PROFILES OF COST CONTAINMENT STRATEGIES
FEBRUARY 2022

Improve Oversight of Provider Consolidation

Cost Driver Targeted: Provider prices

OVERVIEW

State oversight of provider consolidation focuses primarily on preventing horizontal consolidation (between the same type of organization, e.g., hospitals) and vertical consolidation (across different types of organizations, e.g., hospitals and physician practices) that could make markets less competitive and raise provider prices. In some cases, approaches could include "conduct remedies," which require or restrict certain actions by the postmerger entity to maintain competition. They also may include Certificate of Public Advantage (COPA) agreements involving requirements on the transactional parties prior to state approval, with penalties for the providers or unwinding provisions should the consolidation lead to undesired price increases and/or other anticompetitive behavior. Because of extensive provider consolidation activity in recent decades, states may also need to develop robust policies to address anticompetitive contract language and behavior between provider systems and health plans. In limited cases, states may also need to consider unwinding mergers or having entities divest certain assets to recreate a competitive environment.

Five states proposed legislation targeting provider consolidation during the 2021 session. Two states, Oregon and Nevada, successfully enacted new legislation. Nevada has passed two bills requiring notice of "material changes" and prohibiting antitiering and antisteering clauses, two types of anticompetitive contract terms. Oregon's legislation requires parties to provide the Department of Consumer and Business Services or the Oregon Health Authority with at least 180 days' advance written notice of any "material change transaction." Transactions that are found to "have a negative impact on access to affordable health care" are subject to disapproval or conditional approval.

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KEY STEPS IN DESIGN AND IMPLEMENTATION

Determine level of authority. All state attorneys general (AG) already have some authority, mostly from statute but also from state constitutions or common law, to oversee health care mergers and acquisitions involving health care providers. This authority exists within one or more divisions in the AG office, such as the charities, antitrust, or the consumer protection divisions. Some states' AG offices have created health care divisions to respond more comprehensively to issues that arise from provider consolidation. Some states have additional statutory authority to review potential mergers and acquisitions or to prohibit anticompetitive contract terms. Moreover, some states may block transactions that they deem anticompetitive.

Consider including other agencies. One option for states is expanding other agency (besides the AG) involvement in this activity. Currently, 35 states have some Certificate of Need authority within a state agency that could contribute to the review of certain transactions and analyze potential impacts of mergers and acquisitions.[1] Some states have assigned new authority to an existing agency or created a new agency to assist with reviews. In Massachusetts, the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC) provide additional data and analytical capacity for reviewing transactions. In Rhode Island, the AG receives notice of nonprofit hospital transactions only, while the Rhode Island Department of Health receives notice of all hospital transactions.

Require notification of health care mergers or acquisitions. The federal government, via the Federal Trade Commission and the Department of Justice, receives notice of transactions exceeding $92 million as required by the 2021 Hart–Scott–Rodino Antitrust Improvements Act (HSR). However, most transactions fall below this threshold, never facing review unless the state requires it. States will likely want to set their own standards for notice to capture transactions below the HSR level. Several important criteria for states to consider include:

- *Organizations required to report:* States may choose to include for-profit providers and/or investors in addition to the standard nonprofit authority of the AG. Because of the increase in vertical mergers and acquisitions, states also may want to include organizations other than hospitals. Connecticut, for example, requires hospitals and group medical practices to provide the AG with 30 days' notice of merger or affiliation agreements.
- *Types of transactions that are reportable:* Instead of trying to anticipate the myriad possible transactions or the dollar amount needed to trigger noticing, one option for states is using "material change" language, which can then be defined and updated through state guidance or regulation. Washington recently passed legislation requiring notice for any "material change" to a provider organization, which is currently defined to include a merger, acquisition, or contracting affiliation between two or more hospitals, hospital systems, or provider organizations. States may want to include language regarding contracting affiliation, as those relationships can have the same impact on price and competition as mergers and acquisitions.
- *Length of notice period:* When determining the length of the notice period, states have selected options ranging from 30 days to 180 days before the effective date of the transaction. However, some states have flexibility in extending the period if additional time is needed to assess the transaction and to coordinate a response.

Request data and conduct analysis. States may predetermine the standard data and documents needed to adequately review the potential impacts of the transaction. They also may consider adding authority to request supplementary documentation if needed. States with all-payer claims databases and analytical capacity will be better positioned to analyze price and market conditions before the transaction and estimate changes that may occur.

1 Of note, the impact of Certificate of Need programs themselves on health care expenditures is mixed. See Christopher J. Conover and James Bailey, "Certificate of Need Laws: A Systematic Review and Cost-Effectiveness Analysis," BMC Health Services Research 20, no. 1 (Aug. 14, 2020): 748.

Determine action. Some states have the authority to block certain transactions without court action. For example, Rhode Island's Hospital Conversions Act grants state officials the authority to reject mergers that will decrease competition. Without this authority, states have the choice of pursuing legal action or compelling the entities to meet certain requirements under ongoing state oversight. States can impose conditions in several ways. States with authority can approve transactions subject to specific conditions. States with COPA authority can protect hospitals from the enforcement of state and federal antitrust action by putting in place a framework for active oversight. COPA agreements and state oversight continue indefinitely. Finally, states without either authority can seek court approval to impose conditions through negotiated consent decrees. No matter which mechanism is used, states can impose numerous conditions on the behavior of the merged entity, such as limiting cost growth and requiring that health systems keep certain services in operation. Taking legal action and monitoring terms of agreements can require substantial resources for the state and are not always vigorously pursued. Moreover, some oversight approaches are time-limited and provide no assurance that the entity won't pursue anticompetitive behavior once the oversight ends.

Develop strategies to prohibit noncompetitive contract terms between payers and providers. Because more than 90 percent of U.S. health care markets are already considered anticompetitive, states may need to focus their efforts on developing strategies to restrict anticompetitive contract terms between payers and providers. These terms include "all-or-nothing" clauses, antitiering or antisteering clauses, "most favored nation" exclusive contracting, anti-incentive clauses, and gag clauses. Several states, including Massachusetts, have restricted anticompetitive contract clauses through legislation, and the National Academy for State Health Policy has developed model legislation for states. Some states have also focused on capping high prices or price increases, as described separately in these profiles.

EVIDENCE OF IMPACT

There is significant research documenting that more concentrated health care markets have higher commercial prices and that both horizontal and vertical consolidation increase prices. Therefore, it is logical to expect that by preventing mergers that would reduce competition in a particular market, states would be able to maintain lower commercial prices in that market.

There also are numerous examples where states have put in place requirements on transactions to ensure continued access, cap price increases, or constrain anticompetitive behavior. However, most of these agreements have been time limited, and we were unable to find evidence of sustained impact on improving the competitiveness in a market for the long term. More recent efforts by states to enact stronger, more comprehensive legislation are new and have not been evaluated.

In terms of the effect of banning noncompetitive contract terms, the Congressional Budget Office and the Joint Committee on Taxation recently found that banning antitiering and antisteering clauses in markets with a dominant health care provider and no single dominant insurer would have a modest effect, decreasing premiums by approximately 0.05 percent.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

The strategy is likely best suited for states that have:

- provider systems with significant market share
- the willingness to take on large provider systems
- significant data analysis capacity within the AG office or elsewhere in the state.

Although states with comprehensive legislation in this area have tended to have more progressive political climates, this strategy is already being pursued in AG and Certificate of Need offices in states with a wide range of political dynamics. Legislation was proposed (although not passed) during the 2021 legislative sessions in both Florida and Indiana, suggesting significant interest across political contexts. For those states desiring market-based approaches to health care, ensuring the market is functioning as it should is important and cannot be ignored.

EQUITY CONSIDERATIONS

In general, a strategy that increases competition in a marketplace should reduce health care costs and improve access and quality for all. However, there is some concern that as hospitals aim to maximize profits, they could eliminate services that have a disproportionate share of patients associated with low reimbursement. States could mitigate such outcomes by incorporating specific provisions to assess and improve access and equity for low-income patients. For example, states could require provider commitments to enhance community services, participate in Medicaid programs, or ensure that behavioral health or other services with lower reimbursement continue to serve underserved communities in their approvals of mergers.

In Massachusetts, an agreement that allowed Beth Israel Deaconess Medical Center and Lahey Health to merge included a "good faith effort" to enroll Medicaid and CHIP beneficiaries and "to make over $70 million in investments over eight years to improve access to health care for low-income and underserved communities, with a focus on financial support for community health centers, safety-net hospitals, and behavioral health." When Ballard Health was established in rural Tennessee and Virginia, the COPA agreement included a commitment to invest more than $300 million to expand access to behavioral health, address population health services specific to the community, and direct funds toward children's and rural health.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

A limitation with this strategy is that many markets already have a high degree of consolidation, particularly among hospitals. While it may still make sense to employ a noticing requirement, states may need to focus on the anticompetitive behavior of existing large health systems. These systems may already have significant political clout within a state, making it more difficult to direct policy at those organizations alone. Therefore, other strategies (e.g., cost growth targets and price caps) may be more effective overall. In addition, if states implement agreements in lieu of legal action, they may be forestalling but not preventing price increases and other anticompetitive behavior by the merging entities. There are several state examples of COPAs that initially worked well at achieving policy goals but were later discontinued when state legislatures repealed their COPA laws, leaving the mergers unsupervised.

RESOURCES

Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices: The Role of the States* (Urban Institute, Jan. 2020).

Erin Fuse Brown, "State Policies to Address Vertical Consolidation in Health Care," National Academy for State Health Policy, Aug. 7, 2020.

Katherine L. Gudiksen et al., *Preventing Anticompetitive Contracting Practices in Healthcare Markets* (The Source on Healthcare Price & Competition and Petris Center, Sept. 2020).

Alexandra D. Montague, Katherine L. Gudiksen, and Jaime S. King, *State Action to Oversee Consolidation of Health Care Providers* (Milbank Memorial Fund, Aug. 2021).