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Mitigating the Price Impacts of Health Care Provider Consolidation

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Policy Points

- Laws prohibiting potentially anticompetitive contract terms can apply uniformly to all health insurers and providers, fostering a more competitive market.
- State policymakers seeking to address provider market power have options, including passing laws to prohibit specific clauses in contracts between health insurers and providers.

ABSTRACT

Consolidation is a primary driver of high and increasing health care costs in the United States. Dominant health systems and insurers can use contract clauses to restrain competition, increase costs, and maintain market share. Recognizing these harms, state and federal antitrust enforcers filed a handful of lawsuits in the past 11 years against providers or insurers alleging harms from the use of specific contracting practices. Lawmakers have also considered bans on the use of the most problematic contracting practices, including all-or-nothing contracting, most-favored-nation clauses, anti-incentive clauses, and gag clauses, and a few states passed legislation prohibiting their use in contracts between providers and health insurers. This brief explains how the provisions are used in practice to stifle competition, describes the variation in state laws, and offers best practices to state policymakers seeking to address provider market power. Although litigation can address the use of anticompetitive contracting practices by dominant firms, passing legislation to prohibit the use of these terms in health insurance contracts allows state officials to avoid expending the time and resources needed for trial. Furthermore, laws prohibiting potentially anticompetitive contract terms apply uniformly to all health insurers and providers, fostering a more competitive market for health care services.

INTRODUCTION

A robust and growing body of research demonstrates that the United States pays much higher prices for health care than other countries. Consolidation of health care providers into health systems with market power is a primary driver of those high prices. For example, numerous studies find that prices increase between 20% and

60% following the merger of two neighboring hospitals,[1–8] and researchers have consistently found that physician prices increased by 3% to 14% following an acquisition.[9–11] Importantly, most studies find no statistically significant impacts on quality after a merger.[4,12–19] A congressional report written by the Medicare Payment Advisory Commission summarizes the literature, saying, "[t]aken together, the preponderance of evidence suggests that hospital consolidation leads to higher prices. These findings imply that hospitals seek higher prices from insurers and will get them when they have greater bargaining power."[20] Policymakers at all levels need to act to ensure that provider market power does not further compromise health care access and affordability. While better merger oversight is critical to addressing consolidation, most health care provider and insurer markets are already extremely concentrated. In 2018, 95% of the metropolitan statistical areas had highly concentrated markets for hospitals, 78% had highly concentrated markets for specialist physicians, 41% had highly concentrated markets for primary care, and 74% had highly concentrated markets for insurers.[21,22] Thus, policymakers should consider options to promote competition and limit the ability of dominant companies to exploit their market power to drive up prices.

This paper is the third in a series describing what policymakers can do to address provider consolidation. The first paper discussed actions state and federal governments are taking to increase oversight of competition. It asserts that while collective action is ideal, state lawmakers should also act independently in some instances because federal enforcers lack the resources and the authority to intervene in all of the transactions necessary to constrain consolidation.[23] The second paper examined how states can improve their merger review processes to limit or block mergers with anticompetitive potential.[24] While improved merger review is critical to protecting the competition that remains, health systems in many markets have grown so dominant that any improvement of the merger review process may come too late. As economist Martin Gaynor explains, "firms that have acquired market power have strong incentives to maintain or enhance it. This leads to the potential for anticompetitive conduct by firms that have acquired dominant positions through consolidation."[25] This final publication examines how dominant health systems can exert their market power through contracting practices and offers options and best practices to state policymakers seeking to address provider market power, including passing laws to prohibit specific clauses in contracts between health insurers and providers.

Other Briefs in the Health Care Provider Consolidation Series

Who Can Rein in Health Care Prices? State and Federal Efforts to Address Health Care Provider Consolidation. Examines how federal and state 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.

State Action to Oversee Consolidation of Health Care Providers. Examines the variation in state merger review practices across the country and identifies the key elements of a comprehensive state merger review framework.

CONTRACTING PRACTICES CAN AMPLIFY HARMS OF CONSOLIDATION

Competition exists in at least three places in health care markets, and dominant entities may use contracting practices to thwart competition in all of them.

- **Competition between Providers for Network Inclusion.** The first type of competition occurs when providers and health systems compete for inclusion in an insurance network. In theory, an insurance carrier with more covered lives can negotiate lower payment rates with providers because inclusion in the carrier's plan increases the provider's patient volume. In competitive markets, insurers can exclude providers that are too expensive or provide low-quality care from their networks. As such, the fear of exclusion motivates providers to negotiate significant price discounts for inclusion in networks.

- **Competition between Insurers for Health Plan Enrollment.** The second type of competition occurs when insurance companies compete to enroll the most covered lives by appealing to employers or individuals purchasing coverage. Typically, employers and individuals compare insurance plans based on the network and cost, including premiums, deductibles, and other cost-sharing.

- **Competition between Providers for In-Network Patients.** The third type of competition occurs when in-network providers compete for enrollees of the insurance plans they accept. Providers may compete for patients on quality, reputation, patient experience, and cost. While patients are often shielded from the full cost of treatment by insurance, insurers may use tiered co-pays or other means to steer patients to higher-value providers and restrain costs. In competitive markets, providers or insurers would compete on cost and other factors to gain and maintain market share.

Unfortunately, consolidation and anticompetitive contracting practices have stunted competition in all three areas, limiting the ability of competition to constrain costs. The most common contract terms that threaten competition in health care contracts are all-or-nothing clauses, most-favored-nation clauses, anti-tiering/anti-steering provisions, and gag clauses (see Box 1). Below we outline how these provisions are deployed to stifle competition and give examples of legal approaches that antitrust agencies have used to respond.

Lack of Competition for Inclusion in Insurance Networks

First, provider consolidation and the resulting market power mean that many insurers cannot create desirable networks without high-priced health systems. In 2017, 57% of hospital markets had a single, dominant system that accounted for the majority of hospital discharges.[26] In most areas, these hospitals are likely "must-have" providers — hospitals that insurers must include to meet network adequacy laws or create a commercially viable network. Since then, national health systems have continued to grow, and smaller health systems that previously had market power in one city have expanded into large regional health systems.[27] As a result, many health systems contain at least one must-have provider and may be able to require any insurer wanting to contract with the must-have facility to contract with other facilities controlled by the health system. When using all-or-nothing or affiliate contracting, a health system demands that any health plan that wants to contract with a particular provider or affiliate in a health system must contract with all other providers or a specific affiliated provider in the health system (see Box 1). All-or-nothing contracting allows a health system to compound the negotiating leverage of one or more must-have providers, allowing the health system to demand supracompetitive rates (i.e., pricing above what can be sustained in a competitive market) for its other providers and facilities.[28]

Box 1: Potentially Anticompetitive Contract Provisions

1. **All-or-Nothing or Affiliate Contracting:** A requirement that any health plan that wants to contract with a particular provider or affiliate in a health system must contract with all other providers or a specific affiliated provider in the health system.
2. **Most-Favored-Nation Clause (Price Parity Clause):** A guarantee that an insurer gets terms (prices) from a health system that are at least as favorable as all other insurers.
3. **Anti-Tiering or Anti-Steering Clause (Anti-Incentive Clause):** A contractual agreement in which the insurers must place all facilities associated with a health system in the most favorable tier (anti-tiering) or agrees not to steer patients to other health systems (anti-steering).
4. **Gag Clause (Price Secrecy Provision)**: A contractual agreement in which providers and insurers agree not to disclose prices, including negotiated rates from patients or plan sponsors.

Lack of Competition for Enrollment in Insurance Plans

In the second type of competition, insurers compete for enrollees, either from employers or in the individual market. In theory, insurers with large enrollment should be able to negotiate significant discounts from large health systems because providers may agree to lower prices in exchange for a higher volume of patients. In fact, a number of economic studies have found that larger insurers are able to negotiate greater provider discounts.[29–31] While premiums decreased with increased insurer competition, that effect proved insufficient to offset the impacts of hospital concentration.[32] Furthermore, no study documented lower insurance premiums resulting from the lower prices negotiated by dominant insurers.[33] Health insurance markets are nearly as concentrated as provider markets; the American Medical Association reports that 74% of metropolitan statistical areas (MSAs) had highly concentrated health insurance markets and that in nearly half of the MSAs, one insurer had more than 50% market share.[22] Consequently, insurers face minimal pressure to pass savings on to downstream customers to increase enrollment, and dominant providers and insurers may be able to use contractual agreements to split any excessive profits that would not exist in a competitive market.

Like health systems that can use all-or-nothing provisions to expand market power, dominant insurers may also use contracting provisions to stifle competition and ensure that no competitor can negotiate lower prices. In markets with dominant providers and insurers, contractual agreements may allow the two parties to collaborate to stifle competition and drive up prices. Specifically, most-favored-nation clauses allow insurers to guarantee that all competitors face the same or higher provider rates by prohibiting the health system from giving a lower rate to any other insurer (see Box 1). MFNs can be contemporaneous, meaning that the health system must give the insurer the best rate at the time the contract is signed, or retroactive, meaning that the health system agrees to refund the difference between the current and future price if it offers a lower provider payment rate to another insurer during the term of the contract. MFNs can increase costs because insurers no longer have an incentive to negotiate for lower prices. Furthermore, dominant health systems may be able to "sell" an MFN to an insurer and charge higher rates in exchange for the MFN.[34] Researchers explain that "[i]n markets that have high hospital and high insurer consolidation, economic theory would suggest that the dominant insurer and dominant hospital are likely simply splitting the surplus that comes from monopoly pricing."[32]

In an agreement of this type, dubbed the "handshake in the snow," Partners HealthCare agreed to give Blue Cross Blue Shield of Massachusetts the best prices.[35] While this "market agreement" did not appear as an MFN in contracts because the executives were wary of the legal risks, the MFN-like arrangement resulted in premium increases of almost 9% a year — more than double the annual rate of premium increases in the years preceding the agreement.[35] In addition to these collusive harms, MFNs can cause exclusionary harms because they can prevent other insurers from entering the market. Specifically, if an insurer has an MFN, any rival insurer that is aware of the MFN recognizes that they will be unable to compete on price with the current insurer in the market, even if the rival insurer could offer a large increase in patient volume to the system through narrow networks or other new insurance products.

Lack of Competition for Patients by Providers within an Insurance Plan

The third type of competition, when in-network providers compete for patients, is often based on factors other than cost. Insurance generally shields patients from the full cost of their care, often minimizing cost considerations.[36] Furthermore, patients are likely to choose the provider recommended by their doctors or with high quality ratings, even if that provider is more expensive.[37,38] While savings can be substantial for patients who shop for lower-cost care, especially for interchangeable services like MRIs or lab tests, multiple studies show that only a small number of patients use price comparison tools.[38–42]

Rather than relying on patients to compare prices, insurers and employers may control costs by encouraging or incentivizing patients to choose higher-value providers. For example, some insurance plans use tiered networks that group providers into tiers based on price and

quality. The insurer may then offer financial incentives, such as lower co-payments or co-insurance, to patients choosing providers from a lower-cost, higher-value tier. Outside of tiering, insurers may also try to steer patients to lower-cost or higher-value providers by giving preferred providers a specific designation or offering other incentives for patients to seek care from them.[43] Tiered networks or other steering tools give patients clear and actionable information about which providers offer the highest value. One study found that enrollees often selected lower-tiered hospitals for inpatient services, resulting in projected baseline spending reductions of 8% to 17% after three years.[44] Another study found that tiered networks had minimal effects on enrollees' relationships with their existing providers, but when enrollees chose a new doctor, they rarely selected one from the lowest-value tier.[45]

Not surprisingly, dominant health systems may use contract clauses to restrict insurers from using network design tools to steer patients to higher-value care. Specifically, through anti-tiering clauses, health systems may demand placement in the most favorable tier in a tiered network to contract with a health plan, even if some or all of their facilities do not meet the cost or quality metrics for inclusion in that tier. Additionally, health systems using anti-steering clauses may even limit the ability of insurers to give softer steering signals, like listing preferred providers on their websites.

Lack of Price Transparency Hides Anticompetitive Contracting Provisions

Finally, a lack of transparency around prices and contracts can hide the use of anticompetitive contract terms from employers, patients, policymakers, and the public. Dominant health systems may use gag clauses and confidentiality agreements to prohibit contracting parties from disclosing price or other information to a third party. Gag clauses prevent patients, employers sponsoring care, and even policymakers from getting detailed price information to determine where markets are not functioning properly. Often, gag clauses prevent self-funded employers from knowing the prices that their third-party administrator (TPA) pays for services provided to their employees.

Fortunately, Congress prohibited most gag clauses in health insurance contracts in the Consolidated Appropriations Act, passed at the end of 2020. The law prohibits any group or individual health plan from "enter[ing] into an agreement with a health care provider … that would directly or indirectly restrict a group health plan … from providing provider-specific cost or quality of care information … to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage."[46] Furthermore, two new federal rules — the Hospital Price Transparency Rule[47] and the Transparency in Coverage Rule[48] — should allow the public and policymakers increased information about prices so that they can better assess price disparities and market function.[23,49,50] Compliance with the Hospital Price Transparency Rule, however, has been mixed,[51] and the Transparency in Coverage Rule will not be fully effective until January 1, 2024. Because detailed price information is critical to assess cost-shifting or other payment inequities, states should support these federal efforts through state all-payer claims databases and by passing laws that permit TPAs to share the terms of their provider contracts with employers sponsoring coverage.

LITIGATION AND LEGISLATION TO PROHIBIT SPECIFIC CONTRACTING PRACTICES

Lawsuits against Sutter Health, Atrium Health, and BCBS of Michigan demonstrate that vigorous antitrust enforcement can address the use of any of these anticompetitive contracting practices by dominant firms (see Box 2). Nevertheless, cases take years to reach a resolution and often fail to address widespread contracting practices because they target only the conduct of individual companies. Furthermore, health systems may be able to exert market power through a collection of smaller actions that, on their own, might not be deemed anticompetitive, especially in consolidated markets. While some courts have held that the aggregate of these actions — what some antitrust cases call a "monopoly broth" — may violate antitrust laws, these cases are often challenging to win.[28,52]

In the case against Sutter Health, the plaintiffs alleged that Sutter used the combination of high out-of-network

pricing, leveraging of must-have providers, gag clauses, and anti-tiering and anti-steering clauses to charge supracompetitive prices in northern California (see Box 2).[53,54] Similar arguments were made against Atrium Health,[55] yet both cases took years to reach settlement. No court ruled on the merits of the claims, and no legal precedent was set. While antitrust enforcers at the Department of Justice (DOJ) or state attorneys general (AGs) could bring lawsuits against other health systems for similar practices, litigation requires substantial resources and time. Because of the considerable resources needed, enforcers are likely to prosecute only the most egregious users of anticompetitive contracting practices.

Box 2: Antitrust Lawsuits Alleging Anticompetitive Use of Contract Clauses

United States v. Charlotte-Mecklenburg Hosp. Auth. (Atrium Health): In 2016, the DOJ and the North Carolina AG sued the Carolinas Healthcare System (which later became Atrium Health) alleging that Atrium used anti-steering clauses to prohibit commercial health insurers in the Charlotte area from offering patients financial benefits to use less-expensive health care services and used anti-tiering clauses to require insurers to place Atrium in the most favorable tier, with the lowest cost-sharing in any tiered network. Atrium also allegedly used gag clauses to ensure that the enrollees and plan sponsors would not have access to information about the price and quality of Atrium's health care services compared to its competitors. In 2018, the case was settled after the court denied Atrium's motion for summary judgment, finding that the DOJ plausibly alleged that the steering restrictions limited consumer choices and drove up insurance prices. The injunctive relief contained in the settlement prohibits Atrium from using anti-steering or anti-tiering provisions except in co-branded arrangements where the Atrium logo appears in marketing materials.

UFCW & Employers Benefit Trust v. Sutter Health and People of the State of California ex rel. Xavier Becerra v. Sutter Health: In 2014, employers and labor unions accused Sutter Health of abusing its market power by charging inflated prices, in violation of California's antitrust law. In 2018, the California attorney general filed a similar antitrust suit, and the California Superior Court consolidated the two cases. The plaintiffs alleged that Sutter required health plans wanting to contract with any of Sutter's facilities to allow enrollees to obtain the same services at every other Sutter provider (i.e., used all-or-nothing contracting) and demanded anti-tiering and anti-steering provisions to prevent insurers from encouraging the use of other lower cost facilities. The plaintiffs also alleged that Sutter demanded gag clauses to ensure that no one — not even the employers ultimately paying for the services — would know the price of these services before they are billed. The court gave preliminary approval for the settlement in March 2021 when Sutter agreed to pay $575 million in alleged damages and injunctive relief. The settlement prohibits Sutter from using anti-incentive clauses to prevent insurers from steering patients to higher value care, using all-or-nothing contracting, or conditioning the participation of certain rural or other must-have providers on the participation, pricing, or tiered status of other Sutter hospitals.[32] The injunctive relief also caps out-of-network rates that Sutter can charge for most care and limits annual increases in Sutter's billed charges for five years. Finally, the injunctive relief requires Sutter to allow insurers to disclose price and quality information to enrollees.

Davis v. HCA Healthcare, Inc.: In August 2021, a group of patients sued HCA Healthcare, a large health system, alleging that after HCA bought the nonprofit Mission Health, it used its market power in Asheville, North Carolina, to raise prices for both inpatient and outpatient care. The lawsuit alleges that Mission demands prices for many services that are double the state average. The lawsuit also alleges that HCA uses illegal contracting and negotiating practices, including all-or-nothing and anti-incentive terms; does not comply with price transparency laws; and has cut access to critical rural services. At the time of this publication, no settlement or ruling has been reached.

Recently, a group of patients filed a class action lawsuit against HCA Healthcare, a large health system, alleging that HCA used anticompetitive contract terms to exert its market power and charge supracompetitive prices for both inpatient and outpatient care.[56] This case was filed by a group of patients without assistance from the AG or DOJ, demonstrating that private parties can sue for antitrust damages without action by the government. Nonetheless, this lawsuit suggests that states need additional tools to mitigate the harms from anticompetitive contract clauses.

While antitrust law can unquestionably address anticompetitive contracting practices, states searching for a more proactive solution should also consider passing laws banning particularly problematic practices in health care contracts. As Emilio Varanini, deputy attorney general in the antitrust section of the California Department of Justice, has argued, "while litigation can blaze the way for addressing such anti-competitive conduct, ultimately legislation may be a far more effective tool for carrying out competition as a policy goal."[57]

Federal Attempts to Ban Specific Contract Terms

Other than the 2020 federal legislation prohibiting most gag clauses, Congress has failed to act on anticompetitive contract clauses. In 2019, Senators Lamar Alexander (R-Tenn.) and Patty Murray (D-Wash.) unsuccessfully sponsored the bipartisan Lower Health Care Costs Act that would have banned all contracting clauses discussed in this report, including anti-tiering and anti-steering provisions, affiliate contracting, MFNs, and gag clauses.[58] While some provisions of the Lower Health Care Costs Act were incorporated as parts of other laws (e.g., surprise billing protections and support for state all-payer claims databases), the prohibitions on contract clauses have not yet been passed by Congress.

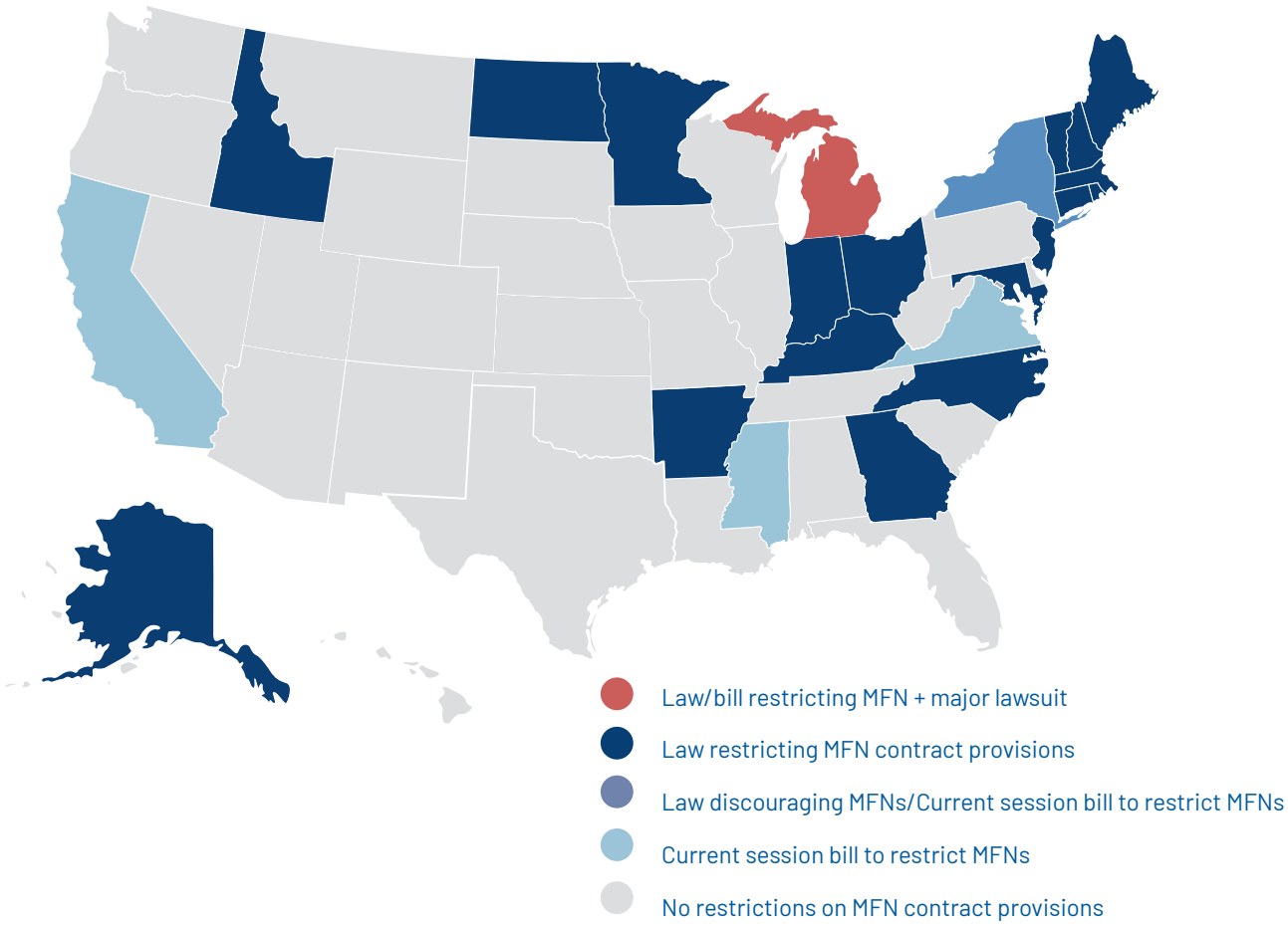
Nevertheless, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have found that the impact of a ban on anti-incentive clauses could be substantial. They estimated that banning anti-incentive clauses in areas with a dominant non-monopolistic health care provider and no single dominant insurer would decrease premiums by approximately 5% due to increased enrollment in tiered networks.[59] The CBO and JCT predict that a nationwide ban on both anti-tiering and anti-steering clauses would reduce the total employment-based health care costs by 0.05% after the effects of the ban are fully realized.[59] This reduction amounts to a savings of more than $500 million per year, but congressional action on contracting practices in health care remains slow and uncertain.

State Laws Banning Specific Contract Terms

Not waiting for federal action, many states have passed laws banning these contract clauses in state-regulated insurance plans. For example, 20 states have laws restricting MFNs. While the statutory language used by the states to restrict the use of MFNs varies, all states with bans have designated MFNs as an unfair trade practice or an unenforceable contract provision (Figure 1).[28] The broadest bans on MFNs prohibit any contract that references the rates that rival insurers pay. Massachusetts declares that "establishing the price to be paid to any health care facility or provider by reference to the price paid, or the average of prices paid" to the provider by other insurers is an unfair and deceptive act in the business of insurance.[60] Some of these laws have been effective for more than two decades, and multiple states passed laws around 2010, the year the DOJ filed the lawsuit against BCBS of Michigan alleging anticompetitive use of MFNs.[61] Since then, momentum has slowly been mounting to pass MFN bans. In 2019, Arkansas passed the most recent ban,[62] and in 2021, four states — New York, California, Mississippi, and Virginia — introduced bills to ban MFNs, but those bills have so far failed to pass.[63]

While many states ban MFNs, only a few states ban the other contract clauses discussed in this brief. Currently, eight states ban gag clauses, and transparency efforts at both the state and federal level will likely increase public access to health care cost and quality data.[23,28] Before 2021, only Massachusetts had restricted anti-tiering/anti-steering clauses or affiliate contracting. In 2010, Massachusetts passed a law prohibiting contracts that limit the ability of an insurer to introduce tiered networks or require an insurer to place all of a health system's facilities in the same tier.[64] The law also has a very

Figure 1: States That Restrict MFNs in Contracts with Health Insurers



narrow ban on all-or-nothing contracting that applies to select network plans.[64] For more than a decade, states have introduced bills to ban some of these terms, but none of the bills advanced out of committee until the 2021 session.

Action in the 2021 Legislative Session

Momentum appears to be building in states to ban anticompetitive clauses in health insurance contracts. In 2021, Nevada became the second state to ban anti-tiering or anti-steering clauses and the first to adopt a widespread ban of all-or-nothing contracting.[65] The Nevada law prohibits providers (i.e., health systems) from entering into a contract or soliciting a contract that (1) restricts the ability of the insurer to steer enrollees to particular providers, (2) restricts the insurer from assigning providers into tiers, (3) requires that the insurer place all providers in the health system into the same tier, (4) requires an insurer to contract with one affiliate of the health system as a condition of contracting with another provider in that health system, or (5) prohibits or penalizes an insurer from contracting with other health systems that are not a party to the contract.[65] In addition, seven other states introduced bills in this session to prohibit all-or-nothing or anti-tiering/anti-steering clauses, including a bill in Washington that passed the state House of Representatives but failed in the Senate.[66] A bill introduced in New York[67] remains active, and many lawmakers have expressed interest in bringing back similar bills in other states in the next session. The National Academy for State Health Policy also wrote model legislation in 2021 to assist states in drafting legislation to ban these contract terms.[68]

CAN LAWS RESTRICTING CONTRACT CLAUSES STIFLE PROCOMPETITIVE USES?

With growing interest in restricting contracting practices that stifle competition in health care markets, what should policymakers consider when writing statutory bans? Critics of these laws often point out that these terms may be used to promote competition, and the competitive effects of these contract clauses depend on several complex, market-specific factors. For example, some economic studies demonstrate that MFN provisions can lead to procompetitive outcomes, or at least play a competitively neutral role, in competitive markets.[69,70] However, at an FTC and DOJ joint workshop in 2012 to develop an administrable MFN enforcement policy,[71] Professors Steven C. Salop and Fiona Scott Morton identified characteristics of MFNs that would raise significant competitive concerns, including MFNs offered by large sellers (e.g., dominant health systems) with market power, MFNs received by the largest buyers (e.g., large insurers), and MFNs where the buyer is more concerned with the relative price than the absolute level of the price.[34]

As all of these conditions apply in many health care markets, antitrust enforcers should scrutinize the use of MFNs in health care contracts. Furthermore, unlike the other contract clauses discussed in this report, MFNs can be used jointly by insurers and health systems to raise prices, creating an incentive to keep the use of MFNs confidential. As both insurers and providers may benefit from MFNs and have an incentive to keep them confidential, state legislative bans on MFNs may be critical to protecting consumers from anticompetitive harms. As discussed earlier, 20 state legislatures determined that the anticompetitive potential of MFNs in health care contracts was sufficient to restrict their use. Eighteen of those states simply banned all MFNs in health insurance contracts, but Kentucky permits them where the insurance commissioner determines the insurer has "nominal" market share[72] and New York permits them following approval by the insurance commissioner.[73]

Similarly, Sutter Health claimed that all-or-nothing contracting improved efficiency, saved administrative costs for both Sutter and the health plans, and was necessary to maximize the potential of the system to provide integrated care.[74] The use of all-or-nothing contracting, however, was a key claim in the antitrust lawsuit against Sutter Health, and the settlement prevents Sutter from using all-or-nothing or similar contracting to leverage the market power of must-have providers or using anti-incentive clauses (see Box 2). Nonetheless, there may be situations where having one contract for the whole system may streamline negotiations. For example, if a health system is compensated on a capitated basis or is in a risk-bearing accountable care organization, anti-incentive clauses might be procompetitive because the health system could steer patients to a lower-cost affiliated clinic, like an imaging center. Recognizing the potential for anti-incentive clauses to be procompetitive in these narrow circumstances, the settlement between the DOJ and Atrium Health allows Atrium to require placement in the most preferred tier in value-based contracting arrangements with a health plan where the Atrium logo appears in marketing material (see Box 2).[75]

Because these contract terms might be used procompetitively in a few market-specific situations, lawmakers drafting bills to ban specific contract clauses might consider a process by which insurers or providers could obtain waivers. These waivers may be granted at an insurer's request, if the health system is compensated on a capitated basis, or if state officials determine that the likely benefits of the clauses outweigh the potential anticompetitive harms. Lawmakers may also consider granting exemptions to the ban when neither party has a significant market share. Lawmakers, however, must narrowly construct any waiver or exemptions to avoid passing laws that are easily circumvented.

BANS ON CONTRACT TERMS MAY BE MINIMALLY EFFECTIVE IN ISOLATION

States with a statutory ban on one of these contract clauses send a clear signal that lawmakers presume their use is anticompetitive. Enforcement, however, may remain a challenge as the contracts are often confidential. States passing laws restricting these terms typically declare that any use of one of these contract provisions is an unfair trade practice, making that provision void and unenforceable. These laws give insurers or TPAs additional leverage when negotiating with large health systems, so enforcement actions by state officials may be minimal. If an employer or other party suspects the use of anticompetitive clauses, the AG may issue a subpoena to review the contract, and if the terms appear in the contract, state laws would invalidate those provisions.

Nevertheless, dominant firms may garner similar benefits without including specific clauses in their written contracts through oral or other agreements. For example, Indiana passed a statewide ban on MFNs in 2007, but a dominant insurer appeared to continue to impose best-rate requirements on hospitals without an explicit MFN in the contracts.[76] As a result, lawmakers should consider passing laws that prohibit offering or entering into an agreement of any kind — written, verbal, or nonverbal — containing these terms. Nonetheless, contractual parties may be able to evade the intent of the laws without explicitly violating them. In a state that bans anti-tiering clauses, for example, a health system might stipulate that the cost-sharing differential between tiers in a network must be small without demanding placement of its facilities in the tier with the lowest cost-sharing. If the difference in cost-sharing is minimal, patients have little incentive to choose providers from the highest-value tier, potentially allowing a dominant health system to reduce the competition for patients that should result from a tiered network.

Consequently, states should consider other policies and mechanisms to support restrictions on contracting practices. At a minimum, states should monitor price disparities to assess when restrictions on contracting practices are insufficient. If bans on specific contracting practices are ineffective at reducing prices, states should consider implementing caps on provider prices, instituting overall cost benchmarks, or even injecting competition into insurance markets through a public option. One approach would be to couple contract clause restrictions with an affordability review process modeled on Rhode Island's process of provider rate review by the state health insurance department. Rhode Island law authorizes the health insurance commissioner to review provider payment rates in certain contracts between insurers and providers and reject any contracts that increase the total cost of services above a threshold.[77] The agency's combined review of both provider rates and rate negotiation practices helps minimize the anticompetitive use of market power.

CONCLUSION

States have recognized the harms of anticompetitive contracting practices by dominant health care providers and have tried to address these harms through both litigation and legislation. To date, 20 states have laws restricting the use of MFNs. Before 2021, only Massachusetts prohibited anti-tiering and anti-steering clauses and had a narrow restriction on all-or-nothing contracting. In October 2021, Nevada will prohibit anti-incentive clauses and become the first state to ban most all-or-nothing clauses. Legislation prohibiting anticompetitive contract terms may give insurers the bargaining leverage to resist price demands of dominant systems and to direct patients to higher-value options, but in isolation, these bans on contract terms are unlikely to mitigate the harms that result from the significant consolidation that occurred over the past decades. Dominant providers can exert leverage from market power in confidential negotiations with terms that never appear in a contract. Prohibiting the use of anticompetitive contract terms signals that state lawmakers are looking for ways to reduce the ability of dominant firms to extend their market power in ways that further harm competition. Yet, states should also consider additional mechanisms and policies to support these prohibitions, such as increased price transparency, cost benchmarks, and provider rate regulation. For example, the Health Policy Commission in Massachusetts may hold a public hearing when a health care entity's costs exceed a statewide cost benchmark,[78] and Office of the Health Insurance Commissioner in Rhode Island can reject

insurance contracts in which the rates paid to hospitals increase faster than inflation.[77]

The unrelenting consolidation of health care providers and insurers has rendered competitive forces unable to restrain escalating prices, and none of these policies in isolation, including bans on particular contracting clauses, is likely to restore markets to allow competitive forces to reduce prices. Consequently, states must adopt a comprehensive and multifaceted strategy to promote and protect competitive markets, including vigorous antitrust enforcement policies, legislative action, and increased oversight by state agencies.[79] Protecting and promoting competition in health care markets remains critical to ensuring that all Americans have access to affordable health care.

NOTES

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