

# A Step Forward for Health Care Market Oversight: Oregon Health Authority's Health Care Market Oversight Program

REPORT

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Robin Davison, Katherine L. Gudiksen,  
Alexandra D. Montague, and  
Jaime S. King

**Milbank**  
Memorial Fund 

## Executive Summary

**C**ontrolling costs and improving access, equity, and quality are critical goals for an effective and efficient health care delivery system. Consolidation has dramatically altered health care markets throughout the country in ways that limit their ability to achieve these goals. Specifically, research has repeatedly shown that consolidation leads to higher prices and reduced access to essential services.<sup>1,2</sup>

Like many other parts of the country, Oregon has experienced significant consolidation in the health care industry. Since 2020, concerns have intensified that provider financial struggles exacerbated by the COVID-19 pandemic would drive further consolidation.<sup>3</sup> A recent report from the Oregon Health Authority (OHA) found that health care costs per person in Oregon grew by 49% from 2013 to 2019, faster than the national average and faster than income and inflation.<sup>4</sup> The service categories that experienced the fastest increases were outpatient services, professional services, pharmacy, and emergency services.<sup>4</sup> Unsurprisingly, these rising costs have resulted in Oregonians spending more of their income on health care, using savings to pay medical bills, incurring debt or medical bankruptcy, delaying medical care, or going without care altogether.<sup>5</sup> Although rising costs can be attributed to a variety of factors, oversight of future consolidation is critical to any effort to protect the people of Oregon from continued cost increases that jeopardize their health and financial stability.

In light of these troubling statistics, the Oregon legislature passed a law in 2021 creating a health care market oversight program and endowed the OHA with the authority to address the unchecked rise in consolidation and the downstream impacts on cost, access, equity, and quality. Although state and federal antitrust enforcement continues to be a crucial tool to combat consolidation in health care markets, the extensive time and resources needed to litigate such cases often limit its use to particularly large and egregious cases. State health care market oversight programs, like Oregon's, can serve as important complements to antitrust enforcement as these programs can review transactions of various sizes, examine the cumulative effects of small transactions on markets, and evaluate transactions across a much wider array of factors beyond just antitrust implications.

When establishing the Health Care Market Oversight Program (HCMO), the Oregon legislature looked to Massachusetts's pioneering Health Policy Commission (HPC) and went a step further by granting OHA the authority to block transactions outright or impose conditions to mitigate the potential for adverse effects. OHA receives notice of a wide range of health care entity transactions and engages in pretransaction

reviews that include an in-depth analysis of the potential effects of transactions on cost, competition, access, equity, and quality and encompasses a broad scope of transactions involving a wide range of health care entities that reach the established financial threshold.

OHA's review process uses a two-phase framework, which consists of a preliminary review and, if warranted, a comprehensive review. Upon receipt of a notice of a proposed transaction, OHA has 30 days to complete its preliminary review. At this phase of the review process, OHA examines readily available data to make an initial determination of whether the transaction is critical to an entity's solvency and the potential impacts of the proposed transaction on cost, access, equity, and quality of health services. After the preliminary review, OHA may approve or conditionally approve the transaction; however, if there are indications during the preliminary review that the transaction may lead to significant adverse effects on cost, access, equity, or quality, OHA may then engage in a comprehensive review. The comprehensive review, which must be completed within 180 days of the initial notice, takes a deeper dive into the factors assessed during the preliminary review. It will likely examine additional data beyond what was used in the first review and may, at OHA's discretion, include input from the community through a Community Review Board.

OHA is also charged with post-transaction monitoring and oversight and is required to conduct post-transaction reviews one, two, and five years after they occur. Furthermore, OHA has demonstrated its dedication to transparency by making information on potential transactions readily available to the public on its website, including notices, public comments, review reports, and final decisions. Finally, OHA must complete a statewide study of the impact of health care consolidation every four years to monitor Oregon's changing health care landscape and address concerning consolidation trends.

Although the HCMO program is new and to date has completed only a few reviews, Oregon has established one of the strongest merger oversight programs in the country. While it is too soon to draw any definitive conclusions about its effectiveness and impact, the early implementation of the law provides insight into the benefits and challenges of implementing a health care market oversight program. The choices made in implementing the HCMO program offer multiple valuable considerations for other states seeking to address harmful consolidation in health care markets. To implement an effective market oversight program:

1. State policymakers need a detailed understanding of the drivers of health care costs in the state.
2. State legislators should aim to give a health care market oversight program as much authority as possible to allow flexibility.
3. States should strike a balance when deciding the breadth of review to use state resources effectively.
4. States should strive for a high-level of transparency and public participation, as both are critical to effectively review transactions and minimize the risk of regulatory failure.
5. Any imposed conditions should be enforceable and targeted.

This report provides an overview of the HCMO program, including a discussion of the transactions that are subject to review, the review process, and post-transaction monitoring and compliance. It also presents the work of the program to date. Finally, the report discusses the current legal challenge to the program and offers broad considerations for other states considering implementing or strengthening policies to oversee and address health care consolidation.

## THE NEED FOR A STATE-LEVEL HEALTH CARE MARKET OVERSIGHT PROCESS

Controlling costs and improving access, equity, and quality are critical goals for an effective and efficient health care delivery system. Across the country, consolidation has dramatically altered health care markets in ways that limit their ability to achieve these goals. Specifically, the overwhelming research evidence is that consolidation leads to higher prices and reduced access to essential services.<sup>1,2</sup>

Like many other parts of the country, Oregon has experienced significant consolidation in the health care industry. In 2003, 43% of Oregon hospitals were independent, but by 2020 the percentage had dropped to 25%.<sup>6</sup> Physicians in Oregon have undergone similar consolidation. In 2018, 71% of Portland-area physicians worked for health systems, a significant increase from 39% in 2016.<sup>6</sup> Since 2020, concerns have arisen that provider financial struggles exacerbated by the COVID-19 pandemic would drive further consolidation.<sup>3</sup> According to an Oregon Health Authority (OHA) report released in July 2022, health care costs in Oregon grew faster than the national average and faster than income and inflation.<sup>4</sup> Health care costs per person grew by 49% from 2013 to 2019.<sup>4</sup> These rising costs have forced Oregonians to spend larger portions of their income on health care, divert savings to pay medical bills, incur debt or medical bankruptcy, delay care, or forgo care altogether.<sup>5</sup> Although there are likely several factors driving these cost increases, oversight of future consolidation is critical to any effort to protect the people of Oregon from continued cost increases that jeopardize their health and financial stability.

To address the unchecked rise in consolidation and the downstream impacts on cost, access, equity, and quality, a few states, including Oregon, have created health care market oversight programs. Although state and federal antitrust enforcement continues to be a crucial tool to combat consolidation in health care markets, the extensive time and resources needed to litigate such cases often limit its use to particularly large and egregious cases. State health care market oversight programs can serve as important complements to antitrust enforcement, as these programs can review transactions of various sizes, examine the cumulative effects of small transactions on markets, and evaluate transactions across a much wider array of factors beyond just antitrust implications.

In 2012, the Massachusetts legislature established the first specialized state agency to oversee health care markets, the Health Policy Commission (HPC). The HPC receives notice of impending provider transactions, reviews transactions for potential adverse impacts, and if it finds that a transaction is likely to have a significant impact on health care costs or market functioning, can conduct a comprehensive investigation called a cost and market impact review.<sup>7</sup> This review culminates in a detailed public report and potential referral to other state agencies, including the Massachusetts attorney general (AG). The AG or other state agency may then decide to challenge the proposed transaction through litigation or through its own regulatory oversight processes. In 2022, the California legislature built on the experience in Massachusetts when establishing the Office of Health Care Affordability (OHCA). OHCA, like the HPC, will receive advanced notice of various health care transactions, assess their potential impact on the health care market, and pass those findings to the appropriate state enforcer, such as the California attorney general.<sup>8</sup> Importantly, the HPC and OHCA receive advance notice and have significant authority and expertise to review the impacts of proposed transactions, but neither agency has the authority to block those transactions they find problematic and must defer to the state attorney general, or another state agency, with authority to challenge the transaction. Nonetheless, these programs provide critical data, tools, and expertise for antitrust enforcers, other state agencies, and state policymakers to track health care market trends, construct a holistic picture of the market, and inform future policy decisions.

The Oregon legislature also built on the experience in Massachusetts when it established the Health Care Market Oversight Program (HCMO) within the OHA in 2021. Oregon, however, stepped beyond the authority of the HPC in Massachusetts or OHCA in California and granted OHA the authority to block transactions outright or impose conditions to mitigate potential detrimental effects resulting from the consummated transaction. OHA receives notice of proposed health care transactions and reviews them to weigh potential benefits and adverse effects on the communities they serve.<sup>9,10</sup> OHA reviews any proposed transaction using a two-phase framework to analyze the proposed transaction's impact on the cost, access, equity, and quality of health care in the state. In addition to identifying the potential impacts of transactions, OHA must also review the effects of transactions after they occur.<sup>11</sup> Furthermore, OHA has also followed the example set in other states by recognizing that transparency is a key piece of an effective market oversight program and making information on potential transactions, including notices, public comments, review reports, and final decisions readily available to the public on its website.<sup>12</sup> Finally, OHA is responsible for monitoring Oregon's changing health care landscape and the broader impact of transactions on health care delivery and outcomes throughout the state. Through this broader analysis, OHA seeks to better understand the situation on the ground and identify and address concerning consolidation trends.

Although the HCMO program is still nascent, Oregon has established one of the strongest merger oversight programs in the country. While it is too soon to draw any definitive conclusions about its effectiveness and impact, the early implementation of the law provides insight into the benefits and challenges of implementing a health care market oversight program. This report provides a comprehensive overview of the HCMO program, including a discussion of the transactions that are subject to review, the review process, and post-transaction monitoring and compliance. It also presents the work of the program to date. Finally, the report discusses the current legal challenge to the program and offers broad lessons for other states considering implementing or strengthening policies to oversee and address health care consolidation.

## TRANSACTIONS SUBJECT TO REVIEW

The first element of OHA's review is pretransaction notice. Various types of health care entities seeking to enter a wide range of transactions, including mergers, acquisitions, corporate affiliations, some clinical and contracting affiliations, new partnerships, joint ventures, and transactions to create new accountable care organizations or management services organizations, must file notice with the OHA at least 180 days before the proposed transaction date.<sup>13,14</sup> The subsequent pretransaction review depends on several factors, including the types of entities involved, whether the transaction constitutes a material change transaction, and the nature of the transaction.

### Types of Entities

The law applies to "health care entities," which are defined by statute and agency rules as physicians, hospitals, health systems, insurers, and coordinated care organizations, as well as any other entities whose primary function is the provision of health care items or services, including parent organizations or closely related organizations to those entities.<sup>15,16</sup> The statute specifically excludes long-term care facilities and residential care facilities from the definition, effectively excluding transactions involving these entities from review.<sup>15,17</sup>

### Nature of the Transaction

Health care entities are now consolidating in a variety of ways, and the broad definition of transaction in the statute likely reflects the legislature's intent to capture a wide array of potentially harmful consolidation, including the involvement of private equity in the health care space. Specifically, in addition to the transactions that are typically thought of as problematic, such as mergers or acquisitions, the law defines transaction to include arrangements that might otherwise escape the review process (Box 1).<sup>15</sup> Unlike the HPC, which requires at least two health care entities as parties to a transaction to trigger the notice and review process,<sup>18</sup> OHA can review transactions involving only one health care entity, providing oversight for a broader scope of transactions.<sup>15</sup> OHA also requires new contracts, clinical affiliations, and contracting affiliations that will eliminate or significantly reduce essential services to submit notice and go through the review process.<sup>19</sup> In addition, OHA requires notice and review for new partnerships, joint ventures, accountable care

organizations, and other arrangements that will eliminate or significantly reduce essential services. This requirement that OHA review only these transactions that effect essential services limits the number of transactions and reduces the number of transactions reviewed by OHA. This limitation is another departure from Massachusetts. Massachusetts is not limited to transactions that impact essential services but is instead restricted to reviewing transactions between two health care entities.

**Box 1: Transactions Reviewed Under Health Care Market Oversight Program (Or. Rev. Stat. § 415.500(10) and Or. Admin. R. 409-070-0010)**

1. Mergers involving at least one health care entity.
2. Acquisitions of a health care entity.
3. New contracts, new clinical affiliations, or new contracting affiliations that will eliminate or significantly reduce essential services.
4. Corporate affiliations involving at least one health care entity.
5. New partnerships, joint ventures, accountable care organizations, parent organizations, or management services organizations that will:
  - a. Eliminate or significantly reduce essential services,
  - b. Consolidate providers of essential services when contracting payment rates with payers or insurers, OR
  - c. Consolidate insurers when establishing health benefit premiums.

The legislature authorized OHA to clarify by rule what constitutes a significant reduction of essential services. In posted guidance, OHA lays out the two-part test to determine whether essential services are at risk: (1) Will the transaction reduce an essential service within 12 months of the transaction? If so, (2) is the reduction significant?<sup>19</sup> Generally, OHA will consider a reduction significant if certain measures relating to access to care change by one-third or more.<sup>19,20</sup> For example, if a transaction will increase the median time existing patients must travel for services by at least one-third or decrease the number of culturally competent providers by one-third or more, the reduction is deemed significant. OHA will consider the impact on measures such as access to and the overall number of providers, median driving time to services, availability of essential services, and appointment wait times, among others.<sup>19</sup> If the reduction is significant, the transaction is subject to the notice, review, and approval requirements of the HCMO program.<sup>19</sup>

## Material Change Transactions

While capturing a broad range of transactions is important for thorough oversight, capturing such a broad range risks overwhelming OHA with small transactions that are unlikely to significantly impact health care delivery in the state. As a result, the statute requires approval only for “material change transactions,” defined as transactions in which at least one party has a net patient or premium revenue over \$25 million and the other party has a net patient or premium revenue over \$10 million over the preceding three years.<sup>21</sup> The law also includes transactions in which a party is a newly organized legal entity with at least \$10 million in projected patient revenue in the first full year of normal operations.<sup>15,22</sup>

## Excluded and Exempt Transactions

To focus OHA’s resources on transactions that are most likely to have adverse impacts, the statute and regulations also exclude other transactions that are unlikely to have a negative impact on health care delivery (Box 2).<sup>23</sup> Examples include transactions that create clinical affiliations for clinical trials, contracts for administrative services, medical services contracts, and transactions that do not impact corporate leadership, governance, and control.<sup>24</sup> For example, a large medical group contract for administrative services to streamline operational efficiencies is not likely to significantly impact cost or competition. Likewise, a transfer agreement between a rural and an urban hospital to provide higher levels of care is unlikely to reduce essential services.<sup>25</sup> OHA issued a guidance document to further clarify these exclusions<sup>25</sup> and, in response to industry pushback, OHA now allows transacting entities to request a pre-filing conference<sup>26</sup> or a written material change transaction determination<sup>27</sup> to receive clarification as to whether they must file and what to expect from the process.

Transacting entities may also apply for emergency exemptions for otherwise reviewable transactions in urgent situations (such as public health emergencies) in which the provision of health care services is at immediate risk and the transaction is critical to protect consumer interests and preserve the entity’s solvency.<sup>28</sup> If OHA agrees, it can approve the transaction without the standard review process. OHA also provides “safe harbor” exemptions for a handful of transactions, including transactions approved by the agency between the legislation’s enactment date and its effective date, as well as transactions involving the sale of practices of solo practitioners due to retirement or death.<sup>25</sup>

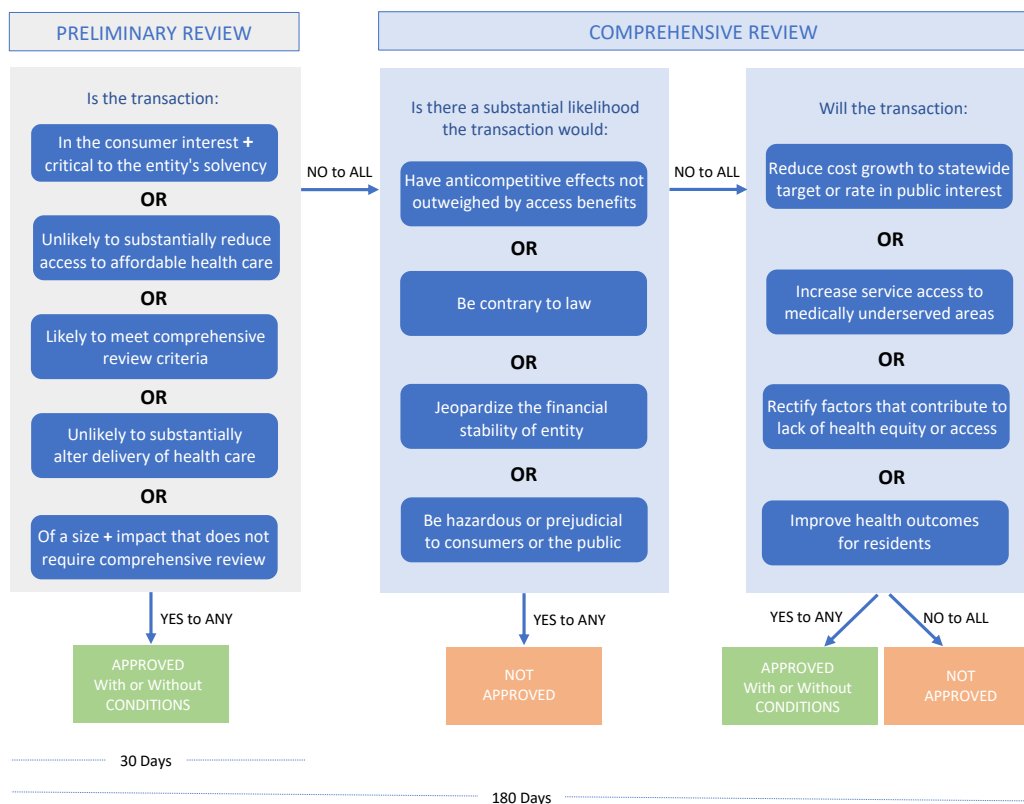
Overall, the post-transaction notification allows OHA to oversee consolidation among a variety of players in the health care industry that had previously been permitted to consolidate unchecked. The revenue thresholds are designed to allow HCMO to cast a relatively wide net with respect to transaction type without overburdening the agency, while the various exclusions and exemptions also help sift out low-risk transactions. Finally, transactions needed in emergency situations can be reviewed and, if appropriate, approved without undue delay.



## **Box 2: Transactions Excluded from Review (OAR 409-070-0020)**

1. Clinical affiliations formed for the purpose of collaborating on clinical trials or graduate medical education programs.
2. Medical services contracts or an extension of a medical services contract.
3. An affiliation that does not impact the corporate leadership, governance, or control of an entity and is necessary to adopt advanced value-based payment methodologies to meet the health care cost growth targets.
4. Contracts under which one health care entity, for and on behalf of a second health care entity, provides patient services or provides administrative services relating to the provision of patient services if the second health care entity
  - a. maintains responsibility and control over the patient services,
  - b. bills and receives reimbursement for the patient services, AND
  - c. does not provide comprehensive management services.
5. Transactions involving federally qualified health centers.
6. Transactions that consist solely of corporate restructures that do not change the ultimate control of the health care entity and do not result in the acquisition of control of the entity by any person not previously affiliated with the entity.
7. Agreements between an affiliate and a health care entity that are subject to ORS 732.574(2)(d)(D), which include management agreements, service contracts, tax allocation agreements, guarantees, and all cost-sharing arrangements.

Figure 1. Oregon Review Process and Criteria for Material Change Transactions



## The Review Process

Once OHA receives notice of a proposed reviewable transaction, it posts a notice of a material change transaction on its website and invites public comment. In a review process that is similar to the HPC's in Massachusetts, the OHA then has 30 days to conduct a preliminary review and determine if a transaction will be subject to a comprehensive review (Box 3).<sup>9</sup>

## Preliminary Review

During the 30 days in which OHA must complete a preliminary review, it examines the potential impact of the deal on the cost, quality, access, and equity of health care services on the communities served, as well as whether the deal is critical to an entity's financial viability. Specifically, OHA considers not only whether the transaction has the potential to reduce access to affordable care, but also whether the transaction will benefit the public in strategic ways—for example, by reducing health care cost growth, increasing access in underserved areas, rectifying health inequities, or generally improving health outcomes for Oregonians.<sup>9</sup>

The preliminary review also provides an initial investigation into whether there is a substantial likelihood of anticompetitive effects from the transaction that outweigh the potential benefits of the transaction.

During its review, OHA assesses specific metrics, dictated by the type of entities involved (e.g., health clinic or medical practice) and the nature of the transaction (e.g., merger or corporate affiliation). While OHA has the authority to require transacting entities to produce documents and other materials, the short window for the preliminary review means that OHA typically relies on readily available data. OHA may collaborate with other state agencies as needed, such as the Oregon Department of Justice, the Oregon Department of Consumer and Business Services (DCBS) if an insurer is involved, and the OHA Office of Actuarial and Financial Analytics if a coordinated care organization is involved.<sup>29</sup> The HCMO program may also collaborate with other OHA programs, including the Cost Growth Target, Hospital Reporting, and the All Payer All Claims Reporting programs. OHA can also further collaborate with other Oregon state agencies and programs when there is responsibility overlap or collaboration would reduce the duplication of work, enhance the quality and speed of reviews, and reduce the need for additional data requests from the transacting entities. Further, OHA may request additional data from the transacting entities to clarify or supplement the notice, including details about the entities, policies and procedures, or patient and community engagement efforts.<sup>9,29</sup> These baseline data are then compared to projected post-transaction data to assess whether the transaction is likely to have a negative impact on the cost, access, equity, or quality of health care services.

When analyzing the potential impact of a transaction on cost, OHA compares the entities' market share, price, spending, and financial condition pretransaction with what it anticipates will occur post-transaction.<sup>29</sup> Will the health care market be more concentrated after the deal and, if so, by how much? Is the transaction likely to increase consumer prices or state spending?

To determine the transaction's potential to impact access, OHA evaluates the availability of services, payer mix, and patient demographics.<sup>29</sup> Is the transaction likely to reduce or eliminate services, particularly for certain patient populations? Will this transaction require patients to travel farther for care? OHA will analyze the impact on quality using clinical processes, patient outcomes, and patient experience. Finally, the impact on health equity will be analyzed through the likely effect on access and quality stratified by demographics, such as race, ethnicity, age, language, gender, and disability status, as well as community engagement and equity-enhancing services.<sup>29</sup>

If a transaction meets at least one of the following criteria, OHA will approve or conditionally approve the transaction after the preliminary review:<sup>9,10</sup>

- The transaction is in the interest of consumers and critical to maintaining a party's solvency.
- The transaction is unlikely to substantially reduce access to affordable health care in Oregon.

- The transaction is likely to meet the comprehensive review criteria.
- The transaction is unlikely to substantially change health care delivery in Oregon.
- The size and impact of the deal do not warrant further review.

When a domestic insurer is a party to the transaction, OHA works closely with DCBS, as the department is ultimately responsible for determining whether to approve, conditionally approve, or block the transaction.<sup>30</sup> Specifically, OHA will conduct a preliminary review and report its findings and determination to DCBS, which will then consider these findings and coordinate with OHA to incorporate those results into DCBS's final determination.<sup>31</sup>

## Comprehensive Review

If OHA does not approve the proposed transaction upon the conclusion of the preliminary review, the deal will be subject to a comprehensive review if all the following related criteria apply:<sup>32,33</sup>

- The preliminary review revealed that the deal has the potential to negatively impact cost, access, equity, or quality and further analysis is needed to determine the extent of the impact.
- The transaction is not urgently needed for the solvency of one of the entities or, if it is urgently needed, that need is outweighed by the potential negative impacts of the deal.
- The transaction may substantially alter health care delivery in the state by negative impacts on cost, access, equity, or quality.
- The potential adverse effects of the transaction would have a meaningful impact on consumers.

The comprehensive review must be completed within 180 days of submission of the notice unless the parties agree to an extension.<sup>9,34</sup> During this phase of the review process, OHA focuses its analysis on the areas of concern that were identified during the preliminary review. In contrast to the preliminary review, which is typically based on readily available data because of the limited time for review, OHA will likely use information from the entities and third-party databases for the comprehensive review.<sup>29,32</sup> Entities may not refuse to provide documentation or other information by claiming the information is confidential; however, OHA will not publicly disclose any information or data that are protected under the law.<sup>9</sup> With the additional data, OHA can more closely examine the impact of the transaction on competition using common antitrust analyses, such as willingness-to-pay, merger simulation, and diversion analyses, as well as an analysis of the potential efficiencies that may be generated from the deal.<sup>30</sup> To help assess the impact on access, equity, and quality for this stage of review, OHA can also request an array of different data sources, including workforce data, insurance contract data, and patient grievance reporting information.<sup>29</sup>

The comprehensive review also permits OHA to contract with outside experts, including economists, accountants, qualitative researchers, and attorneys, to obtain more sophisticated and detailed analyses.<sup>35</sup> Although the agency can charge the transacting entities for the cost of the in-depth review, OHA will provide the entities with an estimated cost prior to engaging the experts to avoid any surprise charges.<sup>36</sup> The OHA program can also choose to further collaborate with other Oregon state agencies and programs when specific knowledge, experience, and expertise are needed for the evaluation.<sup>29</sup>

### Community Review Board

In a process that is unique to the review process in Oregon, OHA may, at its discretion, impanel a Community Review Board (CRB) during a comprehensive review to consider a specific transaction (Box 4).<sup>37,38</sup> CRB members must be selected from the affected community, with a focus on individuals who represent populations experiencing health disparities, consumer advocates, and health care experts, to gain insight into the potential impacts of the deal from the community most affected. The CRB will also provide OHA with a nonbinding recommendation as to whether to approve, conditionally approve, or block the transaction. Because OHA has not yet impaneled a CRB, it remains unknown whether the agency can assemble a new, deal-specific board with the requisite knowledge, experience, and diverse representation within the required timeline. Even so, giving OHA the discretion to designate a recognizes the value of community input in advancing OHA's overarching strategic goal to eliminate health inequities in Oregon by 2030.<sup>39</sup>

Upon completion of the comprehensive review, OHA will permit the transaction to proceed (or proceed with conditions) if it determines there is a substantial likelihood that the deal is in the public good (by reducing growth in patient costs, increasing access to services in medically underserved areas, reversing inequities) or improves health outcomes for Oregonians and that the benefits to underserved communities outweigh any potential anticompetitive effects.<sup>40</sup> Since no reviews have advanced to the comprehensive review phase as of this writing, how this process will work in practice remains an open question. Nonetheless, the HCMO program provides a structured framework for consistent and thorough evaluations while also maintaining flexibility to ensure it captures the uniqueness of each transaction.

### Box 3: Community Review Board

#### General Characteristics

- May be convened during comprehensive review process
- Composed of members appointed by OHA
- May include community members, consumer advocates, health care experts
- Provides input on community impact
- Makes nonbinding recommendation about transaction

#### CRB Member Selection

- Selected specifically for the transaction at issue
- Considers individuals' background, experience, ties to the affected communities
- Individuals are required to disclose any conflicts of interest

#### CRB Review Process

- May hold up to two public hearings
- Considers materials and community feedback
- Must consider the potential impacts of the transaction, including:
  - Will it reduce access to essential services?
  - Does it impact at least 50,000 residents?
  - Will it significantly change the market share of a transacting entity?
- Other factors it may consider:
  - Does the area have a shortage of primary care, mental health, or dental health providers?
  - Might the transaction negatively impact priority and underserved populations?
  - Is more data needed to assess the potential impact?

## CONDITIONAL APPROVALS

If OHA determines that a deal meets the criteria for approval but still has concerns regarding the specific entities or the details of the transaction, OHA may impose conditions to create guardrails that minimize the risk identified during the review (Box 5).<sup>9</sup> Because OHA intends to focus on the unique attributes and risks of each proposed transaction, any conditions imposed would likely be reflective of the specific concerns arising from the deal.

#### Box 4: Examples of Potential Conditions

OHA may impose conditions on transactions it approves. To date, OHA has only conditionally approved one transaction, the acquisition of One Medical by Amazon.<sup>51</sup> In that transaction, OHA imposed conditions that required reporting to assess whether the transaction has an effect on quality, access, or equity and to monitor for changes in the scale of operations in Oregon. The following list includes potential conditions OHA could consider for future transactions that raise other concerns.

##### Cost and Competition

- Limit price increases, tying them to the state's cost growth benchmark.
- Require the entities to make health services prices publicly available to create transparency and accountability.
- Prohibit anticompetitive practices such as:
  - tying arrangements (seller conditions the sale of one product to purchaser's agreement to purchase a different product);
  - all-or-nothing clauses (requiring an insurer that wants to contract with a particular provider to contract with all providers in the system); and
  - anti-steering or anti-tiering clauses (requiring an insurer to give preferred status to a health system).

##### Access and Equity

- Condition approval on participation in Medicare/Medicaid.
- Maintain threshold payer mix to ensure access to care for covered patients.
- Maintain critical services, such as emergency departments and intensive and critical care units.
- Ensure availability of culturally competent providers and services.
- Require entities to make reproductive services and death with dignity assistance available and accessible.
- Require that the entities retain current physicians and staff and prohibit the entities from using noncompete agreements to keep providers from serving other hospitals or health systems.
- Require regular reporting on patient demographics, utilization of services, numbers of providers, and community benefit spending.
- Mandate participation in community needs assessments and community benefit activities.

##### Quality

- Require reporting on quality metrics (readmission rates, infection rates, etc.).
- Require reporting on patient satisfaction survey results.

## POST-TRANSACTION OVERSIGHT AND COMPLIANCE

OHA is required to conduct post-transaction reviews of all approved and conditionally approved transactions (preliminary or comprehensive) one, two, and five years after the transaction completion date.<sup>11</sup> These reviews analyze compliance with conditions, cost and cost-growth trends, and the transaction's impact on health care cost growth targets established under Oregon's Sustainable Health Care Cost Growth Target Program. These reviews will be published on OHA's website.

OHA must also closely monitor the commitments the entities made in their initial application to HCMO to ensure they are meeting their self-imposed obligations. OHA's broad investigative and enforcement authority extends to post-transaction monitoring and oversight, giving it the power to issue subpoenas, take depositions, and compel the production of records and documents to enforce the rules and regulations.<sup>41</sup> In addition to any other penalties that are available by law, the law grants authority to the OHA director to impose civil penalties for violations of the HCMO statute as well as for noncompliance with conditions imposed as part of the approval process. Civil penalties on health care entities can be up to \$10,000 per offense, while penalties imposed on individual health professionals may not exceed \$1,000 per offense.<sup>42</sup> Importantly, follow-up reviews also examine post-transaction changes that may impact health care delivery.

In addition to reports on the impacts of specific transactions, OHA must also complete a statewide study of the impact of health care consolidation every four years to evaluate the overall impact of the collective transactions on consumer cost and quality of care.<sup>43</sup> The first of these reports must be commissioned by September 15, 2026.

These reviews are critically important on two levels. First, by monitoring the impacts of individual transactions over time, OHA can develop a robust picture of the ways in which these deals alter health care delivery to the communities they serve and help to identify red flags that may inform reviews of future deals. It may also help identify serial acquirers whose graduated rise in market power may otherwise be overlooked. Second, viewing these deals collectively will give OHA insight into real-time changes in the health care landscape and provide a broader perspective into whether the state is moving closer to achieving its goals related to health care cost, access, equity, and quality.

### Is the Process Working in Oregon?

The two-step review process enables HCMO to direct its limited resources toward reviewing transactions that are likely to adversely impact the cost, access, quality, or equity of health care in Oregon. As of February 2023, eight notices of material change transactions have been submitted. OHA approved three transactions after preliminary review, conditionally approved one transaction after preliminary review, determined that one transaction was exempt from review,<sup>44</sup> and is currently reviewing three transactions.<sup>45</sup>



### Box 5: HCMO 2022 Annual Report

In December of 2022, OHA released an annual report detailing the work of the agency since the enactment of the new law and updates regarding the agency's work in 2023.<sup>46</sup>

- **Reach of transactions reviewed in 2022**
  - Reviewed transactions involving private equity firms, home and hospice health agencies, dental entities, insurance companies, and primary care providers
  - Transactions covered 21 counties
  - Transaction involved 22 provider locations affecting 14,000 patients
- **OHA has built collaborative relationships with other Oregon state programs including:**
  - Department of Consumer and Business Services
  - Department of Justice, Charitable Activities Section
  - OHA's Certificate of Need program
  - OHA's Office of Actuarial and Financial Analytics
  - OHA's Equity and Inclusion Division
- **Staffing for HCMO program**
  - Hired economists, research analysts, and policy analysts to run the program
  - Created pool of outside advisors with expertise in:
    - Community engagement
    - Health care management
    - Economics
    - Finance and accounting
    - Actuarial analysis
    - Claims analytics
    - Qualitative analysis
- **What is ahead in 2023**
  - Beginning in January 2023, entities will now be responsible for paying a fee when filing notice
  - OHA will complete follow-up reviews of the transactions approved
  - OHA will also be closely examining the impacts of consolidation across Oregon for the statutorily mandated 2026 study of the state of consolidation in Oregon
  - Notable trends OHA will be monitoring include:
    - Vertical consolidation
    - The impact of large, national transactions on Oregon's health care market
    - The impact of COVID-19 on consolidation
    - Private equity transactions
    - Cross-market consolidation

In the first approved transaction, OHA approved the purchase of KAH Hospice by Falcon Hospice, a company with private equity investment, saying the transaction posed no transaction-specific concerns regarding access to affordable health care or to health care delivery.<sup>47</sup> In the order approving the transaction, however, OHA acknowledged that private equity-driven growth has a track record of using aggressive cost-cutting strategies to maximize profits that can harm patients and their families.<sup>48</sup> Though no conditions were imposed, OHA specifically noted its intention to monitor spending trends and quality data post-transaction. Given that OHA monitors all approved transactions, the inclusion of this language likely signals that OHA has concerns about these types of transactions generally, but did not have specific concerns regarding these entities or the transaction itself.<sup>48</sup> In the second approved transaction, OHA allowed UnitedHealth Group Inc. to acquire LHC Group, Inc., a provider of in-home health care services, noting in its summary that the Federal Trade Commission had requested additional information about the transaction.<sup>49</sup> In the third, OHA approved the sale of an ownership stake of two for-profit dental practices by their parent company to a private equity firm.<sup>50</sup>

Most recently, OHA issued its first conditional approval, placing conditions after the preliminary review of Amazon's \$3.9 billion purchase of One Medical, a membership-based primary care practice.<sup>51</sup> The OHA concluded that the transaction is not likely to substantially reduce access to affordable care in Oregon for a few reasons. First, OHA was satisfied with Amazon's expectation that it will retain One Medical employees and contractors and will also expand One Medical's network of clinics throughout Oregon, suggesting increased access to care. Second, OHA found that One Medical clinics are located in competitive markets, suggesting that they felt that the existing competition would prevent any potential negative competitive effects from the acquisition. OHA further found that a comprehensive review was not warranted due to the size and nature of the transaction, as One Medical operates only a small number of clinics in one region of Oregon and serves only a small population in that area. To monitor for any future concerning changes to the quality, access, or equity of care and to monitor any changes in the scale of One Medical's presence in Oregon, OHA imposed multiple reporting requirements on the deal. The conditions require semiannual reporting for five years of the number of One Medical members and their visits to clinics, quality metrics, and any changes to One Medical's footprint in the state, including any changes to services offered, number of providers, and the number of locations. These reporting requirements suggest that while OHA does not have pressing concerns about the deal now, they intend to keep a close eye on any subsequent changes.

How effective OHA's overall monitoring and enforcement will be remains unknown. Both monitoring and enforcement require a significant expenditure of time, personnel, and resources, all of which are in short supply in many state governments. Although it may take time for the official enforcement process to mature, the public nature of the review process and the publication of the transacting entities' obligations promote public accountability and oversight.

## A LEGAL CHALLENGE TO OHA'S AUTHORITY

Although lower costs and improved access, equity, and quality are widely accepted goals for health care delivery, the bill establishing the HCMO program was not well received by hospitals and medical centers, which have historically been subject to minimal regulatory oversight of the business side of their dealings. Hospitals, health systems, and provider organizations continue to resist these oversight efforts. On October 3, 2022, the Oregon Association of Hospitals and Health Systems filed a complaint in District Court alleging that the new law is unconstitutional under both the United States and Oregon Constitutions.<sup>52</sup> Specifically, the association alleges that the statute is unclear and does not establish standards for prohibited conduct and the triggers for penalties, in violation of the Due Process Clause of the US Constitution. The association also claims that the legislature inappropriately shifted its law-making responsibilities by empowering OHA to determine the types of entities and transactions that are subject to the law and the criteria for review, in violation of the Oregon Constitution's nondelegation doctrine. While legislative bodies can generally delegate power to administrative agencies as long as the legislative intent is clear and the law includes standards to guide administrative actions, the nondelegation principle in constitutional and administrative law limits to what extent that power can be delegated.<sup>53</sup> Although we cannot predict how the District Court will rule, the statutes and the rules promulgated by the agency appear to provide clear boundaries for OHA's authority and provide standards about how that authority will be applied. Furthermore, significant legal precedent supports the delegation of authority in matters involving technically complicated industries when the expertise and experience of an administrative agency make it well positioned to review and make decisions in complex situations.<sup>54</sup> The nondelegation claim will be especially important to watch—should the court find that the legislature improperly delegated authority to OHA, other states may hesitate to develop similar health care market oversight programs out of concern they cannot give sufficient authority to an agency to carry out such a program. Although the decision will be limited to Oregon, it may provide valuable insight into how other courts will view these types of programs.

## WHAT CAN OTHER STATES LEARN FROM OHA'S EXPERIENCE?

Unchecked health care consolidation is a primary reason for health care cost growth.<sup>2</sup> While state and federal antitrust enforcement remain important tools in preventing some mergers that harm competition,<sup>55</sup> a state-based health care market oversight program might create a greater willingness to challenge transactions that would otherwise likely go unopposed in the traditional antitrust context. The HCMO program in Oregon gives OHA the authority to deny mergers in an administrative process that should be less resource intensive than a trial and allows greater flexibility and oversight on a wider array of health care transactions within the state. Although the HCMO program is still developing and it is too early to quantitatively assess its effectiveness, other states may draw several lessons from the experience in Oregon when considering or implementing similar programs.

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1. States need a detailed understanding of the drivers of health care costs in the state to implement an effective market oversight program.
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Reviewing mergers requires detailed and robust data about the performance of health care markets in the state and requires both a geographic- and sector-specific understanding of the drivers of health care costs so that the administrative agency can identify areas of concern. Oregon has been collecting health care data on insurance coverage, cost and utilization of health services (including medical claims, pharmacy claims), and other data from public and private payers in their Oregon All Payer All Claims (APAC) database since 2009.<sup>56</sup> Additionally, Oregon implemented a sustainable health care cost growth target in 2021, which sets a target for the annual per capita rate of growth of total health care spending in the state and has a process, which includes financial penalties, to hold insurance companies and large providers accountable if their cost growth rises above the target.<sup>57</sup> The APAC database provides the state with critical data when assessing proposed mergers, and the cost growth target places some guardrails on the ability of entities to raise prices post merger.

Any state seeking to follow Oregon's lead in establishing a market oversight program should not underestimate the resources and expertise required to obtain similar data. Although states can require insurers to submit claims in a timely manner, some claims require adjustments (e.g., claims changed due to appeals or payments that were adjusted due to risk-sharing or other value-based payments). For example, because of variations in claims lag, OHA does not release data from the APAC database for approximately two years.<sup>4</sup> While other data (like hospital discharge data and hospital financial data) may be available in a more timely manner, the data lag issue is a fundamental limitation that states need to consider when implementing a market oversight program. States interested in establishing a market oversight program should consider giving the agency the authority to require parties to submit data that can provide real-time insight into health care cost drivers, including confidential data and documents, while protecting this information from disclosure.

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2. States should aim to give a health care market oversight program as much authority as possible to allow flexibility.
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As the agency responsible for the health care market oversight program will ultimately have the best understanding of what is happening on the ground, state legislatures should give that agency as much flexibility as possible while providing sufficient clarity and direction to avoid due process or nondelegation claims. State administrative agencies exist to provide expertise and oversight over various complex industries and have long been given deference by courts when their decisions are challenged in court.<sup>58</sup> In the context of health care market

oversight programs, legislatures must provide the responsible agency sufficient discretion to thoroughly review the transactions that could negatively impact health care patients and to respond to changing market dynamics throughout the state.

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3. States must strike a balance when deciding the breadth of review to use state resources effectively.

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An effective health care market oversight program must also find the appropriate thresholds for review—too narrow and the program will not catch potentially problematic transactions, but too broad and the program risks being overburdened and inefficient. A comparison of the OHA and HPC review processes illustrates different approaches to defining the breadth of transactions to be reviewed. Because the types of transactions that require notice to the HPC are not limited by the requirement that the transaction reduce essential services, like in Oregon, the HPC receives notice for more varied transaction types. However, notice to the HPC is limited to transactions involving at least two health care entities, whereas OHA receives notice of transactions between a health care entity and non-health care entity. Additionally, the Oregon legislature tried to balance the wide net in transaction type with a revenue threshold to exempt smaller transactions to try to focus state resources on transactions that are most likely to cause harm. Using a monetary threshold (either by revenue or by deal size) is likely an effective way to ensure that the agency reviews significant deals. A deal-size threshold would be analogous to the Hart-Scot Rodino threshold used at the federal level by the Federal Trade Commission and Department of Justice,<sup>59</sup> but states would likely want to set a much lower threshold to capture smaller transactions that do not trigger federal review. While determining the appropriate threshold will be a key point of negotiation for any new legislation, state legislatures should also consider the current levels of market concentration in their state and the current market players. If most markets in the state are already highly consolidated, the legislature may want to set (or direct the agency to use rulemaking to set) thresholds and exemptions that target those large entities absorbing smaller providers or health care entities.

State legislatures should also bear in mind the dangers of stealth consolidation, whereby markets become consolidated through consecutive small transactions that fall below the thresholds for federal and state scrutiny.<sup>60</sup> States should develop ways to monitor small deals without overwhelming the reviewing entity. States could potentially accomplish this by requiring notice when a series of related transactions occur within 12 months that reach the revenue or deal size threshold established for reporting transactions. This language was included in an early version of the Oregon law but was omitted in later amendments.<sup>61,62</sup>

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4. States should strive for a high level of transparency and public participation, as both are critical to effectively review transactions and minimize the risk of regulatory failure.

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Transparency, accountability, and public participation are critical to the success of any market oversight program, as they help engender trust in the agency’s process and increase public awareness of issues with health care consolidation. Oregon’s HCMO program makes transparency a priority by publicly posting all proposals, reports, decisions, and comments on OHA’s website and inviting public comment from individuals and organizations throughout the review process. Additionally, the CRB provides a public participation process, and the required reporting following each transaction keeps OHA accountable for its decision making and entities accountable to their obligations. Other states should consider similar transparency and reporting requirements along with mechanisms to solicit input from communities that may be impacted, especially members of those communities that have historically been underrepresented in policymaking spheres.

Another equally important benefit of robust transparency and reporting requirements is that they establish accountability that can help minimize the corrosive effects of regulatory capture. Regulatory capture is the process through which regulated entities successfully influence agencies to serve the interests of the regulated industry rather than those of the public. Robert Murray, former executive director of Maryland’s Health Services Cost Review Commission and an expert on regulatory failure, recommends the “establishment of and adherence to clear performance metrics or targets . . . with periodic review of performance and the imposition of significant penalties for nonperformance” as a way to galvanize support for an agency and help immunize it from capture or failure.<sup>63</sup> Additionally, strict adherence to a conflict of interest policy is crucial for maintaining agency independence. Oregon’s law prohibits any officer or employee of OHA with the authority to review transactions from having a financial interest in an entity that is a party to a proposed material change transaction, except as an enrollee or patient of a health care entity.<sup>64</sup> Other states might consider a very strong conflict of interest policy that prohibits anyone with decision-making authority from having any financial interest in any health care entity.

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5. Any imposed conditions should be enforceable and targeted.

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Conditional approvals should be used sparingly, as conditions are typically imposed for a limited duration yet the increase in market power from a transaction will endure. Some transactions may pose minimal risk of competitive concerns and a state may choose to approve a transaction with specific conditions intended to address specific access, quality, or equity issues. For example, a state may allow a transaction if the parties agree to hire or train more culturally competent providers for a clinic in an underserved community. Nonetheless, these conditions should be specific, quantifiable, and enforceable and agencies should appoint an independent monitor to ensure compliance with imposed conditions. We do not yet know how effective OHA’s oversight and monitoring will be and what enforcement will look like, as both are time-, labor-, and cost-intensive.

## CONCLUSION

Although federal oversight of health care transactions remains crucial, states have an essential role to play in examining a wide array of health care transactions that escape federal scrutiny, whether due to their size or the type of transaction. Programs that monitor consolidations at the state level can play a critical role in disrupting the steady march of consolidation that is contributing to rising costs and decreasing access. To accomplish this, however, state market oversight programs need sufficient statutory authority, structure, and resources to monitor activity. Creating a post-transaction notice and review process allows the state to monitor the health care landscape in real time and establish some guardrails to protect the public interest and prevent negative consequences. With follow-up monitoring, data collection, and outcome assessments, states can better understand the impacts of transactions, both for individual deals and for all deals in their totality, and the factors that promote and undermine state health care goals. If the data show that mergers, acquisitions, and other transactions do, in fact, improve access, quality, and equity and reduce costs, as is often asserted by health care entities, that will become evident through the follow-up monitoring. Oregon is the latest state to implement oversight authority that has both built on and expanded upon other states' oversight efforts and has raised important questions that will be answered in the months and years to come.

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## ABOUT THE AUTHORS

**Robin L. Davison**, JD, MPH, is a senior health policy researcher for The Source on Healthcare Price and Competition and a research fellow for Dementia Care Aware, a California statewide initiative to improve screening and support for elderly Medicaid patients. Prior to joining the Consortium, she worked as a public health advisor for the Centers for Disease Control and Prevention and project lead for medical-legal partnerships research and implementation focused on underserved communities and people living with HIV. She holds a JD from Cardozo School of Law, an MPH from Columbia University, and a BA from Brandeis University.

**Katherine L. Gudiksen**, MS, PhD, is a senior health policy researcher for the Source on Healthcare Price and Competition. She studies the effects of consolidation and options that state policymakers have to address it, including laws to restrict specific contracting practices, state public option programs, and ways to limit excessive provider rates. She is a graduate of the UCSF/UC Hastings Master of Science in Health Policy and Law program, where she studied policy solutions to promote competition in the pharmaceutical industry. Prior to her work in health policy, she earned a PhD in chemistry from Harvard University and co-founded a cancer diagnostics company.

**Alexandra D. Montague**, JD, is a health policy researcher at the Source on Healthcare Price and Competition. She is a graduate of UC Hastings College of the Law, where she was the executive editor of articles for the Hastings Constitutional Law Quarterly and graduated with a concentration in health law.

**Jaime S. King**, JD, PhD, is the John and Marylyn Mayo Chair in Health Law and Professor of Law at the University of Auckland, Faculty of Law; senior affiliate scholar of the UCSF/UC Hastings, Consortium on Law, Science, and Health Policy; and executive editor of the Source on Healthcare Price and Competition. Professor King's research analyzes the role of legal, economic, political, societal, and market forces in shaping domestic health care systems. Her U.S.-based work specifically focuses on the use of legal and policy initiatives to counteract concentration in health care and improve access to high-quality, affordable health care. She holds a JD from Emory University School of Law and a PhD in health policy from Harvard University.

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645 Madison Avenue  
New York, NY 10022  
[www.milbank.org](http://www.milbank.org)