

**CERTIFICATES OF PUBLIC ADVANTAGE (COPAs): A
PROVISIONAL, STATE-LED SOLUTION TO RURAL HOSPITAL
CLOSURES AND CONSOLIDATION—WHY RURAL HOSPITAL
MARKETS CURRENTLY NEED AN ALTERNATIVE TO BANKRUPTCY
AND ANTITRUST-SCRUTINIZED M&A**

JAY BAKER, JD, MBA*

Rural hospital markets' economics differ from urban hospital markets. Today's federal reimbursement structures and antitrust policies fail to account for the unique economic dynamics present in rural hospital markets. Consequently, these hospitals have experienced a record number of closures in recent years. Such risk of closures has contributed to the coinciding rise in hospital mergers and acquisitions. Both the closure of a rural hospital and the consolidation of a rural hospital presents problems for patients. Thus, there is a pressing need to address both the closure and consolidation of rural hospitals. This paper elaborates on both problems, then proposes a currently available, albeit provisional, solution that states should consider implementing until the underlying causes of these problems are rectified.

Although strict antitrust enforcement may preclude increased post-merger/acquisition prices, it does not address the unique differences in competition that rural hospital markets experience. Conversely, lenient antitrust enforcement may allow rural hospitals to stay open by affiliating with another health system, but that would fail to address the anticompetitive effects associated with consolidation.

A Certificate of Public Advantage (COPA) is the only readily available, precedentially sound framework that simultaneously—if temporarily—addresses the adverse effects of both rural hospital closure and rural hospital consolidation. States should utilize COPA laws where appropriate, as they can help promote healthcare access and improve the quality of healthcare delivery—provided the states effectively supervise the consolidation resulting from an approved COPA. This paper explains why and how states should use COPAs during this critical time in which rural hospitals' financial viability is at risk and there is no pragmatic alternative other than regulated consolidation. COPAs acknowledge the unique market dynamics rural hospitals face and offer a pragmatic alternative to closures and unregulated consolidations.

* Jay Baker received his J.D. and M.B.A. from the University of Montana in 2025. He served as Managing Editor of the Montana Law Review and as a Research Assistant and Teaching Assistant in Contract Law. He has eight years of healthcare industry experience and is currently completing an administrative fellowship at University of Utah Health. The author extends his sincere gratitude to Professors Craig Cowie and Alicia Gilbert for their thoughtful review of this article.

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I. INTRODUCTION

On February 5, 2025, two hospitals serving rural Indiana—Union Hospital and Terre Haute Regional Hospital—submitted an application for a Certificate of Public Advantage (COPA), requesting the state authorize their proposed merger under Indiana’s COPA statutes.¹ At a town hall addressing the matter, 63% of public commentors supported the merger, with only 25% of public commentors opposing it.² However, this COPA was opposed by both the Federal Trade Commission (FTC)³ and Indiana’s Attorney General.⁴ Additionally, during its 2025 legislative session, the Indiana Legislature amended its COPA statutes to preclude hospitals from submitting any more COPA applications, effective May 13, 2025.⁵ Still, on November 9, 2025, the Indiana Department of Health approved this COPA, permitting the merger of these hospitals.⁶ The merger was finalized on December 13, 2025.⁷

Indiana’s need for its recent COPA typifies the condition of rural hospital markets nationally. “Given the role rural hospitals play in the health and well-being of their communities, both closures and mergers may have broad and deep impacts.”⁸ Having such “broad and deep impacts,” the closures and consolidations of rural hospitals nationwide have raised concerns about patient access to affordable, quality health care in rural areas. This article explores some of the economic and legal principles involved in rural hospital closures, consolidations, and COPAs.

A. Background

By the end of 2025, 756 rural hospitals—over 30% of all rural hospitals in the country—were at risk of closing, with 323 rural hospitals at *immediate* risk

1. Union Hospital, Inc. & Terre Haute Regional Hospital, L.P., *Application for Certificate of Public Advantage* (Feb. 5, 2025), <https://www.in.gov/health/cshcr/files/COPA-2025-Application-Reduced.pdf> [https://perma.cc/37CQ-6M3Y].

2. *Determination: Union Hospital, Inc. and Terre Haute Regional Hospital, L.P. Application for Certificate of Public Advantage*, IND. DEP’T OF HEALTH 2 (Nov. 9, 2025), <https://www.in.gov/health/cshcr/files/COPA.Determination.2025.pdf> [https://perma.cc/SGR3-7WS3].

3. Press Release, Fed. Trade Comm’n, FTC Staff Opposes Proposed Indiana Hospital Merger (Sep. 5, 2024), <https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-staff-opposes-proposed-indiana-hospital-merger> [https://perma.cc/9H58-WAU7]; Press Release, Fed. Trade Comm’n, FTC Staff Reaffirm Opposition to Proposed Indiana Hospital Merger (Mar. 17, 2025), <https://www.ftc.gov/news-events/news/press-releases/2025/03/ftc-staff-reaffirm-opposition-proposed-indiana-hospital-merger> [https://perma.cc/JP29-KB56].

4. Letter from Todd Rokita, Att’y Gen., Ind., to Lindsey Weaver, Comm’r, Ind. Dep’t of Health (Apr. 17, 2025), <https://image.subscription.in.gov/lib/fe2e11747364047b721071/m/1/19d30b17-7feb-46ca-838d-b6dbbea7afe6.pdf> [https://perma.cc/QJ2R-BNR5].

5. IND. CODE § 16-21-15-3 (2025).

6. IND. DEP’T OF HEALTH, *supra* note 2.

7. Madeline Ashley, *Union Health, HCA Indiana Hospital Finalize Merger*, BECKER’S HOSP. REV. (Dec. 15, 2025), <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/union-health-hca-indiana-hospital-finalize-merger/> [https://perma.cc/U9JJ-H3RD].

8. Alison Coates et al., *The Impact of Rural Hospital Closures and Mergers on Health System Ecologies: A Scoping Review*, 82(5) MED. CARE RSCH. REV. 359, 360 (2025).

of closing.⁹ On average, these hospitals receive “less than half the median profit margins of urban hospitals,”¹⁰ making them prone to financial instability. This lack of solvency exacerbates their risk of bankruptcy.¹¹ In 2025, twenty-three hospitals closed¹² and twenty declared bankruptcy.¹³ Simply put, “[s]mall rural hospitals are being forced to close because they are not paid enough to cover the cost of delivering care to patients in rural areas.”¹⁴

From 2005 through 2025, 195 rural hospitals either closed or converted—152 of those having occurred since 2010.¹⁵ Except for a handful of exceptions, these hospitals had fewer than 100 beds.¹⁶ Coinciding with these hospital

9. Molly Gamble, *756 Hospitals at Risk of Closure, State by State*, BECKER'S HOSP. REV. (Dec. 26, 2025), <https://www.beckershospitalreview.com/finance/756-hospitals-at-risk-of-closure-state-by-state/> [<https://perma.cc/RU32-AECL>]; see also *Rural Hospitals at Risk of Closing*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM 1 (Apr. 2024), https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf [<https://perma.cc/7FKX-SSVU>] (citing Saving Rural Hospitals, *How to Prevent Rural Hospital Closures*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, <https://ruralhospitals.chqpr.org/Solutions.html#the-need-for-rapid-action-to-prevent-closures-and-sustain-rural-healthcare> [<https://perma.cc/YA6F-F827>] (last visited Feb. 5, 2026) (explaining hospitals are considered at immediate risk of closing when they have “inadequate revenues to cover expenses” and “very low financial reserves”)). Compare Letter from Edward J. Markey, U.S. Sen., et al., to Donald Trump, Pres. of the U.S., Mike Johnson, Speaker of the House, and John Thune, Majority Leader, U.S. Sen. (June 12, 2025), https://www.markey.senate.gov/imo/media/doc/letter_on_rural_hospitals.pdf [<https://perma.cc/D2M9-PQ8A>] (identifying 338 rural hospitals at risk of closure, using Medicaid payor mix and consecutive years realizing negative total margin as criteria).

10. Karl Stark, *The Plight of Rural Hospitals: They've Been Closing at a Faster Rate Than Urban Facilities for Years*, U. OF PA. LEONARD DAVIS INST. OF HEALTH ECON. (Nov. 8, 2022), <https://ldi.upenn.edu/our-work/research-updates/rural-hospitals-are-smaller-and-make-less-money-than-urban-facilities> [<https://perma.cc/8PQY-MS8H>].

11. Shayann Ramedani et al., *The Bystander Effect: Impact of Rural Hospital Closures on the Operations and Financial Well-Being of Surrounding Healthcare Institutions*, 17 J. OF HOSP. MED. 901 (Sep. 2022) (manuscript at 5), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9633382/pdf/nihms-1834590.pdf> [<https://perma.cc/AE5P-6C9Q>] (noting that “[a] hospital’s solvency is based on the amount of reimbursements Medicare gives for cash positive service lines. If a hospital cannot meet these requirements, they can be at a higher risk of bankruptcy.”).

12. Madeline Scheetz, *23 Hospital Closures in 2025*, BECKER'S HOSP. REV. (Nov. 17, 2025), <https://www.beckershospitalreview.com/finance/2-hospital-closures-in-2025/> [<https://perma.cc/RK99-B335>].

13. Madeline Scheetz, *20 Healthcare Bankruptcies in 2025*, BECKER'S HOSP. REV. (Dec. 18, 2025), <https://www.beckershospitalreview.com/finance/7-healthcare-bankruptcies-in-2025/> [<https://perma.cc/X79E-8MH4>].

14. Saving Rural Hospitals, *Problems and Solutions for Rural Hospitals*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, <https://ruralhospitals.chqpr.org/Overview.html#fn1> [<https://perma.cc/S4UG-9YEX>] (last visited Feb. 5, 2026) (noting that, although small rural hospitals comprise approximately one quarter of U.S. hospitals, “less than 3% of total national spending on hospitals” goes to these small rural hospitals).

15. The Cecil G. Sheps Ctr. for Health Serv. Rsch., *Rural Hospital Closures*, UNIV. OF N.C. CHAPEL HILL, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures> [<https://perma.cc/BZ2Z-XQT6>] (last visited Feb. 5, 2026) (“Closed hospitals” being described as hospitals that no longer provide any healthcare services; “converted hospitals” being described as hospitals that no longer provide in-patient care but continue to provide some healthcare services).

16. *Id.*

closures has been an increase in hospital mergers and acquisitions (M&A).¹⁷

To avoid bankruptcy, rural hospitals are often forced to affiliate or merge with larger health networks.¹⁸ Consequently, as of 2022, 72% of hospitals were affiliated with a health network.¹⁹ There were fifty-three hospital M&A deals in 2022, sixty-five in 2023, seventy-two in 2024, and forty-six in 2025.²⁰ Prior to 2023, the percentage of hospital M&A involving a financially distressed hospital decreased annually: 18.6% in 2019, 16.7% in 2020, 15.2% in 2021, and 15.0% in 2022.²¹ Then, for three consecutive years, from 2023 to 2025, financially distressed hospitals comprised a record-breaking share of each year's hospital M&A—27.7%, 30.6%, and 43.5%, respectively.²² This indicates a disconcerting trend of hospital M&A being increasingly fueled by hospitals' financial distress—a trend that is likely to continue and disproportionately affect rural hospitals.²³ Taken at face value, this gives cause for concern, and “the full extent of market stress is likely understated, particularly in rural and underserved communities.”²⁴

When a rural hospital closes, the “bystander” hospitals in that region raise their prices, for they are providing treatments to the patients who would have gone to the now-closed hospital.²⁵ This causes a “spillover effect,” which is the exacerbation of the region's already-scarce quantity of healthcare providers; this, in turn, increases the remaining providers' patient load—increasing the bystander hospitals' financial distress and resulting in a cycle that “tends to perpetuate itself until there is either a regional monopoly or no infrastructure exists.”²⁶

From 1998 to 2021, 1,887 hospital mergers were announced.²⁷ This resulted in a 25% reduction in the number of hospitals patients could choose from, as the

17. Anu Singh, *Hospital and Health System M&A in Review: Financial Pressures Emerge as Key Driver in 2023*, KAUFMANHALL (Jan. 18, 2024), <https://www.kaufmanhall.com/insights/research-report/2023-hospital-and-health-system-ma-review> [https://perma.cc/7MBQ-JG3D].

18. Ramedani et al., *supra* note 11, at 904; Coates et al., *supra* note 8, at 360 (“Financial distress is also reported to contribute to mergers or affiliations . . . as rural hospitals look to improve financial performance to survive.”).

19. Ramedani et al., *supra* note 11, at 904.

20. Kris Blohm et al., *Hospital and Health System M&A In Review: Uncertainty Transitions to Continued Momentum in 2025*, KAUFMAN HALL (Jan. 15, 2026), <https://www.kaufmanhall.com/insights/research-report/hospital-and-health-system-2025-ma-review-uncertainty-transitions-continue> [https://perma.cc/E4UW-79G9].

21. *Id.*, at 5; Anu Singh, *Hospital and Health System M&A in Review: Despite Industry Stabilization, Numbers Reveal Ongoing Distress in 2024*, KAUFMAN HALL (Jan. 9, 2025), <https://www.kaufmanhall.com/insights/research-report/hospital-and-health-system-ma-review-despite-industry-stabilization> [https://perma.cc/4QGV-JMT9].

22. Blohm et al., *supra* note 20, at 5.

23. *Id.* at 9.

24. *Id.*

25. Ramedani et al., *supra* note 11.

26. *Id.* at 905.

27. Hoag Levins, *Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality*, UNIV. OF PA. LEONARD DAVIS INST. OF HEALTH ECON. (Jan. 19, 2023), <https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/> [https://perma.cc/28FG-5NBT].

number of U.S. hospitals decreased from 8,000 to just over 6,000 during this time.²⁸ A mere two years before the first of these 1,887 hospital mergers occurred, the Department of Justice (DOJ) and the FTC were of the opinion that “[m]ost hospital mergers and acquisitions . . . do not present competitive concerns.”²⁹ Since then, though, it has become increasingly recognized that the lack of antitrust enforcement which sprung from these agencies’ opinion helped enable the rise of anticompetitive effects now associated with hospital M&A.³⁰

President Biden addressed hospital M&A’s anticompetitive effects in his executive order on competition in 2021, noting that “[t]hanks to unchecked mergers, the ten largest healthcare systems now control a quarter of the market.”³¹ In 2023, the DOJ and FTC responded by withdrawing some of their lenient policy statements.³² In 2025, President Trump revoked President Biden’s 2021 executive order on competition,³³ but “the FTC’s and DOJ’s joint 2023 Merger Guidelines [remain] in effect and are the framework for this agency’s merger-review analysis.”³⁴

“Like the FTC under the Biden administration, the FTC under the Trump administration is likely to continue to be skeptical of claims that mergers are necessary to prevent unprofitable hospitals and other businesses from closing” and, as seen in Indiana, will continue its skepticism of COPAs.³⁵ Speaking of

28. *Id.*

29. U.S. DEP’T OF JUST. & U.S. FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 1, 8 (1996), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf [<https://perma.cc/2VYZ-9Z5M>].

30. Jaime S. King et al., *Antitrust’s Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power*, 74 HASTINGS L. J. 1057, 1063 (2023).

31. Promoting Competition in the American Economy, Exec. Order No. 14036, 86 Fed. Reg. 36987 (July 9, 2021); Fact Sheet: Executive Order on Promoting Competition in the American Economy, Briefing Room Statements and Releases, Exec. Order No. 14,036, 86 C.F.R. 36987 (2021) (citing Ion Skillrud et al., *The potential for rapid consolidation of health systems*, DELOITTE (Dec. 10, 2020), <https://www2.deloitte.com/us/en/insights/industry/health-care/hospital-mergers-acquisition-trends.html>).

32. Press Release, Fed. Trade Comm’n, Federal Trade Commission Withdraws Healthcare Enforcement Policy Statement (July 14, 2023), <https://www.ftc.gov/news-events/news/press-releases/2023/07/federal-trade-commission-withdraws-health-care-enforcement-policy-statements> [<https://perma.cc/L2LV-ZNEE>]; see also Union Hospital, Inc. & Terre Haute Regional Hospital, L.P., *supra* note 1 and accompanying text (noting that the DOJ withdrew the policy statements four months earlier, on Feb. 3, 2023).

33. Revocation of Executive Order on Competition, Exec. Order No. 14,337, 90 Fed. Reg. 40,227 (Aug. 13, 2025).

34. See Letter from Andrew N. Ferguson, Chairman, U.S. Fed. Trade Comm’n, to FTC Staff, Merger Guidelines (Feb. 18, 2025), https://www.ftc.gov/system/files/ftc_gov/pdf/ferguson-memo-re-merger-guidelines.pdf [<https://perma.cc/953H-V34H>]; see also Memorandum from Omeed Assefi, Acting Assistant Att’y Gen., U.S. Dep’t of Just., to Antitrust Division Staff, Use of the 2023 Merger Guidelines (Feb. 18, 2025), <https://www.justice.gov/atr/media/1389861/dl?inline> [<https://perma.cc/4BQ6-TRDZ>].

35. Herbert F. Allen, Nathan Richardson & Madeline Greathouse, *Deregulation, Actually: Why Health Care Will Remain a Prime Target of Antitrust Enforcement in Trump 2.0*, AM. HEALTH L. ASS’N (May 1, 2025), <https://www.americanhealthlaw.org/content-library/connections-magazine/article/ba0f0c22-afeb-417e-8e3c-895b87e54a19/deregulation-actually-why-health-care-will-remain> [<https://perma.cc/PFV5-BWH4>].

the COPA application in Indiana, FTC Chair Andrew Ferguson posited, “eliminating competition in healthcare markets rarely serves Americans well.”³⁶ This article holds a different perspective on COPAs, viewing them incapable of eliminating competition where no real competition exists—namely, in rural hospital markets.

B. Premise of Argument

Rigorously enforcing antitrust law is an intuitive response to the recently acknowledged harms of hospital consolidation, but it does not account for the fact that a growing percentage of hospital M&A activity is fueled by hospitals’ financial distress. Simply preventing rural hospital M&A will not benefit patients in the relevant markets because, although hospital consolidation is a problem contributing to consumer harm, it is also the only available solution to the problem of hospital closures which, too, is contributing to consumer harm.

In 2016, Judge John E. Jones III observed, “[w]e find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here.”³⁷ In other words, the FTC is using antitrust law in an attempt to counteract the inevitable necessity for rural hospitals to consolidate—a necessity which “the same federal government . . . has created” through, “among other changes, the institution of the Affordable Care Act, fluctuations in Medicare and Medicaid reimbursement, and the adoption of risk-based contracting.”³⁸ This “evolving landscape of healthcare” that Judge Jones III noted a decade ago has further evolved into a national market unfriendly to independent hospitals, as evidenced by the aforementioned statistics.

Government payors’ decreased and stagnant reimbursement rates³⁹ have further exacerbated rural hospitals’ financial difficulties, and the One Big Beautiful Bill Act⁴⁰ adds to the number of federal schemes effectively encouraging hospital consolidation,⁴¹ accelerating the timeline by which the

36. *Id.* n. 31.

37. *FTC v. Penn State Hershey Med. Ctr.*, 185 F. Supp. 3d 552, 564 (M.D. Pa. 2016), *rev’d*, 838 F.3d 327 (3rd Cir. 2016).

38. *Id.*

39. *Calendar Year (CY) 2025 Medicare Physician Fee Schedule Proposed Rule*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (July 10, 2024), <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2025-medicare-physician-fee-schedule-proposed-rule> [<https://perma.cc/FUC6-9XDA>].

40. Pub. L. No. 119-21, 119th Cong. (2025).

41. The One Big Beautiful Bill will reduce federal Medicaid spending in rural areas by an estimated \$137 billion over the next 10 years. Zachary Levinson, Scott Hulver & Tricia Neuman, *First-Year Rural Health Fund Awards Range From Less Than \$100 Per Rural Resident in Ten States to More Than \$500 in Eight*, KFF (Jan. 6, 2026), <https://www.kff.org/state-health-policy-data/first-year-rural-health-fund-awards-range-from-less-than-100-per-rural-resident-in-ten-states-to-more-than-500-in-eight/> [<https://perma.cc/MR43-6AAM>]. *See also* Letter from Edward J. Markey, et al., to Donald Trump, et al., *supra* note 9. Although the \$50 billion in funds allocated to states through the Rural Health Transformation Program may help offset this

underlying causes of rural hospitals' financial difficulties must be addressed.

Neither closures nor consolidations offer a sustainable solution to rural hospitals' current plight, as patients suffer from either option. Legislators and regulators should address the financial distresses incentivizing hospitals to merge or close at record numbers. Specifically, rural hospitals must be able to achieve economies of scale or gain rate-negotiating power without resorting to consolidation. Until independent hospitals are able to accomplish this through means other than consolidation, states should intercede and allow financially distressed, rural hospitals to consolidate subject to ongoing state supervision—as Indiana did in 2025 through the use of a COPA.

Albeit with a negative connotation, the FTC succinctly describes this regulatory measure available to states:

Certificates of Public Advantage (also known as “COPAs”) are regulatory regimes adopted by state governments that are intended to displace competition among healthcare providers. COPAs purport to immunize mergers and collaborations from antitrust scrutiny under the state action doctrine.⁴²

Since its origination in 1943, the state-action doctrine has repeatedly been upheld.⁴³ This doctrine exempts private parties from antitrust law, provided their consolidatory conduct is (1) “clearly articulated and affirmatively expressed as state policy” and (2) “actively supervised by the State itself.”⁴⁴

The FTC claims COPAs “intend[] to displace competition among healthcare providers.”⁴⁵ However, this claim overgeneralizes market dynamics and fails to consider rural hospital markets' unique economic challenges, which other industries, and even urban hospital markets, do not face. Where competition is nonexistent, there is no competition to displace. “[M]ost rural communities have

reduction in spending, it is less than half the estimated reduction in federal spending and is not likely to save rural hospitals from their upcoming financial struggles. Carole Johnson, *The “One Big Beautiful Bill,” Now Law, Does Not Protect Rural Hospitals*, HEALTH AFF. (July 23, 2025), <https://www.healthaffairs.org/content/forefront/one-big-beautiful-bill-now-law-does-not-protect-rural-hospitals> [https://perma.cc/88FG-VH3V]; see generally Alan Condon, *Will Hospitals Benefit from \$50B Rural Health Program? 8 Things to Know*, BECKER'S HOSP. REV. (July 28, 2025), <https://www.beckershospitalreview.com/finance/will-hospitals-benefit-from-50b-rural-health-program-8-things-to-know/> [https://perma.cc/Q2ZM-63E7].

42. *Certificates of Public Advantage (COPAs)*, U.S. FED. TRADE COMM'N, <https://www.ftc.gov/news-events/features/certificates-public-advantage-copas> [https://perma.cc/S3M2-PBBG] (last visited Apr. 13, 2026).

43. See, e.g., *Parker v. Brown*, 317 U.S. 341 (1943); *Hallie v. Eau Claire*, 471 U.S. 34 (1985); *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621 (1992); *FTC v. Phoebe Putney Health Sys.*, 568 U.S. 216 (2013); *N.C. State Bd. of Dental Exam'rs v. FTC*, 717 F.3d 359 (4th Cir. 2013), *aff'd*, 574 U.S. 494 (2015); *La. Children's Med. Ctr. v. AG of the United States*, 2023 WL 6293887 (E.D. La. 2023).

44. *N.C. State Bd. of Dental Exam'rs*, 717 F.3d at 366 (quoting *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)); *Phoebe Putney Health Sys.*, 568 U.S. at 225 (quoting *California Retail Liquor Dealers Ass'n*, 445 U.S. at 105 (1980)).

45. U.S. FED. TRADE COMM'N, *supra* note 42.

only one hospital that is easily accessible, if they have a hospital at all.”⁴⁶ Thus, rural hospitals are often already monopolies in their respective local markets; however, these hospitals do not enjoy monopolistic leverage over their supply and demand, for their prices are dictated by third-party payors—over which they have little to no bargaining power.⁴⁷

Along with being unable to achieve meaningful economies of scale,⁴⁸ rural hospitals’ inability to negotiate higher reimbursement rates has contributed to their financial distress,⁴⁹ leading to the large number of rural hospitals currently at risk of closure. Merging with another hospital or health system gives the rural hospital the two capabilities it currently lacks: better economies of scale and more negotiating power with payors.⁵⁰ Of course, this allows the hospital to capitalize on its monopolistic position in the market, which rightfully invokes antitrust scrutiny. Therefore, M&A activity does present anticompetitive concerns here—not because it displaces competition, but because it allows the rural hospital to take advantage of its existing monopolistic position in the local market.

If no consolidation occurs, rural patients may suffer from their only nearby hospital being financially distressed or closing; if consolidation does occur, rural patients may suffer from the consequential anticompetitive effects; COPAs were created to address this catch-twenty-two problem.

With COPAs, a state may help rural hospitals avoid closure by authorizing qualifying consolidations that are subject to active state supervision and contingent on the terms and conditions agreed to prior to the merger. This allows for consolidation, but it mitigates the anticompetitive effects associated with such consolidation. COPAs acknowledge and address today’s rural hospital markets’ unique, and even dire, economic needs. After addressing rural-hospital economics, this article reviews the state-action doctrine and COPA laws, then it identifies which statutory provisions should be included in states’ COPA statutes.

46. Saving Rural Hospitals, *The Importance of Rural Hospitals*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, <https://ruralhospitals.chqpr.org/Importance.html> [https://perma.cc/59PW-U27S] (last visited Feb. 5, 2026).

47. Jacob Dorn, Dynamic Bargaining Between Hospitals and Insurers 3–4 (Apr. 25, 2025) (unpublished manuscript), <https://jacobdorn.info/files/job-market-paper.pdf> [https://perma.cc/6PFE-TRZD]. The author points out that “[t]he estimated hospital and insurer demand functions are key inputs to the bargaining model,” *id.* at 3, and finds that “small hospitals receiv[e] roughly take-it-or-leave-it offers,” *id.* at 4.

48. Lawton R. Burns & Mark V. Pauly, *Transformation of the Health Care Industry: Curb Your Enthusiasm?*, 96 THE MILBANK Q. 57, 78–79 (2018), DOI: 10.1111/1468-0009.12312 [https://perma.cc/YJE7-ECV9]; *but see* Tengiz Verulava, *Economies of Scale, Efficiency and Optimal Size of the Hospital*, 9 GLOBALIZATION & BUSINESS 129, 132 (June 2024), DOI: 10.35945/gb.2024.17.012 [https://perma.cc/7CJP-FGPX] (concluding “there is an economy of scale in health care, but it is significantly lower (11–14%) than in other sectors of the economy (60–95%).”).

49. Yuvraj Pathak & David Muhlestein, *Hospital System Market Share and Commercial Prices: A Cross-Sectional Approach Using Price Transparency Data*, 14 HEALTH ECON. REV. 102 (2024).

50. Coates et al., *supra* note 8.

II. HOSPITAL FINANCES

In 2024, the U.S.'s healthcare expenditure accounted for 18% of the nation's gross domestic product (GDP), and it is projected to be a 20.3% contributor to the national GDP in 2033.⁵¹ Measured by revenue, the hospital industry is the second largest industry in the nation.⁵² As such, this industry is also the country's sixth largest employer.⁵³ Although rural hospitals are a part of this large industry, they face significant financial challenges due to their unique payment structures and economic dynamics.⁵⁴ Consolidation helps alleviate these financial challenges, but such consolidation is also correlated with increased prices and spending.⁵⁵ This section explores the economic environment driving the need for COPAs.

A. Hospital Supply and Demand

Hospital competition exists in two stages: The first stage entails hospitals competing to be "in network" with insurers; the second stage entails hospitals competing for patients under those insurers' coverage.⁵⁶ Defining relevant markets in health care is difficult because insurers pay most of the expenses patients incur, so patients are "largely insensitive to healthcare prices."⁵⁷ After selecting an insurer, patients are not incentivized to shop for the most cost-

51. *NHE Fact Sheet*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet> [https://perma.cc/ECC5-LGFW] (last visited Feb. 5, 2026).

52. *Top 10 Largest Industries in the U.S. by Number of Businesses & Revenue*, CLEARLY PAYMENTS (July 8, 2025), <https://www.clearlypayments.com/blog/top-10-largest-industries-in-the-u-s-by-number-of-businesses-revenue/> [https://perma.cc/WR2V-75FM] (noting the health and medical insurance industry is the largest US industry by revenue).

53. Zachary Levinson & Scott Hulver, *Mapping Hospital Employment By State*, KFF (May 21, 2025), <https://www.kff.org/medicaid/mapping-hospital-employment-by-state/> [https://perma.cc/DG2Q-S3LN].

54. Statement from the Am. Hosp. Ass'n. to the Committee on Finance's Subcommittee on Health Care of the U.S. Senate, *Improving Health Care Access in Rural Communities: Obstacles and Opportunities 4–5* (May 17, 2023), <https://www.aha.org/system/files/media/file/2023/05/aha-statement-to-senate-finance-committee-subcommittee-on-health-on-improving-rural-health-care-access-5-17-2023.pdf> [hereinafter *Statement from AHA to Subcommittee on Health Care*].

55. King et al., *supra* note 30, at 1061; CHERYL L. DAMBERG, *HEALTH CARE CONSOLIDATION: THE CHANGING LANDSCAPE OF THE U.S. HEALTH CARE SYSTEM 2–3* (RAND Corp. 2023) (Testimony Submitted to the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health).

56. *FTC v. Penn State Hershey Med. Ctr.* 838 F.3d 327, 342 (3rd Cir. 2016); Hankyul Song, *Blackouts and Holes: Analyzing Cross-Market Geographic Mergers in the Healthcare Services Market*, 28 CARDOZO J. EQUAL RTS. & SOC. JUST. 633, 642 (2022).

57. *Penn State Hershey Med. Ctr.*, 838 F.3d at 342; *see also* JULIAN O. VON KALINOWSKI ET AL., *ANTITRUST LAWS AND TRADE REGULATION 4* § 70.04(3)(b)(ii) (2d ed. 2023); Anne M. Helm, *Optimizing Private Antitrust Enforcement in Health Care*, 11 ST. LOUIS. U. J. HEALTH L. & POL'Y 5, 24 (2017) (citing *W. Penn Allegheny Health Sys., Inc.*, 627 F.3d 85, 104 (3rd Cir. 2010)).

effective hospital,⁵⁸ for they are unaware of competing hospitals' prices—not only before receiving treatment (due to a lack of pricing transparency and predictability), but also after receiving treatment (due to insurers paying the majority of healthcare bills).⁵⁹ Further, even if patients were aware of nearby hospitals' prices, the prices within that geographic market would likely not experience any notable changes as a result because, unlike most products and services in competitive markets, “the demand for hospital services . . . is highly inelastic under competitive conditions.”⁶⁰

In a free market, the more perfectly elastic the supply and demand, the more efficient the market, as its cost savings are passed to the consumers.⁶¹ If, though, a firm obtains enough market power to become monopolistic and dictate the supply, it will enjoy cost savings without passing those savings to the consumers.⁶² High pre-merger profit margins often indicate an inelastic demand because otherwise, if the demand were elastic, the firm would have to lower its prices to compete with other firms for the responsive consumer demand.⁶³ Thus, a firm with high pre-merger profit margins offering services with inelastic demands can raise its post-merger prices without suffering large predicted loss or large critical loss.⁶⁴ Therefore, because hospitals offer many services with inelastic demand, a hospital that has obtained a substantial share of its relevant market can raise its already high pre-merger prices to exorbitant post-merger prices without incurring economic loss.

B. Rural Hospitals' Financial Distress

More than 50% of U.S. hospitals operated at a financial loss in 2022.⁶⁵ Rural hospitals are especially prone to financial distress because a sizeable percentage of their patients are covered by Medicare⁶⁶ or Medicaid.⁶⁷ The Center for Medicare and Medicaid Services (CMS) reimburses hospitals less than what it

58. David Gaines, *Healthcare's Cost Problem: Lack of Price Elasticity of Demand*, CAREIGNITION (Jan. 18, 2023), <https://www.careignition.com/blog/the-driver-of-healthcares-cost-problem-lack-of-price-elasticity-of-demand> [https://perma.cc/R637-YVWC].

59. Helm, *supra* note 57, at 31–32.

60. Kalinowski et al., *supra* note 57, at 2 § 30.03(7)(b) (2d ed. 2023) (quoting *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1388 (7th Cir. 1986)); *see also* Gregory Day, *Anticompetitive Healthcare*, 101 WASH. U. L. REV. 1539, 1575–76 (2024).

61. Roger D. Blair et al., *Hospital Mergers and Economic Efficiency*, 91 WASH. L. REV. 1, 40 n.215 (2016).

62. *Id.* at 40.

63. *See* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *Merger Guidelines* 44 (2023).

64. *Id.*

65. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 5.

66. Gina Turrini et al., *Access to Affordable Care in Rural America: Current Trends and Key Challenges*, OFF. OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUM. SERVS. 4 (July 9, 2021), <https://aspe.hhs.gov/sites/default/files/2021-07/rural-health-r.pdf> [https://perma.cc/87D4-LZGV] (stating “1 in 3 rural adults is enrolled in Medicare.”).

67. *Medicaid and Rural Health*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N 1 (Apr. 2021), <https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf> [https://perma.cc/5GVB-FWH5] (noting nearly 25% of rural residents under the age of 65 are covered by Medicaid).

costs hospitals to provide care for Medicare and Medicaid patients,⁶⁸ resulting in billions of dollars in underpayments each year.⁶⁹ Exacerbating this cost-reimbursement discrepancy, “hospital expense increases between 2019 and 2022 [were] more than double the increases in Medicare reimbursement for inpatient care during that same time.”⁷⁰ In 2022, Medicare paid eighty-two cents for every dollar hospitals spent in caring for Medicare patients,⁷¹ and this reimbursement-to-cost ratio has continued to fall since.⁷² Hospitals cannot negotiate rates with Medicare or Medicaid, as those reimbursement rates are established by CMS every year.⁷³ Hence, hospitals must either accept or reject Medicare and Medicaid payments.

Rural hospitals also have lower patient volumes than urban hospitals, so there are fewer opportunities to subsidize government payors’ reimbursements with reimbursements from commercial payors.⁷⁴ Additionally, patients in rural areas are more likely to be uninsured and, thus, delay hospital visits due to costs, which often exacerbates their conditions and leads to higher hospital expenses.⁷⁵ Rural hospitals also endure significant staffing shortages, as “only 10% of physicians in the United States practice in rural areas and over 65% of primary care Health Professional Shortage Areas are located in rural or partially rural areas.”⁷⁶ Moreover, general inflation and increases in hospital expenses have outpaced hospital prices’ growth, and the costs to stay in compliance with industry regulations are more burdensome to rural hospitals than to larger hospitals.⁷⁷

These economic burdens impose serious financial distress on rural hospitals, which has prompted Congress to create a variety of rural-hospital categories.⁷⁸ CMS refers to these categories when determining how Medicare and Medicaid

68. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 3.

69. *Id.*; *Medicare Significantly Underpays Hospitals for Cost of Patient Care*, AM. HOSP. ASS’N 1 (Jan. 2024), <https://www.aha.org/system/files/media/file/2024/01/medicare-significantly-underpays-hospitals-for-cost-of-patient-care-infographic.pdf> [<https://perma.cc/C2LK-8237>].

70. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 4.

71. *Medicare Significantly Underpays Hospitals for Cost of Patient Care*, *supra* note 69, at 1.

72. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 40.

73. *Id.*

74. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 2; Alicia Gilbert, *Frenemies: Why the FTC Should Explore the Utility of State COPAs to Address Anticompetitive Consolidation in Healthcare*, 85 LA. L. REV. 51, 53 (2024) (stating “[rural] hospitals have challenging payor mixes and high populations of uninsured patients populations with worse health outcomes.”).

75. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 2; Gilbert, *supra* note 74, at 53 (stating “rural hospitals have challenging payor mixes and high populations of uninsured patients populations with worse health outcomes.”).

76. *Statement from AHA to Subcommittee on Health Care*, *supra* note 54, at 4.

77. *Id.* at 5; *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to Higher-quality, Affordable Care*, AM. HOSP. ASS’N 13–14 (Feb. 2019), <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf> [<https://perma.cc/4Y2F-4ES9>].

78. MARCO A. VILLAGRANA ET AL., CONG. RSCH. SERV., R47526, CLOSED, CONVERTED, MERGED, AND NEW HOSPITALS WITH MEDICARE RURAL DESIGNATIONS: JANUARY 2018–NOVEMBER 2022, 1 (2023).

will pay each rural hospital, as payments depend on the type of designation each rural hospital has received.⁷⁹ While Medicare and Medicaid have switched to cost-based reimbursements to account for rural hospitals' precarious financial situations, the primary reason why rural hospitals lose money is due to private insurers' inadequate payments.⁸⁰

Private insurers often pay rural hospitals less than they pay large hospitals for the same services.⁸¹ The smaller the hospital, the less likely that hospital is to earn a profit on privately insured patients.⁸² Because small hospitals treat fewer patients than large hospitals do, there is less opportunity for the small hospitals to receive enough payments to not only recover their fixed costs, but also to earn a profit on their variable costs.⁸³ Further still, "if a provider manages to deliver care more efficiently, Medicare and commercial payors' reimbursement system will pay that provider less."⁸⁴ Thus, due to its lack of bargaining power with commercial payors, rural hospitals experience difficulties maintaining financial viability.

A hospital can receive better reimbursement rates by merging with another hospital, as this increases its bargaining leverage with commercial payors.⁸⁵ These payors, in turn, pass on their higher costs to their insureds.⁸⁶ Thus, hospital consolidation can contribute to higher insurance premiums and deductibles.⁸⁷ If no consolidation occurs, though, the hospital could close—putting additional strain on the community's economy,⁸⁸ patients,⁸⁹ and surrounding hospitals.⁹⁰

To significantly reduce their risk of closure, rural hospitals often merge or

79. *Id.* at 1–2.

80. *A Better Way to Pay Rural Hospitals*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM 1 (Apr. 2024), https://ruralhospitals.chqpr.org/downloads/Better_Way_to_Pay_Hospitals.pdf [<https://perma.cc/P6N7-3C9Y>].

81. *Id.* at 2.

82. Saving Rural Hospitals, *The Causes of Rural Hospital Problems*, CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, https://ruralhospitals.chqpr.org/Problems.html#Differences_in_Payment_Amounts_from_Commercial_Insurance_Plans [<https://perma.cc/FGE5-AK6L>].

83. *A Better Way to Pay Rural Hospitals*, *supra* note 80, at 2.

84. Gaines, *supra* note 58.

85. THEODOSIA STAVROULAKI, HEALTHCARE, QUALITY CONCERNS AND COMPETITION LAW 130–32 (Hart Studies in Law & Health 2023) (citing *FTC v. Jefferson Health and Albert Einstein Healthcare Network*, 505 F. Supp. 3d 522 (E.D. Pa. 2020)); Gregory S. Vistnes, *Cross-Market Hospital Mergers: Assessing Likely Harm and Implications for Government Action*, 86 ANTITRUST L. J. 251, 288 (2024) ("The [Common Linked Employer] theory predicts that cross-market mergers increase the merged system's overall bargaining power, which in turn implies that such mergers will lead to higher prices at both the acquired and acquiring hospitals.").

86. STAVROULAKI, *supra* note 85, at 118–19 (citing *Jefferson Health and Albert Einstein Healthcare Network*, 505 F. Supp. 3d 522).

87. *Id.*

88. George M. Holmes et al., *The Effect of Rural Hospital Closures on Community Economic Health*, 41 HEALTH SERVS. RSCH. 467 (2006), <https://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2005.00497.x> [<https://perma.cc/QSV2-DRKG>].

89. U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-93, RURAL HOSPITAL CLOSURES: AFFECTED RESIDENTS HAD REDUCED ACCESS TO HEALTH CARE SERVICES (2020).

90. Ramedani et al., *supra* note 11.

affiliate themselves with a larger hospital or health system.⁹¹

III. HOSPITAL INTEGRATIONS

Consolidation within the hospital industry has been comprised of vertical integrations, horizontal integrations, and cross-market integrations—which, collectively, produce a market with no meaningful competition and, consequently, increased prices without corresponding increases in quality.⁹²

A. Vertical Integration: Hospitals and Physicians

In 2000, 57% of physicians practiced independently.⁹³ This ratio held fairly consistent through 2012, at which time 53% of physicians were either full or part owners of their respective practices.⁹⁴ The following twelve years were not like the previous twelve, though: By the start of 2024, only 22.4% of physicians remained independent.⁹⁵ From 2019 through 2023 alone, 44,200 physician practices were acquired.⁹⁶ Such vertical integrations have contributed to an increase in hospital prices:

[H]ospitals that have stronger affiliations with physicians have been found to have higher prices. Similarly, if a hospital or health care system had market power before it acquired a physician organization, the acquisition could increase physician market power if it foreclosed rival physician organizations from access to hospital services. The combined effect of higher hospital and physician prices results in health insurance premiums becoming even more unaffordable to many employers and consumers.⁹⁷

Nationally, corporate-owned practices nearly doubled from 2019 to 2024,⁹⁸ and private-equity acquisitions increased from seventy five deals in 2012 to 484

91. H. Joanna Jiang et al., *Risk of Closure Among Independent and Multihospital-Affiliated Rural Hospitals*, 3(7) JAMA 1 (2022), DOI: 10.1001/jamahealthforum.2022.1835 [https://perma.cc/GA8W-R9LQ]; see also Burns & Pauly, *supra* note 48, at 78–82 (“Not only are more hospitals now members of systems, but they are also members of larger-sized systems.”).

92. Day, *supra* note 60, at 1541, 1559–62.

93. Carol K. Kane & David W. Emmons, *New Data on Physician Practice Arrangements: Private Practice Remains Strong Despite Shift Toward Hospital Employment*, AM. MED. ASS’N 1 (2013).

94. *Id.* at 4.

95. Avalere Health, *Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019–2023*, PHYSICIANS ADVOCACY INST. 13 (Apr. 2024).

96. *Id.* at 16.

97. Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, HEALTH AFF. 1535 (Sep. 2017), DOI: 10.1377/hlthaff.2017.0556 [https://perma.cc/XYV3-D7CS].

98. Avalere Health, *supra* note 95, at 18.

deals in 2021.⁹⁹ Private-equity firms' acquisitions of physician practices are correlated with statistically significant price increases across specialties.¹⁰⁰ They are also correlated with higher rates of clinician turnover.¹⁰¹ When a community's healthcare workforce is stable, its health outcomes and quality metrics are improved, and its used resources are reduced.¹⁰² These desirable outcomes are pursued differently by private-equity firms, which implement "a distinct business model for profit generation" that emphasizes a high volume of prescribed tests, procedures, and patients seen per day.¹⁰³ Physicians may complain about "the loss of autonomy, pressure to increase volume and coding intensity, and greater reliance on nonphysician practitioners that come with selling to a private equity investor,"¹⁰⁴ but they often sell their practices anyways for financial reasons¹⁰⁵—such as Medicare paying hospitals more than it pays physician offices for the same service.¹⁰⁶

As of April 2025, private-equity firms own approximately 488 hospitals—over a quarter of which serve rural populations.¹⁰⁷ Concerningly, recent data indicate that hospitals acquired by private-equity firms experience an increase in adverse hospital events and adverse patient outcomes.¹⁰⁸ Thus, private equity's involvement in hospital ownership may come at a cost to patients not only economically, but also clinically.¹⁰⁹

99. RICHARD M. SCHEFFLER ET AL., AM. ANTITRUST INST., PETRIS CTR., WASH. CTR. FOR EQUITABLE GROWTH, *MONETIZING MEDICINE: PRIVATE EQUITY AND COMPETITION IN PHYSICIAN PRACTICE MARKETS* 6 (July 10, 2023).

100. *Id.* at 24.

101. Joseph Dov Bruch et al., *Workforce Compensation in Private Equity-Acquired Versus Non-Private Equity-Acquired Physician Practices*, 42 HEALTH AFF. 121 (2023), <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00308> [<https://perma.cc/8P3E-U7UC>].

102. *Id.* at n.12–15.

103. *Id.* at n.30 (citing ERIN FUSE BROWN ET AL., USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL'Y, *PRIVATE EQUITY INVESTMENT AS A DIVINING ROD FOR MARKET FAILURE: POLICY RESPONSE TO HARMFUL PHYSICIAN PRACTICE ACQUISITIONS* 8 (Oct. 2021)).

104. FUSE BROWN ET AL., *supra* note 103, at 6.

105. Dov Bruch et al., *supra* note 101, at n.9.

106. Brady Post et al., *Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments*, 56 HEALTH SERVS. RSCH. 7 (Jan. 2021), DOI: 10.1111/1475-6773.13613, [<https://perma.cc/YAZ9-TPZJ>].

107. *PESP Private Equity Hospital Tracker*, PRIVATE EQUITY STAKEHOLDER PROJECT, <https://pestakeholder.org/private-equity-hospital-tracker> [<https://perma.cc/YW4U-8UGE>] (last visited Feb. 5, 2026).

108. Sneha Kannan, Joseph Dov Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition*, 330 JAMA 2365 (Dec. 26, 2023) ("Medicare patients at private equity-owned hospitals suffered a 25% increase in hospital-acquired complications compared to Medicare patients at hospitals not owned by private equity."); see also Maya Brownstein, *Private Equity's Appetite for Hospitals May Put Patients at Risk*, HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Dec. 16, 2024), <https://hsph.harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/> [<https://perma.cc/HEL5-MF9J>].

109. King et al., *supra* note 30, at 1061.

B. Horizontal Integration: Hospitals and Hospitals

A hospital that merges with a larger hospital gains access to more capital¹¹⁰ with which the smaller hospital may purchase equipment and offer services it was unable to provide prior to the merger. With this increased capital and additional service offerings, the hospital can hire more employees, which is particularly significant in rural communities, where hospitals are typically the largest or second-largest employer.¹¹¹

The Patient Protection and Affordable Care Act (ACA) encourages consolidation among healthcare providers because such consolidation can enhance hospital efficiency, streamline care delivery, and improve patient outcomes.¹¹² Findings from the American Hospital Association's analyses on the subject supports this hypothesis, concluding that "hospital acquisitions benefit patients by providing access to higher-quality care at a lower cost."¹¹³ This statement is supported by the finding that "acquisitions [are] associated with a statistically significant 3.3 percent reduction in annual operating expense per adjusted admission at the acquired hospitals" and that "[r]evenue per admission at acquired hospitals also declines relative to non-merging hospitals by a statistically significant 3.7 percent," which indicates merged hospitals' savings are passed to health plans and patients.¹¹⁴

One explanation for this positive spillover effect is that integrated health care can be delivered more efficiently and, consequently, more affordably than care delivered by non-consolidated healthcare providers.¹¹⁵ This should result in economies of scale for the integrated providers, which could reduce costs by up to 30%.¹¹⁶ For non-integrated providers, however, economies of scale remain elusive due to geographical constraints.¹¹⁷ Cross-market mergers help resolve this issue.

110. *The Impact of Hospital Consolidation on Medical Costs*, NAT'L COUNCIL ON COMP. INS. (July 11, 2018), https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx# [<https://perma.cc/NQ3C-CMF4>].

111. *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to Higher-quality, Affordable Care*, *supra* note 77, at 3.

112. Gilbert, *supra* note 74, at 53; Matthew G. Gibson, *Exceptional Efficiencies: A Valuable Defense for Healthcare Mergers*, 122 COLUM. L. REV. 1957, 1959 n.21 (2022); NAT'L COUNCIL ON COMP. INS., *supra* note 110, at n.7; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

113. Sean May, Monica Noether & Ben Stearns, *Hospital Merger Benefits: An Economic Analysis Revisited*, AM. HOSP. ASS'N 1 (Aug. 2021), <https://www.aha.org/system/files/media/file/2021/08/cra-merger-benefits-revisited-0821.pdf> [<https://perma.cc/3F7C-GJCU>].

114. *Id.*

115. NAT'L COUNCIL ON COMP. INS., *supra* note 110.

116. *Id.*

117. Verulava, *supra* note 48, at 133 (noting that the demand for a hospital's services decreases as the geographical distance between the patient and hospital increases); *see also* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, *supra* note 67, at 4.

C. Cross-market Mergers: Economies of Scale for Hospitals

“Cross-market mergers refer to consolidation in seemingly different markets.”¹¹⁸ In the context of hospital markets, cross-market mergers mean mergers that “involve hospitals located far enough apart that, from an antitrust perspective, they would be viewed as competing in separate geographic markets.”¹¹⁹ Approximately 50% of U.S. hospital mergers are cross-market mergers.¹²⁰ This prevalence in cross-market mergers may be attributed to hospitals’ need for economies of scale.¹²¹

Due to the physical nature of healthcare delivery, a patient typically must physically visit the hospital to receive care, so the patient’s options in hospitals are limited by their geographic proximity.¹²² Likewise, a hospital’s potential patient pool is limited by the number of individuals living in close proximity to the hospital.¹²³ Thus, a hospital’s potential for economies of scale is restricted because its relevant market is confined to the patients within its geographic vicinity.¹²⁴ Consequently, unless these geographic restrictions are eliminated, “there are no scale economies in hospital systems.”¹²⁵ Moreover, a hospital system may even experience scale diseconomies as it grows.¹²⁶

Cross-market consolidation is necessary to achieve scalable financial success because large health systems can expand across geographical regions, which diversifies its payor mix and spreads both its financial risks and revenues across multiple markets.¹²⁷ For this reason, “[b]y 2019, 59% of hospital systems in the United States . . . had facilities in more than one geographic market.”¹²⁸ This economic development has led to increased prices: “nonprofit hospitals that were members of national or regional systems” were more aggressive in their pricing than nonprofit hospitals that were independent or members of a local system.¹²⁹

Acknowledging the evidence suggesting that cross-market mergers cause

118. Gilbert, *supra* note 74, at 68.

119. Vistnes, *supra* note 85, at 252.

120. *Id.*

121. STAVROULAKI, *supra* note 85, at 100; Gilbert, *supra* note 74, at 54 (“All of these challenges have encouraged rural hospitals to consolidate to achieve economies of scale through increased volume, better collaboration of services, and decreased costs.”).

122. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, *supra* note 67, at 4.

123. Verulava, *supra* note 48, at 133 (noting that the demand for a hospital’s services decreases as the geographical distance between the patient and hospital increases).

124. *Id.*

125. *Id.* at 79, 132 (concluding “there is an economy of scale in health care, but it is significantly lower [11–14%] than in other sectors of the economy [60–95%].”).

126. *Id.*

127. STAVROULAKI, *supra* note 85, at 99–101.

128. King et al., *supra* note 30, at 1061 (citing Brent D. Fulton et al., *The Rise of Cross-Market Hospital Systems and Their Market Power in the US*, 41 HEALTH AFFS. 1652, 1654–55 (2022) (“defining a geographic market using commuting zones to better capture where individuals would be willing to drive in between their homes and places of employment for healthcare.”)).

129. U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 3, 16 (2004).

consumer harm,¹³⁰ the antitrust agencies have grown increasingly concerned by such consolidation.¹³¹ Historically, however, the antitrust agencies have not challenged hospital cross-market mergers,¹³² and some legal scholars even contend that the agencies are unable to address such mergers under current antitrust law because defining the relevant market—an integral step in antitrust analyses—is difficult where third-party payors are involved.¹³³

This lack of antitrust enforcement has contributed to health systems' expansion across markets: "By 2017, in most markets, a single hospital system had more than a 50-percent market share of hospital discharges."¹³⁴ On a national scale, from 2014 to 2018, the ten largest health systems controlled nearly a quarter of the market share and realized twice as much revenue growth as their competitors.¹³⁵ According to "conventional economic wisdom," such threat to competition and consumer harm is exacerbated by the market's barriers to entry, with which hospital markets are replete.¹³⁶

Cross-market mergers allow hospitals to achieve economies of scale,¹³⁷ but the corresponding decrease in localized hospital markets poses significant patient harms.¹³⁸ In response, for the sake of health care accessibility in rural areas, state legislatures should enact laws that allow rural hospitals to consolidate and, thus, maintain financial viability—but the state should authorize such consolidation and supervise its post-merger prices. COPA laws are such laws.

IV. COPAS: ADDRESSING PRICE AND QUALITY IN RURAL HOSPITAL MARKETS

In competitive markets, competition can improve quality and lower

130. Gilbert, *supra* note 74, at 69.

131. Vistnes, *supra* note 85, at 253.

132. *Id.*

133. Gilbert, *supra* note 74, at 69 n.117.

134. Damberg, *supra* note 55, at 2.

135. Ion Skillrud et al., *The potential for rapid consolidation of health systems*, DELOITTE (Dec. 10, 2020), <https://www2.deloitte.com/us/en/insights/industry/health-care/hospital-mergers-acquisition-trends.html> [<https://perma.cc/7YZM-48EW>].

136. Matthew C. Baker & Thomas Stratmann, *Barriers to entry in the healthcare markets: Winners and Losers from certificate-of-need laws*, SOCIO-ECONOMIC PLANNING SCIENCES (Oct. 2021) (acknowledging the prevalence of barriers to entry in the hospital market but identifying the advantages to such barriers, consistent with the ACA's intent to minimize duplicative healthcare services within a geographic market); *see also* United States v. Oracle Corp., 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004) ("In addition to market concentration, probability of consumer harm in that case was established by factors such as legal barriers to new entry, low elasticity of consumer demand, inability of consumers to move to distant hospitals in emergencies, a history of collusion and cost pressures creating an incentive to collude.").

137. STAVROULAKI, *supra* note 85, at 99–101; Gibson, *supra* note 112, at Section I.B n.74; Coates et al., *supra* note 8 ("Mergers or affiliations may allow rural hospitals to achieve efficiencies of scale that they cannot as small, standalone entities.").

138. Vistnes, *supra* note 85, at 259 ("[E]conomic theory predicts—and evidence is emerging—that cross-market hospital systems raise price by exerting market power across markets." (quoting Fulton, *supra* note 97, at 1652, 1655)).

prices.¹³⁹ In rural hospital markets, though, where no such competition exists, quality improvements are not entirely dependent on competition, so antitrust law may be insufficient: “when market power is not the source of harm, antitrust enforcement is insufficient to foster an affordable, accessible, and high-value health system.”¹⁴⁰ Thus, price reduction in rural hospital markets may only be achievable through regulated consolidation.

Antitrust law is a regulatory tool used to benefit consumers by promoting competition—the expected outcomes of which are lowered costs and improved quality.¹⁴¹ In their own attempt to lower costs and improve quality, hospitals use a transactional tool—consolidation.¹⁴² Regardless of which tool is used, its effectiveness should be measured by its ability to (a) lower prices and (b) improve quality. When used responsibly, COPAs offer the benefits of consolidation without the anticompetitive harms correlated with consolidation. In other words, they can help lower prices and improve quality.

The ACA encourages consolidation and aims to avoid duplicative—or, in other words, competitive—services within a geographic market,¹⁴³ yet the antitrust agencies scrutinize hospital consolidation.¹⁴⁴ Judge John E. Jones III of the Third Circuit also acknowledged this tension, noting that “the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances.”¹⁴⁵ That is to say, although the FTC discourages hospital consolidation, the ACA and other federal schemes encourage it.¹⁴⁶ The reason for these fundamentally different perspectives on hospital consolidation is this: Although they both consider competition effective for lowering costs, they differ on whether competition or consolidation improves quality.

On one hand, *decreased* consolidation is thought to increase competition and,

139. *Competition Counts: How Consumers Win When Businesses Compete*, FED. TRADE COMM’N 2 (May 2015), https://www.ftc.gov/system/files/attachments/competition-counts/pdf-0116_competition-counts.pdf [<https://perma.cc/5LPH-H9ZD>].

140. Yash Singh, *The Antitrust Antidote to Hospital and Nursing Home Corporatization—Promises and Pitfalls*, 393 N. ENGL. J. MED. 1761 (2025), <https://pubmed.ncbi.nlm.nih.gov/41181922/> [<https://perma.cc/T7BU-SGQT>].

141. *Mergers and Competition*, U.S. FED. TRADE COMM’N, <https://www.ftc.gov/news-events/topics/competition-enforcement> [<https://perma.cc/39W7-XHUN>] (last visited Mar. 13, 2026); *Health Care Competition*, FED. TRADE COMM’N, <https://www.ftc.gov/news-events/topics/competition-enforcement/health-care-competition> [<https://perma.cc/MZH2-836P>] (last visited Apr. 13, 2026).

142. Gibson, *supra* note 112, at 1958 n.11.

143. Gilbert, *supra* note 74, at 53; Gibson, *supra* note 112, at 1959 n.21; NAT’L COUNCIL ON COMP. INS., *supra* note 110, at n.7.

144. Press Release, Fed. Trade Comm’n, *supra* note 32; see Union Hospital, Inc. & Terre Haute Regional Hospital, L.P., *supra* note 1 and accompanying text (noting that the DOJ withdrew the policy statements four months earlier, on Feb. 3, 2023); see also Letter from Andrew N. Ferguson to FTC Staff, *supra* note 34, at 1–2.

145. *FTC v. Penn State Hershey Med. Ctr.*, 185 F. Supp. 3d 552, 564 (M.D. Pa. 2016), *rev’d*, 838 F.3d 327 (3rd Cir. 2016).

146. *Id.*

consequently, increase quality.¹⁴⁷ On the other hand, *increased* consolidation is thought to increase efficiencies and, consequently, increase quality.¹⁴⁸ The FTC adopts the former rationale; the ACA adopts the latter. While the former should be adopted for competitive hospital markets, the latter should be adopted for rural hospital markets. This is the underlying reason for COPAs.

Most rural hospitals are monopolies,¹⁴⁹ yet many are at risk of closure because they cannot capitalize on their monopolistic position in the market. Thus, preventing consolidation through enhanced antitrust enforcement does not increase competition, which means there is no increase in competition to benefit patients financially.¹⁵⁰ Simultaneously, although “health system advocates have argued that integration can yield operational efficiencies and quality-of-care enhancements, research suggests that hospital consolidation leads to increased costs and prices without a corresponding improvement in care quality.”¹⁵¹ Thus, consolidation also does not benefit patients financially. Therefore, neither the regulatory tool nor the transactional tool is lowering costs, so patients are harmed either way.

A third tool should be considered: COPAs. COPAs facilitate improved quality of care by allowing hospitals to consolidate and improve quality through increased efficiencies, while relying on medical professionals’ motivation to improve the quality of their care regardless of whether competition exists. COPAs facilitate lowered costs by implementing state regulation of prices.¹⁵² In competitive hospital markets, the existing competition may effectuate lower prices and quality improvements. In rural hospital markets, though, where there is no meaningful competition either before or after an acquisition, medical care must be improved through consolidation and prices lowered through localized regulation.

147. GAO, *Antitrust: DOJ and FTC Jurisdictions Overlap, but Conflicts are Infrequent*, GAO-23-105790 (Jan. 3, 2023) (“Competition in a free market benefits American consumers through lower prices, better quality and greater choice.”).

148. Zachary Levinson et al., *Ten Things to Know About Consolidation in Health Care Provider Markets*, KFF (Apr. 19, 2024) <https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/> (“[C]onsolidation could allow providers to operate more efficiently. . . . These potential efficiencies could in turn benefit patients, for example, if they lead to higher quality care or reduced costs. . . .”).

149. ERIN C. FUSE BROWN, MILBANK MEM’L FUND, *HOSPITAL MERGERS AND PUBLIC ACCOUNTABILITY: TENNESSEE AND VIRGINIA EMPLOY A CERTIFICATE OF PUBLIC ADVANTAGE* 6 (Sep. 26, 2018) (“Most rural areas struggle to support even one major health care provider, let alone multiple competitors.”); Saving Rural Hospitals, *supra* note 46 (stating “most rural communities have only one hospital that is easily accessible, if they have a hospital at all.”).

150. See Singh, *supra* note 140 (stating “when market power is not the source of harm, antitrust enforcement is insufficient to foster an affordable, accessible, and high-value health system”).

151. Suhui (Evelyn) Li et al., *How Do Hospitals Exert Market Power? Evidence From Health Systems and Commercial Health Plan Prices*, 3(1) HEALTH AFFS. SCHOLAR 1,1 (2025), DOI: 10.1093/haschl/qxae179 [<https://perma.cc/2HK4-HWKR>].

152. TEX. HEALTH & SAFETY CODE ANN. § 314A.102 (2025).

A. Lowering Prices: Competition or Regulation?

The FTC anticipates that promoting competition within the healthcare market will, as is expected in other markets, reduce costs, incentivize innovation, and improve the quality of services rendered.¹⁵³ “Competition is always about the existence and availability of alternatives.”¹⁵⁴ Contrarily, concentration is the prevalence of combination within a market, caused by the merging of two or more previously independent undertakings, or by the acquiring of one or more undertakings—whether in part or in whole.¹⁵⁵ In concentrated markets, few firms hold significant market power, with which they can negotiate “higher-than-competitive payment rates.”¹⁵⁶ Under the standards set in the DOJ and FTC’s horizontal merger guidelines, “more than 80% of hospital markets are considered ‘highly concentrated.’”¹⁵⁷

Non-coordinated effects are defined as “the removal of important competitive constraints on one or more firms, which gain increased market power, without resorting to coordinated behavior.”¹⁵⁸ Such effects are more probable in markets with only a few “significant competitors,”¹⁵⁹ who can increase their market power without resorting to coordinated behavior because they have leverage over the market supply, so they can raise demand—and, thus, prices—by artificially decreasing the supplies in circulation, which saves them money in supply purchases without compromising sales.¹⁶⁰ This describes most rural hospital markets, where there are few competitors, which offer the same or similar services and can increase demand of a service by restricting the available quantity of that service. However, a standalone rural hospital cannot capitalize on its monopolistic position in the market, for it has insufficient bargaining power in its reimbursement-rate negotiations with commercial insurers.¹⁶¹

Monopolies can substantially control the available supply in the market, and

153. *Health Care Competition*, *supra* note 141.

154. Herbert J. Hovenkamp, *Competitive Harm from Vertical Mergers* 21 (UNIV. OF PA. INST. FOR L. & ECON. Research Paper, Paper No. 20-51, 2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3683386 [<https://perma.cc/T4SB-SRCX>].

155. Kalinowski et al., *supra* note 57, at 1 § 203.07(1)(a) (2d ed. 2023).

156. PAUL B. GINSBURG, *WIDE VARIATION IN HOSPITAL AND PHYSICIAN PAYMENT RATES: EVIDENCE OF PROVIDER MARKET POWER* 1 (2010).

157. Maryclaire M. Farrington, *Stuck Between a Doc and a Hard Place: How Hospital Price Transparency and Other Regulatory Statutes Fail Against Ever-Growing Monopolistic Hospital Systems*, 17 *Health. L. & Pol’y Brief* 47, 51 (2022) (citing Zack Cooper & Martin Gaynor, *Addressing Hospital Concentration and Rising Consolidation in the United States*, 1% Steps for Health Care Reform 1, <https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/> [<https://perma.cc/WST2-UJQK>] (last visited Apr. 14, 2026)).

158. Kalinowski et al., *supra* note 57, 1 § 203.07(3).

159. *Id.* at 1 § 203.07(3)(b)(i)(I).

160. *See id.*

161. Dorn, *supra* note 47, at 3–4 (“The estimated hospital and insurer demand functions are key inputs to the bargaining model.”) (finding that “small hospitals receiv[e] roughly take-it-or-leave-it offers”).

in a market with an inelastic demand, they can raise their prices without concern that consumers will choose to forego the service or product entirely.¹⁶² For many of the services offered by hospitals, there is an inelastic demand.¹⁶³ However, unlike most other monopolists, hospitals are not able to independently dictate their own prices.¹⁶⁴ Rather, they must negotiate the reimbursement rates that private insurers will pay.¹⁶⁵ This means a hospital can only enjoy its monopolistic position within a market if it also has enough negotiating leverage over these third-party payors.¹⁶⁶

Absent an affiliation with a larger health system, rural hospitals do not have the bargaining power needed to negotiate profitable reimbursement rates from private insurers.¹⁶⁷ Thus, in rural hospital markets, being a monopoly does not equate to being profitable. For a hospital to be profitable, it must have sufficient negotiating power. Therefore, even if there were two competitors within a rural hospital market, this would not necessarily result in lower prices, for the prices are not dictated by either hospital—they are dictated by the negotiations between a hospital and the insurers. Notably, insurers have been gaining bargaining power through consolidation of their own, which further decreases the little leverage small hospitals have had in these negotiations.¹⁶⁸

Large health systems with a heterogenous payor mix have greater bargaining power to dictate their own prices.¹⁶⁹ When such a health system

162. Blair et al., *supra* note 61, at 40.

163. *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1388 (7th Cir. 1986) (stating “the demand for hospital services by patients and their doctors is highly inelastic under competitive conditions.”).

164. Dorn, *supra* note 47, at 3–4 (“The estimated hospital and insurer demand functions are key inputs to the bargaining model.”); Kate Ho & Robin S. Lee, *Insurer Competition in Health Care Markets*, 85 *ECONOMETRICA* 379, 384–85 (2017) (assuming in its predictive modeling that “[Employers bargain] over premiums with the insurers that it offers, and that these insurers also bargain with hospitals over reimbursement prices.”).

165. Dorn, *supra* note 47, at 3–4; Ho & Lee, *supra* note 164, at 384–85.

166. Dorn, *supra* note 47, 4 (finding that “small hospitals receiv[e] roughly take-it-or-leave-it offers”).

167. *Id.*

168. JOSÉ R. GUARDADO & CAROL K. KANE, AMA, *COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF U.S. MARKETS* 9–10 (2025), <https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf> [<https://perma.cc/J8T9-KDHT>]; Leemore Dafny, *Health Insurance After Corporatization—What Next?*, 394 *N. ENGL. J. MED.* 521, 522 (2026), <https://www.nejm.org/doi/abs/10.1056/NEJMp2415746> [<https://perma.cc/R4J9-PDPT>] (“Larger insurers can threaten to disfavor or exclude provider organizations from their networks unless they agree to lower rates — and this threat is credible particularly in relation to organizations without substantial countervailing market power.”).

169. Kate Ho & Robin S. Lee, *Insurer Competition and Negotiated Hospital Prices* 3, 2 (Sep. 2013) (Nat’l Bureau of Econ. Rsch., Working Paper No. 19401), https://www.nber.org/system/files/working_papers/w19401/revisions/w19401.rev1.pdf [<https://perma.cc/XJ76-EB8R>] (expecting “the most attractive hospitals to have the greatest ability to negotiate higher prices when insurer market power is low; other hospitals may see smaller price increases, or even price reductions, because the effect of insurer competition on premiums outweighs the offsetting effect,” and noting that “changes in [negotiated hospital] prices . . . may encourage further provider consolidation, benefit some hospitals more than others, and lead to potential distortions in investment incentives.”).

acquires a standalone rural hospital, it can take advantage of that hospital's monopolistic position in the rural market, resulting in higher reimbursement rates,¹⁷⁰ which then results in higher insurance premiums and deductibles for patients.¹⁷¹ Therefore, because competition is nonexistent in rural hospital markets both before and after antitrust enforcement, competition cannot be the answer for lower prices here. Moreover, consolidation is often the only alternative to bankruptcy or closure for rural hospitals. Thus, states should allow these hospitals to affiliate with larger health systems, then turn to localized regulation—not competition—to lower post-merger prices. COPAs allow states to do exactly this.

B. Improving Quality: Competition or Self-regulation?

The FTC has consistently taken positions aligning with the idea that “quality will improve only to the extent that rigorous competition, information and choices are ensured.”¹⁷² The rural hospital market, however, is different.

The healthcare market generally is incapable of ensuring information and choices are available to patients in the same way they are available to consumers in other markets. As consumers seeking to purchase medical care, patients must receive information and choices that are personalized and that require expert opinions.¹⁷³ Thus, patients receive information and are offered choices from licensed medical providers, who are both the gatekeepers and catalysts for consumers in the market for healthcare services.¹⁷⁴ Due to this information asymmetry, patients have little choice but to rely on their provider's professional advice regarding their consumer choices in this market.¹⁷⁵ Physicians are knowledgeable of the services and insurers are knowledgeable of the prices, but patients are not equipped with the knowledge necessary for them to explore and choose higher-quality services.¹⁷⁶ Therefore, competition does not improve the

170. STAVROULAKI, *supra* note 85, at 118, 130–32 (citing *FTC v. Jefferson Health and Albert Einstein Healthcare Network*, 505 F. Supp. 3d 522 (E.D. Pa. 2020)); Vistnes, *supra* note 85, at 252 (“The [Common Linked Employer] theory predicts that cross-market mergers increase the merged system's overall bargaining power, which in turn implies that such mergers will lead to higher prices at *both* the acquired and acquiring hospitals.”).

171. STAVROULAKI, *supra* note 85, at 118–19 (citing *Jefferson Health and Albert Einstein Healthcare Network*, 505 F. Supp. 3d 522). See Robin S. Lee & Kyna Fong, Markov-Perfect Network Formation: An Applied Framework for Bilateral Oligopoly and Bargaining in Buyer-Seller Networks 32–33 (Sep. 2013) (unpublished manuscript), <https://robinlee.sites.fas.harvard.edu/papers/MPNENetworkFormation.pdf> [<https://perma.cc/ZZA5-GFBK>] (“[I]f hospitals possessed greater bargaining power and hence captured a larger share of industry rents, they would have an incentive to lower negotiated per-patient rates in order to increase total patient volume. Nonetheless, for those mergers in which hospitals find it profitable to merge, this effect does not often occur; in general, mergers seem to predominantly lead to higher premiums and fewer patients insured.”).

172. STAVROULAKI, *supra* note 85, at 86.

173. *Id.* at 29–33.

174. *Id.* at 29–33.

175. *Id.* at 87.

176. *Id.* at 84–85; Day, *supra* note 60, at 1543.

quality of medical care in the same way it improves quality in other markets.¹⁷⁷

Rather than improving through competition alone, the quality of medical care may improve only insofar as healthcare providers function as a self-regulated profession.¹⁷⁸ Unlike other markets—which experience improvements in quality through competition, information, and choices—the hospital market, in which information asymmetry is inherent, may experience quality improvements because medical professionals hold themselves to a professional standard that entails a consistent effort to improve the quality of their services, regardless of whether competition exists in the market.¹⁷⁹

In rural hospital markets, little to no competition exists.¹⁸⁰ If a hospital in a rural area is acquired by a larger health system, competition still does not exist in that geographic area. However, unlike in other industries, this lack of competition may not disincentivize healthcare providers from improving the quality of their services. To the contrary, such consolidation will likely improve the quality of services due to the decreased financial distress and increased efficiencies associated with provider integration.¹⁸¹ Therefore, in rural hospital markets, consolidation—not competition—is likely the more effective method for improving the quality of medical care. COPAs allow for such consolidation.

V. COPA LAWS

Certain consolidations may implicate antitrust laws: Although the existence of a monopoly is not inherently illegal,¹⁸² “[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce” is illegal.¹⁸³ To simultaneously prevent antitrust scrutiny while promoting hospital consolidation in rural areas, state legislatures can exercise the state-action doctrine, which is the legal theory under which COPAs operate.¹⁸⁴

The “leading indicator of monopoly power” is a firm’s market share.¹⁸⁵ When bringing a monopolization claim, the plaintiff must “prove (1) the defendant had a specific intent to monopolize; (2) the defendant engaged in predatory or anticompetitive conduct; and (3) there is a dangerous probability

177. STAVROULAKI, *supra* note 85, at 29–33.

178. *Id.* at 86; Gibson, *supra* note 112, at 1959 n.21; *A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets*, U.S. FED. TRADE COMM’N 7–9 (June 18, 2019), https://www.ftc.gov/system/files/documents/public_events/1508753/session1_transcript_copa.pdf [<https://perma.cc/3FMT-3FZR>].

179. STAVROULAKI, *supra* note 85, at 86; Gibson, *supra* note 112, at 1959 n.21; U.S. FED. TRADE COMM’N, *supra* note 178.

180. FUSE BROWN, *supra* note 149, at 6 (“Most rural areas struggle to support even one major health care provider, let alone multiple competitors.”).

181. Gilbert, *supra* note 74, at 53; Gibson, *supra* note 112, at 1959 n.21 (2022); NAT’L COUNCIL ON COMP. INS., *supra* note 110, at n.7.

182. *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko*, 540 U.S. 398, 407 (2004) (“The mere possession of monopoly power, and the concomitant charging of monopoly prices, is not only not unlawful; it is an important element of the free-market system.”).

183. 15 U.S.C. § 1 (2024).

184. U.S. FED. TRADE COMM’N, *supra* note 42.

185. Kalinowski et al., *supra* note 57, at 4 § 70.04(6)(a).

that the defendant will achieve monopoly power.”¹⁸⁶ When firms enter agreements that do not readily appear to have adverse economic effects from restrained trade, courts “analyz[e] the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed.”¹⁸⁷ Where “the procompetitive effects outweigh the anticompetitive effects of the restraint at issue,” courts may allow the arrangement.¹⁸⁸ COPA laws have existed since 1993 and use the state-action doctrine to immunize anticompetitive hospital M&A from this antitrust scrutiny.¹⁸⁹ For this immunity to attach to a COPA merger or acquisition, the hospital consolidation must satisfy the state-action doctrine’s requirements—which, in effect, ensure the anticompetitive activity accomplishes the same result that the courts look for in antitrust litigation: “the procompetitive effects outweigh the anticompetitive effects of the [hospital consolidation].”¹⁹⁰

Understanding the state-action doctrine’s requirements allows legislators to draft COPA laws in a way that maximizes their effectiveness. In this section, the state-action doctrine is analyzed, then states’ COPA laws are evaluated against the doctrine’s two requirements.

A. State-action Doctrine

Under the state-action doctrine, M&A transactions may be immune from federal antitrust law.¹⁹¹ This immunity is sometimes referred to as “*Parker* immunity.”¹⁹² In *Parker v. Brown*, the Supreme Court held that the Sherman Act was not “intended to restrain state action or official action directed by a state.”¹⁹³

186. *Id.* (citing *Spectrum Sports v. McQuillan*, 506 U.S. 447, 458–59, (1993); *Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883, 893 (9th Cir. 2008)).

187. Danielle Beth Rosenthal, *Are Independent Pharmacies in Need of Special Care? An Argument Against an ANTITRUST EXEMPTION FOR COLLECTIVE NEGOTIATIONS OF PHARMACISTS*, 13 YALE J. HEALTH POL’Y L. & ETHICS 198, 206 (quoting *Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679, 692 (1978)).

188. *Id.*

189. Amy Y. Gu, *Updated: States with Certificates of Public Advantage (COPA) Laws*, THE SOURCE ON HEALTHCARE PRICE & COMPETITION (Aug. 10, 2021), <https://sourceonhealthcare.org/updated-states-with-certificate-of-public-advantage-copa-laws/> [https://perma.cc/5AS7-93D6]; U.S. FED. TRADE COMM’N, *supra* note 42.

190. *See* Rosenthal, *supra* note 187, at 206; *see, e.g.*, W. VA. CODE § 16-29B-28(c) (2025); NEB. REV. STAT. § 71-7706(1) (2025); TENN. CODE ANN. § 68-11-1303(b) (2025); OHIO. REV. STAT. § 3727.22(B) (2025); WASH. REV. CODE § 43.72.010(6) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314.002(a), (d) (2025).

191. *Parker v. Brown*, 317 U.S. 341, 352 (1943); *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 42–43 (1985); *FTC v. Phoebe Putney Health Sys.*, 568 U.S. 216, 217 (2013) (explaining that, under the state-action doctrine, “immunity from federal antitrust law may extend to nonstate actors carrying out the State’s regulatory program”).

192. Day, *supra* note 60, at 1583.

193. *Parker*, 317 U.S. at 351 (“In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state’s control over its officers and agents is not lightly to be attributed to Congress.”); *But see* Gregory Day, *Antitrust Federalism and the*

Therefore, although seemingly contradictory to the concept of preemption,¹⁹⁴ “federal antitrust laws are subject to suppression by state regulatory programs.”¹⁹⁵ The purpose of the state-action doctrine is “to respect the federal balance and to ‘embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution.’”¹⁹⁶

The Supreme Court has explained that the promotion of competition should not come “at the expense of other values a State may deem fundamental.”¹⁹⁷ The Court has further reasoned that the state-action doctrine is permissible because, “[w]here the actor is a municipality, there is little or no danger that it is involved in a *private* price-fixing arrangement.”¹⁹⁸ Based on this rationale, courts presume that municipalities act in the public’s interest.¹⁹⁹ Moreover, municipalities are “checked to some degree through the electoral process.”²⁰⁰ Thus, *Parker* immunity may apply “when it is clear that the challenged anticompetitive conduct is undertaken pursuant to the ‘State’s own’ regulatory scheme.”²⁰¹ Specifically, there are three scenarios in which *Parker* immunity may apply:

- (1) The state itself takes an action, for a “state’s own actions ‘ipso facto are exempt’ from the antitrust laws.”²⁰²
- (2) The private parties’ conduct is “clearly articulated and affirmatively expressed as state policy” and their actions are “actively supervised by the State itself.”²⁰³
- (3) The municipalities “act pursuant to state policy to displace

Prison-Industrial Complex, 107 Minn. L. Rev. 2193 (2023) (arguing that “federalism cannot support *Parker*’s broad scope”).

194. See Gilbert, *supra* note 74, at 55.

195. *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 632–33 (1992).

196. *N.C. State Bd. of Dental Exam’rs v. F.T.C.*, 574 U.S. 494, 503 (2015) (quoting *Cnty. Cmms’ns Co. v. Boulder*, 455 U.S. 40, 53 (1982)). (The state-action doctrine has now “been expanded to apply to all of the federal antitrust laws.” See Hunnicutt v. Tafoya-Lucero, No. CV21-00867 JCH/JFR, 2022 WL 832566, at *4 (D.N.M. Mar. 21, 2022)).

197. *N.C. State Bd. of Dental Exam’rs*, 574 U.S. at 503 (citing generally *Exxon Corp. v. Governor of Maryland*, 437 U.S. 117, 133 (1978)); Frank H. Easterbrook, *Antitrust and the Economics of Federalism*, 26 J. LAW & ECON. 23, 24 (1983)).

198. *Hallie v. Eau Claire*, 471 U.S. 34, 47 (1985) (emphasis in original). *But see* Day, *supra* note 60, at 1583 (contending “it’s increasingly apparent that states restrain trade to bestow monopoly profits on favored corporations”).

199. *Hallie*, 471 U.S. at 45.

200. *Id.* at 45 n.9.

201. *F.T.C. v. Phoebe Putney Health Sys.*, 568 U.S. 216, 217 (2013) (quoting *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 635 (1992)).

202. *N.C. State Bd. of Dental Exam’rs v. F.T.C.*, 717 F.3d 359, 366 (4th Cir. 2013), *aff’d*, 574 U.S. 494 (2015) (quoting *Hoover v. Ronwin*, 466 U.S. 558, 568 (1984)).

203. *Id.* (quoting *California Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)); *Phoebe Putney Health Sys.*, 568 U.S. at 225 (quoting *Midcal Aluminum, Inc.*, 445 U.S. at 105).

competition with regulation or monopoly public service.”²⁰⁴

The second scenario is the focus of this analysis. In the second scenario, where *Parker* immunity attaches to private parties’ conduct, there need not be an expressed statement from the legislature for a clearly articulated state policy to be found.²⁰⁵ If no such expressed statement exists, though, “the anticompetitive effect must have been the ‘foreseeable result’ of what the State authorized.”²⁰⁶ Additionally, the state supervisor must consider the substance of the anticompetitive conduct, and “the supervisor must not be an active market participant.”²⁰⁷ The state cannot merely defer to a private party’s price-fixing arrangement; rather, for *Parker* immunity to apply, there must be “[a]ctual state involvement.”²⁰⁸

Over the last eight decades, the Supreme Court has repeatedly reaffirmed the state-action doctrine,²⁰⁹ allowing states to “suppress competition as ways of promoting the public’s welfare and regulating local markets.”²¹⁰ However, it has also noted that, “given the antitrust laws’ values of free enterprise and economic competition, ‘state-action immunity is disfavored.’”²¹¹ Similarly, the FTC views the state-action doctrine negatively:

Hospital mergers subject to COPAs can result in higher prices for patients without improvements in quality of care, reduced patient access to healthcare services, and lower wages for hospital employees who face fewer employment options.²¹²

Regulatory oversight under COPAs is administered by state agencies, and such oversight—which may include regulating the hospital’s price controls, cost-saving mechanisms, and contractual terms with private insurers—may place a burden on state resources.²¹³ Additionally, if a COPA expires or is repealed, a monopolist hospital could be left without supervision.²¹⁴ This, among other reasons, has prompted the FTC to recommend states avoid COPAs, explaining there is insufficient evidence to suggest that such state-sponsored

204. *N. C. State Bd. of Dental Exam’rs*, 717 F.3d at 367 (quoting *Phoebe Putney Health Sys.*, 568 U.S. at 225).

205. *Id.*

206. *Phoebe Putney Health Sys.*, 568 U.S. at 217 (quoting *Hallie v. Eau Claire*, 471 U.S. 34, 42–43 (1985)); *City of Columbia v. Omni Outdoor Advertising*, 499 U.S. 365, 372–73 (1991).

207. STAVROULAKI, *supra* note 85, at 69 (citing *N.C. State Bd. of Dental Exam’rs v. F.T.C.*, 574 U.S. 494, 497 (2015)).

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

209. *See N.C. State Bd. of Dental Exam’rs*, 574 U.S. at 503.

210. *Day*, *supra* note 60, at 1584.

211. *Phoebe Putney Health Sys.*, 568 U.S. at 217 (quoting *Ticor Title Ins. Co.*, 504 U.S. at 621, 636).

212. U.S. FED. TRADE COMM’N, *supra* note 42.

213. FED. TRADE COMM’N, *FTC POLICY PERSPECTIVES ON CERTIFICATES OF PUBLIC ADVANTAGE* 1 (Aug. 15, 2022), available at https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf [<https://perma.cc/6BVA-GPKQ>].

214. *Id.* at 3–4.

consolidations “produce better results than market-based competition.”²¹⁵

However, COPAs’ efficacy should not be compared to market-based competition’s efficacy, for both the third-party-payor system and the information asymmetry inherent in rural hospital markets compromise the economic advantages typically associated with market-based competition in other industries.²¹⁶ Regulated consolidation, not competition, is the paradigm under which rural hospitals are more likely to decrease prices and improve quality²¹⁷—while also maintaining accessibility to health care by preventing hospital closures.²¹⁸ Thus, COPAs’ potential benefits address the known failures of the United States’ rural hospital markets, which Professor Erin C. Fuse Brown has aptly summarized:

[H]ealth care payment reforms have spurred a wave of industry consolidation. Providers argue that consolidation is necessary to achieve the scale and scope needed to assume greater financial risk in the shift to value-based payment, to invest in information technology infrastructure, and to take on population health improvement. As a result of widespread consolidation, hospital market concentration in the United States has increased by 40% in the past 30 years. No hospital market in the United States remains “highly competitive,” nearly half of all hospital markets in the nation are “highly concentrated,” and most rural areas struggle to support even one major health care provider, let alone multiple competitors. As competition diminishes, prices rise because monopoly providers are able to negotiate with payers on an all-or-nothing basis, and payers lose the ability to walk away from negotiations with dominant providers when building their provider networks.²¹⁹

Professor Brown further explains that state governments, especially in rural areas, “are also contending with the closure of rural hospitals,” so they are turning to COPAs as a tool “to allow health system integration to support their rural health care infrastructure and direct resources toward population health, while controlling the adverse effects of consolidation on health care costs, quality, and access.”²²⁰ Therefore, although COPAs are a “risky solution” because the underlying transaction would fail antitrust scrutiny if *Parker* immunity were not conferred to it by the state, “COPAs may be the only alternative states face to denying monopoly-creating provider consolidations” while also preventing hospital closures in rural areas.²²¹

When planning to use COPAs to prevent both the closure of rural hospitals

215. *Id.* at 1.

216. *See supra* Part IV.A–B.

217. *See supra* Part IV.A–B.

218. *See supra* Part I–III.

219. FUSE BROWN, *supra* note 149, at 6.

220. *Id.* at 7.

221. *Id.* at 2, 5.

and the price-raising acquisitions of those hospitals, states should realize that *Parker* immunity is an affirmative defense, so the transacting parties bear the burden of proof.²²² Thus, state legislators should carefully craft their COPA laws to ensure the participating hospitals meet the state-action doctrine's requirements.

B. Analysis of COPA Laws' Compliance with the State-action Doctrine

Currently, seventeen states have codified exercisable COPA laws for hospitals.²²³ Prior to 2025, nineteen states allowed hospitals to apply for COPAs, but Colorado repealed its COPA statutes,²²⁴ and Indiana amended its statute to disallow hospitals from applying for COPAs.²²⁵ COPA laws immunize qualifying hospital consolidations from antitrust laws, so long as the consolidation meets the statutory guidelines and the two-prong test for *Parker* immunity.²²⁶ For *Parker* immunity to apply, the consolidating hospitals' conduct must be (i) authorized and (ii) supervised by the state.²²⁷

1. State Authorization

To authorize a party's anticompetitive conduct, the state must have "articulated a clear and affirmative policy to allow the anticompetitive conduct."²²⁸ Ensuring they have "clearly articulated" a state policy that COPAs serve to advance, most state legislatures have included an explanation of their intentions for COPA laws.²²⁹ A state that has not clearly articulated such a policy may nevertheless satisfy this requirement if the "the inherent, logical, or ordinary result" of the conduct that the state is authorizing has foreseeable anticompetitive effects that are "consistent with its policy goals."²³⁰ This "implicit endorsement" constitutes state authorization as required for *Parker* immunity.²³¹

222. *Yeager's Fuel, Inc. v. Pennsylvania Power & Light Co.*, 22 F.3d 1260, 1266 (3rd Cir. 1994) (citing generally *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 625 (1992)).

223. *Health System Consolidation*, NAT'L CONF. OF STATE LEGISLATURES, <https://www.ncsl.org/health/health-system-consolidation> [<https://perma.cc/7RE4-5U5H>] (last updated Feb. 7, 2024) (assertion supported by information available via permalink).

224. *See* COLO. REV. STAT. §§ 25.5-1-501–516 (repealed 2025).

225. IND. CODE § 16-21-15-3(a) (2025) (stating "a hospital may not submit an application under this chapter after May 13, 2025").

226. Gilbert, *supra* note 74, at 54–55.

227. *N.C. State Bd. of Dental Exam'rs v. F.T.C.*, 717 F.3d 359, 367 (4th Cir. 2013), *aff'd*, 574 U.S. 494 (2015) (citing *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)); *F.T.C. v. Phoebe Putney Health Sys.*, 568 U.S. 216, 225 (2013) (citing *Midcal Aluminum, Inc.*, 445 U.S. at 105); *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 631 (1992).

228. *Ticor Title Ins. Co.*, 504 U.S. at 631.

229. *Phoebe Putney Health Sys.*, 568 U.S. at 225 (quoting *Midcal Aluminum, Inc.*, 445 U.S. at 105).

230. *N.C. State Bd. of Dental Exam'rs v. FTC*, 574 U.S. 494, 506–07 (2015) (quoting *Phoebe Putney Health Sys.*, 568 U.S. at 229).

231. *Id.*; *Phoebe Putney Health Sys.*, 568 U.S. at 229.

Corroborating the positions taken in this article related to the economic realities of today's rural hospital markets, the State of Washington has provided one of the most comprehensive explanations for its COPA laws' purpose:

(1) The legislature recognizes that competition among health care providers, facilities, payers, and purchasers will yield the best allocation of health care resources, the lowest prices for health care services, and the highest quality of health care when there exists a large number of buyers and sellers, easily comparable health plans and services, minimal barriers to entry and exit into the health care market, and adequate information for buyers and sellers to base purchasing and production decisions. However, the legislature finds that purchasers of health care services and health care coverage do not have adequate information upon which to base purchasing decisions; that health care facilities and providers of health care services face legal and market disincentives to develop economies of scale or to provide the most cost-efficient and efficacious service; that health insurers, contractors, and health maintenance organizations face market disincentives in providing health care coverage to those Washington residents with the most need for health care coverage; and that potential competitors in the provision of health care coverage bear unequal burdens in entering the market for health care coverage.

(2) The legislature therefore intends to exempt from state anti-trust laws, and to provide immunity from federal anti-trust laws through the state action doctrine for activities approved under this chapter that might otherwise be constrained by such laws and intends to displace competition in the health care market: To contain the aggregate cost of health care services; to promote the development of comprehensive, integrated, and cost-effective health care delivery systems through cooperative activities among health care providers and facilities; to promote comparability of health care coverage; to improve the cost-effectiveness in providing health care coverage relative to health promotion, disease prevention, and the amelioration or cure of illness; to assure universal access to a publicly determined, uniform package of health care benefits; and to create reasonable equity in the distribution of funds, treatment, and medical risk among purchasers of health care coverage, payers of health care services, providers of health care services, health care facilities, and Washington residents. To these ends, any lawful action taken pursuant to chapter 492, Laws of 1993 by any person or entity created or regulated by chapter 492, Laws of 1993 are declared to be taken pursuant to state statute and in furtherance of the public purposes of the state of Washington.²³²

232. WASH. REV. CODE § 43.72.300(1)–(2) (2025).

Florida's legislature has specified that its COPA laws are intended "to foster the development of rural health networks."²³³ Acknowledging that rural hospital markets need unique market intervention, it specifies that, pursuant to its COPA laws, these markets' "competitive market forces shall be replaced with state regulation."²³⁴ The Florida Legislature stipulated that rural hospitals' consolidation under these laws are only exempt from antitrust law if they "improve the quality of health care, moderate cost increases, and are made between members of rural health networks," for it "is within the public policy of the state to facilitate the provision of quality, cost-efficient medical care to rural patients."²³⁵

Texas likewise focuses on rural hospital markets, but it goes a step further and narrows the applicability of its COPA laws to hospitals within certain low-population counties.²³⁶ The Texas legislature expressly immunizes qualifying hospital mergers from antitrust laws, stating "it is in the state's best interest to supplant state and federal antitrust laws with a process for regulatory approval and active supervision by the designated agency."²³⁷ Similarly to Florida, Texas notes that these COPAs are intended to be used "to address unique challenges in providing health services in rural areas."²³⁸ Mississippi also aims for COPAs to be used in rural communities, but it does not restrict non-rural hospitals from applying for COPAs.²³⁹

Rather than focusing on rural hospitals, West Virginia has authorized state-action immunity for COPAs involving academic medical centers.²⁴⁰ Like other states with COPA laws, West Virginia has concluded that "it is in the state's best interest to supplant [antitrust laws] with regulatory approval and oversight" when the merger's benefits are likely to outweigh the disadvantages associated with the decrease in competition.²⁴¹ Unlike most other states with COPA laws, West Virginia may approve a COPA only if the anticipated benefits include not only enhanced economies of scale, improved quality of care, and increased accessibility to care, but also enhanced medical-education opportunities and affordability.²⁴²

Other states have used broader language in their COPA laws, focusing primarily on COPAs' intended benefits rather than the settings under which they may be authorized by the state. Wyoming notes that the state policy underlying

233. FLA. STAT. § 381.04065(1) (2025).

234. *Id.*

235. *Id.*

236. TEX. HEALTH & SAFETY CODE ANN. § 314A.002 (2025) (applying COPA laws exclusively to hospital mergers "within a county that: (1) contains two or more hospitals; and (2) has a population of: (A) less than 100,000 and is not adjacent to a county with a population of 250,000 or more; or (B) more than 100,000 and less than 150,000 and is not adjacent to a county with a population of 100,000 or more.").

237. TEX. HEALTH & SAFETY CODE ANN. § 314A.003 (b) (2025).

238. *Id.* at § 314A.003 (a) (2).

239. MISS. CODE ANN. § 41-9-307 (1)–(2) (2024).

240. W. VA. CODE § 16-29B-28 (a)–(d) (2025).

241. *Id.* at (c).

242. *Id.* at (d).

its COPA laws serves to promote (i) health care quality, (ii) health care access, (iii) health care affordability, and (iv) “[a] comprehensive health care system in the state.”²⁴³ Tennessee states that the use of regulation instead of competition furthers its state policy “to promote cooperation and coordination among hospitals,” as it believes this approach can result in benefits that “outweigh any disadvantages attributable to a reduction in competition.”²⁴⁴

A COPA—regardless of its intended benefits (whether they be for rural healthcare access, medical education, or an entirely different public benefit)—may receive *Parker* immunity if it advances a clearly articulated state policy.²⁴⁵ Because these legislatures have clearly articulated and affirmatively expressed a state policy being advanced by COPAs under their respective state statutes, COPA-qualifying hospital M&A transactions may be exempt from antitrust laws.

Conversely, some states—such as Wisconsin, South Carolina, Oregon, Nebraska, Kansas, and Louisiana—have not expressly identified which of their state policies is intended to be advanced through COPAs.²⁴⁶ However, the absence of an expressed state policy in the COPA laws does not preclude a COPA from satisfying the state-authorization requirement for *Parker* immunity, provided that the state has “foreseen and implicitly endorsed the anticompetitive effects” of the hospital consolidation.²⁴⁷

For example, a New York statute satisfied the state-authorization requirement when it contained language that indicated “the legislature clearly foresaw that [the state-established healthcare corporation] could be party to anticompetitive contractual arrangements with private parties.”²⁴⁸ In 2023, the language in Louisiana’s COPA laws was deemed sufficient to demonstrate that the state has a “policy in favor of COPA-approved mergers regardless of their anticompetitive effects.”²⁴⁹

Because implicit endorsement can satisfy the “clearly articulated”

243. WYO. STAT. ANN. § 35-24-101 (2025).

244. TENN. CODE ANN. § 68-11-1303 (a)–(b) (2025).

245. See *F.T.C. v. Phoebe Putney Health Sys.*, 568 U.S. 216, 217 (2013) (holding that *Parker* immunity applies only where the challenged restraint is the foreseeable result of a clearly articulated and affirmatively expressed state policy to displace competition); *City of Columbia v. Omni Outdoor Advertising*, 499 U.S. 365, 372–73 (1991) (explaining the clear-articulation requirement).

246. See WIS. STAT. §§ 150.84–150.86 (2025); S.C. CODE ANN. § 44-7-530 (2025); OHIO REV. STAT. § 3727.21 (2025); NEB. REV. STAT. § 71-7701–03 (2025); KAN. STAT. ANN. § 65-4957 (2024).

247. *N.C. State Bd. of Dental Exam’rs v. F.T.C.*, 574 U.S. 494, 506–07 (2015); *Phoebe Putney Health Sys.*, 568 U.S. at 228.

248. *LaFaro v. New York Cardiothoracic Group, PLLC*, 570 F.3d 471, 478 (2nd Cir. 2009).

249. *Louisiana Children’s Med. Ctr. v. Att’y Gen. of the United States*, No. 23-1305, 2023 WL 6293887 at *7 (E.D. La. 2023) (quoting Louisiana’s COPA law: “It is the intent of the legislature that supervision and control over the implementation of these agreements, mergers, joint ventures, and consolidations substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements, mergers, joint ventures, or consolidations state action immunity for actions that might otherwise be considered to be in violation of state antitrust laws, federal antitrust laws, or both.”); LA. STAT. ANN. § 40:2254.1 (2025).

requirement, states likely satisfy the clear-articulation test simply by enacting COPA laws—even if the legislature declines to explicitly identify which state policy the COPAs will be advancing.

2. *State Supervision*

Ensuring the state actively supervises every COPA, as is necessary for *Parker* immunity, legislatures promulgate the supervision processes in COPA laws.²⁵⁰

The supervision requirement compels the state to “exercise ultimate control” of the anticompetitive acts that it has authorized, ensuring that the antitrust-exempted business conduct is indeed advancing the articulated state policy.²⁵¹ This means the stage agency must “have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.”²⁵² In other words, “[t]he mere presence of some state involvement or monitoring does not suffice.”²⁵³

For active supervision to exist, the state must “exercise[] sufficient independent judgment and control so that the details of the challenged action have been established as a product of deliberate state intervention.”²⁵⁴ If it merely provides “generic oversight” instead of a “review and approval of the ‘particular anticompetitive acts,’” the state is not actively supervising the COPA.²⁵⁵ However, “[a]ctive supervision need not entail day-to-day involvement.”²⁵⁶

The Supreme Court has held that “active supervision is flexible and context dependent.”²⁵⁷ Regardless of the context, though, a state’s supervision plan should give “realistic assurance” that the private party’s “anticompetitive conduct ‘promotes state policy, rather than merely the party’s individual interests.’”²⁵⁸ To this end, there are three “constant requirements of active supervision” courts should enforce:

- (1) The supervisor must review the substance of the anticompetitive decision;
- (2) The supervisor must have the power to veto or modify particular

250. *N.C. State Bd. of Dental Exam’rs v. FTC*, 717 F.3d 359, 367 (4th Cir. 2013), *aff’d*, 574 U.S. 494 (2015); *Phoebe Putney Health Sys.*, 568 U.S. at 225.

251. *Patrick v. Burget*, 486 U.S. 94, 100–101 (1988) (citing *Hallie v. Eau Claire*, 471 U.S. 34, 46–47 (1985)).

252. *N.C. State Bd. of Dental Exam’rs*, 574 U.S. at 507 (quoting *Patrick*, 486 U.S. at 101).

253. *Patrick v. Burget*, 486 U.S. 94, 101 (1988) (citing generally *324 Liquor Corp. v. Duffy*, 479 U.S. 335, 345 n.7 (1987)).

254. *N.C. State Bd. of Dental Exam’rs*, 717 F.3d at 369 (quoting *F.T.C. v. Ticor Title Ins. Co.*, 504 U.S. 621, 634 (1992)) (original brackets omitted).

255. *Id.* (quoting *Interlocutory Order In re North Carolina State Bd. of Dental Exam’rs*, 151 F.T.C. 607, 630, 2011 WL 3568990 (FTC Feb. 3, 2011) (quoting *Patrick*, 486 U.S. at 101)).

256. *N.C. State Bd. of Dental Exam’rs*, 574 U.S. at 515.

257. *Id.* at 497.

258. *Id.* (quoting *Patrick*, 486 U.S. at 100–101).

- decisions to ensure they accord with state policy; and
- (3) The “mere potential for state supervision is not an adequate substitute for a decision by the State.”²⁵⁹

In most COPA-issuing states, the health department has been tagged as the supervising authority.²⁶⁰ Louisiana instead designates the Department of Justice as the supervising entity.²⁶¹ Other states, such as Tennessee and Texas, blend these two approaches, giving their attorneys general investigatory powers and advisory roles.²⁶² The health departments possess rulemaking authority,²⁶³ can modify the terms of a COPA,²⁶⁴ and may revoke or terminate COPAs if the hospital fails to comply with the COPA’s terms²⁶⁵—which are set by the supervising agency after it has reviewed and approved the COPA.²⁶⁶ These statutory provisions allow the supervisor to review the hospitals’ decision to consolidate, and modify the COPA’s terms to reflect the state policy they are intended to advance. Thus, they satisfy the three “constant requirements of active supervision.”

By enacting COPA statutes, legislatures provide a realistic assurance that, under the state’s supervision, consolidated hospitals’ conduct will advance a state policy. Thus, states with COPA laws have reduced the likelihood of the FTC successfully challenging a COPA on the basis that it fails to meet the supervision criteria necessary for *Parker* immunity. This was recently demonstrated in Louisiana.

In December 2022, the Louisiana Department of Justice (LADOJ) approved the acquisition of three hospitals and granted the COPA applied for by the transacting parties.²⁶⁷ The Louisiana district court, when discussing the second prong of the test for *Parker* immunity, determined that the agency met the three constant criteria: the supervising agency reviewed “the substance of the

259. *Id.* at 515 (quoting *Ticor Title Ins. Co.*, 504 U.S. at 638) (reformatted with enumeration); *accord*. *Teladoc, Inc. v. Tex. Medical Bd.*, 2015 U.S. Dist. LEXIS 166754 at *8 (W.D. Tex. 2015) (holding that the state medical board failed to meet the supervision prong of the state-action doctrine because it did not have any veto or modification authority over the private party’s decisions).

260. *See, e.g.*, TENN. CODE ANN. § 68-11-1302(3) (2025); W. VA. CODE § 16-29B-30(a) (2025); NEB. REV. STAT. § 71-7702(3) (2025); MISS. CODE ANN. § 41-9-305(f) (2024); WASH. REV. CODE § 43.72.310(6) (2025); WYO. STAT. ANN. § 35-24-102(a)(vi) (2025).

261. LA. STAT. ANN. § 40:2254.2 (2025).

262. TENN. CODE ANN. § 68-11-1303(f) (2025); TEX. HEALTH & SAFETY CODE ANN. §§ 314.002(g), 314.003 (2025).

263. *See, e.g.*, LA. STAT. ANN. § 40:2254.9 (2025); WYO. STAT. ANN. § 35-24-103 (2025).

264. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(g) (2025); WASH. REV. CODE § 43.72.310(6) (2025); WYO. STAT. ANN. § 35-24-115(d) (2025).

265. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(g) (2025); NEB. REV. STAT. § 71-7707 (2025); KAN. STAT. ANN. § 65-4958 (2024); LA. STAT. ANN. § 40:2254.6 (2025); MISS. CODE ANN. § 41-9-307(7) (2024); WASH. REV. CODE § 43.72.310(6) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314A.004 (2025).

266. *See, e.g.*, W. VA. CODE § 16-29B-28(e)(2)(i) (2025); LA. STAT. ANN. § 40:2254.10 (2025); WYO. STAT. ANN. § 35-24-101(b) (2025).

267. *Louisiana Children’s Med. Ctr. v. Att’y Gen. of the United States*, No. 23-1305, 2023 WL 6293887 at *1–2 (E.D. La. 2023).

acquisition,” “had the power to veto or modify the acquisition,” and actually approved and actively supervises the COPA, as opposed to merely having the potential for supervision.²⁶⁸ Moreover, the state’s COPA laws contain additional supervisory mechanisms, and the COPA’s terms and conditions further “empower the LADOJ to ‘actively supervise’ both the transaction itself and the new health system on an ongoing basis.”²⁶⁹ Because the three “constant requirements of active supervision” were met here, and because “the adequacy of supervision . . . depend[s] on all the circumstances of a case,”²⁷⁰ the court held that the supervision requirement for *Parker* immunity was satisfied.²⁷¹

The FTC has offered guidance on what constitutes active supervision.²⁷² Adding to the factors laid out by the courts, the FTC claims that “active supervision must precede implementation of the allegedly anticompetitive restraint.”²⁷³ This is consistent with the courts’ requirement that the agency must review the substance of the acquisition because, to effectively supervise a COPA-holding hospital, the state agency must first receive adequate information to determine whether it should approve the COPA. Therefore, to facilitate the state’s supervision, a COPA’s application, approval, and review processes should be documented with specificity.

VI. COPA APPROVALS, REVIEWS, AND CHALLENGES

Just as the LADOJ, all supervising agencies should analyze the anticipated effects of a COPA before deciding whether to approve it.²⁷⁴ For this reason, the COPA application, and any resulting agreement between the parties and the state, should be as comprehensive as is practicable.

Most COPA-issuing states prioritize public engagement, asking for public comments and making applications open to the public.²⁷⁵ Typically, a state may approve a COPA only if its “likely benefits . . . outweigh any disadvantages

268. *Id.* at *8 (internal quotations omitted).

269. *Id.* at *9 (brackets omitted) (quoting the COPA Terms and Conditions, R. Doc. No. 75-14, ¶¶12–14, 30–37).

270. *N.C. State Bd. of Dental Exam’rs v. FTC*, 574 U.S. 494, 515 (2015).

271. *La. Children’s Med. Ctr.*, No. 23-1305, 2023 WL 6293887 at *8–9.

272. *See generally*, *FTC Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants*, FED. TRADE COMM’N (Oct. 2015), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf [<https://perma.cc/2GZ9-9ZHT>].

273. *Id.* at 10.

274. *La. Children’s Med. Ctr.*, No. 23-1305, 2023 WL 6293887 at *8 (noting the “extensive analysis by LADOJ attorneys and staff regarding the transaction, the facilities, and the likely effects on health care and competition in the state, which also included input from expert consultants who reviewed the COPA application”).

275. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(d) (2025); OHIO REV. STAT. § 3727.23 (2025); W. VA. CODE § 16-29B-28(e)(2) (2025); LA. STAT. ANN. § 40:2254.4(B) (2025); WYO. STAT. ANN. §§ 35-24-106 (2025); TEX. HEALTH & SAFETY CODE ANN. §§ 314.002(c), (g), 314.004(b) (2025).

attributable to a reduction in competition.”²⁷⁶ Nebraska, Tennessee, and Texas also require the applicants demonstrate with clear and convincing evidence that this outweighing-benefits standard is met.²⁷⁷

A. Tennessee and Virginia: 2017 COPA Challenge

In 2017, the FTC challenged a COPA application submitted by hospitals in Tennessee and Virginia.²⁷⁸ After considering the FTC’s protests against the COPA application, the Tennessee Department of Health nevertheless decided to approve the COPA.²⁷⁹ It determined, based on its knowledge of the local market and the fifty page COPA Terms of Certification to which it would hold the merging hospitals accountable, that this state-supervised hospital consolidation would result in a net benefit for local patients.²⁸⁰

This COPA primarily involved rural hospitals, of which there were nineteen, spanning across twenty one counties in both Tennessee and Virginia.²⁸¹ To be effective, such a COPA “may require stringent state oversight of prices, quality, and access.”²⁸² This was a worthwhile tradeoff for the hospitals, though, as they had been experiencing financial and public-health difficulties akin to those that most rural hospitals currently face.²⁸³ Tennessee has extensive COPA-application requirements, and both Tennessee and Virginia weighed specific advantages and disadvantages when considering whether to approve the application.²⁸⁴ The states’ departments of health provided their bases for approving the COPA, along with the supervisory responsibilities each would take.²⁸⁵

This type of COPA, where there are sufficient state resources and clear regulatory guidelines, allows local governments to continuously supervise consolidated hospitals in an attempt to further the public’s wellbeing—which is

276. W. VA. CODE § 16-29B-28(c) (2025); *accord.* NEB. REV. STAT. § 71-7706(1) (2025); TENN. CODE ANN. § 68-11-1303(b) (2025); OHIO REV. STAT. § 3727.22(B); TEX. HEALTH & SAFETY CODE ANN. § 314.002(a), (d) (2025).

277. NEB. REV. STAT. § 71-7706(1) (2025); TENN. CODE ANN. § 68-11-1303(e)(1) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314.002(d) (2025).

278. *See* FED. TRADE COMM’N, FED. TRADE COMM’N STAFF’S THIRD SUBMISSION TO THE TENNESSEE DEP’T OF HEALTH REGARDING THE CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF MOUNTAIN STATES HEALTH ALLIANCE & WELLMONT HEALTH SYS. (July 18, 2017), available at https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staffs-third-submission-tennessee-department-health-regarding-certificate-public-advantage/ftc_-_third_comment_to_tennessee_-_final_public_version.pdf [https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staffs-third-submission-tennessee-department-health-regarding-certificate-public-advantage/ftc_-_third_comment_to_tennessee_-_final_public_version.pdf].

279. *Tennessee Approves Ballard Health COPA Over FTC Protests*, MANATT (Oct. 23, 2017), <https://www.manatt.com/insights/newsletters/antitrust-law/tennessee-approves-ballad-health-copa-over-ftc-pro> [<https://perma.cc/U7D2-9QE7>].

280. *Id.*

281. FUSE BROWN, *supra* note 149, at 8–9.

282. *Id.* at 8.

283. *Id.* at 9.

284. *See id.* at 12–15.

285. *See id.* at 21–29.

the primary purpose underlying COPAs and the state-action doctrine.

B. Louisiana: 2023 COPA Challenge

In 2023, the FTC challenged a COPA acquisition in Louisiana.²⁸⁶ The FTC challenged this hospital acquisition after the transaction had occurred, bringing suit to contest the state-action doctrine which exempted the acquisition from antitrust laws.²⁸⁷ The FTC, the State of Louisiana, and the hospitals included in the case filed motions for summary judgment.²⁸⁸ The Eastern District Court of Louisiana granted the state and the hospitals' motions, and denied the FTC's motion, holding that the private parties' transaction met the requirements for *Parker* immunity.²⁸⁹

Louisiana's COPA statute allows the LADOJ to approve a COPA application, which it did in this case.²⁹⁰ The LADOJ and the acquiring hospital agreed to terms and conditions by which the agency was to supervise the hospital.²⁹¹ The state agency may "revoke the COPA" not only if the hospital fails to comply with these terms and conditions, but also if it "determines that the transaction is not resulting in lower health care costs or greater access to or quality of health care."²⁹²

This case reaffirms the legitimacy of COPAs under the state-action doctrine, and it demonstrates how a state agency may effectively supervise hospital consolidation by repeatedly reassessing whether it is advancing the state's articulated policy.

C. Indiana: 2025 COPA Challenge

In March of 2025, the FTC challenged a COPA application in Indiana.²⁹³ Indiana's legislature had included a date by which no more COPA applications would be considered—July 1, 2026.²⁹⁴ In its 2025 legislative session, it amended this expiration date, changing it to May 13, 2025.²⁹⁵ However, this amendment was likely not intended to signal a disapproval of COPAs.²⁹⁶ Rather, the Indiana

286. *See* La. Children's Med. Ctr. v. AG of the United States, No. 23-1305, 2023 WL 6293887 (E.D. La. 2023).

287. *Id.* at *1.

288. *Id.*

289. *Id.* at *1, 7–8, 12.

290. *Id.* at *2.

291. *Id.* (stating that the hospitals closed the transaction after its approval).

292. *Id.* (quoting the COPA Terms and Conditions, R. Doc. No. 75-17, at 3).

293. *See* FED. TRADE COMM'N, FED. TRADE COMM'N SUPPLEMENTAL STAFF SUBMISSION TO INDIANA HEALTH DEP'T REGARDING 2025 CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION OF UNION HEALTH & TERRE HAUTE REG'L HOSP. (Mar. 17, 2025), https://www.ftc.gov/system/files/ftc_gov/pdf/in-copa-comment-3-17-2025-public-redacted.pdf [<https://perma.cc/DQ6T-NAL3>].

294. IND. CODE § 16-21-15-3(a) (2024).

295. IND. CODE § 16-21-15-3(a) (2025).

296. *See Hearing on S.B. 119 Before the H. Comm. on Pub. Health*, 124th Gen. Assemb. (Ind. Apr. 1, 2025) (video recording available at https://iga.in.gov/session/2025/video/committee_public_health_1500, at 22:50) [hereinafter *Hearing on S.B. 119*].

General Assembly's discussion surrounding the amendment indicates that the statute was enacted to facilitate the COPA application submitted and approved in 2025, and should another hospital pursue a COPA in the future, the statute may once again be amended to allow for such an application.²⁹⁷

In its decision to approve the COPA merging Indiana's Union Hospital and Terre Haute Regional Hospital, the Indiana Department of Health considered the forty-five proposed commitments to which the hospitals would be held accountable by the health department.²⁹⁸ To ensure this COPA "[m]erger would benefit the population's health outcomes, health care access, and quality of care in a manner that outweighs the disadvantages of the Proposed Merger's anticompetitive effects," these commitments related to "[q]uality, [p]ricing, [p]reservation of [a]ccess, [e]nhancement, [e]mployment and [e]conomic [i]mpact, [p]opulation [h]ealth, and [o]ther" miscellaneous matters.²⁹⁹ The health department articulated with specificity these commitments in the COPA's terms and conditions.³⁰⁰

At first glance, Indiana's 2025 amendment to its COPA statute may look like an attempted course correction following the approval of a COPA in the face of opposition from the FTC³⁰¹ and state Attorney General.³⁰² However, after considering the town hall's public comments, the Indiana Department of Health's determination, and the Indiana General Assembly's discussion, it becomes evident that Indiana enacted its COPA statutes for this specific merger, for which the COPA application took two years to complete.³⁰³ Indiana's amendment to preclude future hospital COPA applications should not be inferred as a stance against COPAs; instead, other states should look to Indiana's 2025 COPA as an example of how to apply for, review, and approve a COPA for rural hospitals.

This COPA's two-year application process, along with the terms and conditions governing this COPA, give onlooking states and hospitals a strong example of how to use a COPA to address rural hospital markets' unique economic challenges. To build on this example and provide a resource for state legislators considering proposing COPA laws, the next section will consider all currently enacted COPA statutes and provide recommendations on which key provisions should be included in a state's COPA laws.

297. *Id.*

298. IND. DEP'T OF HEALTH, UNION HOSP., INC. & TERRE HAUTE REG'L HOSP., L.P. APPLICATION FOR CERTIFICATE OF PUBLIC ADVANTAGE 2 (Nov. 9, 2025).

299. *Id.*

300. *Id.* at Ex. 1.

301. FTC Staff Opposes Proposed Indiana Hospital Merger, *supra* note 3; FTC Staff Reaffirm Opposition to Proposed Indiana Hospital Merger, *supra* note 3.

302. Letter from Todd Rokita, *supra* note 4.

303. IND. DEP'T OF HEALTH at n. 23, *supra* note 298; *Hearing on S.B. 119*, *supra* note 296 (expressing apprehension toward disallowing future COPA applications and discussing a willingness to amend the statute at a later date, allowing future COPA applications once another COPA is being pursued).

VII. RECOMMENDED COPA LAW PROVISIONS

A model COPA statutory scheme for state legislatures to enact will entail the core tenants found below.

A. Application

The information required in a COPA application should, at minimum, include the following:

1. General Information

- a. Name and contact information of all applying parties;³⁰⁴
- b. Description of the proposed cooperative agreement;³⁰⁵ and
- c. Geographic area(s) impacted.³⁰⁶

2. Public Benefit and Antitrust Justification

- a. Explanation of how the agreement improves quality of or access to health care;³⁰⁷
- b. Description of expected cost savings or efficiencies;³⁰⁸ and
- c. Demonstration that the likely benefits outweigh the potential harms to competition.³⁰⁹

3. Community Impact

- a. Public hearing and community input.³¹⁰

B. Approval

The supervising agency should be permitted to approve a COPA application only if specific factors consistent with its articulated state policy have been met. These factors should help the supervising agency determine whether the likely benefits outweigh any potential disadvantages resulting from the possible reduction in competition.³¹¹ Such factors may include the following:

304. *See, e.g.*, WYO. STAT. ANN. § 35-24-104(a) (2025).

305. *See, e.g.*, NEB. REV. STAT. § 71-7703 (2025); WIS. STAT. § 150.85(2) (2026).

306. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(e)(2)(B) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314A.056(b)(2) (2025).

307. *See, e.g.*, LA. STAT. ANN. § 40:2254.4(B) (2025).

308. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 314A.056(b)(3) (2025); W. VA. CODE § 16-29B-28(d)(3).

309. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(b) (2026).

310. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(d); W. VA. CODE § 16-29B-28(e) (2025).

311. *See e.g.*, TENN. CODE ANN. § 68-11-1303(e–g); NEB. REV. STAT. § 71-7706 (2025); W. VA. CODE § 16-29B-28(c); KAN. STAT. ANN. § 65-4957(a) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314.002(e)–(f).

1. *Enhancement of Quality of Health Care*,³¹²
2. *Access to Healthcare Services in Underserved or Rural Areas*,³¹³
3. *Gains in Cost Efficiency of Services*,³¹⁴
4. *Improvements in Population Health or Public Health Outcomes*,³¹⁵
5. *Avoidance of Duplication of Hospital Resources*,³¹⁶
6. *Improvements in Access to Care*,³¹⁷
7. *Extent of Reduction in Competition*,³¹⁸ and
8. *Impact on Pricing, Innovation, or Patient Choice*³¹⁹

C. Authorization

To ensure it meets the “clear articulation” test for *Parker* immunity, COPA laws should contain language expressly identifying the state policy intended to be advanced by COPAs. Washington’s introduction to its COPA laws³²⁰ may be the most comprehensive statutory language to emulate when the legislature’s intent is to address the needs of rural hospital markets. If the state would like to restrict its COPAs exclusively to rural hospitals, it should consider Texas’s statutory language.³²¹ If the state intends to allow COPAs for a purpose other than to address rural hospitals’ needs, it may look to West Virginia’s statutory provisions.³²²

D. Supervision

To ensure it meets the state-supervision requirement for *Parker* immunity, COPA laws should contain language granting the supervising agency the “power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.”³²³ The statute’s provisions should give a “realistic assurance” that the supervision will hold the hospital accountable to actually advancing the articulated state policy.³²⁴ Specifically, it should mandate the supervising agency “review the substance of the anticompetitive decision,”

312. See e.g., TENN. CODE ANN. § 68-11-1303(e)(1); NEB. REV. STAT. § 71-7706(2)(a); KAN. STAT. ANN. § 65-4957(e)(1).

313. See e.g., TENN. CODE ANN. § 68-11-1303(e)(2)(g).

314. See e.g., TENN. CODE ANN. § 68-11-1303(e)(2)(c); NEB. REV. STAT. § 71-7706(2)(c); KAN. STAT. ANN. § 65-4957(e)(3); TEX. HEALTH & SAFETY CODE ANN. § 314A.056(a)(1)(A).

315. See e.g., TENN. CODE ANN. § 68-11-1303(e)(2)(f).

316. See e.g., TENN. CODE ANN. § 68-11-1303(e)(2)(e); KAN. STAT. ANN. § 65-4957(e)(5); W. VA. CODE § 16-29B-28(f)(4)(G).

317. See e.g., W. VA. CODE § 16-29B-28(d)(2)(A); TEX. HEALTH & SAFETY CODE ANN. § 314A.056(a)(1)(A).

318. See, e.g., TENN. CODE ANN. § 68-11-1303(e)(3); KAN. STAT. ANN. § 65-4957(f).

319. See, e.g., TENN. CODE ANN. § 68-11-1303(e)(3)(C).

320. WASH. REV. CODE § 43.72.300(1)–(2) (2025). See *supra* Part V.B.1.

321. See TEX. HEALTH & SAFETY CODE ANN. § 314A.002 (2025). See *supra* Part V.B.1.

322. W. VA. CODE § 16-29B-28(c). See *supra* Part V.B.1.

323. N.C. State Bd. of Dental Exam’rs v. F.T.C., 574 U.S. 494, 507 (2015) (quoting *Patrick v. Burget*, 486 U.S. 94, 101 (1988)).

324. *Id.* at 497 (quoting *Patrick*, 486 U.S. at 100–01).

and grant the agency the authority to “veto or modify particular decisions to ensure they accord with state policy.”³²⁵ The drafters may also want to note that the agency has actual supervisory authority—not merely the potential for supervision.³²⁶

Every state ought to require the hospital submit a report on an annual or biannual basis.³²⁷ The state should include information similar to the information found in the COPA application. That way, the supervising agency can decide each year or every other year whether, by a showing of clear and convincing evidence, the COPA’s benefits are still likely to outweigh any disadvantages from any reduction in competition caused by the COPA.³²⁸

To help fund the supervision of a COPA, states should mimic Texas and charge the hospital an annual fee consistent with the reasonable costs the agency incurs from supervising the COPA.³²⁹ Like Tennessee, states may consider giving their supervising departments the right to periodically conduct onsite inspections of the COPA-holding hospital.³³⁰ For additional supervisory mechanisms, states may look to the FTC’s guidance on state-action supervision.³³¹

E. Termination

Much like Tennessee requires, states should mandate the hospital submit a “plan of separation” before the agency’s supervision of that COPA can be discontinued—which will only occur if the agency deems that the plan of separation is completed.³³²

VIII. CONCLUSION

Rural hospital closures and consolidations have garnered significant attention in recent years, and both scenarios pose significant access issues for patients in rural communities. Consolidation may prevent a hospital from closing, helping it achieve economies of scale and gain reimbursement-bargaining power. Consequently, though, patients may experience post-merger price increases. However, such anticompetitive effects do not occur because competition has been displaced, for competition is already nonexistent in most rural hospital markets; consolidation simply allows the

325. *Id.* at 515; *accord.* *Teladoc, Inc. v. Tex. Medical Bd.*, 2015 U.S. Dist. LEXIS 166754 at *8 (W.D. Tex. 2015) (holding that the state medical board failed to meet the supervision prong of the state-action doctrine because it did not have any veto or modification authority over the private party’s decisions).

326. *See Id.*

327. *See, e.g.*, TENN. CODE ANN. § 68-11-1303(g) (2025); TEX. HEALTH & SAFETY CODE ANN. § 314A.059.

328. TENN. CODE ANN. § 68-11-1303(g) (2025).

329. *See* TEX. HEALTH & SAFETY CODE ANN. § 314A.105 (assessing “an annual supervision fee in an amount that is at least \$75,000 but not more than \$200,000”).

330. Tenn. Comp. R. & Regs. R. 1200-038-01-.06(7) (2025).

331. *See generally*, FED. TRADE COMM’N, *supra* note 272.

332. TENN. CODE ANN. § 68-11-1303(g); *see also* TENN. CODE ANN. § 68-11-1306(b).

hospital to take advantage of its existing monopolistic position in the market. Therefore, using antitrust law to preclude M&A activity may prevent anticompetitive effects, but it does not drive competition. Thus, in rural hospital markets, antitrust enforcement does not engender the benefits of competition, and it does not lead to lower costs or higher quality.

While the FTC attempts to prevent consolidation in these markets, other federal policies incentivize consolidation—whether directly or indirectly. Because urban hospital markets can support multiple competitors, antitrust enforcement may lead to lower costs and higher quality in those markets. Conversely, though, rural hospital markets are typically home to one hospital, and they do not offer a high enough demand for would-be competitors to enter this market. Because no meaningful competition exists in most rural hospital markets, local healthcare providers' delivery of care is not currently being incentivized by competition. Thus, the quality of the care they deliver is not tied to the amount of competition they face. Likewise, their motivation to improve the quality of their care may not be diminished if their employer hospital consolidates. In fact, such consolidation may alleviate the hospital's financial distress, allowing more opportunities to invest in patient services rather than financial survival. To ensure such consolidation results in better care at lower cost for patients, states may use COPAs to supervise the hospital's post-merger conduct.

COPAs permit hospital consolidation, implement post-consolidation ongoing regulatory oversight, account for rural hospital markets' unique economic dynamics, and create a third option for rural hospitals that may be choosing between closing their doors or entering a merger that may lead to higher costs for their patients. Using COPAs is not an ideal or long-term solution, but rather, the most readily available and viable option for rural hospitals to avoid closure, receive the benefits of consolidation, and provide their patients with accessible health care. Therefore, to provide financially distressed, rural hospitals with this option, states should consider enacting COPA statutes.