each such benefit:
 - a description specifically describing how the applicants intend to achieve the benefit;
 - a description of what the applicants have done in the past with respect to achieving or attempting to achieve the benefits independently or through other types of collaborations;
 - an explanation of why the benefit can only be achieved through a Cooperative Agreement and not through other less anticompetitive arrangements;
 - a description of how the applicants propose that the Department monitor the extent to which the applicants have been able to achieve the proposed benefit (*currently not required in the Proposed Regulations*);
- A description of the market and the competitive dynamics for health care services in the applicants' respective services areas (*note that we have proposed new language for this section in Attachment A*), including at a minimum:
 - The zip codes that constitute the primary service area (PSA) and secondary service areas (SSA) for each of the applicant hospitals, and for each such PSA and SSA:
 - The identity of any other hospital located in the service area;
 - Estimates of the share of hospital services furnished by each of the applicants and any other hospitals;
 - A listing of the physicians employed by or under contract with the hospital, including their specialty and office location(s);
 - The identity of physicians in each service area that are not employed by or under contract with either applicant, including their specialty and office location(s);
 - The identity of any potential entrants in the applicants' service areas and the basis for any belief that such entry is likely in the near term;
 - A list of each applicant's top 10 commercial insurance payors by revenue;

Submission of Amerigroup Corporation

- A description of any potential adverse impact of the proposed Cooperative Agreement on quality, availability and price of health care services (*currently not required in the Proposed Regulations*);
 - A description of any commitments the applicant is willing to make to address any potential adverse impacts resulting from the Cooperative Agreement, and for each such commitment (*currently included at 1200-38-01-.02(2)(a)(13)(x)*):
 - the applicant's proposed benchmarks and metrics to measure achievement of the proposed commitments;
 - how the applicant proposes that data be obtained and analyzed to evaluate the extent to which the commitments have been met;
 - the consequences the applicant proposes will follow if its proposed commitment is not met;
 - A description of how the applicants would propose that they return to a pre-consolidation state in the event that the Cooperative Agreement is terminated (*currently included at 1200-38-01-.02(2)(a)(17)*); and
 - Data and documentation sufficient to support the above responses.
- 2) Further information.** Responses to the above specifications will give the Department and the Attorney General a useful set of baseline information to begin an evaluation of the application. But this likely will only be a starting point and the Department and/or the Attorney General should seek additional information to follow-up on specific issues raised by the Application—indeed the Proposed Regulations provide for this and for tolling of the review time until all requested information is submitted. § 1200-38-01-.02(3)(a).
- 3) Transparency.** To provide for meaningful public input, the application and all supporting submissions should be made available to the public, except for information that would be exempt from disclosure pursuant to state or federal law. This is currently provided for in § 1200-38-01-.02(3)(d) of the Proposed Regulations. In addition to the extent the application and supporting materials contain any protected health information, compliance with state and federal health privacy laws should be required. Such transparency should continue through the duration of the COPA, if approved. Thus, for example, the results of the State monitoring and supervision of the parties, including data on the

parties' performance in meeting any commitments, should be made public and easily accessible, for example, through the internet. We have proposed this addition in our redline comments to the Proposed Regulations in § 1200-30-01-.06.

- 4) Tennessee Attorney General input.** The Tennessee statute and regulations require the Department to consult with the Tennessee Attorney General before issuing a COPA. This is an important provision because the Tennessee Attorney General is better able to investigate any reduction in competition and the corresponding disadvantages; and potential benefits similar to an analysis under the HMG. The fact that the parties may file an application for a COPA does not eliminate the need for such an investigation; indeed it increases the need for two reasons. First, the Attorney General must be in a position to seek to block the merger, if warranted, in the event a COPA application is not approved.³³ Second, the Attorney General, through the course of an investigation, can obtain access to crucial evidence regarding the potential benefits and adverse effects of the proposed merger. The Attorney General should provide such information to the Department to assist in their deliberations.
- 5) Consult with the FTC or DOJ.** Similarly, the statute provides that the Tennessee Attorney General may consult with the FTC or the DOJ in the course of its review of the proposed Cooperative Agreement. T.C.A. § 68-11-1303(f). The Tennessee Attorney General should coordinate with the federal antitrust enforcers to the extent possible, and the federal enforcers should be encouraged to independently investigate the proposed merger and provide input to the Attorney General and the Department.
- 6) Coordination with other jurisdictions.** The Department should confer and consult with other affected jurisdictions in order to ensure that the COPA, if granted, is consistent with other affected jurisdictions. In addition, consulting with other states is critical to assure that there are no adverse, spillover effects in Tennessee from conduct in other states that might not be protected under the state action exemption granted by the Tennessee statute.

³³ We note that the Attorney General can also seek to block a Cooperative Agreement before it is approved or up until 30 days after the Cooperative Agreement is granted. T.C.A. § 68-11-1305.

- 7) **Remedy.** The applicants should be asked what they expect should happen if, after a COPA is granted, it is later determined that the Agreement should be revoked. They should explain whether and how they would unwind their arrangement. The Proposed Regulations provide for this by requiring the parties to outline, and update annually, a Plan of Separation, in the event COPA ends. § 1200-38-01-.02(2)(a)(18); § 1200-38-01-.06(3). In addition, the applicants should have to waive statute of limitations objections to future challenges to the merger under antitrust laws for private actions. We have proposed this in our comments to the draft regulations.

V. Active Supervision of Health Plan Contracts

To the extent that a COPA significantly reduces competition, it raises serious concerns that the merged entity will have the ability to insist on terms in its contracts with health plans that could have significant adverse effects on the cost, quality and accessibility of health care. These could affect not only privately-insured individuals including those who obtain coverage through exchanges, but also individuals who obtain health care coverage through Medicaid and Medicare managed care plans. For this reason, T.C.A. § 68-11-1303(e)(3)(A) explicitly includes as a potential disadvantage that must be assessed any likely adverse impact “on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers.” Similarly, T.C.A. § 68-11-1303(e)(3)(C) identifies another concern as the “likely adverse impact on patients in the quality, availability, and price of health care services.”

While there is no complete substitute for competition, the Department can seek to address these issues by actively supervising the contracts entered into by the merged entity. Section V.A below proposes an approach for overseeing contract rates to try to assure that the merged entity’s rates are reasonable and reflect, to the extent possible, what would result in a competitive market. Section V.B below proposes oversight regarding non-price terms and other contracting practices. These are designed to help ensure that the merged entity does not create barriers to entry or otherwise abuse its dominant market position.

A. Caps on health plan rates

1) Overview

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One key goal of active supervision by the Department should be to allow for outcomes, to the extent possible, that would otherwise be obtained under competitive conditions. In effect, supervision is intended to act as a substitute for the disciplining effects of competition, given that behavior of market participants under competitive conditions is thought to be efficiency improving. A competitive market generates many signals on prices, margins, quality, and costs, which create appropriate incentives for market participants. This is done automatically and replacing the signals with regulatory constraints and incentives is a significant challenge.

In addition, since a competitive market changes over time, a well-designed COPA (and the associated regulatory supervision) ought to be dynamic, i.e., the regulation should be designed in a flexible manner that can adapt to changes in the competitive environment, such as the introduction of innovative forms of production or organization that might impact market structure or new contracting methods. While these organizing principles are clear and straightforward, the design and implementation of effective oversight that achieves these objectives can be a daunting task, given the trade-offs that need to be evaluated with respect to designing rules that cannot be gamed by market participants but which, at the same time, do not impose an undue burden in terms of measurement and monitoring.

As noted above, there are only a few examples of hospital mergers being granted an exemption from antitrust scrutiny under the state action doctrine. In these examples, the oversight typically has taken the form of caps on variables such as the overall amount of profit margins the relevant providers may earn, and/or on the amount of costs they might incur from providing inpatient and outpatient services, in comparison to relevant competitors.³⁴ Sometimes the regulatory focus has been on an overall revenue cap or an average price cap for inpatient and outpatient services.³⁵ While these metrics are not overly burdensome for regulators to implement and periodically review, their broad nature can lead to distortions in the market and provide incentives and opportunities for the merging parties to game the

³⁴ See e.g., Original Mission Health COPA § 4.8 (margin cap) and 4.5 (cost cap) available at http://www.wncchoice.com/files/copa_docs/1995%20COPA.pdf; Mission Health Second Amended COPA § 4, available at http://www.wncchoice.com/files/copa_docs/2005%20COPA.pdf. These caps are often supplemented by other provisions regarding reporting requirements (See Montana COPA § 14, available at <https://dojmt.gov/wp-content/uploads/2011/05/decisionamended19961.pdf>; Original Mission Health COPA § 11); fair dealing with insurers (See Original Mission Health COPA § 7); and physician employment restrictions (See Montana COPA § 7; Original Mission Health COPA § 8).

³⁵ See e.g., Montana COPA § 1 (imposing a cost and revenue cap).

regulation through various means. For this reason, a mechanism that directly imposes restrictions on the rates charged by the merging entity is likely to be more effective.

Instead, we propose that the restriction imposed by the Department be in the form of a cap on the negotiated *case-mix adjusted revenue per discharge*, and that such a potential restriction be specifically provided for in the regulations.³⁶ Both payors and hospitals are accustomed to calculating this figure as they typically do so in the course of analyzing rate proposals. It has the advantage of taking into account case-mix and volume changes. It also allows plans and providers to decide on what basis they wish to structure their payment methodology (e.g. discounted charges, DRGs, fee schedules, or bundled pricing) and gives them the flexibility to change such approaches over time.

The rate cap should build in the applicants' commitments to cost-saving efficiencies and quality improvements. This is to ensure that to the extent the parties have urged that a COPA is needed for them to achieve certain cost-savings or quality improvements, such commitments have consequences and are reflected in caps on their contracted rates. The merged entity would be free to offer rates that are below the caps. Each year its revenues by payor would be calculated to determine if they exceeded the cap; if they do, future rates would be adjusted downward to offset the excess.

The proposal also allows for different rates across payors, which is also intended to reflect a competitive market. In a world without the merger agreement, the rates negotiated between each payor and the relevant providers reflect the current competitive dynamics in the marketplace. These rates often reflect the amount of patient volume that the provider stands to receive from each payor. Because the provision of health care services involves a high degree of fixed costs, high-volume payors are key to helping health care providers meet their fixed-cost commitments, thereby enabling providers to earn higher incremental margins on their patients. In addition to patient volume, the variation in negotiated rates across payors also reflects differences in other dimensions of competition, such as the payor's cost-saving infrastructure for processing claims, its speed in paying provider claims, rewards for quality or utilization control, or the frequency of claim denials. In effect, in a competitive market, those payors that are able to channel a large volume of patients to providers and who offer other valuable services to the provider are rewarded with lower rates.

³⁶ A comparable cap can be set for outpatient services.

This suggests that any proposed rate regulation that imposes a uniform rate cap across all insurers necessarily penalizes some insurers and benefits others in a manner that is not reflective of a competitive process. Because the uniform rate is typically calculated by averaging the rates paid by all insurers, the payors that had negotiated lower rates by way of leveraging high enrollments, superior service, prompt payment policies or other attractive attributes would face an increase in their rates, and thereby, an erosion of their competitive advantage. This might well lead to higher premiums for their enrollees if all or part of the rate increase is passed on by these payors. Therefore, a rate cap should acknowledge existing differences across payors in terms of their current competitive standing if it is to reasonably approximate a competitive outcome.

One alternative is to start with the current competitive situation, i.e., the current set of rates paid by insurers, and add in a rate cap escalator that captures added costs due to inflation. While this approach would capture the current competitive environment in the insurer market, it would fall short of the goal that the regulation needs to be dynamic. Specifically, it might lock in the current differentials in rates in the market, thereby limiting incentives for the merged entity to reward increased volume from a given payor with lower rates. This also might dampen incentives by insurers to compete for volume or to provide other valuable services to the provider that might yield lower rates.

To address this limitation, we propose a form of rate caps that would start with the current set of market conditions and factor in annual rate increases that are specific to each payor with a five percent share or more of the merged entity's commercial business, with the amount of increase related to the increases the payor is obtaining in contracts in other parts of the state.

2) Specific elements of the proposal

The main elements of the rate cap proposal presented here include the following:

- **Payor-specific initial rate caps.** In setting the rate caps in the initial year of the COPA, the Department should use as a starting point the case-mix adjusted revenue per discharge that the merging hospitals have under each of the parties' current contracts (i.e. prior to the COPA) with each payor; the analysis should be done separately for each type of product (Par, PPO, HMO, Exchange, Medicare and Medicaid). These reflect the current competitive situation in the market. If both parties have a current contract with a particular payor, the initial cap is based on the

average over both systems. Each payor that accounts for 5% or more of the commercial revenues of the merged system will receive its own rate cap that reflects its own current contracts. An “all other” payor rate cap would be established, which would be set at the weighted average rate for the remaining smaller payors that do not have a specific rate set for them.

- **Adjustment for proposed cost-savings.** The initial rate caps for the merged system should be adjusted to reflect its proposed cost-savings in its application for a COPA. As part of the application review process, the applicants should be required to produce a combined pro forma analysis of the revenues and costs of the combined facility over the first five years in comparison to a similar pro forma showing the consolidated financials of the applicants if they remained separate. Similar types of investment analyses are likely to be performed in the normal course of the parties’ consideration of the benefits of merging, so the creation of such pro formas should not be burdensome. Both pro forma analyses would include an assumed net operating margin to be set by the Department and chosen to reflect a statewide median for similar hospitals or some other reasonable benchmark. The difference in the two pro formas would reflect a financial measure of the commitments the applicants are making to generate efficiencies and cost-savings from higher quality, if allowed to merge under the COPA. The five-year plan would also include the financial impact of any capital improvements needed to achieve these better results and reflect accurately the timing of the expected improvements. This pro forma difference becomes a clear statement of the proposed net benefits of the combination and it can be used by the Department in its consideration of whether the advantages of the proposed Cooperative Agreement exceed the disadvantages from reduced competition. In short, if a COPA is granted, in part based on such proposed cost-savings, the merged entity should be held accountable for achieving them, and failing to do so should result in lower rate caps.
- **At-risk amounts subject to achieving quality goals.** Similarly, the applicants may assert in their COPA application that their merger will enable them to achieve certain quality improvements that they would be unable to accomplish absent a consolidation, and such assertions may weigh in the decision as to whether a COPA should be granted. If an Agreement is granted, the parties should be held accountable for delivering on their proposal. They also should be held accountable for meeting certain quality standards that other providers are able to achieve,

whether or not they reference these standards in their application. This approach to “value-based reimbursement” is being widely adopted by both the Medicare and Medicaid program, and commercial health plans.³⁷

As described in Section VI.C, we also are proposing that a defined percentage, e.g. 10% of total revenues, be at risk depending on how well the merged entity scores on a variety of quality metrics. The Department, with input from the Advisory Group described further in Section VI below, would set forth the relevant metrics, benchmarks and mechanism for computing any deductions for poor quality performance. This is already contemplated in the Proposed Regulations and we have proposed some additional refinements in our proposed redline in Attachment A. Note that the proposal here is that there is only downside risk with respect to these measures. That is because the parties are justifying their merger based on achieving such improvement and there should be consequences if they fail to live up to their commitments. If they fail to do so, or if quality otherwise declines, it is equivalent to an increase in the “quality-adjusted price” of their services, and thus should result in a commensurate reduction in the payment cap.

- **Rate cap increases after the initial year.** In reviewing contract rate increases after the initial year, the regulatory approach should be dynamic – i.e., it ought to reflect changes happening market-wide in other reasonably competitive markets. We propose establishing payor-specific rate increases, by product and service, based on the average rate increases experienced by the payor in other relevant markets in the state while dealing with comparable providers (e.g. other non-academic medical centers). This adjustment is not perfect – payors may experience differential rate increases in other markets for reasons that are not present in the market subject to the COPA. Nevertheless, it is an attempt to reflect some of the dynamic changes that are occurring in Tennessee markets. Thus if a health plan elsewhere in Tennessee is able over time to negotiate rates that are lower than its competitors, it should gain that benefit in the area covered by the COPA, and likewise a plan that

³⁷ CMS already uses a value-based payment methods for physicians and hospitals. See Section VII; see e.g., <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-11-27.html>; Health and Human Services recently announced that by the end of 2018 it has a goal of tying 85% of traditional fee-for-service Medicare payments to quality or value-based payments. See HHS *Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value*, January 26, 2015, available at <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>.

over time is paying higher rates relative to its competitors will similarly have that reflected in the rate of increase in the cap that applies to it.

- **Rate review must address other changes that could cause unjustified higher costs.** The rate cap review proposed here should address most concerns about the merged entity using its enhanced market power to increase health care costs. But there are ways that such cost increases could result even if there is a cap on case-mix adjusted revenue per discharge, if the merged entity insists on contract changes that have the effect of increasing the volume of covered services. This could occur, for example, by changing contract provisions that provide for utilization management, medical record review, audits regarding claim submissions, or other mechanisms that can have a significant impact on overall health care costs. Accordingly, the Department should review any contract changes that may have the effect of inappropriately increasing total health care expenditures, and the COPA should allow for a reduction in the rate caps to offset any such increases.
- **Accommodating new types of contracts.** If the merged hospital and a given payor believe that an alternative contracting approach (e.g., one that may involve risk-sharing for the merged hospital) might save money and that each side of the negotiation will benefit by the new contract, then the contract can be written with penalties or rewards set relative to the revenue cap. That is, the negotiating parties can develop innovative approaches to contracting for shared savings so long as the overall cost to the payor is lower. Further, the merged hospital will not want to sign such a contract unless it too is likely to enjoy a reward for those savings.
- **Allowances for new payors/products.** An “any willing payor” concept should apply to hospital systems that are merged through the Cooperative Agreement process. This is necessary because plans covering Medicaid and Medicare beneficiaries are likely to be required to contract with the merged entity to obtain regulatory approval. Commercial health plans also will require a contract for them to be commercially viable in the relevant market. The need for such a provision is particularly acute if the merged entity has its own health plan – without such protection, the merged entity could use its dominant position as a provider to reduce health plan competition. Under this approach, the merged entity would be required to contract with any payor that desires to contract with it as long as the terms are reasonable and consistent with the COPA framework.

In instances where the payor introduces a new product (rate structure) that did not exist at the time the COPA was entered into, the Department would need to first establish a reasonable statewide comparative benchmark and then utilize that as a basis for establishing rate caps. For any payors that are new to the market or that did not have an existing agreement with the merged entity at the time the COPA was established, the payor would freely negotiate a contract, but the regulated entity would be required to “cap” the maximum rates it could extract from this payor at the lesser of the highest rates it receives from an existing payor or the “all other” payor rate, which is the weighted average rate calculated for the remaining payors that do not have a specific rate set for them. Consideration should be given to the relative size of the new entrant; that is, where appropriate, the set of payors being considered as the benchmark would include those that are at least as large as the new entrant.

- **Third-party reviewer/auditor.** Given the large amount of confidential data required from a number of parties and the complexity of developing and monitoring the rate caps, this proposal will require the appointment of a third-party reviewer/auditor who will be responsible for obtaining the required information, processing it and helping the Department to resolve any disputes that might arise over rates. Also, the Department (with whatever expert assistance is needed—such as from the Advisory Group) should periodically review and update the methodology as appropriate to ensure that any changes in the competitive environment are accurately reflected. These reviews should be scheduled every three years, or sooner as needed.
- **Physician and other provider rates.** The above discussion relates to caps for hospital services (both inpatient and outpatient). The same concept should be applied to caps on the rates of the merged entity for other types of providers, such as physicians and ambulatory services, for which the merged entity will have market power as a result of the merger.
- **Independent hospital-based physicians.** Many hospitals contract on an exclusive basis with independent physician groups to provide certain hospital-based services, such as anesthesiology, radiology, pathology and emergency room services. Often payors, as part of their negotiations with hospitals, obtain assurance from the hospital that the hospital-based physicians will participate in the payors’ plan at

reasonable rates. Absent such contracts, the payors can normally threaten to steer patients to alternative hospitals who have hospital-based physicians who are willing to contract at reasonable rates. This alternative may no longer exist where hospitals have merged pursuant to a COPA. In such a situation, the hospital should be at risk for hospital-based physician rates that exceed a competitive benchmark.

- **Other considerations.** This proposal depends heavily on the regulation of payor-specific and product-specific rates and, possibly, separately by service line (inpatient vs. outpatient) as well as for physicians and perhaps other provider types. This requires a good deal of detailed proprietary data from various sources, detailed regulatory calculations, extensive monitoring, and a strong belief that the initial rates are well-set. Many of these calculations and data-gathering exercises will have to be conducted annually. In sum, the success of the COPA will hinge as much on a thoughtful design as it would on effective implementation, and the administrative burden imposed by the regulation should not be underestimated.

B. Non-price contract terms

In addition to rate caps, it is important the Department ensure that the merged system does not impose contract terms that enable it to create entry barriers or otherwise abuse its dominant position. The FTC and DOJ, in the context of their guidelines for Accountable Care Organizations, have identified several such contracting practices that can be anticompetitive when imposed by a dominant hospital system.³⁸ They include the following:

- Preventing or discouraging health plans from directing or incentivizing patients to choose certain providers through “anti-steering,” “anti-tiering,” “guaranteed inclusion,” “most-favored-nation,” or similar contractual clauses or provisions.
- Tying sales (either explicitly or implicitly through pricing policies) of some of the health system’s services to the health plan’s purchase of other services from the health system.

³⁸ Federal Trade Commission and Department of Justice Antitrust Division, “Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program,” 76 Fed. Reg. 67026 (Oct. 28, 2011), available at <http://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf>.

Submission of Amerigroup Corporation

- Restricting a health plan’s ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan.

VI. Oversight of Quality

In the health care sector, as in other sectors of the economy, market forces play a crucial role in driving quality and performance improvement. Providers compete with respect to their ability to deliver the highest quality, best value care to patients, and those who pay for the care. Where a COPA has been issued and competition has been displaced, it is critical that there be adequate supervision to ensure the delivery of safe, appropriate and high value health care. Such supervision must be ongoing and dynamic to reflect changes in health care delivery, as well as advances in how to measure quality.

Below, we discuss sources of quality metrics that can be incorporated in the oversight of a COPA based on (a) what the applicants have proposed they will accomplish through their merger; and (b) other measures that are currently widely used. We then address the need for transparency in reporting on quality, as well as how quality performance should affect the payment rates of the merged entity. The section concludes by recommending certain changes to provisions in the Proposed Regulations that relate to the Advisory Group so that the Advisory Group can also provide on-going input to the Department in selecting quality measures and benchmarks, communicating quality results, and developing the specific mechanisms for linking quality and payment.

A. Metrics regarding the applicants’ own quality goals

Among the potential advantages of a Cooperative Agreement listed in Section 68-11-1303(e)(2) and the corresponding regulation are “enhancement of the quality of hospital and hospital-related care provided to Tennessee citizen” and “demonstration of population health improvement of the region served according to criteria set forth in the agreement and approved by the department.” To the extent approval of a COPA will rest on these proposed advantages, the parties should be held accountable for their performance in these areas. As part of the COPA Application, therefore, the applicants should provide the following information, much of which is already required to be submitted under the Proposed Regulations:

Submission of Amerigroup Corporation

- The specific quality improvements that the parties believe should be considered as potential advantages;
- A proposal regarding how each such quality improvement will be measured, including metrics that establish;
 - The current level of quality;
 - The estimated level of quality in the absence of the Cooperative Agreement. This is important because the only quality improvements that deserve weight are those that are not likely to be achieved absent the merger; otherwise there is no justification for the merger;
 - The estimated level of quality the applicant believes would be achieved under the Cooperative Agreement.
- The basis for the metrics (e.g. whether the metrics are widely used or endorsed by authoritative entities, such as CMS, the National Quality Forum (NQF), NCQA, specialty societies, or others);
- Benchmarks for the metrics, and their basis; and
- A plan for how the requisite data for assessing quality will be obtained.

Vague promises of improved quality should be given no weight—if the parties cannot articulate specifically how they will improve quality, and how such improvements will be measured, there is no reason to believe that there will be any meaningful quality improvements and, moreover, no way to hold the merged entity accountable. Similarly, in reviewing submitted information about the proposed quality improvements, weight should be given commensurate with the level of their scope and scale, their detail and specificity, and the extent to which assumptions underlying the proposal are well-documented and supported.

Note that while the above discussion refers to proposed benefits that involve quality, the same approach should be followed with respect to other proposed benefits, such as improved access, better utilization of services, avoidance of duplication of hospital resources, and participation in the state Medicaid program. In short, for whatever dimensions the applicants propose there will be improvement as a result of the Cooperative Agreement, the applicants should be required to provide the type of information described here so that the extent of proposed improvement can be assessed in considering a proposed Cooperative Agreement, and adequately measured if an agreement is granted.

B. Other quality metrics

Quality assessment must go far beyond the specific quality-related proposed advantages that the parties identify in their Cooperative Agreement. It should seek to encompass all areas of quality that will be potentially affected by the reduction in competition between the parties; of course, this covers many dimensions and attributes. It is impossible for all these to be adequately assessed, so at best the Department can focus on what are likely to be most important to patients, employers, health plans and others who will be affected.

Assessing health care quality is a complex and difficult endeavor, and one which is still in its early phases. But there are a number of references to which the Department, in conjunction with the Advisory Group, can now turn because in recent years there has been growing interest on the part of Medicare, private payers, employers, consumers, academics and others in assessing health care quality, and using such assessments in determining payment amounts through so-called “value-based” payment approaches.³⁹ Metrics from these sources are useful because many of them have been closely vetted and are widely accepted, and are considered “state of the art.” In addition, the merging parties are likely to be familiar with many of these measures, and already may be collecting data and participating in payment arrangements that depend on their use. Commercial plans also are developing and employing a large number of quality performance measures.⁴⁰ Some of these overlap with the Medicare measures, but others complement them or address specific populations or conditions.

C. Reporting results

As with all the other aspects of the COPA process, there should be complete transparency with respect to the development of the quality measures, as well as with implementation of the measures and reporting the results. The Proposed Regulations currently contemplate this through the formation of the Advisory Group to develop the appropriate

³⁹ See e.g., *Pay-for-Performance Health Policy Brief*, HEALTH AFFAIRS, October 11, 2012, available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78.

⁴⁰ See Aparna Higgins, German Veselovskiy and Lauren McKown, *Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate*, HEALTH AFFAIRS, 32, no. 8 (2013): 1453-14621, available at <http://content.healthaffairs.org/content/32/8/1453.full.html> (finding in a survey of health plans in 2011- 2012 the use of 546 distinct performance measures). Some of the most notable commercial sources of quality metrics are: The Joint Commission; The National Quality Forum; the NQCA Healthcare Effectiveness Data and Information Set; and Leapfrog.

measures. For the same reasons, there should be full disclosure of the performance of the merged entity on the selected metrics.

D. Tying results to payment

Public disclosure can provide for some accountability, but it necessarily is very limited if the COPA eliminates competition, and patients, employers, and health plans have no alternative place to turn if they are dissatisfied with the level of quality furnished by the merged entity. For this reason, if a COPA is approved, it should be approved only subject to the merged entity putting at risk a substantial amount of payment dependent on the achievement of satisfactory quality scores. This approach is consistent with the current trend of both government and commercial payers, which is to put an increasing share of payment at risk based on performance. For example, the Medicare program has established the goal that 85% of fee-for-service payments should be tied to quality or value by the end of 2018.⁴¹ CMS estimates that in FY17, 8% of the fee-for-service amount paid to hospitals will be at risk; the comparable number for physicians is 9%.⁴²

We propose that 10% of the payments from commercial payers be tied to performance, either through the rate caps (as described in Section V above), or other mechanisms. This percentage is consistent with what Medicare and other payers are beginning to require. An even higher percentage is warranted because, in the absence of competition because of a COPA, such risk may be the only effective way (short of revoking the COPA) that the Department has to ensure that the merged entity is providing adequate quality and meeting its quality commitments.

E. Advisory Group

The quality proposal outlined above necessarily is complex, and will require substantial expertise to implement. To assist the Department in this task, we recommend that the role of

⁴¹ See HHS Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value, January 26, 2015, available at <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>.

⁴² See Presentation by Dr. Patrick Conway, M.D., MSC CMS Chief Medical Officer and Deputy Administrator for Innovation and Quality, Director Center for Medicare and Medicaid Innovation, Director Center for Clinical Standards and Quality, *CMS Innovation and Health System Transformation AHIP Hill Briefing: How Health Plans are Improving Delivery of Care*, October 8, 2014, at 12, available at www.ahip.org/.../DrConway-Slides/.

Submission of Amerigroup Corporation

the Advisory Group contemplated in § 1200-38-01-.03 of the Proposed Regulations be amended to ensure that the Advisory Group assists the Department in identifying evidence-based quality metrics in such areas as patient safety, health outcomes, patient satisfaction and access to care, in addition to more general measures to objectively track the public advantage of a Cooperative Agreement. Moreover, on an ongoing basis—not just at the time the COPA is granted—the Advisory Group should be charged with reviewing, and making recommendations regarding, possible modifications to the metrics. In addition, the Advisory Group should make recommendations concerning how best to report performance on the quality metrics, and how the quality metrics should be tied to reimbursement payments.

To achieve this goal, we recommend the Advisory Group be comprised of:

- A representative of the Department of Health who would serve as Chair of the panel.
- The Chief Medical/Quality Officer from the merged entity.
- One or two Chief Medical /Quality Officer/MDs from other state market areas with no affiliation to the provider system being monitored.
- One or two Medical/Quality Officers from health plans that have subscribers in the affected area.
- One or two unaffiliated individuals who are expert in the area of health quality measurement and performance.
- A consumer and/or employer representative from the affected area, to be determined by the Department of Health.

The physician representatives should be actively engaged as leaders in patient safety and quality activities at their respective institutions and/or systems. All panel members should be knowledgeable regarding performance measurement activities undertaken by NCQA, the NQF, the Joint Commission, the AHRQ and other similar organizations engaged in the development of quality standards and best practices. Staff of the Department of Health can support the Advisory Group in its work.

VII. Amerigroup's Specific Comments to the Proposed Regulations

As mentioned elsewhere in these comments, Amerigroup supports the Proposed Regulations. In advance of the public hearing to discuss these regulations, Amerigroup has included in this section, specific comments regarding elements of the Regulations that should be retained, as well as suggested revisions. Attachment A includes a redline of specific suggested changes.

- **It is important to retain the requirement that a letter of intent must be submitted at least 45 days prior to submission of the formal application.** Section 1200-38-01-.02(1) requires the parties to notify the Department at least 45 days prior to filing an application through the submission of a letter of intent. This puts the Department on notice about the impending application and affords sufficient time to prepare for the review of the application. It also allows for the timely initiation of an antitrust investigation of the merger by the Attorney General—who the Department is required to consult with – as well as the federal antitrust enforcers. This preliminary application is especially important because once an application is filed, certain statutory deadlines apply regarding the review, hearing schedule, recommendation and written decision. Although in many instances it may be public knowledge that parties intend to file an application for a COPA, the timing for such an application may be uncertain. In other cases it may be a closely held transaction and state authorities could be caught off-guard when a new application is filed.
- **Additional information should be required in the Application.** The Proposed Regulations as drafted require a robust set of information to be submitted in a COPA Application. There are three general categories of information we propose requiring in greater detail:
 - 1) more specific information on the market and competitive dynamics. This information is similar to what is requested by federal antitrust enforcers in evaluating a potential merger;
 - 2) a detailed description of each benefit that the applicants propose will be achieved through the Cooperative Agreement. Such input from the applicants can be used for, among other things, providing input into the Measures to be used in the Index, and possible commitments that should be imposed on the applicants if a COPA is approved; and
 - 3) a description of any commitments the applicants are willing to make to address any potential adverse impacts resulting from the Cooperative Agreement. While the Department may require commitments based on its own review, the Parties should be required upfront to propose what commitments they believe are appropriate.

- **Delete the waiver provision.** Section 1200-38-01-.02(3)(d) which allows the Department to waive certain Application requirements should be deleted because it could potentially be abused and prevent the creation of a full public record.
- **Specify that the Department may impose certain conditions in a COPA and, in particular, pricing caps.** The Proposed Regulations do not provide any guidance on what conditions the Department may impose on the parties if a COPA is granted. While the regulations do not need to spell out every possible condition that could be included in a COPA—and should afford the Department flexibility—they should make explicit that the Department can condition the approval of a COPA on an agreement to cap the negotiated case-mix adjusted revenue per discharge in addition to several other important conditions outlined in the redline and discussed elsewhere in this submission. As to potential pricing caps, the regulations should specify the following:
 - Separate caps for each health plan covering 5% or more of the commercial population in the affected area, with separate caps by product.
 - Adjustment of the caps to reflect proposed savings from the parties.
 - Provide for updating of the caps and other contract terms, including (e.g. terms governing pay for performance, utilization management, review processes) based on the actual experience of health plans in other parts of the state.
 - Clarify that the caps should cover hospital-based physicians that are employed by or have exclusive contracts with the Parties.
 - Provide for similar caps on outpatient, physician or other services where competition for such services may be adversely affected under the COPA.
- **Include a waiver of statute of limitations for antitrust challenges brought post-separation.** The Proposed Regulations require the parties to submit a “Plan of Separation” with their application and update the Plan annually as part of the Department’s active supervision. This critical requirement puts the onus on the parties to tackle the challenging task of explaining whether and how they would unwind their arrangement if the COPA ends.

In addition, as noted above, the regulations should require that the parties waive statute of limitations objections to future challenges to the merger under antitrust laws in the event that the COPA is ever revoked or withdrawn.

- **Expand the role of the Advisory Group to provide support to the Department in performing ongoing and active supervision over any approved COPA.** Antitrust immunity will not apply unless the review and supervision of a COPA meet specific requirements of “active supervision” as defined under the law.⁴³ For this reason, the regulations importantly provide a method for how the Department should actively supervise the parties through the use of an Index tracking measures. We include some specific recommendations to the composition of the Advisory Group and propose that the Advisory Group be retained beyond the initial COPA evaluation process to assist the Department in ensuring the conditions and monitoring are dynamic and appropriately adjust for changes in the healthcare system.
- **Clarify grounds for when the Department may terminate a COPA.** The Proposed Regulations do not provide any language indicating that the Department may enforce or terminate a COPA, beyond the statutory provision relating to the benefits no longer outweighing the disadvantages. The Department should have the ability to terminate a COPA for a number of reasons in addition to the benefits no longer outweighing the disadvantages. This approach is consistent with the approach Virginia has taken.
- **Detailed line item comments in Tennessee Proposed Regulations.** Our mark-up also includes a number of more minor suggested changes to clarify certain points and achieve consistency.

VIII. Conclusion

There is general consensus among economists that regulation will often be an imperfect proxy for competition, with distortions arising from shortcomings either in the structure of the regulation or in the way in which it is implemented. In addition, unless carefully designed, regulation can be too rigid to keep up with changes in the regulated entities or the broader

⁴³ See *California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.*, 445 U.S. 97, 106 (1980) (“The national policy in favor of competition cannot be thwarted by casting . . . a gauzy cloak of state involvement”); see Section III.B. for a more fulsome discussion of the active supervision requirement.

Submission of Amerigroup Corporation

competitive environment. This is true especially in healthcare, which is undergoing a period of extensive change in the wake of the passage of the Affordable Care Act.

As discussed, a COPA that imposes fairly broad restrictions on merging providers might be susceptible to gaming and fail to reflect the disciplining effects of competition. On the other hand, an Agreement that has specific, targeted stipulations might prove to be a vast, complex undertaking that might be too burdensome, in terms of data requirements and implementation efforts, to be worth the effort. But there is no other alternative if competition is to be displaced by meaningful regulatory oversight. The Tennessee Proposed Regulations go far in attempting to stipulate robust requirements for a COPA but certain changes to those regulations should be implemented to assure the final regulations ensure the most comprehensive regulatory oversight possible.