

Fordham Urban Law Journal

Volume 45

Number 3 *The Realities of Renting*

Article 7

2018

Collaboration Versus Competition in Health Care: The Role of State Action Antitrust Immunity in New York's Medicaid Reform Initiative

Zachary E. Sproull

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**COLLABORATION VERSUS COMPETITION IN
HEALTH CARE: THE ROLE OF STATE ACTION
ANTITRUST IMMUNITY IN NEW YORK’S
MEDICAID REFORM INITIATIVE**

*Zachary E. Sproull**

Introduction	876
I. New York’s DSRIP Program and COPA Antitrust Immunity.....	879
II. The Conflict Between Health Care Reform and Antitrust Enforcement: The Role of the State Action Immunity Doctrine	882
A. Efficiency and Quality Through Collaboration: The Basis for Health Care Reform	882
B. Antitrust Enforcement in Health Care and the Role of the State Action Doctrine	884
III. The Viability of New York’s COPA Immunity Efforts Under the State Action Doctrine.....	888
A. The Implications of New York’s COPA State Action Statute.....	889
B. The COPA Statute and the Clear Articulation Requirement	891
C. The COPA Monitoring Regulations and the Active Supervision Requirement	895
1. DSRIP-PPS Merger Scenario	900
2. DSRIP-PPS Clinical and Financial Integration Scenario.....	902
IV. Recommendations.....	904
Conclusion.....	907

* J.D., 2017, Fordham University School of Law; B.A., 2011, Colgate University. I would like to thank both Professor Mark R. Patterson for his guidance and encouragement, and the editorial board and staff of the *Fordham Urban Law Journal* for their time and hard work. I would also like to give special thanks to my family for their unconditional support throughout this process.

INTRODUCTION

Enacted on March 23, 2010, the Patient Protection and Affordable Care Act (“ACA”) promised sweeping reforms to address the dramatic rise in American health care costs that continued unchecked throughout the previous decade.¹ These rising costs stemmed from factors including increasing prices for drugs, medical equipment, and hospital services.² Spending for Medicaid, the joint federal and state program that covers uninsured, low-income Americans, rose 5.3% annually between 2001 and 2010.³ New York traditionally spends more money on Medicaid than any other State.⁴ For example, in 2005, New York⁵ spent roughly forty-five billion dollars—fifteen percent of the total spent nationally on Medicaid.⁶ To control social health care spending, the ACA promotes the formation of Accountable Care Organizations (“ACOs”), or groups of health care providers that collaborate by pooling resources, information, and services to generate efficiencies in care delivery while simultaneously lowering costs.⁷ New York followed suit in 2014, initiating its

1. See Mike Patton, *U.S. Health Care Costs Rise Faster than Inflation*, FORBES (June 29, 2015), <http://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-care-costs-rise-faster-than-inflation/#2dbe7dd06ad2> [https://perma.cc/RCA7-YJ26].

2. See *id.*

3. See THOMAS P. DiNAPOLI, N.Y. STATE COMPTROLLER, MEDICAID IN NEW YORK: THE CONTINUING CHALLENGE TO IMPROVE CARE AND CONTROL COSTS 6 (2015), https://www.osc.state.ny.us/reports/health/medicaid_2015.pdf [https://perma.cc/K9KP-66RB].

4. CITIZEN BUDGETS COMM’N, MEDICAID IN NEW YORK: WHY NEW YORK’S PROGRAM IS THE MOST EXPENSIVE IN THE NATION AND WHAT TO DO ABOUT IT 2–3 (2006), http://www.cbcny.org/sites/default/files/reportsummary_medicaid_04202006.pdf [https://perma.cc/5GDB-2VHJ].

5. Medicaid is an entitlement program that provides health care for low income individuals in the United States. See Andy Schneider & Victoria Wachino, *Chapter IV: Medicaid Administration*, in THE MEDICAID RESOURCE BOOK, 129, 131–33 (2003). The program is jointly operated by the federal and state governments. Though state participation in Medicaid is optional, every state has opted to participate. *Id.* Under Medicaid, states administer programs to provide health care on a day-to-day basis pursuant to a set of federal guidelines and under the supervision of the Centers for Medicare and Medicaid Services at the Department of Health and Human Services. *Id.* The federal government provides funds that match state expenditures associated with the costs of providing health services and administering the program. *Id.*

6. See CITIZEN BUDGETS COMM’N, *supra* note 4, at 3.

7. See Cory H. Howard, *The Federal Trade Commission and Federal Courts’ Scrutiny of Healthcare Mergers: Do Inflexible Standards and Increased Scrutiny Stifle the Legislative Intent of the Patient Protection and Affordable Care Act?*, 18 QUINNIPIAC HEALTH L.J. 67, 84 (2015).

Delivery System Reform Incentive Payment (“DSRIP”) Program, which, through an agreement with the U.S. Center for Medicaid and Medicare Services, reinvests approximately eight billion dollars to promote the creation of Performing Provider Systems.⁸ A Performing Provider System (“PPO”) is a form of ACO meant to improve the quality of care and reduce the costs attributable to Medicaid.⁹

However, increased collaboration among competing health care providers can create antitrust problems, as a PPS is a state-created cartel.¹⁰ Collaborations or combinations among rivals may reduce the number of competitors in the market and result in increased prices and reduced alternatives from which consumers may choose.¹¹ To protect its health care reform efforts from antitrust enforcement, the New York State Government has given each PPS the option to apply for a Certificate of Public Advantage (“COPA”). A COPA is a statutory mechanism that purports to provide certain collaborations with immunity from private or government actions under the federal antitrust laws by invoking the state action doctrine.¹² The Supreme Court established the state action doctrine, which protects states’ ability to regulate their markets and displace competition in a manner inconsistent with the antitrust laws.¹³ A private entity may raise state action immunity as a defense to an antitrust claim if (1) it engaged in anticompetitive conduct pursuant to a “clearly articulated and

8. See David Evans, *New York State Health Care—DSRIP, PPSs, COPAs, and Antitrust “Immunity,”* KELLEY DRYE CLIENT ADVISORIES: PUBLICATIONS & BLOGS (Nov. 16, 2015), http://www.kelleydrye.com/publications/client_advisories/1004 [<https://perma.cc/R2W6-ALY4>].

9. See *Frequently Asked Questions – PPS*, NEWYORK-PRESBYTERIAN HOSP., <http://www.nyp.org/pps/faq> [<https://perma.cc/CL4Q-BJZ5>]. The members of a PPS are intended to integrate their health care delivery operations, their budget, their resources, and their management to foster efficiencies. *Id.* These efficiencies are geared towards generating savings specifically for New York’s Medicaid program. *Id.*

10. See Robin E. Remis, *Healthcare and the Federal Antitrust Laws: The Likelihood of a Harmonious Coexistence*, 13 J. CONTEMP. HEALTH L. & POL’Y 113, 116 (1996).

11. See *id.*

12. See generally N.Y. COMP. CODES R. & REGS. tit. 10, § 83-1.1 (2018).

13. See *Parker v. Brown*, 317 U.S. 341, 351–52 (1943) (establishing the state action doctrine for antitrust immunity); see also *City of Columbia v. Omni Outdoor Advert., Inc.*, 499 U.S. 365, 370 (1991) (“Relying on principles of federalism and state sovereignty, we held that the Sherman Act did not apply to anticompetitive restraints imposed by the States ‘as an act of government.’”).

affirmatively expressed state policy to displace competition,”¹⁴ and (2) the conduct is actively supervised by the state.¹⁵

Although the New York COPA statute purports to provide broad antitrust immunity, it only vaguely forecasts the specific anticompetitive conduct and effects that the State will tolerate. As such, the COPA statute’s substance most likely falls short of providing a clearly articulated policy as would be required for the state action doctrine to apply.

Further, it is unclear whether the regime satisfies the requirement of active state supervision. The COPA framework requires the New York Department of Health to monitor the providers’ conduct and empowers the New York Attorney General to withdraw immunity and challenge conduct it deems outside the State’s intended scope of collaboration. However, those remedies may be insufficiently meaningful. First, the State’s broad terms of review do not provide clear guidance to participating collaborations, increasing the risk they engage in anticompetitive, prohibited conduct. Second, state agencies lack the intermediate power to control and correct the conduct, short of initiating antitrust enforcement litigation under federal and state law. Given that an antitrust challenge could threaten the legal viability of the entire PPS program and the State’s overarching aim of promoting greater collaboration among health care providers, there are substantial disincentives for the State to bring an antitrust challenge against its own program. The State, therefore, may be inclined to tolerate substantial abuse of the COPA immunity, such as practices that arguably raise prices in the intermediate timeframe, before targeting the abuse. Without a meaningful tool to provide active supervision, and a clearly articulated policy, the state action doctrine is unlikely to provide immunity to the PPS regime. Without that immunity, the PPSs are cartels vulnerable to legal challenge.

However, there are several strategies New York might adopt to increase its success in invoking state action immunity to protect health care reform. For example, the legislature might amend the COPA statute to provide clearer guidance on permitted practices. As it stands, the statute covers an overly broad range of possible anticompetitive conduct and creates blanket immunity.¹⁶ However, the State can improve its likelihood of satisfying the state action doctrine’s “clear articulation” requirement if the State specifies the

14. *FTC v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216, 226 (2013).

15. *FTC v. Ticor Title Ins.*, 504 U.S. 621, 633 (1992).

16. *See infra* Section III.B.

scope of permissible conduct and clarifies the circumstances in which immunity should apply.¹⁷ Additionally, the New York Attorney General can refine the standards it will apply in reviewing COPA applications and PPS performance and strengthen its power to intervene with tailored, remedial action. With a clearer set of guidelines and the power to control anticompetitive conduct short of wholesale withdrawal of antitrust immunity, New York's COPA program stands a stronger chance of also satisfying the state action doctrine's "active supervision" requirement.¹⁸

This Note examines the question of whether New York's attempt to provide certain health care collaborations with immunity from federal antitrust laws comports with recent Supreme Court decisions clarifying the state action doctrine.¹⁹ Part I describes New York's DSRIP Program and the accompanying COPA immunity framework. Part II examines the foundations of the ongoing policy debate over the role of antitrust law in health care reform and the principles of the state action doctrine as they apply in that context. Part III analyzes the viability of New York's COPA immunity under the state action doctrine. Part IV proposes a number of changes New York might consider to secure its immunity initiatives.

I. NEW YORK'S DSRIP PROGRAM AND COPA ANTITRUST IMMUNITY

On April 14, 2014, Governor Andrew M. Cuomo announced that New York had entered into a Medicaid Section 1115 Waiver Amendment agreement²⁰ with the U.S. Centers for Medicare and Medicaid Services.²¹ This agreement enables New York to reinvest eight billion dollars in federal savings produced by Medicaid

17. *See infra* Part IV.

18. *See infra* Part IV.

19. *See generally* N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101 (2015); *Phoebe Putney*, 568 U.S. 216.

20. *See* Social Security Act § 1115, 42 U.S.C. § 1315 (2012). An Expansion waiver granted under section 1115 permits individual states to implement the Affordable Care Act's Medicaid expansion in ways beyond the scope provided by federal law. *See* MaryBeth Musumeci & Rubin Rudowitz, *The ACA and Medicaid Expansion Waivers: Executive Summary*, KAISER FAMILY FOUND. (Nov. 20, 2015), <http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/> [https://perma.cc/B4DC-RGQU].

21. Press Release, Governor Andrew M. Cuomo, Governor Cuomo Announces Final Approval of \$8 Billion MRT Waiver to Protect and Transform New York's Health Care System (Apr. 14, 2014), <https://www.governor.ny.gov/news/governor-cuomo-announces-final-approval-8-billion-mrt-waiver-protect-and-transform-new-yorks> [https://perma.cc/85TW-Q36C].

Redesign Team (“MRT”)²² reforms. Under the MRT Agreement, reforms will be implemented through the DSRIP Program, which allows health care providers in a given area who meet certain criteria to form collaborative units known as Performing Provider Systems or PPSs.²³ Such collaborations are designed to improve care quality and lower costs through improvement and innovation.²⁴ For example, the participating health care providers in a qualifying DSRIP PPS would share resources and information on the provision of medical services with the aim of providing more efficient, less redundant care in a given community.²⁵ According to Governor Cuomo, increasing collaboration among providers will simultaneously improve care quality while reducing avoidable hospital utilization by up to twenty-five percent over a five-year period.²⁶ The goal of such collaboration is to reduce the costs ultimately attributable to Medicaid.²⁷

Increased federal funding distributed by the DSRIP Program serves as the incentive for providers to aggressively pursue collaborative efficiency.²⁸ To apply for PPS status, providers must come together, form plans for their collaboration, and apply as a group. Each prospective PPS must serve a population of at least five thousand Medicaid members. Medicaid compensation for care

22. *Id.* Governor Cuomo created the Medicaid Redesign Team “to address underlying health care cost and quality issues in New York’s Medicaid program,” and develop a long-term plan for health care reform. *See Redesigning the Medicaid Program: DSRIP and MRT Waiver Amendment Information – About the Medicaid Redesign Team*, N.Y. STATE DEP’T OF HEALTH, https://www.health.ny.gov/health_care/medicaid/redesign/ [https://perma.cc/V335-9DBD].

23. Section 1115 of the Social Security Act empowers states to experiment with adjustments to their Medicaid programs. *See* Samantha Artiga, Kaiser Comm’n on Medicaid & the Uninsured, *Five Key Questions and Answers About Section 1115 Demonstration Waivers*, KAISER FAMILY FOUND. (June 2011), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf> [https://perma.cc/X6C8-3DKJ]; *see also* 42 U.S.C. § 1315.

24. *New York State’s \$8 Billion Medicaid 1115 Waiver Amendment to Improve Access, Quality and Efficiency in the State’s Health Care Delivery System*, ROPES & GRAY ALERT (May 14, 2014) [hereinafter Ropes & Gray Alert], <https://www.ropesgray.com/newsroom/alerts/2014/May/New-York-States-8-Billion-Medicaid-1115-Waiver-Amendment-to-Improve-Access-Quality-and-Efficiency> [https://perma.cc/6RTT-9GFR].

25. *See DSRIP Overview*, N.Y. STATE DEP’T OF HEALTH, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm [https://perma.cc/69L6-SGAB].

26. *See* Ropes & Gray Alert, *supra* note 24.

27. *See DSRIP Overview*, *supra* note 25.

28. N.Y. STATE DEP’T OF HEALTH, MRT WAIVER AMENDMENT/DSRIP SPECIAL TERMS AND CONDITIONS 55–56 (2012), http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2015-10-01_special_terms_and_conditions.pdf [https://perma.cc/6XCJ-EEL7].

delivery will depend on meeting certain efficiency benchmarks set and monitored by the State.²⁹ Typically, Medicaid reimburses providers for services at rates determined by the State.³⁰ The MRT Agreement terms make the level of funding provided by the federal government contingent on New York meeting overall performance goals, and may be reduced if savings and performance benchmarks are not met.³¹

Health care providers may be deterred from creating PPSs because they fear such collaboration with competitors could expose them to antitrust enforcement. To combat this fear and encourage DSRIP collaboration, New York offers prospective collaborators the opportunity to apply for state action immunity under New York Public Health Law article 92-F (“the COPA statute”).³² Pursuant to the COPA statute, the New York Department of Health promulgated regulations to govern the COPA application process, as well as monitor the PPSs’ performance and competitive effects.³³ This performance review determines the levels of additional funding a PPS will receive from the State, and also serves to monitor and reevaluate a PPS’s COPA status. To apply for COPA immunity, the PPS must submit a copy of the relevant collaboration agreements and a description of their nature and scope, along with their contractual terms and other performance data.³⁴ The PPS must also provide documentation pertaining to the PPS’s financial position and the present market conditions for regular review.³⁵ The New York Department of Health, along with the New York Attorney General’s office review the COPA application according to these terms to decide whether the State’s policy to encourage innovation is best served by granting immunity.³⁶

29. See *DSRIP Overview*, *supra* note 25, at 42.

30. See Uwe Reinhardt, *How do Hospitals Get Paid? A Primer*, N.Y. TIMES: ECONOMIX (Jan. 23, 2009), <http://economix.blogs.nytimes.com/2009/01/23/how-do-hospitals-get-paid-a-primer/> [<https://perma.cc/GBM6-BWGH>].

31. N.Y. STATE DEP’T OF HEALTH, *supra* note 28, at 54–55.

32. See, e.g., N.Y. PUB. HEALTH LAW § 2999-aa (McKinney 2017).

33. Evans, *supra* note 9.

34. See *id.*

35. N.Y. COMP. CODES R. & REGS. tit. 10, § 83-1.10 (2018).

36. *Id.*

II. THE CONFLICT BETWEEN HEALTH CARE REFORM AND ANTITRUST ENFORCEMENT: THE ROLE OF THE STATE ACTION IMMUNITY DOCTRINE

Federal and state efforts to reform the health care landscape reflect an evolving policy debate about whether the law should treat health care as a social system or a market entity.³⁷ As costs continued to rise through the 1990s, policy makers focused on how health care was delivered and paid for, which prompted a shift towards the view that systematic collaboration should be emphasized over pure competition.³⁸ Consequently, antitrust laws have been a source of tension in health care reform because they are based on the principle that competition among providers ultimately benefits patients.³⁹ This section examines the policy debate about how the American health care system should function in the antitrust context and discusses the role of New York's state action immunity statute in this debate. Although they approach the issue from potentially conflicting perspectives, both antitrust laws and pro-collaboration reforms are aimed at exactly the same goal: lowering the cost and improving the quality of care given to patients. The state action doctrine comes into play when the two approaches collide. Section II.A provides background on some recent changes in the American health care system and discusses the associated policy positions. Section II.B describes both the enforcement of the antitrust laws in health care and the role of state action immunity in health care reform efforts.

A. Efficiency and Quality Through Collaboration: The Basis for Health Care Reform

In the current debate about the nature of health care, one side approaches the provision of medical services as a market that should be subject to the forces of competition, while the other treats it as a social system that functions best in a less competitive environment.⁴⁰ Supporters of the market paradigm argue that maintaining competition forces health care providers to continually seek

37. See James F. Blumenstein, *Antitrust Enforcement in the Health Care Industry: A Battleground of Competing Paradigms*, 156 U. PA. L. REV. 421, 421–22 (2008).

38. See Howard, *supra* note 7, at 88.

39. See *id.* at 71.

40. See, e.g., James F. Blumenstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1459 (1994).

efficiencies that permit them to offer better services at lower prices.⁴¹ Supporters of the social system paradigm argue that health care differs from other markets in the sense that patients—the key consumers—are not cost conscious actors.⁴² Patients, who often lack knowledge about medical science, technology, and the potential outcomes of different treatments, are not sufficiently informed to measure the value of different treatment options.⁴³ Further, patients typically do not bear the immediate costs of the services they receive.⁴⁴ The fact that either insurance companies or government programs bear these costs, combined with the lack of available cost comparison information, leaves patients without the motivation or ability to question a doctor’s recommended treatments, regardless of the price.⁴⁵ Providers will often take advantage of this dynamic, for instance, by charging multiple times for the same service or on an individually itemized basis, because higher fees result in increased recoupment.⁴⁶

These inefficiencies have largely defined the structures used to pay for health care. For example, inefficiency was prevalent in the “fee-for-service” and managed care payment models that pervaded through the 1980s and 1990s.⁴⁷ Under the fee-for-service model, providers billed on an individual basis for each test and procedure provided and every resource expended, the costs of which were generally passed on to insurance companies.⁴⁸ This motivated providers to extend hospitalizations and exercise less cost discretion in their treatment.⁴⁹ The managed care system was intended to correct these problems by requiring that insurance companies pay for specific services covered by the policy, rather than individual services and resources.⁵⁰ As a result, providers tailored their treatment to the patient’s insurance cost caps.⁵¹ Although managed care slowed the cost increases in the short term, the providers’ focus shifted to the

41. *See* Blumenstein, *supra* note 37, at 423.

42. *See id.* at 427.

43. *See* Blumenstein, *supra* note 40, at 1475.

44. *See* Elizabeth L. Rowe, *Accountable Care Organizations: How Antitrust Law Impacts the Evolving Landscape of Health Care*, 2012 U. ILL. L. REV. 1855, 1856 (2012).

45. *See id.* at 1881.

46. *See id.* at 1858.

47. *See id.* at 1858–59.

48. *See id.*

49. *See id.*

50. *See id.*

51. *See id.*

amount charged rather than the treatment process, which degraded the quality of care provided.⁵²

Advocates for treating the healthcare industry as a social system argue that competition among providers exacerbates the problem of low quality care because it prevents providers from cooperating efficiently.⁵³ As medical science and technology advanced and professional specialties improved, individual providers increasingly lacked the capacity to provide the full array of services that might be available to treat a given illness. A single patient's treatment might be in the hands of multiple providers from competing institutions who were not predisposed to share information and resources or to fully cooperate. The resulting redundancies and inefficiencies contributed to escalating health care costs.⁵⁴ In contrast, the ACA's ACO reforms promote the creation of efficiencies through sharing information and pooling resources and create financial incentives for pursuing such efficiencies.⁵⁵ The theory is that increased collaboration will foster seamless, integrated care that is focused on the quality and efficiency of the service, while removing incentives for redundancy.⁵⁶

B. Antitrust Enforcement in Health Care and the Role of the State Action Doctrine

Increased collaboration among providers can collide with antitrust laws, which are motivated by the basic assumption that vigorous competition in the market benefits consumers, and that health care is not an exception.⁵⁷ Antitrust enforcement in the health care system originated when the Supreme Court rejected the previously established "learned profession exception" to the antitrust laws in its 1975 decision in *Goldfarb v. Virginia State Bar*.⁵⁸ After *Goldfarb*, those practicing medicine and providing health care—previously considered exempt "learned professionals"—were subject to antitrust

52. *See id.*

53. *See* Blumenstein, *supra* note 40, at 1483.

54. *See* Rowe, *supra* note 44, at 1858.

55. ANN MARIE MARCIARILLE ET AL., BREAKING DOWN BARRIERS TO CREATING SAFETY-NET ACCOUNTABLE CARE ORGANIZATIONS: FEDERAL STATUTORY AND REGULATORY ISSUES 2 (2011), https://www.law.berkeley.edu/files/chefs/FINAL_assembled_SafetyNetACO.0817-1.pdf [<https://perma.cc/9YS3-745V>].

56. Ropes & Gray Alert, *supra* note 24.

57. Letter from FTC, to N.Y. Dep't of Health, Regarding Certificate of Public Advantage Applications Filed Pursuant to New York Public Health Law, 10 NYCRR, Subpart 83-1, at 3 (Apr. 22, 2015) [hereinafter FTC Letter].

58. *See* 421 U.S. 773, 787 (1975).

regulation.⁵⁹ Since then, the Federal Trade Commission (“FTC”) and the Department of Justice Antitrust Division (together “the Agencies”) have actively policed the health care system, challenging mergers and collaborative efforts that they deem anticompetitive.⁶⁰ The Agencies maintain that mergers, acquisitions, total integration, and comprehensive collaboration arrangements can reduce the number of competitors in a given market and increase the collaboration’s market power. This in turn can create monopolies or oligopolies, and lead to supra-competitive pricing,⁶¹ exclusive dealing, barriers to the entry of new health care providers, and other practices that antitrust laws prohibit.⁶² The threat of enforcement under the Sherman Act and the Clayton Act, which together regulate anticompetitive agreements among competitors, monopolization of markets, and mergers, can chill health care providers’ attempts to collaborate, especially where collaboration might be interpreted as potentially consolidating the market or increasing market power.⁶³

Given that New York’s DSRIP Program aims to extend the desired benefits of collaboration as aggressively as possible, and that antitrust laws might impede those efforts in geographic markets with already limited competition, it follows that New York would seek to provide collaborators with state action immunity. Protection from the threat of costly and often damaging antitrust litigation frees providers to vigorously pursue New York’s desired collaborative efficiencies.

The state action doctrine originated in *Parker v. Brown*,⁶⁴ in which the Supreme Court first recognized that states acting in their sovereign capacity were immune from the antitrust laws.⁶⁵ The Court held that neither the Sherman Act’s text nor history suggested that it

59. *See id.*

60. *See* Evans, *supra* note 9.

61. *See* Phillip Areeda & Donald F. Turner, *Predatory Pricing and Related Practices Under Section 2 of the Sherman Act*, 88 HARV. L. REV. 697, 702–03 (1975). Supra-competitive prices are prices that are higher than they would be if they were subject to competition. *Id.* Antitrust doctrine rests on the premise that competition will force rival firms to continually improve their products and sell them at prices that are at or near the cost of production. *Id.* This will be the case because firms that charge prices that are significantly above their costs will lose business to competitors who charge lower prices for comparable products. *Id.* When competition is constrained or eliminated, firms have the power to charge prices well above the cost of the product. *Id.*

62. *See* Rowe, *supra* note 44, at 1861.

63. *See generally* Sherman Antitrust Act, 15 U.S.C. §§ 1–7 (2012); Clayton Antitrust Act, 15 U.S.C. §§ 12–27 (2012); *see also* Rowe, *supra* note 44, at 1861.

64. 317 U.S. 341 (1943).

65. *See id.* at 350–53.

was intended to limit the states' authority to regulate markets within their own borders.⁶⁶ Although antitrust laws represent the national policy that competition is essential to the "preservation of the free market and a system of free enterprise,"⁶⁷ the principles of federalism dictate that states retain the right to regulate their own economies in ways that are inconsistent with the value of competition.⁶⁸ However, because of the value of competition to free markets, grants of "state-action immunity [are] disfavored, much as are repeals by implication."⁶⁹ The state action doctrine has continually evolved, and now provides an affirmative defense for actions taken by private parties so long as two requirements are met.⁷⁰ "First, the challenged restraint must be one clearly articulated and affirmatively expressed as state policy; second, the policy must be actively supervised by the State itself."⁷¹

The FTC has, unsurprisingly, voiced concerns about New York's COPA framework.⁷² These concerns are twofold. First, the FTC believes that such a broadly cast immunity is not necessary for DSRIP PPSs to achieve the desired efficiencies, because the collaboration the program incentivizes is procompetitive, and will not tend to lessen competition in the health care market.⁷³ Second, and more importantly, the FTC fears that this broad grant of immunity will protect collaboration beyond the scope of DSRIP, and empower otherwise competing actors to lessen competition that would otherwise benefit consumers.⁷⁴ The FTC argues that immunity is unwarranted because the DSRIP Program aims to streamline health care delivery, generate efficiencies, cut costs, and improve quality, all of which are typically considered procompetitive functions, and are not necessarily antitrust violations.⁷⁵ According to the FTC's understanding, the State does not have to grant immunity to certain health care providers, because the health care reform objectives can be met without shielding overtly anticompetitive conduct from

66. *See id.* at 350–51.

67. *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 632 (1992).

68. *See id.*; *see also* *FTC v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216, 223–27 (2013).

69. *Ticor*, 504 U.S. at 636.

70. *See id.* at 633.

71. *Id.* (citing *Cal. Liquor Dealers v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)).

72. *See* FTC Letter, *supra* note 57, at 1.

73. *See id.* at 1–3.

74. *See id.* at 3–5.

75. *See id.* at 2–4.

antitrust enforcement.⁷⁶ The antitrust laws permit firms to collaborate for efficiency as long as the procompetitive value of the efficiencies outweighs their anticompetitive effects.⁷⁷ Therefore, the antitrust laws would theoretically permit most of the collaborative conduct PPSs are inclined to pursue, regardless of immunity. By implication, the only possible remaining conduct gaining immunization by the DSRIP scheme would be activities that are especially anticompetitive and pose a substantial threat to the health care market.⁷⁸

The FTC illustrated its point in the context of three PPSs that had applied for COPA protection.⁷⁹ The three PPSs were all in rural or otherwise geographically isolated regions with limited competitors in the health care market.⁸⁰ Under such conditions, mergers or cooperative agreements that entail full clinical and financial integration would consolidate competitors in an already small market. As such, the PPSs would have a hard time passing muster under the antitrust laws absent immunity, because they are likely to unacceptably restrain competition.⁸¹

Although the Agencies favor competition as a means of protecting patients' interests, they are not deaf to national policy favoring

76. *See id.*

77. The Sherman Act has been interpreted to prohibit only contracts, combinations, or conspiracies that unreasonably restrain trade. *See generally* PHILLIP E. AREEDA & HERBERT HOVENKAMP, *ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION* 301 (Wolters Kluwer eds., 4th ed. 2017). Thus, courts tasked with deciding whether a challenged restraint constitutes an antitrust violation apply the rule of reason. *Id.* In applying the rule of reason, courts weigh the challenged restraint's anticompetitive and procompetitive effects, and determine whether alternative courses of action could produce the desired procompetitive effects without restraining competition. *Id.* A restraint is permissible if it, on balance, creates procompetitive efficiencies that cannot be generated in a less restrictive means, and the benefits of the procompetitive effects outweigh the anticompetitive effects. *Id.*

78. *See* FTC Letter, *supra* note 57, at 5.

79. *See id.* at 4.

80. The Federal Trade Commission's Comment Letter to the New York Department of Health expressed the Bureau of Competition Office of Policy Planning's views on the COPA framework generally, but also relayed specific concerns about three COPA applications that had been filed at that time. These included the Adirondack Health Institute DSRIP PPS, the Advocate Community Partners DSRIP PPS, and the Staten Island DSRIP PPS. *See id.* at 6 nn.2-4.

81. *See id.* at 5. For background, see generally FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS* (2000); FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *STATEMENT OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE* (1996).

collaboration and efficiency.⁸² The Agencies have issued a series of guidelines on how they approach and analyze various types of consolidation and integration in the health care sphere.⁸³ These guidelines describe what factors the agencies assess and how they weigh those factors in determining whether conduct should be challenged. They also establish “safety zones” that set parameters for collaborations that avoid anticompetitive issues.⁸⁴ The guidelines, however, do not account for New York’s desire for these efficiencies to benefit Medicaid’s system and patients in areas where competition and collaboration cannot coexist in their fullest forms. In such cases, New York would prefer to replace competition with collaboration.⁸⁵

Both New York’s Medicaid policy promoting collaboration and efficiency and the federal antitrust policy of protecting healthy competition aim to produce precisely the same end results: higher quality care at lower costs. However, they are pursuing the same goal from opposite ends of the ideological spectrum. The antitrust rationale suggests that competition among rivals in health care markets will force providers to do a better job at the lowest cost.⁸⁶ New York’s DSRIP rationale, which perceives that higher degrees of collaboration will improve overall quality and lower costs, seeks to replace antitrust regulation of the competitive landscape with its own regulation of collaborative performance.⁸⁷ The state action doctrine provides the State with a legitimate means to do so. Yet, as the FTC has pointed out,⁸⁸ most of the collaborative conduct in which DSRIP PPSs engage will not be anticompetitive in nature. Because the range of potentially concerning conduct is small, there may be regulatory measures the State might pursue to isolate and control specific anticompetitive conduct short of blanket immunity.⁸⁹

III. THE VIABILITY OF NEW YORK’S COPA IMMUNITY EFFORTS UNDER THE STATE ACTION DOCTRINE

New York’s attempt to shield certain PPSs with antitrust immunity reflects its intent to encourage the aggressive pursuit of efficiencies

82. See STATEMENT OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, *supra* note 81, at 3.

83. See *id.* at 1.

84. See *id.* at 5–6.

85. N.Y. PUB. HEALTH LAW § 2999-aa (McKinney 2017).

86. See Rowe, *supra* note 44, at 1870–71.

87. N.Y. PUB. HEALTH LAW § 2999-aa.

88. FTC Letter, *supra* note 57, at 1.

89. See *infra* Part IV.

for the benefit of Medicaid’s uninsured and low-income beneficiaries.⁹⁰ However, it is unlikely that this effort comports with the substantive requirements that must be met for the state action doctrine to protect the actions of private market participants. Specifically, New York’s COPA statute and its accompanying regulations neither adequately forecast nor supervise the specific anticompetitive conduct and effects the State seeks to condone. Part III discusses the basic aims and parameters of New York’s COPA program, as compared to the elements of the state action doctrine, and argues that the State’s efforts do not clearly satisfy either prong of the analysis.

A. The Implications of New York’s COPA State Action Statute

The COPA framework is intended to facilitate improvements to Medicaid, but does not specifically account for the competitive effects experienced by private payors. The DSRIP Program aims to benefit the Medicaid system, and by extension, its uninsured and low-income beneficiaries.⁹¹ The Medicaid system pays providers state-established rates for their services, and supplemental funding from the DSRIP Program depends on whether the PPS achieves its preset performance and efficiency benchmarks.⁹² However, the PPSs will still negotiate rates and fees privately with insurance companies.⁹³

By consolidating the market, a PPS may be able to increase its market power, which could set the stage for a range of anticompetitive behavior.⁹⁴ For example, a PPS in a market with few competitors could behave as a cartel.⁹⁵ If the collaborators negotiate with private payors using a single identity, or negotiate separately while sharing sensitive operational information, they could maximize their bargaining power and raise prices to supra-competitive levels.⁹⁶ Moreover, the PPS could use its market power to deter new providers from entering the market.⁹⁷ According to the Agencies,

90. See FTC Letter, *supra* note 57, at 1.

91. See Evans, *supra* note 9.

92. See Reinhardt, *supra* note 30; see also N.Y. STATE DEP’T OF HEALTH, *supra* note 28, at 55.

93. See Reinhardt, *supra* note 30.

94. See, e.g., Nicole Harrell Duke, Comment, *Hospital Mergers Versus Consumers: An Antitrust Analysis*, 30 U. BALT. L. REV. 75, 82 (2000).

95. See, e.g., *id.* at 82–83.

96. See Tara Adams Ragone, *Structuring Medicaid Accountable Care Organizations to Avoid Antitrust Challenges*, 42 SETON HALL L. REV. 1443, 1447 (2012).

97. See *id.*

collaborations among even small health care providers can pose serious antitrust risks because these providers typically operate in smaller geographic markets with limited numbers of competitors.⁹⁸ Given these risks, the FTC has indicated that New York's COPA law will not discourage it from following its policy of investigating and challenging hospital collaborations it deems anticompetitive.⁹⁹ If this is the case, it is unclear whether New York's purported protection from antitrust litigation satisfies the requirements of the state action doctrine.

As discussed above, antitrust immunity attaches automatically to actions taken by a state legislature or high court acting in its sovereign capacity.¹⁰⁰ When a private entity or a sub-state entity is acting as a normal market participant, however, this principle may not apply.¹⁰¹ In order for either a sub-state entity, such as a municipality or state agency, or a private enterprise acting pursuant to state authority to invoke state action immunity as an antitrust defense, two conditions must be met.¹⁰² First, "the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy.'"¹⁰³ Second, the challenged conduct must have been subject to active supervision by the state.¹⁰⁴ The DSRIP PPSs are formed and act pursuant to state statutory authority and are therefore private entities that must show both elements to qualify for state action immunity. Thus, for the COPA statute to provide an affirmative defense in the event of a challenge, the PPS will have to establish both that the statutory policy permitting anticompetitive activity is clearly articulated, and that the authorized anticompetitive conduct is being actively supervised by the state.¹⁰⁵

It is not certain that New York's COPA immunity will withstand judicial scrutiny under the Supreme Court's most recent decisions. On its face, the COPA statute clearly evinces the State's intent to provide blanket immunity from antitrust enforcement. However, one might argue that the COPA framework in reality sidelines antitrust laws wholesale, rather than replacing antitrust laws in a specific

98. See FTC Letter, *supra* note 57, at 1.

99. *Id.*

100. See *Parker v. Brown*, 317 U.S. 341, 350–52 (1943).

101. See *Cal. Retail Liquor Dealer's Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105–06 (1980).

102. See *id.* at 105.

103. *Id.*

104. *Id.*; see also *N.C. Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101, 1113 (2015) (quoting *Midcal*, 445 U.S. at 105).

105. See *Patrick v. Burget*, 486 U.S. 94, 100–01 (1988).

sphere based on the economic merits of competition. Given this focus, the COPA provisions reflect only that health care providers should be allowed to collaborate in contravention of the antitrust laws under certain circumstances, but is not clear as to what these circumstances are. Although the accompanying COPA regulations provide for comprehensive and regular supervision and give state agencies the power to demand correction of unanticipated anticompetitive conduct,¹⁰⁶ active supervision requires the State to actually exercise this power.¹⁰⁷ New York's vague police power and mixed political incentives raise questions about whether the supervisory power will actually be exercised and whether the State will tolerate abuses outside the immunity's scope.¹⁰⁸

B. The COPA Statute and the Clear Articulation Requirement

Since New York's COPA statute took effect on June 29, 2011,¹⁰⁹ the Supreme Court has revisited the state action doctrine's clear articulation requirement. In *FTC v. Phoebe Putney Health Systems, Inc.*,¹¹⁰ the Court reviewed a Georgia statute that granted corporate powers, including merger and acquisition abilities, to public hospital authorities.¹¹¹ The question considered was whether this power enabled the hospital authorities to engage in mergers that would tend to create monopolies otherwise prohibited by section 7¹¹² of the Clayton Act.¹¹³ The Court held that the state action doctrine did not protect the hospital merger because the general grant of corporate power did not clearly articulate and affirmatively express a policy to permit mergers that would substantially lessen competition.¹¹⁴ Although a statute does not need to make the state's desire to displace competition explicit, the protected conduct must be clearly expressed and the anticompetitive effect must be the foreseeable result of the authorized conduct.¹¹⁵

106. See N.Y. COMP. CODES R. & REGS. tit. 10, § 83-1.1 to -1.16 (2018).

107. See *Burget*, 486 U.S. at 100–01.

108. N.Y. PUB. HEALTH LAW § 2999-aa (McKinney 2017).

109. *Id.*

110. 568 U.S. 216 (2013).

111. See *id.* at 219–23.

112. Section 7 of the Clayton Act prohibits mergers and acquisitions that tend “substantially to lessen competition” or “create a monopoly.” Clayton Act § 7, 15 U.S.C. § 18 (2012).

113. See *Phoebe Putney*, 568 U.S. at 219–24. The FTC also pursued its theory under section 5 of the Federal Trade Commission Act. See 15 U.S.C. § 45.

114. See *Phoebe Putney*, 568 U.S. at 227–33.

115. See *id.* at 227.

The COPA statute provides: “it shall be the policy of the state to encourage, where appropriate, cooperative, collaborative and integrative arrangements including but not limited to, mergers and acquisitions among health care providers or among others who might otherwise be competitors, under the active supervision of the commissioner.”¹¹⁶ Further, in the event that these arrangements, their planning, or their negotiation might be anticompetitive under the federal or state antitrust laws, “the intent of the state is to supplant competition with such arrangements under the active supervision and related administrative actions of the commissioner as necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws.”¹¹⁷ As such, the COPA statute evinces the State’s desire to promote the development of certain collaborative efficiencies at the expense of protecting competition.

The statute’s language reflects the New York legislature’s intent to create blanket immunity that protects virtually all collaborative conduct that would violate the antitrust laws, so long as the relevant state agencies approve. Similarly, the statute explicitly states the legislature’s intent to “supplant” competition. In *Phoebe Putney*, the Court stated that a legislature does not need to explicitly define the specific ways in which it intends to supplant antitrust laws, as long as anticompetitive conduct is the clear and logically foreseeable result of the State’s directive.¹¹⁸ On the one hand, the COPA statute clearly anticipates suppression of competition. On the other hand, its references to types of conduct are vague and general. Further, any contemplation of the prospective anticompetitive effects is also vague. Based on the Court’s reasoning, it is most likely not enough for the State to indicate that it wants to create blanket immunity, without clearly articulating a policy that contravenes competition. The active policy here is to improve Medicaid, and the statute does not shed any light on what types of conduct the State will or will not tolerate, or what will be considered an abuse outside the immunity’s scope. Similarly, the statute does not specifically replace competition with an opposing policy in the areas that will be most harmed by anticompetitive conduct, such as private payor negotiations.¹¹⁹

116. N.Y. PUB. HEALTH LAW § 2999-aa (McKinney 2017).

117. *Id.*

118. *See Phoebe Putney*, 568 U.S. at 227–33.

119. *Compare* N.Y. PUB. HEALTH LAW § 2999-aa, *with* N.Y. PUB. AUTH. LAW § 3405 (McKinney 2017). New York passed a state law after the Supreme Court ruled in *Phoebe Putney*. The law’s text provides a more specific forecast of the

In contrast to the claim of state action immunity reviewed in *Phoebe Putney*, New York’s statute seems to insulate a wide range of conduct, with an equally broad range of potentially anticompetitive effects.¹²⁰ Rather than point to specific entities deemed worthy of immunity by the state legislature, the COPA statute delegates the power to state agencies to decide on a case-by-case basis which specific types of conduct will be blanketed with immunity.¹²¹ Although *Phoebe Putney* dealt with a specific set of powers that did not include the ability to take anticompetitive action, the Court’s holding suggests that the legislature’s articulation must be more specific than what New York’s COPA statute provides.¹²²

The lack of articulation can be seen by comparing the 2011 COPA statute with section 3405 of the New York Public Authorities Law (“Nassau Health statute”).¹²³ Passed by the New York legislature in 2013 after *Phoebe Putney* was decided, this statute grants corporate powers to the Nassau Health Care Corporation, a public hospital.¹²⁴ The statute authorizes the entity to “engage in arrangements, contracts, information sharing and other collaborative activities” that “may have the effect of displacing competition in the provision of hospital, physician, or other health care-related services.”¹²⁵

specific hospital’s prospective corporate conduct and its likely anticompetitive effects. See *infra* note 124.

120. See N.Y. PUB. HEALTH LAW § 2999-aa.

121. See *id.*

122. See *Phoebe Putney*, 568 U.S. at 227–33.

123. See N.Y. PUB. AUTH. LAW § 3405.

124. See *id.*

125. *Id.* In full, the relevant statutory text provides:

[T]he corporation is authorized to engage in arrangements, contracts, information sharing and other collaborative activities with public or private entities and individuals irrespective of the competitive consequences of these activities and notwithstanding that these activities may have the effect of displacing competition in the provision of hospital, physician, or other health care-related services. These collaborative activities may include without limitation: joint ventures; joint negotiations with physicians, hospitals and payors, whether such negotiations result in separate or combined agreements; leases; and/or agreements which involve delivery system network creation and operation, provided that, the corporation shall exercise state oversight by determining whether particular collaborations with public or private entities and individuals further the interests of the state as set forth in this subdivision and in subdivision three of section thirty-four hundred one of this title. In undertaking these collaborative activities, the corporation and the public or private entities and individuals with which it collaborates shall be immunized from liability under the federal and state antitrust laws.

Id.

Unlike the COPA statute, the Nassau Health statute most likely satisfies the clear articulation requirement, because it protects specific conduct that it recognizes may have anticompetitive effects.¹²⁶ The legislature authorized a specific hospital system to engage in a number of types of collaborative agreements, but does not limit them.¹²⁷ It also clarifies that the legislature foresees Nassau Health's collaborations being anticompetitive within the meaning of the federal and state antitrust laws.¹²⁸ Similarly, the statute lists specific examples of anticompetitive conduct that might result, which includes joint negotiations with physicians and private payors.¹²⁹ The statute also requires that Nassau Health consider whether potential collaborations would further the State's aims and file annual reports that focus on information pertaining to any joint negotiations with private payors.¹³⁰ In sum, the Nassau Health statute permits a specific entity to take potentially anticompetitive actions, indicates that those actions will displace competition, forecasts a range of anticompetitive effects, and reveals the State's reasons for tolerating these effects. As such, this statute provides a viable model for meeting the clear articulation requirement after *Phoebe Putney*.¹³¹

In contrast, the COPA framework seems to accept an undefined range of anticompetitive effects in the private market for the benefit of Medicaid. While not every statute must necessarily provide the precise level of detail contained in the Nassau Health statute, the COPA statute clearly falls short of the minimum threshold.¹³² It addresses neither the intended effects on private payment negotiations nor potential market entrants. Similarly, because reduced competition is part of the plan to improve Medicaid, rather than the specific goal of the program itself, the COPA statute does little to define the extent to which restraints of competition will be tolerated.¹³³ Because it lacks the specific contemplation as to the form and effects of the conduct, and rather provides blanket immunity for various types of conduct, the COPA statute does not

126. *See id.*

127. *See id.*

128. *See id.*

129. *See id.*

130. *See id.*

131. *See generally* FTC v. Phoebe Putney Health Sys., Inc., 568 U.S. 216 (2013).

132. *Compare* N.Y. PUB. AUTH. LAW § 3405 (McKinney 2017), *with* N.Y. PUB. HEALTH LAW § 2999-aa (McKinney 2017).

133. *See* N.Y. PUB. HEALTH LAW § 2999-aa.

appear to conform to the Supreme Court's guidance in *Phoebe Putney*, and is not as likely constitute clear articulation.¹³⁴

C. The COPA Monitoring Regulations and the Active Supervision Requirement

In addition to the clear articulation requirement, the state action doctrine will also require a PPS to establish that its behavior was actively supervised by the state.¹³⁵ Whether New York's regulatory program will satisfy this requirement is unclear. The Supreme Court has recognized that when private parties engage in anticompetitive conduct pursuant to state policy, there is a real risk that the private parties will "pursue their own self-interests under the guise of implementing state policies."¹³⁶ To account for this risk, the state action doctrine will only serve as a defense for a private party that can prove the state monitored the challenged restraint to ensure that it was consistent with state policy.¹³⁷

This Section will consider the disposition of New York's COPA statute and the accompanying regulations under the active supervision requirement. As with the clear articulation requirement, New York's COPA review and monitoring program appears to grant the State both comprehensive review power and the meaningful ability to correct any deviations from policy. However, the State is also required to exercise this power.¹³⁸ The State's statutory standard of review entails balancing the benefits and harms of the PPSs' anticompetitive conduct.¹³⁹ Although the regulations provide examples of relevant advantages and anticompetitive disadvantages,¹⁴⁰ they do not clearly address how heavily each of these factors will be weighed in the State's analysis. How these standards will be applied is even less clear given the State's mixed incentives in reviewing PPS behavior. Additionally, failure to adequately address potential antitrust concerns statutorily could create problems correcting anticompetitive effects if they are found to

134. *See Phoebe Putney*, 568 U.S. at 229.

135. *See Cal. Retail Liquor Dealer's Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

136. *Phoebe Putney*, 568 U.S. at 226 (citing *Hallie v. Eau Claire*, 471 U.S. 34, 46–47 (1985)).

137. *See N.C. State Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101, 1109 (2015).

138. *See id.* at 1116; *see also* N.Y. PUB. HEALTH LAW § 2999-aa.

139. *See* N.Y. PUB. HEALTH LAW § 2999-aa.

140. *See id.*

outweigh the benefits after the fact. This section will illustrate how these problems might play out in several hypothetical scenarios.

The state action doctrine requires active supervision to ensure that the state remains politically accountable for its policy.¹⁴¹ This accountability is essential because, when a private party engages in anticompetitive behavior with state permission, there is a real danger that the party will use the immunity as cover to pursue its own private interests.¹⁴² In *FTC v. Ticor Title Insurance Co.*,¹⁴³ the Supreme Court opined that:

[T]he purpose of the active supervision inquiry is not to determine whether the State has met some normative standard, such as efficiency, in its regulatory practices. Its purpose is to determine whether the State has exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties.¹⁴⁴

The Court's description of the standard for active supervision, indicates that the State must exercise a high degree of control over the anticompetitive conduct. Superficial or ineffective review and supervision is insufficient.¹⁴⁵

In *Ticor*, the Supreme Court considered whether the state action defense applied to title insurance companies that had been charged with price fixing fees for title searches.¹⁴⁶ Arizona, Connecticut, Montana, and Wisconsin authorized rate bureaus to set standard prices charged by all of the member firms for the searches.¹⁴⁷ The firms negotiated a rate and submitted it to the respective states' insurance offices, and this rate automatically took effect if the state declined to reject it within a set period of time.¹⁴⁸ The Court ruled that the state action doctrine did not apply because the states' passive veto power over the rates did not amount to a specific inquiry into the nature of the price fixing agreement, and therefore was not an affirmative decision to condone it.¹⁴⁹ The record indicated that the state insurance agency generally only checked the filings for

141. *See N.C. State Bd. of Dental Exam'rs*, 135 S. Ct. at 1116.

142. *See Patrick v. Burget*, 486 U.S. 94, 100 (1988).

143. 504 U.S. 621 (1992).

144. *Id.* at 634–35.

145. *See id.*

146. *See id.* at 634.

147. *See id.* at 628.

148. *See id.* at 629.

149. *See id.* at 634–35.

mathematical accuracy, and often did not review them or their competitive ramifications at all.¹⁵⁰ This oversight was insufficient because it lacked the political accountability that the state action doctrine requires.¹⁵¹ The principles of federalism underlying the state action doctrine require that states maintain and “exercise power to review particular anticompetitive acts of private parties and disprove those that fail to accord with state policy.”¹⁵² Therefore, “[t]he question is not how well state regulation works, but whether the anticompetitive scheme is the State’s own.”¹⁵³ Under *Ticor*, it is most likely not enough that a state policy provides for passive monitoring in cases where the State government lacks the incentive to remain active in monitoring the anticompetitive conduct.

Although the Supreme Court has not explicitly identified elements that will substantiate active supervision, the FTC has identified factors it views as indicators of sufficient monitoring. According to the agency, a well-developed factual record including adequate notice and the opportunity for public comment, a written decision on the restraint’s merits, and a specific quantitative and qualitative assessment of the restraint’s relationship to the state legislature’s standards tend to reflect the fact that the state sufficiently examined and monitored the conduct.¹⁵⁴ While these factors may provide a good view of the State’s involvement in the questioned restraint, they are ultimately procedural in nature and are not necessarily synonymous with active supervision.

On their face, the COPA regulations and their underlying statute provide for the comprehensive monitoring and control of PPS behavior. All COPA applications will be reviewed by the Department of Health, in consultation with the Attorney General and the Health Planning Counsel.¹⁵⁵ The review process involves weighing the potential benefits of the proposed collaboration against the potential restraints of competition.¹⁵⁶ Factors the State considers include the participants’ financial condition, the relevant market

150. *See id.* at 638.

151. *See id.* at 636.

152. *Id.* at 643.

153. *Id.* at 635.

154. *See* TODD J. ZYWICKI ET AL., OFFICE OF POLICY PLANNING, REPORT OF THE STATE ACTION TASK FORCE 55 (2003), https://www.ftc.gov/sites/default/files/documents/reports/report-state-action-task-force-recommendations-clarify-and-reaffirm-original-purposes-state-action/stateactionreport_0.pdf [<https://perma.cc/6V5N-5SHX>].

155. *See* N.Y. COMP. CODES R. & REGS. tit. 10, § 83-1.5 (2018).

156. *See id.*

dynamics, the likelihood of decreased competition, and adverse effects on payors' ability to negotiate rates.¹⁵⁷ Each COPA application can be made contingent on certain protective provisions that can theoretically lessen the anticompetitive effects of the collaboration.¹⁵⁸ After the State grants COPA status, the PPS's conduct is regularly reviewed according to these terms as well as its DSRIP performance metrics.¹⁵⁹ If, upon review, a PPS is found to not comply the COPA conditions, a PPS is found to have leveraged its market power beyond the State's intended scope, or a PPS's anticompetitive effects outweigh its benefits, the Attorney General may demand that corrective measures be taken.¹⁶⁰ If the PPS fails to comply, the Attorney General may withdraw the immunity and pursue an antitrust action.¹⁶¹ These regulations provide for regular monitoring of the PPS behavior, and provide some level of state control.¹⁶²

Although the COPA statute purports to supplant competition and provide immunity, its focus is on Medicaid, a part of the health system that is ancillary to the competitive landscape. Medicaid payments are determined according to government policy, rather than through bargaining by consumers or payors.¹⁶³ The COPA framework does not specifically address the parts of the system that competition is thought to protect. However, the structure of the COPA statute implies that it means to permit potentially anticompetitive conduct in the private market, for the benefit of efficiencies in the closed Medicaid market.¹⁶⁴ The State's power to monitor and intervene in the conduct will not necessarily constitute active supervision because the standards of review on which it relies are vague.¹⁶⁵ The regulations specify that increased costs and prices, diminished quality or availability of care, reduced competition, and the inability of health care payors to negotiate rates are among the results that will be considered disadvantages.¹⁶⁶ However, they do not lay out clearly defined standards for what will and will not trigger a withdrawal of

157. *See id.*

158. *See id.* § 83-1.6.

159. *See id.* § 83-1.10.

160. *See id.*

161. *See id.* § 83-1.12(c).

162. *See generally id.* § 83-1.4.

163. *See Schneider & Wachino, supra* note 5, 131–33.

164. *See* N.Y. COMP. CODES R. & REGS. tit. 10, § 83-1.2 (2018).

165. *See generally id.* § 83-1.5.

166. *See id.* § 83-1.5(d).

immunity.¹⁶⁷ Specifically, the procedure of evaluating whether the “benefits . . . no longer outweigh the disadvantages” of the collaboration, sheds little light on what the State’s tolerance for anticompetitive behavior is.¹⁶⁸ In the context of negotiations with private payors, the case-by-case basis review may be inconsistent.¹⁶⁹

In addition to vague review standards, the regulatory program may lack the tools to intervene and control specific anticompetitive effects without fully withdrawing immunity. Unanticipated anticompetitive effects might stem from elements of the collaboration that cannot be fixed without muting the desired efficiencies, and the State lacks the statutory or regulatory power to intervene and mitigate the problematic conduct. For example, if a PPS’s negotiations with private payors result in higher prices, neither the COPA statute nor the regulations provide a mechanism for New York’s Department of Health or Attorney General’s Office to take control of the negotiations or enforce more appropriate rates. The State can only demand changes that might not be easily complied with if the unfair negotiations are directly attributable to the health care providers’ bargaining position as a single identity under a PPS.

If the State’s demands are not met, its chief recourse is to withdraw the immunity and mount an antitrust challenge.¹⁷⁰ However, the State might have mixed incentives that prevent it from exercising this option. On the one hand, New York’s agreement with the U.S. Centers for Medicare and Medicaid Services makes the amount of federal funding awarded contingent on the State meeting overall cost reduction benchmarks.¹⁷¹ This gives the State an incentive to closely monitor and police PPS performance and conduct. If it condones overly anticompetitive conduct, the PPS might be able to generate greater costs, raise prices, or reduce quality, all of which would harm the State’s overall performance. On the other hand, New York’s application of the COPA law to the DSRIP Program encourages PPSs to pursue the State’s health care reform policy aggressively. If the State weighs disadvantages heavily and makes aggressive demands on participants or alternatively strips the immunity and mounts antitrust challenges, it could devalue the COPA statute as an incentive to pursue efficiencies. This could, in turn, prevent other

167. *See id.* § 83-1.10(b).

168. *Id.*

169. *See id.*

170. *See id.* § 83-1.12.

171. *See* N.Y. STATE DEP’T OF HEALTH, *supra* note 28, at 54–55.

institutions from pursuing the efficiencies the State is ultimately seeking.

Anticompetitive effects may be more challenging and costly to correct after-the fact. Rather than controlling a specific type of conduct, the process of weighing advantages against anticompetitive disadvantages amounts to replacement of federal antitrust review with the State's own review. The danger here is that the State could permit prospective collaboration and integration that would otherwise violate the antitrust laws, and decide later that the immunity should not apply because the disadvantages outweigh the advantages. Since the State does not have the ability to take control of a specific restraint, remedying the situation could possibly require undoing collaboration, which could be even more damaging to the health care system in the area than the anticompetitive conduct is. In this case, the State would benefit from the ability to control the conduct, rather than adjust it by way of an antitrust claim.

The essence of the active supervision requirement is to ensure that private entities do not use state policy as a pretext for pursuing their own interests.¹⁷² The danger posed by the COPA program is that a PPS might gain immunity and function as an anticompetitive agent, rather than produce the State's desired efficiencies. The New York Department of Health's procedure of weighing the benefits of the conduct against the harms is vague, and provides little guidance about what circumstances will be found contrary to the State's policy. Further, the State might not have the necessary incentives to actively exercise its police power because doing so could do more harm than good.

The following sections illustrate these issues in the context of hypothetical examples. Section III.C.1 examines possible issues that could arise if an immunized PPS pursues a merger in a highly consolidated market. Section II.C.2 similarly discusses the antitrust problems that could arise when competing hospitals clinically and financially integrate.

1. DSRIP-PPS Merger Scenario

The problems with the COPA framework's vaguely articulated supervision standards come to light in the merger context. Assume that two hospitals exist in a narrow geographic market that serves a substantial number of Medicaid beneficiaries, and they are the only two hospitals in the area. Independently, the two hospitals have a

172. *See supra* Section III.B.

variety of facilities, but each has capabilities that the other does not. Suppose further that one of the hospitals is consistently underutilized, while the other's resources are constantly spread too thin. These hospitals might be prime candidates to form a PPS under New York's DSRIP policy.

However, their merger would constitute a two-to-one consolidation that would create a monopoly in the geographic market, which is ordinarily problematic for antitrust purposes. After consummation of the merger, the surviving entity would be the sole negotiator with third-party payors.¹⁷³ State regulators would be faced with a tough decision. A merger might produce the greatest possible efficiencies, and could generate substantial Medicaid savings. Given its obvious anticompetitive ramifications, State policy dictates that this prospective PPS would need COPA protection to merge.¹⁷⁴ If the collaboration is approved and COPA immunity is granted, and the entities are able to merge without any additional scrutiny from the antitrust agencies, they would begin to integrate immediately, and consolidate into one entity with a single corporate identity, as well as unified financial and medical operations.

If the merger occurred, the newly merged PPS would regularly report on the progress of the integration and its attempts to generate efficiency. If the merger went as planned, the integration would result in allocation of patients and services between facilities, sharing of patient information, and allocation of financial resources. If this resulted in lowering costs attributable to Medicaid, it would be a success in the eyes of the State. However, if the reports indicated that efficiencies had been generated, and costs to Medicaid had dropped, but the prices charged to insurers either remained the same or increased, the overall value of the integration would be much less clear. State regulators would be forced to balance the value of the integration against the anticompetitive harms.

If the merged entity does produce efficiencies, and can generally meet patient demand in the area, it could deter other possible providers from establishing hospitals in the area. If the anticompetitive restraints on trade become severe enough to warrant the withdrawal of immunity, the next step would likely be to undo the merger. To do so would be problematic for the State because it would cancel the efficient benefits. Moreover, requiring disintegration of the merger would be complicated and would likely

173. See N.Y. COMP. CODES R. & REGS. tit. 10, § 83-1.1(c) (2018).

174. See *supra* Section III.B.

damage the remaining entities' ability to provide quality health care in the area. The DOJ and FTC premerger notification process is, itself, predicated on the idea that it may be too challenging or damaging to the merged entities to undo a merger once it has been completed.¹⁷⁵ This scenario illustrates that the State's framework for monitoring and evaluating potential collaborations also entails weighing the costs of correcting unforeseen anticompetitive conduct, which might deter the State from exercising the extent of its power. As a result, this hypothetical would most likely not satisfy the active supervision requirements of state action immunity.

2. *DSRIP-PPS Clinical and Financial Integration Scenario*

Another problem with New York's active supervision framework is its apparent lack of competition-specific review standards. The DSRIP Program assumes that promoting collaboration will create efficiencies, and these efficiencies will benefit Medicaid and private payors alike.¹⁷⁶ This assumption underlies the State's ultimate goal to have PPSs function as completely integrated systems with a single identity.¹⁷⁷ Private sector insurance plans have cited concerns that in certain cases, this will guarantee monopolistic or oligopolistic behavior.¹⁷⁸ Analysis of a project's competitive advantages and disadvantages, including the balance of bargaining power with private payors, is only one of the factors weighed in COPA review. The regulations do not clarify how these values will be weighed, and it is therefore unclear whether the review program does or can amount to active supervision of the PPS's effects on the competitive landscape.

For example, take the hypothetical PPS discussed in Section II.C.1. Assume that, rather than merging, the two hospitals enter into a comprehensive cooperative agreement that encompasses care delivery, personnel, IT services, accounting, and other internal services, all of which would be integrated to function seamlessly.¹⁷⁹

175. See PREMERGER NOTIFICATION OFFICE, FTC, INTRODUCTORY GUIDE I: WHAT IS THE PREMERGER NOTIFICATION PROGRAM? 1 (2009), <https://www.ftc.gov/sites/default/files/attachments/premerger-introductory-guides/guide1.pdf> [<https://perma.cc/J69L-PRVP>].

176. See Ropes & Gray Alert, *supra* note 24.

177. See *id.*

178. See Letter from the N.Y. State Conference of Blue Cross & Blue Shield Plans et al., to Tara Isa Koslov, Deputy Dir., FTC Office of Planning & Peter J. Mucchetti, Chief, Litig. Section, U.S. Dep't of Justice Antitrust Div. (Oct. 10, 2014), <http://origin-states.politico.com.s3-website-us-east-1.amazonaws.com/files/NYS%20DSRIP%20FTC%20DOJ%20Letter.pdf> [<https://perma.cc/GKN2-JGPR>].

179. See *id.*

To comply with COPA conditions intended to protect fairness in private payor negotiations, state regulators may require that the PPS incorporate internal safeguards to maintain the separate identity of each institution.¹⁸⁰ In theory, this would preserve fairness in private negotiations.

Maintaining meaningful separation for the sole purpose of private negotiations seems unrealistic where the entities reach complete integration. Even if negotiations are carried out independently, it will be hard to separate the individual entities from the whole. The pooling of operational information is one of the key aspects of New York's integration policy.¹⁸¹ The DSRIP framework envisions that PPS participants share usage information so that they can allocate and streamline their services.¹⁸² Even if this information is not directly related to private price negotiations, it is inherently related to the competitive dynamic between the two hospitals. Therefore, it will be nearly impossible for the two hospitals to retain separate identities for negotiation purposes.

The COPA statute purports to eliminate private causes of action for antitrust violations, leaving private payors that perceive unfairness in the negotiating process with limited options.¹⁸³ The only real possibility is to complain to the New York Attorney General. The State is then faced with deciding how to weigh the complaint. If the PPS otherwise creates efficiencies that improve quality and lower overall costs, the State may not be inclined to intervene, since intervention could risk disruption of the efficiency-driven progress.

All of this underscores a potential failure in the State's supervision. The regulations do not clearly provide protection for third-party payors or a competition-focused means of policing negotiations. The extent to which the immunity extends to interactions outside the relationship with Medicaid is not clear. Similarly, it is not clear how the identities of otherwise integrated providers can be meaningfully differentiated. The State's supervision does not reach individual negotiations with private payors, and the exercise of regulatory power to monitor and police them likely hinders the State's underlying purpose of generating efficiencies.

180. *See id.*

181. *See id.*

182. *See id.*

183. N.Y. PUB. HEALTH LAW § 2999-aa (McKinney 2017).

IV. RECOMMENDATIONS

Judicial precedent applying the state action doctrine emphasizes its roots in the principles of federalism, and clarifies that the antitrust laws do not interfere with a State's rights to regulate economies and markets within its borders.¹⁸⁴ However, the doctrine also requires that when a State chooses to supplant competition in favor of its own regulatory policy that permits private anticompetitive conduct, the State must maintain full legal accountability for the behavior it condones.¹⁸⁵ New York's DSRIP Program and COPA immunity framework reflect its intent to foster collaboration in the health care system at the expense of healthy competition.¹⁸⁶ Nevertheless, it is not clear that the State retains the level of accountability that the state action doctrine requires. There are several approaches the State might take to resolve these potential problems. First, efforts to make both the statute and the applicable regulations more specific in terms of the forms of anticompetitive conduct and effects the legislature intends for PPSs to engage in will improve COPA's position under the clear articulation requirement. Second, amending the statute and regulations to clarify the State's review standards and intervention powers will make it more likely that the grant of immunity will withstand scrutiny in light of the active supervision requirement.

As previously discussed, one of the principal problems with New York's COPA regime is that, if upheld, it effectively sidelines federal antitrust review. Without federal regulation, the State is left to its own devices to decide where and when it wants to supplant competition. While state action jurisprudence permits states to do so, New York's policy is broadly cast in its terms, reflecting the state legislature's intent to grant blanket immunity for a variety of anticompetitive behavior in discrete circumstances. Similarly, the State has a nondescript monitoring policy and limited power and incentive to intervene if the immunized behavior strays from the intended scope.¹⁸⁷ Because of these possible shortcomings, it is not clear that the COPA program constitutes either clear articulation or active supervision.

There are a number of steps the New York legislature and the relevant state agencies can take to reinforce their immunity grants under the Supreme Court's guidance on the state action doctrine.

184. *See* *Parker v. Brown*, 317 U.S. 341, 350–52 (1943).

185. *See* *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 634 (1992).

186. *See* *Evans*, *supra* note 9.

187. *See supra* Sections III.B, III.C.

The New York legislature should amend the COPA statute to more clearly articulate and affirmatively express the State's policy to displace competition and provide clearer guidance on the State's role as an active supervisor. Revisions may also be made to the COPA regulations to clarify the State's supervision standards and provide more corrective power short of withdrawal of immunity. Further, State lawmakers should consult the agencies regarding planned revisions. This Part describes these possibilities in more detail.

As discussed above, New York's COPA statute casts its desired immunity broadly in an attempt to immunize a wide range of conduct with an equally wide range of possibly anticompetitive effects. It is unlikely that this attempt to provide blanket immunity will constitute clear articulation under the Supreme Court's decision in *Phoebe Putney*.¹⁸⁸ In contrast, New York's subsequently passed Nassau Health immunity statute is far more specific in its terms. Given the scope of the DSRIP Program, which is meant to reach every general health care provider that accepts Medicaid patients, it is not feasible for the New York legislature to pass an individual statute for every institution it seeks to protect. However, the New York legislature could amend the current statute to make certain terms more specific. For example, the legislature could identify the specific ways that displacement of competition could permissibly affect the health care system. This could include clear indication that the legislature intends for COPA protected entities to negotiate as a single unit with private payors, and provide for a price control mechanism to prevent abuse of increased bargaining power. If the legislature can amend the statute to be more specific in the terms of the immunized conduct and its potential effects, it will be clearer whether the immunity applies in a given set of circumstances. Similarly, the fact that the COPA statute pertains to a broad range of PPS collaborations might be offset by incorporating more decisive statutory directives to the New York Department of Health and the State Attorney General about which collaborations should be immune. These types of changes would provide a clearer articulation of New York's intent to supplant competition.

The clear articulation requirement is closely related to the active supervision requirement. "Both are directed at ensuring that particular anticompetitive mechanisms operate because of a deliberate and intended state policy."¹⁸⁹ Because of this close

188. *See generally* FTC v. Phoebe Putney Health Sys., Inc., 568 U.S. 216 (2013).

189. *Ticor*, 504 U.S. at 636.

relationship, the state legislature should also amend the COPA statute to strengthen the State's position under the state action doctrine's active supervision prong. The active supervision requirement relies just as much on the monitoring procedures in place as it does on the State's actual application of those procedures.¹⁹⁰ The State will need to diligently exercise whatever regulatory system is in place. However, including guiding thresholds for what the permissible anticompetitive boundaries are could improve the New York Department of Health's ability to weigh the advantages and disadvantages of a given PPS collaboration.

Moreover, the Department of Health could also amend the accompanying COPA regulations to clearly delineate how different factors are weighed upon review. At the moment, the anticompetitive permissions granted by the State are pointed at Medicaid, a separate part of New York's health care system.¹⁹¹ The Department of Health should clarify how the interests of the private market weigh in terms of the State's tolerance for reduced competition. This will help inform market participants about exactly what the State's policy is—and when a collaboration has strayed from it.

Along the same lines, the Department of Health could amend the regulations regarding the setting of custom terms for each COPA awarded. It follows that these custom terms would be tailored to quell the anticompetitive effects of each given situation. If the agency were to, in addition, provide generally applicable rules, it would reflect a higher degree of state control over the conduct. For example, some of the PPS specific terms might apply to how price negotiations are carried out with private payors. Application of general rules would set clearer limits on the range of permissible collaborative conduct.

The state legislature and Department of Health should also amend the statute and regulations to provide the State with more intermediate corrective power. At the moment, the law only provides the state agencies with the ability to demand correction of certain conduct, and, if these demands prove ineffective, withdraw COPA status and pursue an antitrust challenge.¹⁹² The lack of intermediate power presents the State with a supervision problem.¹⁹³ The

190. *See supra* Sections III.B, III.C.

191. *See supra* Part III.

192. *See* N.Y. COMP. CODES R. & REGS. tit. 10, § 83-1.10 (2018); *see also* discussion *supra* Section III.C.

193. *See supra* Section III.B.

withdrawal of immunity and pursuit of a challenge is an aggressive option that risks devaluing the immunity as a means of promoting State reform policy. If the State had more intermediate power to step in and take control of the anticompetitive conduct, and subdue the anticompetitive effects, it could maintain immunity as a viable option, while still promoting its underlying reform policy.

The State would also be wise to consult with the FTC and the DOJ about any changes to the policy it is considering. If the State can incorporate agency input into the potential reforms, the odds that the Agencies will challenge the immunity decrease, and the odds that the immunity serves to protect the State's reform policy increase.

CONCLUSION

Health care reform has been one of the defining issues in the national political landscape for over two decades. Although there is contentious disagreement over how we should view the health care system and how it should function, few disagree with the idea that the constantly rising costs of care need to be curbed, especially since the increased costs do not correspond to any particular improvement in the quality of care provided. This conversation took a sharp turn when the Patient Protection and Affordable Care Act was enacted. Amongst its many goals, the ACA aimed to reduce health care costs by encouraging providers to collaborate, sharing resources, information, and expertise to provide higher quality care at lower costs. As in any market, however, collaboration among competitors can conflict with the federal antitrust laws. New York has focused on improving its Medicaid program in the hopes of ensuring greater access to improved health care to the state's low-income citizens. The application of New York's Certificate of Public Advantage statute to this effort reflects the State's desire to encourage health care providers to aggressively pursue efficiencies without fear of antitrust enforcement. This move implicates the state action doctrine, which revolves around the fundamental balance between individual states' rights to regulate their own markets, and the prevailing national policy to protect competition. However, it is not clear whether New York's attempt to invoke state action immunity comports with the Supreme Court's most recent rulings on the subject, which have clarified and arguably raised its requirements.

Although the Certificate of Public Advantage statute makes the State's intentions to provide blanket immunity clear, the state action doctrine's clear articulation prong requires a more specific contemplation of the manner and scope of the anticompetitive

conduct being condoned. Similarly, the doctrine's active supervision prong requires that the State both have and exercise the power to actively supervise the specific anticompetitive conduct. Efforts to make both the statute and the accompanying regulatory regime more specific as to what types of anticompetitive conduct and effects the legislature is willing to condone will better support a finding of clear articulation. Further, amending the statute and regulations to clarify the State's review standards and increasing its intervention power will support the finding that the State controlled the conduct and ensured that the providers acted in accordance with the State's overriding policy objectives.