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Who Can Rein in Health Care Prices? State and Federal Efforts to Address Health Care Provider Consolidation

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Policy Points

- Effective oversight of health care market conduct requires collaboration between state and federal policymakers
- Policymakers are beginning to address the consequences of health care provider concentration through increased price transparency, improved merger review, oversight of anticompetitive conduct, and increased competition through a public option

ABSTRACT

Decades of ineffective antitrust enforcement have left many US health care markets with insufficient competition to control prices. Increasingly, hospitals have merged to form dominant health systems that can exert market power and charge anticompetitive prices that reduce wage growth and burden the economy. Effective oversight of market conduct requires collaboration between state and federal policymakers. This brief describes actions taken by federal and state policymakers to address the consequences of health care provider concentration through increased price transparency, improved merger review, oversight of anticompetitive conduct, and increased competition through a public option.

INTRODUCTION

Health care is increasingly unaffordable for many Americans. In the middle of the coronavirus pandemic, nearly one in five adults in the United States, about 46 million people, reported that someone in their household skipped necessary medical care because of cost in the past year.[1] The lack of affordable health care not only affects individual families, but also stunts wage growth,[2] contributes to growing economic inequality,[3,4] and may dampen economic growth.[5,6]

Americans pay higher prices for health care services compared with residents of similar nations, without commensurate increases in quality, which contributes significantly to our overall health care spending.[7] The consolidation of health care providers into health systems with substantial market power, which can be leveraged in price negotiations with insurers, has driven American health care prices to new heights.[8-12] Unfortunately, a lack of rigorous antitrust enforcement over the past three decades has exacerbated provider

consolidation. By 2018, over 95% of metropolitan areas had highly concentrated hospital markets, and nearly 80% had highly concentrated specialist physician markets.[13] The coronavirus pandemic may further accelerate consolidation as acquisition by large health systems or private equity firms may offer relief to financially distressed physician practices.[14] As Harvard University scholars warn, "the challenges of rising health care costs and market power will still be with us after Covid-19 has passed, and further consolidation will make costs even harder to restrain."[15]

This brief describes actions taken by federal and state policymakers to address the consequences of health care provider concentration through increased price transparency, improved merger review, oversight of anticompetitive conduct, and increased competition through a public option (Figure 1). While the Biden administration has demonstrated a commitment to strong antitrust enforcement and Congress is considering sweeping reforms of federal antitrust law, federal responses remain uncertain and time-consuming. As a result, continued state action remains critical to protect consumers against the harms of health care consolidation.

Figure 1. Federal and State Actions to Address Health Care Provider Consolidation

	Federal Actions	State Actions

Price transparency	• 2 final rules established in 2019 (hospital transparency rule and transparency in coverage rule)
	• No Surprises Act enacted as part of the Consolidated Appropriations Act, 2021
	  ○ One-time funding for states to create all-payer claims databases (APCDs)
	  ○ Standardized data format for voluntary submission by self-funded payers
		• 18 states have APCDs with mandatory reporting for all public and fully funded commercial plans (5 more states are in the process of implementation)

Merger review	• New Vertical Merger Guidelines • Federal Trade Commission retrospective study on physician mergers • Klobuchar bill would strengthen existing federal merger statutes	• 30 states require pre-transaction notification of hospital mergers to attorney general's office or other state agency (in 17 states, that notice is limited to nonprofit hospital mergers) • 3 states (Connecticut, Massachusetts, and Washington) require pre-transaction notification of physician mergers
Anticompetitive conduct	• Biden appointments suggest increased focus on monopoly and market power • Antitrust Law Enforcement Reform Act (S. 225) would prohibit exclusionary conduct by firms with market power	• Sutter Health (California) and Atrium Health (North Carolina) lawsuits alleging anticompetitive use of contracting practices • 20 states have laws restricting most-favored-nation provisions • Massachusetts bans anti-tiering and anti-steering provisions
Increased competition through a public option	• Proposed federal public option bills • Could support state public options through waiver approvals	• Washington starts selling a public option in January 2021 • Nevada will begin selling a public option in 2026 and other states (e.g., Colorado) appear poised to follow.

NEED FOR INCREASED PRICE TRANSPARENCY TO SUPPORT OTHER COST-CONTROL EFFORTS

A first step toward demonstrating the impact of health care consolidation — and promoting affordability — has been to make more information about health care prices publicly available. Policymakers and regulators need detailed price information from all payers, including self-funded employers, to assess where market interventions may be needed to address consolidated market power. Detailed information about pricing for all payers is critical to assess cost-shifting or other payment inequities.[16]

One of the biggest hurdles faced by state lawmakers seeking critical price information is the federal Employee Retirement Income Security Act (ERISA) of 1974, which preempts state laws regulating self-funded health plans.[17] After the 2016 Supreme Court decision in *Gobeille v. Liberty Mutual Insurance Co.*, states have been unable to require self-funded plans to report claims data, including negotiated prices, to state all-payer claims databases (APCDs).[18] In response, the Trump administration issued two final rules — one requiring hospitals to disclose payer-specific negotiated rates[19] and one requiring health insurers and most self-funded employers to disclose their negotiated rates with health care providers.[20] Since the hospital transparency rule took effect in January 2021, numerous hospitals appear to be choosing to pay the small fine rather than disclose the information, so additional penalties may be needed to ensure compliance.[21-23] The final rule on transparency in coverage, which applies to payers, does not require any disclosures until January 2022, so the impact of that rule remains unknown.

In addition to administrative action, Congress included assistance for state APCDs in the No Surprises Act enacted as part of the Consolidated Appropriations Act, 2021.[24] This support included one-time financial support for states to establish or improve existing APCDs. In addition, the No Surprises Act requires the Department of Labor to develop a standardized data format and provide guidance to states to obtain data from self-funded and other group plans.

These efforts by the federal government acknowledge that states may be best positioned to collect and use data from an APCD, and more and more states are implementing these databases. But states require resources and federal action to fill in gaps in their authority created by ERISA. Transparency alone, moreover, is unlikely to constrain health care price increases, and state policymakers may need additional support from the federal government to effectively address consolidation and anticompetitive business practices.

IMPROVED MERGER REVIEW: PREVENTING NEW TYPES OF ANTICOMPETITIVE CONSOLIDATION

Price transparency can uncover the effect of consolidation on prices, but to effectively control costs, policymakers need additional tools to identify and block potentially harmful consolidation before it occurs. The price impact of horizontal consolidation of hospitals is well established,[9,10,25-29] but consolidation into large, vertically integrated, national health systems continues largely unopposed. Because these mergers often involve groups that do not directly compete with each other for patients (e.g., hospitals in different geographic markets; insurers with providers; physician groups or clinics with hospitals), they may not initially appear to be anticompetitive. Nonetheless, research shows that these mergers increase prices,[11,30,31] so state and federal governments must work to implement policies to better oversee these mergers.

Federal Agencies' Focus on Vertical Consolidation

Vertical mergers combine companies operating at different stages within a supply chain, such as a hospital or health system acquiring a physician practice or outpatient clinic, and have been largely overlooked by the Federal Trade Commission (FTC) and Department of Justice (DOJ). Specifically, the FTC challenged only two acquisitions of physician practices by a health system between 2012 and

2018,[32-34] even though the number of physician practices owned by hospitals more than doubled during that time.[35] Recognizing the need to improve and clarify enforcement policies, the FTC and DOJ issued new Vertical Merger Guidelines in 2020 to better assess possible harms from vertical mergers.[36] Additionally, the FTC announced in January 2021 that it will conduct a retrospective study of the effects of physician practice acquisitions between 2015 and 2020.[37] Similar retrospective studies have helped the FTC hone its approach to hospital merger review by showing that mergers involving nonprofits can result in anticompetitive effects and that its approach to defining geographic markets was flawed.[37] The retrospective study of physician acquisitions will allow the FTC to more effectively assess and, when appropriate, challenge future consolidation of physician practices, but these studies cannot turn back the clock on the consummated mergers that have led to highly consolidated markets.

Potential Congressional Reform of Antitrust Law

While federal antitrust enforcers try to increase the effectiveness of existing authority, Congress is considering giving the FTC and DOJ additional oversight tools. In one of the most "sweeping" efforts aimed at "overhauling and modernizing" antitrust enforcement,[38] Senator Amy Klobuchar (D-Minn.) introduced the Competition and Antitrust Law Enforcement Reform Act (Figure 2).[39] While this bill is not specific to health care, if passed, it would allow antitrust enforcers to more easily challenge health care mergers and anticompetitive conduct.

These actions demonstrate a renewed commitment to regulating anticompetitive health care consolidation, but federal regulators cannot oppose mergers that go unnoticed. Federal law only requires merging entities to report transactions valued above the Hart-Scott-Rodino (HSR) filing threshold to federal antitrust enforcers before consummating the merger.[40] For 2021, that threshold is $92 million, leaving nearly all acquisitions of physician groups and even some smaller hospitals unmonitored by federal antitrust agencies.[41] The HSR threshold is set by statute and adjusted annually based on the gross national product. While changing the way the HSR threshold is set would require an act of Congress, many states already require pre-merger notification of a broader set of health care transactions.

Figure 2. Key Provisions of the Competition and Antitrust Law Enforcement Reform Act (S. 225, the Klobuchar bill)

Revises standard for merger review. Current federal law, the Clayton Act and Section 5 of the FTC Act, prohibits any acquisition that "substantially lessens" competition, or "tends to create a monopoly." The Klobuchar bill would strengthen this law by prohibiting mergers that "create an appreciable risk of materially lessening competition, or to tend to create a monopoly or a monopsony."

Shifts burden of proof to merging parties. Current law requires the government to prove that a merger is likely to reduce competition. The Klobuchar bill would shift the burden to the merging parties to demonstrate that a merger will not "create an appreciable risk of materially lessening competition" in certain circumstances, including if the merger would lead to a significant increase in market concentration in any relevant market or if the merger would result in one entity with more than 50% market share.

Prohibits "exclusionary conduct." The bill provides that any "exclusionary conduct" by an entity with 50% market share, or that "otherwise has significant market power," violates federal antitrust laws unless the conduct creates "distinct procompetitive benefits" or falls into other narrow exceptions.

Provides additional funding to the FTC and DOJ.

States' Critical Role in Merger Review

The limitations in federal oversight mean that states must actively review health care mergers. Many state legislatures have passed laws to fill gaps in federal oversight. Specifically, 30 states and the District of Columbia currently require most hospitals to report to a state agency before merging, and three states — Connecticut, Massachusetts, and Washington — require notification of most physician practice mergers.[42] As a result, state agencies may be able to monitor and restrict "stealth consolidation," in which consecutive small transactions that may not raise antitrust concerns individually may significantly impact market power

collectively over time.[43] Moreover, while federal regulators must go to court to block a transaction,[44] 14 states have approval requirements that allow regulators to block transactions administratively.[40] Many of those states can also impose conditions on mergers without going to court or undergoing a lengthy negotiation process.

States have enhanced local knowledge and, in many cases, authority that is complementary to the FTC and DOJ. However, many state agencies are underfunded, so collaboration with federal antitrust authorities can provide valuable resources and expertise for state merger-review processes. Effective merger review requires cooperation between state and federal agencies to protect remaining competition in health care markets.

ENHANCED ANTITRUST ENFORCEMENT OF MARKET CONDUCT

While antitrust enforcement to protect and promote competition may be ideal, many markets are already so heavily consolidated that preventing future mergers is insufficient to limit supracompetitive price increases. The federal government is likely to increase attention to anticompetitive conduct, but states may be better able to moderate anticompetitive conduct in health care because of broader regulatory and, in some states, statutory authority.

Increased Federal Efforts to Limit Anticompetitive Conduct

The Biden administration has increased attention to mitigating the harms of consolidation. Multiple appointments include those of Tim Wu to the National Economic Council and Lina Khan as FTC Commissioner. In addition, President Biden's appointment of Secretary of Health and Human Services Xavier Becerra, who oversaw a settlement in a groundbreaking antitrust lawsuit against Sutter Health alleging that its contracting practices violated California's antitrust law, confirms the administration's intention to extend this scrutiny to health care markets. Additionally, the Senate Judiciary Committee held a committee meeting on competition policy and health care consolidation,[45] and the Klobuchar bill, if passed, would prohibit most "exclusionary conduct" by an entity with 50% market share.[39] The congressional attention and administrative appointments demonstrate increased attention to the abuse of market power, but even with increased federal attention, state laws may enable states to more effectively regulate conduct in health care markets.

Regulation of Nonprofits by States and the Department of Justice

While the FTC reviews *mergers* of health care providers, it is prohibited from enforcing antitrust laws against nonprofit entities, including many hospitals and health systems, for anticompetitive conduct.[46] As a result of this limitation on its authority, the FTC cannot use the knowledge gained from its merger review to challenge post-merger anticompetitive behavior of a merged entity. Consequently, according to Acting FTC Chair Rebecca Kelly Slaughter, "all of the healthcare industry expertise that the FTC has worked for decades to, and continues to, develop cannot be deployed alongside the DOJ and state enforcers to stop anticompetitive practices by roughly half of all hospitals nationwide."[47] States have helped bridge this gap in FTC authority and provided local expertise to the DOJ by bringing two major lawsuits against nonprofit entities alleging anticompetitive contracting practices — one against a dominant insurer, in *United States v. Blue Cross Blue Shield of Michigan*,[48] and one against a dominant health system, in *United States v. Charlotte-Mecklenburg Hospital Authority* (a.k.a. Atrium Health).[49]

State Antitrust Statues: Broader Than Federal Statutes

In addition to providing expertise into anticompetitive conduct, state attorneys general — unlike their federal counterparts — have the advantage of choosing whether to bring a case under state or federal antitrust statutes. In addition, many states have passed antitrust statutes that are broader than federal statutes. For instance, some allow more predatory pricing claims than federal antitrust laws, while others allow indirect purchasers to sue for damages.[50-52] By being able to file suit under

federal or state antitrust laws, state attorneys general have the freedom to choose the more favorable forum. For example, in lawsuits alleging similar contracting practices, California's attorney general filed a lawsuit in state court against Sutter Health alleging violation of California's Cartwright Act,[53] whereas the North Carolina attorney general and the DOJ filed a lawsuit in federal court against Atrium Health alleging violation of the Sherman Act.[49]

State Bans on Specific Health Care Contracting Practices

State legislators have been more successful than Congress at passing laws prohibiting anticompetitive contracting practices between insurers and health care providers.[54] Over a decade ago, the Massachusetts legislature banned the use of several contracting practices in health insurance contracts.[55] In 2019, Congress failed to pass the Lower Health Care Costs Act, which would have prohibited use of specific contract terms, costing Americans an estimated $1 billion over 10 years.[56] This calculation and increasing recognition that dominant health systems may exploit their market power to drive up prices may motivate other state legislatures to pass legislation banning these practices. Nonetheless, ERISA remains an impediment to applying these state efforts to self-funded plans, and congressional action is required to impose uniform restrictions on contracting practices for all health insurance plans.

INJECTING COMPETITION BY OFFERING A PUBLIC OPTION

In addition to protecting markets through better merger review and oversight of anticompetitive conduct, lawmakers are also considering increasing competition in health care markets by creating a public option. A public option is a health insurance plan offered by a government agency that competes with private health insurance companies.[57] By offering a public option, the government can drive down the cost of both premiums and health services, but only if it limits provider rates or other costs to apply competitive pressure.[58]

With the federal public option facing what has been called "the biggest health care fight since Obamacare,"[59] and without the votes in the Senate to overcome a filibuster, states may find it easier to create a public option plan than the federal government would. While the federal government has fewer legal constraints than state governments face when designing a public option, such as budget neutrality and waiver requirements, states have taken the lead in designing and prototyping public option plans.[58] Specifically, Washington started selling a public option plan on its Health Benefit Exchange on January 1, 2021,[60] and other states, including Colorado[61] and Nevada,[62] appear poised to follow Washington's example.

While the initial premiums for Washington's public option plan were higher than its proponents hoped,[63] Washington may now experiment with lower provider rate caps or additional cost controls.[58] The states that choose to offer public option plans may help refine provider caps and network requirements to ensure that public option plans can control costs and provide adequate networks. Lawmakers in the forerunner states recognize that they cannot wait for the federal government to implement new laws and policies and are forging ahead with public options designed to fulfill state goals like covering the remaining uninsured.

NEED FOR STATE AND FEDERAL GOVERNMENT COLLABORATION TO MANAGE MARKET POWER

Decades of ineffective antitrust enforcement have left many US health care markets with insufficient competition to control prices. Hospitals have merged to form dominant health systems that can exert market power and charge anticompetitive prices that reduce wage growth and burden the economy. Collectively, recent actions by the executive and legislative branches of the federal government demonstrate increased attention to the harms of consolidation and market power, especially in health care, but the feasibility of meaningful change at the federal level remains uncertain, and any changes that do occur will take time to pass and

implement. Meanwhile, the consolidation of health care providers into large health systems continues to accelerate,[64] and in many geographic markets, competition has eroded to the point where market forces cannot control prices.

States have distinct advantages in addressing the potential harms arising from consolidation in health care markets. While federal efforts are needed to support state transparency efforts, states with functioning APCDs likely have a detailed understanding of existing price disparities due to market power and distortions in negotiating leverage. States with pre-merger notification requirements that are broader than the federal requirements may be better able to track and respond to successive transactions. When reviewing mergers, state policymakers can be more responsive to market conditions, may have deeper knowledge than federal regulators about the local markets and dynamics, and can review and impose conditions on mergers that reflect cost and other priorities, like health care access and job creation. Furthermore, state antitrust enforcers may be able to discover and challenge anticompetitive conduct more easily than their federal counterparts can. Finally, state-level reforms, like a public option, can be tailored to work best for each state. Nonetheless, many state agencies remain resource-constrained and lack the deep expertise in reviewing health care markets that federal agencies have.

Effective oversight of market conduct requires collaboration between state and federal policymakers. The status quo is unsustainable, and elected officials must be willing to enact multiple, reinforcing policies to reinvigorate markets, stimulate competition, and control prices. A comprehensive and multifaceted approach is critical to address health care consolidation and ensure Americans continue to have access to affordable health care. The next two briefs in this series will provide more detail on how state officials can (1) oversee health care consolidation and (2) mitigate the impact of past consolidation.

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