641—201.26(135,75GA,ch158) Criteria for decision.

201.26(1) The department shall not approve an application unless the department determines that the arrangement is more likely to result in lower costs, increased access, or increased quality of health care, than would otherwise occur under existing market condition or conditions likely to develop without an exemption from state and federal antitrust law. In the event that a proposed arrangement appears likely to improve one or two of the criteria at the expense of another one or two of the criteria, the department shall not approve the application unless the department determines that the proposed arrangement, taken as a whole, is likely to substantially further the purpose of this chapter. In making such a determination, the department may employ a cost/benefit analysis.

201.26(2) Factors.

a. Generally applicable factors. In making a determination about cost, access, and quality, the department may consider the following factors, to the extent relevant:

(1) Market structure: actual and potential sellers and buyers, or providers and purchasers; actual and potential consumers; geographic market area; and entry conditions;

(2) Current market condition;

(3) The historical behavior of the market;

(4) Performance of other similar arrangements;

(5) Whether the proposal unnecessarily restrains competition, or restrains competition in ways not reasonably related to the purposes of this chapter; and

(6) The financial condition of the applicant.

b. Cost. The department's analysis of cost must focus on the individual consumer of health care. Cost savings to be realized by providers, health carriers, group purchasers, or other participants in the health care system are relevant only to the extent that the savings are likely to be passed on to the consumer. However, where an application is submitted by providers or purchasers who are paid primarily by third-party payers unaffiliated with the applicant, it is sufficient for the applicant to show that cost savings are likely to be passed on to the unaffiliated third-party payers; the applicants do not have the burden of proving that third-party payers with whom the applicants are not affiliated will pass on cost savings to individuals receiving coverage through the third-party payers. In making determinations as to costs, the department may consider:

(1) The cost savings likely to result to the applicant;

(2) The extent to which the cost savings are likely to be passed on to the consumer and in what form;

(3) The extent to which the proposed arrangement is likely to result in cost-shifting by the applicant onto other payers or purchasers of other products or services;

(4) The extent to which the cost-shifting by the applicant is likely to be followed by other persons in the market;

(5) The current and anticipated supply and demand for any products or services at issue;

(6) The representations and guarantees of the applicant, and their enforceability;

(7) Likely effectiveness of regulation by the department;

(8) Inferences to be drawn from market structure;

(9) The cost of regulation, both for the state and for the applicant; and

(10) Any other factors tending to show that the proposed arrangement is or is not likely to reduce cost.

c. Access. In making determinations as to access, the department may consider:

(1) The extent to which the utilization of needed health care services or products by the intended targeted population is likely to increase or decrease. When a proposed arrangement is likely to increase access in one geographic area, by lowering prices or otherwise expanding supply, but limits access in another geographic area by removing service capabilities from that second area, the department shall articulate the criteria employed to balance these effects;

(2) The extent to which the proposed arrangement is likely to make available a new and needed service or product to a certain geographic area; and

(3) The extent to which the proposed arrangement is likely to otherwise make health care services or products more financially or geographically available to persons who need them.

If the department determines that the proposed arrangement is likely to increase access and bases that determination on a projected increase in utilization, the department shall also determine and make a specific finding that the increased utilization does not reflect overutilization.

d. Quality. In making determinations as to quality, the department may consider the extent to which the proposed arrangement is likely to:

(1) Decrease morbidity and mortality;

(2) Result in faster convalescence;

(3) Result in fewer hospital days;

(4) Permit providers to attain needed experience or frequency of treatment likely to lead to better outcomes;

(5) Increase patient satisfaction; and

(6) Have any other features likely to improve or reduce the quality of health care.