



RESEARCH REPORT

Addressing Health Care Market Consolidation and High Prices

The Role of the States

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Executive Summary

This decade has seen an unprecedented increase in hospital merger and acquisition activity resulting in highly concentrated hospital markets throughout most of the country. Largely as a result of the lack of competition among hospitals and alternative health delivery channels, the payment rates that providers negotiate with commercial insurers has risen steadily, now at alarming rates.

In the late 1990s, commercial rates for inpatient services were 110 percent of Medicare payment rates. In the most recent study, conducted in 2017, the commercial rates for inpatient care in a sample of 25 states had reached 204 percent of Medicare, while the composite rate for both inpatient and outpatient care had risen to 241 percent. Health services research has documented that high prices have become the dominant reason the US spends nearly two times more on health care services than most countries in the Organisation for Economic Co-operation and Development. In this decade, service use has been flat, yet health care expenditures have risen because of provider prices.

The response from the federal government has been tepid at best. Over 90 percent of hospital markets have become highly concentrated. In the meantime, hospital acquisition of physician practices, or “vertical mergers,” and development of multihospital health care systems crossing many local health care markets, or “cross-market mergers,” proceed unchallenged, despite evidence that both are associated with substantial price increases, without evidence of quality improvement or greater efficiency. The Trump administration recently finalized new rules to make negotiated prices more transparent to the public, and pending legislation in the House and Senate would address some of the drivers of health care prices, including anticompetitive contract clauses and a lack of price transparency, but these initiatives remain in nascent stages. Prospects for federal leadership to address consolidation and high prices remain uncertain.

Accordingly, states have adopted numerous initiatives to address failed competition and high health care prices in provider markets. In this report, we explore a wide range of policy options that attempt to introduce needed competition in provider markets and regulate prices directly. We argue that transparency initiatives will support both regulatory and competition-based policy options, and certain approaches to regulation complement and support efforts to improve market competition. Thus, although we largely divide the report in to two parts, competition and regulation, states do not have to select one course or the other but can take action in both areas.

Project Overview

In the report, we explore state efforts to do the following:

- promote transparency of price information, especially through all-payer claims databases
- strengthen the effectiveness of antitrust enforcement by state attorneys general
- develop state public option plans to compete in provider markets
- develop state commissions to address health care costs and prices
- develop insurance and provider rate review and approval regulations
- impose price limits for state employee health benefit plans
- develop new approaches to state-based, hospital rate setting

We also examine the commonly held presumption that certificate of need programs are inherently anticompetitive because they present a major barrier to entry of would-be competitors.

Key Findings

Following a comprehensive introduction on price increases and market consolidation in the last several decades and an overview of the constraints imposed on state legislatures by the Employee Retirement and Income Security Act of 1974, we present and analyze information on recent state attempts to promote competition and control prices in health care that we gathered from academic literature, state legislation, federal and state litigation, and key informant interviews. We present some of our key findings below:

Transparency

Access to comprehensible and reliable health care price and utilization data promote transparency and is essential for effective policymaking, regardless of the approaches selected. Nineteen states have passed laws creating an all-payer claims database, which gather health care claims data and can generate information for consumer-oriented websites to facilitate price comparisons, as well as inform policymakers about the drivers of health care spending and the efficacy of policy initiatives.

Competition

State attorneys general have an important role to play in enhancing and protecting competition in health care markets that extends beyond supplementing federal antitrust enforcement efforts.

- States can identify vertical and cross-market mergers that federal antitrust enforcers may not receive notice of or identify as anticompetitive. Washington recently required all mergers involving a hospital or a physician group to provide notice to the attorney general.
- States can expand the use of “conduct remedies” that seek to restrain the behavior of the postmerger entity. The report presents a new taxonomy of a broad range of conduct remedies used in consent decrees that govern the approval of a proposed merger, the equivalent of an approval with “strings attached.” The Massachusetts attorney general recently approved the merger between the Beth Israel Deaconess Medical Center and Lahey Health, contingent on the merged entity agreeing to abide by conduct constraints and to make a financial commitment to care for the undeserved.
- A handful of state attorneys general, including those in Pennsylvania and Massachusetts, have reorganized their offices to promote cross-department information sharing and balance competition-related concerns with concerns related to use of charitable assets and consumer protection to enhance broad oversight of health care markets.
- States also use litigation to challenge specific anticompetitive behaviors by health care entities with market power, including use of anticompetitive contract terms such as most-favored-nations clauses, antitiering and antisteering provisions, nondisclosure agreements, and all-or-nothing provisions. Recently, the California attorney general, labor unions, and self-insured employers brought and settled a suit to challenge Sutter Health’s alleged use of anticompetitive contract clauses to increase provider payment rates and keep those supracompetitive rates from public scrutiny.
- Some states are prohibiting or restricting the use of anticompetitive contract provisions that powerful health care systems have demanded in their contracts with private insurers. Twenty states currently ban most-favored-nations clauses, and New York requires the insurance commissioner to review any contract between an insurer and provider that includes a most-favored-nations provision for potential harm to competition.
- States are experimenting with designs for state-based public insurance options to enhance competition in consolidated health care marketplaces. While 15 states have considered some

form of a public option, Washington and Colorado have passed legislation to create public option plans.

Regulation

States are using existing regulatory structures in new ways to promote competition and control health care spending directly by limiting hospital and other provider prices.

- Despite theoretical and empirical claims that certificate of need programs are inherently anticompetitive, our review of the literature does not support that assumption. Given that about half the states have retained certificate of need for short-term hospitals, it is important to assess the precise effects of these programs on market competition, health care spending, and quality of care and how state variations in program design and administration affect these outcomes.
- Rhode Island and Colorado have charged their state insurance commissioners with maintaining the affordability of health insurance. While Colorado's initiative remains in implementation, Rhode Island's insurance commissioner used the authority to create Affordability Standards, which enable the commissioner to review proposed insurance premium rates, as many states permit and to review and approve hospital payment rate increases included in insurance contracts under specified circumstances.
- Two states, Montana and Oregon, have implemented price ceilings on hospital payment rates within their state employee health benefit plans. In each instance, provider groups challenged the initial price ceilings proposed by the states. In North Carolina, provider groups postponed a similar approach that included ceilings on rates for hospitals and physicians. If successful, price ceilings within state employee plans could be models for state price ceilings on provider payments in the private market.
- In 2014, Maryland modified its long-standing rate setting approach used to control hospital spending and moved to setting all-payer hospital budgets. Vermont and Pennsylvania have also received Medicare demonstration authority, enabling them to set and administer global budgets for all hospitals and for rural hospitals, respectively.
- In contrast to all-payer rate setting and budget setting, states have also considered new approaches that (1) establish annual update percentages or absolute dollar amounts that hospitals can add to the current negotiated base rates or (2) set upper limits on commercial

insurance payments as a percentage above the Medicare payment rate, similar to what Montana and Oregon implemented in their state employee benefit plans. In contrast to the infrastructure required in states now setting budgets, setting upper limits on negotiated rates and limiting annual updates to established rates focuses more on outliers and updates, which likely would make them less intrusive and require a relatively small commitment in staff and resources. While directly limiting high prices, these approaches can complement market competition that reward other aspects of care, including reducing unnecessary services, and improving quality of care and patient experiences.

1. Introduction

In 2003, Gerard Anderson and colleagues documented that the high prices paid by private health insurers are the major reason the US spends so much more on health care services than all other developed countries, whether measured as per capita spending or percentage of gross domestic product (GDP) (Anderson et al. 2003). Sixteen years later, provider prices have increased substantially, even as use of health care services have moderated. In 2017, the US spent 17.9 percent of GDP on health care services, with virtually all increases in recent years coming from hospitals' and other providers' price increases (CMS, n.d.).

While high pharmaceutical prices clearly deserve corrective action and are actively part of both national and state policy discussions, prescription drug costs represent only 10 percent of health care spending, whereas costs for short-term hospitals, physicians, and other health professionals together compose about 60 percent of overall health care spending.² Spending on short-term hospital services alone accounts for 44 percent of total personal health care spending for the privately insured.¹

Although in the first 15 years of this century, health policy researchers and analysts focused a lot of attention on variations in the use of health care services, particularly in Medicare, in recent years, attention has shifted because of the growing recognition that prices for health care services has become a much more important factor driving high and rising health care spending experienced by US health care. In turn, growing concentration in provider markets—especially hospital markets—has been a dominant factor driving these prices. Over two decades, market power has shifted from payers to providers as reflected in the relative leverage that the parties bring to the negotiating table over prices.

Yet, despite the growing evidence of the powerful influence of provider prices driving spending, policy solutions are few and far between, at least partly reflecting the paralysis in federal policymaking in a highly polarized political environment, as reflected to a significant degree in the orientation of the 2011 Patient Protection and Affordable Care Act (ACA) to broadening Medicaid and establishing state-based Marketplaces in order to expand insurance coverage, the states are assuming a much larger role in health care policy. Many states have initiated activities that address high and rising health care provider prices.

In this report, we provide a survey of these activities and provide detail on how these and other possible initiatives can address market consolidation both by creative approaches to insert more competition into health care markets and, where market failure seems inevitable, pragmatic regulatory approaches, particularly to limit prices that hospitals and physicians are able to command. We will argue

that in important ways, certain approaches to regulating prices actually promotes better-functioning, more competitive markets. We explore in depth the changing role of state attorneys general in addressing high and varying prices, the trade-offs between preventing or limiting mergers versus attempting to restrict the conduct that merged provider systems typically engage in, whether certificate of need laws actually compromise market competition as commonly assumed, and, finally, a range of approaches states can take to regulate payment rates while mounting initiatives to promote more provider competition in health care markets.

The Price of American Health Care

A series of studies document that unprecedented merger and acquisition activity produced anticompetitive hospital market concentration. From 1998 to 2015, 1,412 hospital mergers occurred, with about 40 percent of those mergers taking place from 2010 to 2015 (Gaynor 2018). After two decades of vigorous merger and acquisition activity, there are now 5,262 community hospitals² and about 4,000 short-term acute care hospitals in the US.³ In just the last three years for which we have data (2015 to 2017), 724 hospitals merged. In contrast to prior years, in 2017, more acquisitions took place across regions than within the same market (MedPAC), reflecting the emergence of cross-market mergers as the form of consolidation for which there has not been a successful antitrust response.

Given rapid consolidation within and across markets, hospitals have achieved market power in their negotiations with insurance companies over prices and other terms and conditions in their contracts. Nine in 10 metropolitan areas are now considered “highly consolidated” as measured by the broadly accepted metric for characterizing market concentration: the Herfindahl-Hirschman Index (Fulton 2017).

For their part, insurance markets are also concentrated. The result is that even dominant insurers do not need to achieve low prices, only the lowest rates among their competitors to establish favorable market conditions and prevent entry of would-be insurer competitors, which, facing higher provider rates, would have difficulty putting together a price competitive provider network (Dafny 2010; Dafny, Mark Duggan, and Ramanarayanan 2012). That is, lack of insurer competition perversely supports the persistence of high prices that large, merged hospital systems command. Because of the unique features of health care, the assumption that countervailing power by insurers will result in substantially lower hospital prices is wrong, as demonstrated in the infamous “handshake” between Blue Cross, Blue Shield of Massachusetts and Partners Health.⁴

Several studies highlight the growing divide between commercial and Medicare prices in the face of unchecked provider leverage. Selden and colleagues determined that commercial inpatient prices were 175 percent of Medicare in 2012, up from 110 percent in the late 1990s (Selden et al. 2015). Maeda and Nelson found that commercial inpatient prices had risen to 189 percent of Medicare in 2013 (Maeda and Nelson 2017). The recently published RAND hospital price transparency study, by White and Whaley, found that average commercial inpatient prices had reached 204 percent of Medicare in 2017 and 293 percent of Medicare for outpatient care, for a composite, weighted average of 241 percent (White and Whaley 2019). In short, private health insurance prices continue to rise substantially in relation to Medicare prices, which have become the commonly used, comparative yardstick.

Researchers also demonstrate wide variation in commercial prices, creating what market participants often describe as “have” and “have-not” hospitals. In 2010, Ginsburg and colleagues surveyed four national insurers and found that across major health care markets, average inpatient payment rates ranged from 147 percent of Medicare in Miami to 210 percent in San Francisco but that, in extreme cases, hospitals negotiated almost 500 percent of Medicare for inpatient care and 700 percent for outpatient care. The Ginsburg et al. study also showed substantial intramarket variations. For example, the hospitals with prices at the 25th percentile of all Los Angeles hospitals received only 84 percent of Medicare inpatient rates, whereas the hospitals at the 75th percentile received 168 percent of Medicare, almost twice as much (Ginsburg 2010). A recent study of California hospitals found that the 10 percent of California hospitals with the highest ratio of private health insurance Medicare payment had a ratio of 364 percent of Medicare, whereas the 10 percent with the lowest ratio had an average of 89 percent of Medicare, representing a fourfold variation in payment levels (Kronick and Neyaz 2019).

A follow-up study analyzing claims in 13 markets found that the highest-paid hospitals had negotiated rates 60 percent higher than the lowest-priced hospital for inpatient services. In three of the markets, the highest-priced hospital was paid more than twice as much as the lowest-priced hospital for inpatient services. Differentials were greater for outpatient care (White, Bond, and Reschovsky 2013). MedPAC performed a similar analysis on a national basis, finding a nearly 2:1 payment ratio between the 90th percentile and 10th percentiles of hospitals” (MedPAC 2011).

Less studied but just as important is the fact that hospitals negotiate different rates for the same services with the many different payers. A report from the Minnesota all-payer claims database showed that the variation in rates for the same services at a given hospital facility varied even more than the variation in average price between different hospitals (MDH, 2015).

Although national attention has rightly focused on trying to reduce unneeded and often inappropriate use of health care services—often labeled utilization or volume—price increases by providers have overwhelmed the widespread success in reducing utilization increases. For example, between 2013 and 2017, commercial insurance utilization of health care services decreased by 0.2 percent, whereas weighted average prices increased 17.1 percent—or 4 to 5 percent a year—far faster than inflation in the economy as well as inflation for goods and services in the health care sector (Reinhardt 2019).⁵ Recently, the Massachusetts Health Policy Commission found that commercial inpatient spending increased 10.7 percent from 2013 to 2018, despite a 12.8 percent decrease in volume. The increase in spending was driven primarily by rising prices and upcoding (MHPC 2019).⁶

As a result, many hospitals for the past few years have enjoyed consistently positive and rising operating margins, supporting high executive and other management salaries, high staffing ratios, and substantial retained earnings, which in turn generates substantial, additional investment income for the hospitals (Papanicolas, Woskie, and Jha 2018),⁷ some of which is for capital acquisitions and service line expansion, which together produce still greater concentration of resources. From 2010 to 2017, aggregate operating margins for hospitals, excluding critical access hospitals, ranged from 5.1 percent to 6.4 percent, reaching 5.9 percent in 2017,⁸ higher than in earlier periods. Total margins, which include investment income, were 7.1 percent in 2017 (MedPAC 2019).

Large nonprofit health care systems that care for a disproportionately high share of hospital care have profited from these high and rising margins. Preliminary work we have initiated to examine public filings made by such systems reveal that these profits have contributed to the accumulation of invested reserves in the billions of dollars.⁹

Independent physicians in sole or group practice also receive payment levels exceeding the Medicare standard but not nearly as high as hospitals. Cooper and others found that from 2007 to 2014, hospital prices for care grew 42 percent for inpatient care and 25 percent for outpatient care, while physician prices grew 18 percent for inpatient care and 6 percent for outpatient care (Cooper et al. 2019). However, increasingly, hospitals have been either acquiring physician practices or directly employing physicians and then using their own market power to raise prices for their employed or owned physicians. Today, about 44 percent of all physicians are employed by hospitals, while about 30 percent of physician practices actually are owned by hospitals (PAI 2019). Furthermore, the continued acquisition of provider groups by health systems often flies under the radar of antitrust enforcement, allowing it to go on largely unchallenged (Capps, Dranove, and Ody 2017; Dafny, Ho, and Lee 2016; Greaney and Richman 2018).

Proponents of the development of large health care systems extending over broad geographic areas assert that these mega-organizations permit efficiency-producing economies of scale and scope such that costs will come down and, further, that the integrated care permitted by the integration of hospitals and physicians will substantially improve both the quality and efficiency of care provision. A recent study confirmed the concern that accountable care organizations (ACOs) could exacerbate market concentration trends. The authors concluded, “These patterns suggest that the consolidation concerns initially raised regarding ACOs were warranted and that gains from care coordination facilitated by ACOs will have to be balanced against higher prices and possibly lower-quality care that could result from consolidation” (Kanter, Polsky, and Werner 2019). A recent study looking at the effects of hospital acquisitions in the past decade found that acquisition by another hospital or hospital system was associated with modestly worse patient experiences and no significant changes in readmissions or mortality rates (Beaulieu et al. 2020).

In sum, to date, the notion that health care systems are more efficient and produce higher quality lacks evidence (Burns, Goldsmith, and Sen 2014), whereas it is clear that such consolidation raises prices substantially (Baker, Bundorf, and Kessler 2014; Berenson 2017; Capps, Dravone, and Ody 2018; Krlewski et al. 2015; McWilliams et al. 2013; Neprash et al. 2015; Robinson and Miller 2014; Scheffler, Arnold, and Whaley 2018).

In 2010, the Massachusetts Attorney General Report concluded,

Price variations are not correlated to quality of care, the sickness or complexity of the population served, the extent to which a provider is responsible for caring for a large portion of Medicare or Medicaid, or whether a provider is an academic teaching or research facility. Moreover, price variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.... Price variations are correlated with market leverage as measured by the relative market position of the hospital or provider group (OAG 2010).

Ten years since this report was issued, we examine policy options that address this long-overlooked problem in US health care.

Federal Policy Has Failed to Address Increasing Provider Prices

Over the last decade, the federal public policy response to address increasing prices that result from consolidation has been absent or ineffective (Greaney and Richman 2019). The well-established public policy and legal presumption that health care costs are best disciplined by market forces, rather than direct government price regulation, has contributed to a dearth of policy action to address the destructive effects of high and varying prices.¹⁰ Furthermore, limited antitrust enforcement allowed significant consolidation, which mutes market forces that might otherwise keep prices in check.

In particular, federal antitrust enforcement has been limited, still focused on narrow “horizontal”¹¹ hospital mergers in local markets, while mostly ignoring the formation of broad health care systems resulting from “vertical” mergers¹² of hospitals and physician groups and the development of large hospital systems that cross broad geographic areas, known as cross-market mergers, that occur both within and across states. Vertically integrated health systems and cross-market mergers contribute to the recent rise in provider prices (Baker, Bundorf, and Kessler; Capps, Dranove, and Ody; Dafny, Ho, and Lee 2016; Kralewski et al. 2015; McWilliams et al. 2013; Neprash et al. 2015; Walston, Kimberly, and Burns 1996), yet federal antitrust policy has not responded effectively (Dafny, Ho, and Lee 2016; Greaney 2019; Salop 2018). At the same time, antitrust has little to say about market power achieved by growth from past mergers too “stale” to take on (Greaney 2017). Challenges to already-consummated mergers have been notoriously difficult to mount because of difficulties inherent in “unscrambling the eggs” of long-standing merged entities (Greaney 2017). Nor has the federal government responded with other policies that address high and rising provider, mostly hospital, prices or the inequitable variations in hospital payment rates that result in what market observers refer to as the haves and have-nots (Berenson 2015a).

Because of the limits of federal antitrust enforcement and of market forces to discipline private payer health care prices, states have the opportunity to complement federal efforts and, perhaps, take the lead in addressing the consequences of failed competition in health care markets.

The Lack of Federal Initiative Leaves Room for States

Scholarship in the past few years has identified a range of market-oriented and regulatory policy approaches available to the federal government and state governments to address the pervasive problem of high and rising provider prices (NASI 2015). Some have focused on the unique attributes of

state government to tackle the problem, consistent with the highly varied political economies of the states (Fuse Brown and King 2016). In the few years since publication of these reviews, a number of states have studied their options, and some have enacted legislation or taken administrative action to address provider prices.

Although state initiatives can both improve health care market function and regulate the results of market failure (e.g., high prices), for purposes of presentation, we separate the discussions into those that primarily attempt to improve competition and those that directly regulate market behavior. However, as discussed in the section on potential state regulatory efforts addressing high and varied prices, we will emphasize that certain approaches to price regulation actually are complementary to efforts to improve market competition. In short, while we divide the paper into two parts, competition and regulation, states do not have to choose one course or the other but rather may well choose to do both at the same time.

2. Employee Retirement Income Security's Act

One cannot embark on a discussion of state options to control costs and promote competition without first examining the role that the Employee Retirement Income Security Act of 1974 (ERISA)¹³ plays in restricting state health policy initiatives. Congress passed ERISA to provide uniform, federal standards for pensions and employee benefit plans, including health plans. At its inception, ERISA was not viewed as a barrier to state health law, but judicial interpretation of the law has expanded its preemptive reach substantially over the last few decades to become one of the greatest impediments to state health policy initiatives (Fuse Brown and King 2019). Consequently, ERISA significantly limits states' abilities to comprehensively protect health care consumers and regulate the health care market by preempting a wide range of laws, including those that govern submissions to all-payer claims databases (APCDs), payment of surprise medical bills, pharmacy benefit manager practices, and insurance coverage mandates.

Section 514 of ERISA expressly preempts state laws that “relate to any employee benefit plan.”¹⁴ The Supreme Court held a state law “relates to” an ERISA plan if it has “[1] a connection with or [2] a reference to such a plan.”¹⁵ A state law makes an “impermissible connection” with an ERISA plan when it “governs a central matter of plan administration” or “interferes with nationally uniform plan administration.”¹⁶ A state law can also make “an impermissible ‘reference to’ ERISA plans where it ‘acts immediately and exclusively on ERISA plans...or where the existence of ERISA plans is essential to the law’s operation.’”¹⁷ But the judicial interpretation of these standards has varied significantly from jurisdiction to jurisdiction, generating further uncertainty for state legislators and industry stakeholders.

Despite its broad preemption over laws that relate to employee benefit plans, states retain the ability to regulate certain spheres of the health care market. In particular, Congress exempted state insurance regulations, including health insurance regulations, from ERISA preemption, but ERISA does not deem self-insured employer benefits to constitute insurance.¹⁸ Therefore, state insurance laws will apply to indemnity employer health plans, in which the insurer accepts the financial risk in exchange for a premium, but they will not apply to self-insured employer plans, in which the employer retains the risk and often hires a “third-party administrator” to help with plan administration. Consequently, state insurance laws do not apply to the self-insured employer plans that cover approximately 60 percent of Americans who receive employer-sponsored insurance. Instead, the US Department of Labor, rather

than the state insurance commissioner, oversees administration of self-insured employer plans.¹⁹ In sum, ERISA will preempt any law that relates to an employee benefit plan, unless it is a state insurance law. However, ERISA prohibits state insurance laws from governing self-insured employer plans, which prevents states from protecting a large percentage of their citizens and regulating an ever-increasing section of the health insurance market.

As a result, many states have attempted to carefully draft legislation to avoid ERISA preemption. ERISA's complicated preemption scheme led some states to position their health reform efforts as laws regulating insurance. For instance, Maine recently passed L.D. 1504,²⁰ a bill that requires insurance carriers to regulate the practices of pharmacy benefit managers that operate on their behalf. The Maine legislature found that this indirect oversight was preferable to the state directly regulating the practices of pharmacy benefit managers, as courts have held some laws regulating pharmacy benefits to have an impermissible connection with ERISA plan administration.²¹ Furthermore, ERISA does not expressly preempt state laws that govern health care providers and only incidentally affect ERISA plans.²² For example, Maryland has the power to establish global budgets for health care spending throughout the state through its Health Services Cost Review Commission, which only incidentally affects ERISA plans (Jordan 1996). As a result, positioning health reform laws as insurance laws or laws regulating providers directly offer opportunities to skirt ERISA preemption.

Nonetheless, states have little ability to regulate or oversee the practices of and coverage provided by self-insured employer plans. For example, in *Gobeille v. Liberty Mutual Ins. Co.*, the Supreme Court held that ERISA preempted the application of a Vermont insurance statute—which required all payers to report their health care claims data to the state's APCD—to self-insured employers, like Liberty Mutual Insurance Co.²³ Several proposals have been made to require self-insured employers to submit claims data to APCDs, including allowing the Department of Labor to require self-insured employers to submit their claims data to state APCDs, amending ERISA to require self-insurer claims submission, amending ERISA to include a waiver for certain state health reform initiatives, and creating a federal all-payer claims database (Fuse Brown and King 2019; King 2019).²⁴

The *Gobeille* decision significantly broadened the scope of ERISA preemption in ways that continue to impinge upon states' abilities to govern health care activities within their borders (Fuse Brown and King 2019). Nonetheless, states continue to pass laws intended to improve the functioning of health insurance markets and health care delivery systems. While these laws may not apply to self-funded employer plans, improved market competition should benefit all state residents. We review opportunities states have regardless of ERISA to improve market competition or otherwise address the failure of competition by directly placing limits on the payment rates providers receive. For example,

states have begun placing health reform statutes, like pharmacy benefit manager regulations and surprise billing laws, into their state insurance laws to allow them to be “saved” from ERISA preemption.²⁵ When politically feasible, states may also regulate providers directly, so long as the law does not relate to an employee benefit plan. For example, to mitigate balance billing, the California legislature considered a bill to limit the amount hospitals charge for emergency and poststabilization services to no more than the reasonable and customary amount or the average contracted rate.²⁶ The bill also limits the amount the hospital can collect from the patient to “no more than the same cost sharing that the patient would pay for the same covered emergency services received from a contracting hospital.”²⁷ Typically balance-billing regulations are written in insurance codes and regulate contracts between insurers and providers, but this bill takes a novel approach to regulating behavior of hospitals. While ERISA prevents a state from setting the rates self-funded plans must pay the hospital for emergency services, this bill protects patients from large-balance bills by limiting the amount hospitals can collect from them. Absent an ERISA amendment, these contortions or indirect regulation of health care markets through insurance provisions are the best states can do.

3. State Efforts to Promote Transparency

Price transparency efforts play a fundamental role in improving health care market functioning by providing relevant information to decisionmakers, including patients, providers, payers, and policymakers, at key decision points (King 2018). Early price transparency efforts of the federal government and many states have focused on changing consumer behavior to encourage them to select providers and services that supply the greatest value at the lowest cost. For instance, California passed two laws in the 2011–12 legislative session, SB 751 and SB 1196, to promote transparency of health care prices by prohibiting the use of “gag clauses” in contracts between providers and health plans that would prohibit disclosure of price information to enrollees and qualified entities.²⁸ Other states, like New Hampshire and Maine, promoted consumer transparency through the creation of consumer-facing websites.²⁹ However, the largest benefit from transparency initiatives result from their ability to inform the broader health policy discussion by providing valuable information to policymakers, researchers, market stakeholders, and the public. This information, often collected in a state all-payer claims database, can be used to evaluate the functioning of markets, identify opportunities for state-based policy interventions, identify payment disparities that result from market power, and garner public support for policymakers seeking to intervene in state health care markets.

State All-Payer Claims Databases

All-payer claims databases (APCDs) form the foundation of many state price transparency initiatives. An APCD is a comprehensive database of medical claims and quality data from payers, including private insurers, Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), dental insurers, prescription drug plans, state employee health plans, and others.³⁰ Because APCDs report actual paid amounts, rather than listed rates or even negotiated rates, they provide foundational data that policymakers can use to assess the functioning of health care markets, including analysis of price variations, potential policy initiatives, and delivery system reforms (Bailit Health 2019).

Currently, 18 states operate APCDs with mandatory reporting for all payers regulated by the state (i.e., not self-funded employers). At least 11 more are in the process of implementing or studying the feasibility of creating an APCD.³¹ Following the same arc as other transparency efforts, APCDs originally provided information intended to promote consumer price shopping. Eight states, including

Maine and New Hampshire, successfully used data from their APCD to create consumer-focused tools to help residents and employers, who are often not aware of the significant variations in provider prices, shop for higher-value care. In New Hampshire, the state APCD provides price information for the state's publicly accessible website, NH HealthCost,³² which gives provider-, procedure-, and insurer-specific median prices, making New Hampshire one of the most transparent health care markets in the country.

State Health Care Shopping Tools

Consumer-facing price comparison tools, like NH Health Cost, increasingly offer insured patients information on their out-of-pocket costs for a particular procedure by a particular provider within their specific plan. Patients can only use price comparison tools for shoppable services, services offered by multiple providers in an area that can be scheduled in advance.³³ Estimates vary on the amount spent on shoppable services from approximately a third of total spending on ambulatory and inpatient services (White and Eguchi 2014) to approximately 43 percent of all spending on health care services (Frost and Newman 2016). Nonetheless, estimated savings from consumer price shopping are modest, and consumer-facing initiatives have not proven sufficient to bend the cost curve. Patients have demonstrated a reluctance to use price transparency tools to shop for care, with approximately 2 to 20 percent of patients using available tools to search for price information, depending on the intervention (Desai et al. 2017; Lieber 2017; Mehrotra et al. 2017; Sinaiko and Rosenthal 2016; Whaley et al. 2014). Nevertheless, many of those studies also demonstrate significant savings, between 10 and 17 percent, for patients who use the tools (Lieber 2017; Whaley et al. 2014).

In response, many state employee benefit plans and private insurers coupled transparency tools with financial incentives in an attempt to increase their use. For example, New Hampshire worked with Anthem Blue Cross and Blue Shield to implement a right to shop program in the state employee health benefits plan.³⁴ Right to shop programs give patients a financial award for choosing a lower-cost provider, typically a portion of the savings realized by the insurer when the patient chooses a provider with lower negotiated rates.³⁵ New Hampshire's Anthem patients were 11 times more likely to use the transparency tool when coupled with a financial incentive.³⁶ In addition, the state saved \$11 million in just the first three years of the program.³⁷ Similarly, the California Public Employees' Retirement System (CalPERS) used reference pricing to encourage its beneficiaries to shop for higher-value care by establishing a maximum price, the reference price, that it will pay for a health care service. CalPERS successfully used reference pricing to reduce spending by 20 percent for joint replacement, 18 percent for cataract removal, 21 percent for colonoscopy, and 17 percent for arthroscopy (Robinson and Brown

2013). In the last few years, many states, including Kansas, Kentucky, and Massachusetts implemented right to shop programs in their employee benefit plans and at least six states have passed laws to encourage their use among private insurers (Florida, Maine, Nebraska, Tennessee, Utah, and Virginia).³⁸ While some evidence suggests that providing patients incentives to choose lower-priced providers can help encourage them to do so,³⁹ physician referrals, rather than lower prices, appear to drive patient selection of providers.⁴⁰

Collectively, a decade of experience using price transparency tools to reduce costs for some shoppable services shows some limited successes but also suggests that increased transparency may be much more valuable in assessing the functioning of health care markets and bringing public attention and support for interventions to address specific problems.

Transparency’s Greater Potential: Public Understanding of Health Care Markets

More recently, some states have used APCD data to quantify waste and identify low-value spending. For example, an analysis of claims in the Virginia APCD from 2014 revealed that more than \$586 million (or 2.1 percent of Virginia’s total health care costs) were “unnecessary costs” (Mafi et al. 2017). In New Hampshire, initial research suggested that NH HealthCost had little impact on prices or price variation across providers because few patients used it to shop for care (Tu and Lauer 2009). In 2018, however, an analysis by economist Zach Brown found that NH HealthCost substantially reduced the price of medical imaging procedures in New Hampshire, saving individuals \$7.9 million and insurers \$36 million over five years (Brown 2019). Interestingly, while a small number of patients used NH HealthCost to identify lower-cost providers, most of the savings came from providers, especially those in highly concentrated markets, who lowered their prices to maintain market share (Brown 2019, 25). These results reinforce the idea that the value of price transparency extends beyond consumers to improve the function of health care markets.

Another study of NH HealthCost, by Tu and Gourevitch, revealed how the public disclosure of prices changed the balance of power in negotiations between providers and insurers (Tu and Gourevitch 2014). The authors note “the price comparisons made by HealthCost and subsequent public reports helped shine the spotlight on Exeter [Hospital]’s outlier status. As one market observer suggested, ‘The sunshine effect [of price transparency]...changed the ground rules [of plan-provider contracting].... There’s recognition now that contractual negotiations are going to be somewhat in the public eye, in a way they never were in the past’” (Tu and Gourevitch 2014). The improved market

functioning in New Hampshire demonstrates the power of price transparency, specifically APCDs, to provide plan sponsors greater leverage in price negotiations.

APCD data can also help employers and insurers identify low-value providers and create benefit plans to steer patients to higher-value care. For instance, the Minnesota Department of Health (MDH), Health Economic Program calculated and reported the average price for four common inpatient surgeries using data from the state's APCD and the prices for (but not the name of) the three highest- and lowest-priced hospitals for those services (MDH, 2015). The MDH also reported that 36% of existing price variation resulted from variation in prices within a hospital that were unexplained by known patient characteristics (disease severity, length of stay, insurance type) (MDH, 2015). MDH found “[t]he bottom line is that unwarranted price variation wastes employers’ health care spending, can impact financial risk for patients through cost sharing, and makes budgeting more difficult. Knowing which high cost treatments are most fraught with pricing irregularities is the first step to taking action. Minnesotans (consumers, employees, patients) stand to benefit if purchasers act to reduce unwarranted price variation through increased market discipline, enhanced competition, and more rational health care pricing” (MDH, 2015).

Finally, data from APCDs can be used to assess potential policy interventions, validate newly implemented policies, and facilitate analyses of price variations. For example, the Center for Improving Value in Health Care (CIVHC) analyzed paid amounts in the Colorado All-Payer Claims Database (CO APCD) and found that, on average, commercial payers paid rates that were 290 percent of Medicare rates for inpatient services and 540 percent of Medicare rates for outpatient services (CIVHC 2018, 3). CIVHC then calculated that commercial payers would save \$49 million if they standardized their rates to the commercial state median⁴¹ or \$178 million (more than 50 percent of their current spend) if the state standardized rates to 150 percent of Medicare rates.⁴² These savings calculations allowed policymakers in Colorado to counteract the prevailing political aversion to regulation. Similarly, White and Whaley used data from the Colorado and New Hampshire APCDs when calculating the variation in hospital rates among states (White and Whaley 2019). The strength of similar studies would increase greatly if all states or the federal government collected and allowed researchers access to comprehensive health care claims data.

Limitations of State-based Transparency Efforts

As noted above, the Supreme Court decision in *Gobeille* prevents states from requiring self-insured employers from disclosing paid amounts to the state APCD. As a result, any state APCD may not have

data for nearly a third of the state population, or approximately 60 percent of those with employer-sponsored coverage.⁴³ As a result, anyone seeking to assess the functioning of health care markets or identify cost-shifting between private and government payers will have incomplete data.

Recognizing this challenge, federal actors have stepped in to help promote health care price transparency in ways that will support state efforts. In June 2019, Senators Lamar Alexander and Patty Murray introduced the Lower Health Care Costs Act,⁴⁴ which included provisions to require submission of claims data from self-insured employers to a federally run APCD and to allow states to submit data from their own APCDs to a central repository. In addition, the bill provides funding to states to facilitate data sharing between state APCDs and the federal database.⁴⁵ A federal APCD, like the one proposed in the Lower Health Care Costs Act, would address the implications of the *Gobeille* decision that prevents states from requiring submission of claims data from self-insured employers to a state-run APCD.

Furthermore, in June 2019, the Trump administration issued an executive order to “enhance the ability of patients to choose the healthcare that is best for them” by requiring hospitals to publicly report negotiated rates for certain shoppable health care services in an online searchable format.⁴⁶ In response, the US Department of Health and Human Services (HHS) recently issued final rules to redefine the public reporting of “standard charges,” to include payer-specific negotiated charges and to require hospitals to display these charges for certain “shoppable services” in a consumer-friendly manner.⁴⁷

In addition, providers, insurers, and self-funded employers commonly object to publicly disclosing negotiated rates on the basis that the rates are confidential and constitute trade secrets. However, courts have not decided whether and under what context negotiated health care prices constitute trade secrets (Feldman and Graves, forthcoming; Gudiksen, Chang, and King 2019). Furthermore, Gudiksen, Chang, and King, as well as the California Court of Appeals, have argued that in some instances, the public’s First Amendment right to information, especially to make decisions about their life or health, ought to supersede any quasi-property right to keep secret the prices Americans pay for health care (Gudiksen, Chang, and King 2019).⁴⁸

Some health economists and affected stakeholders have also noted that the disclosure of negotiated price information could create potential for price collusion that would drive up prices and harm competition (Cutler and Dafny 2011; Sinaiko and Rosenthal 2011). However, in Statements of Antitrust Enforcement Policy in Health Care, the Federal Trade Commission (FTC) and the US Department of Justice (DOJ) assert that providing information about reimbursement rates to a purchaser of health care services “may provide procompetitive benefits and raise little risk of

anticompetitive effects.”⁴⁹ Furthermore, Sinaiko and Rosenthal argue that if prices did go up initially following a release of information, purchasers and health plans ought to be able to use the price information to negotiate lower rates, through shaming or other negotiation tactic, in a reasonably competitive market (Sinaiko and Rosenthal 2011). Overall, courts must evaluate legal challenges to disclosure of negotiated health care prices on trade secrets or antitrust grounds on a case-by-case basis, and therefore, they should not be taken as guaranteed protections for maintaining their secrecy (Gudiksen, Chang, and King 2019).

Conclusion

The value of comprehensive price transparency reaches beyond offering patients a straightforward way to comparison shop. While price transparency tools may help patients choose lower-priced providers for certain services, far greater value likely lies in assessing wasteful spending, assessing geographical variation in prices, and in identifying providers with outlier reimbursement rates. Furthermore, APCD data provide lawmakers critical information for analyzing both where and how to target new health care policies and provide a powerful tool to analyze the effectiveness of those policies in state health care markets. Transparency represents a meaningful foundation for any efforts to improve and assess the performance of state health care markets. Future studies could reveal how transparency affects market function, such as whether naming and shaming highly priced providers leads to lower prices. Future research could also validate whether, or under what circumstances, full transparency leads to price increases through tacit collusion or whether the additional information allows employers and insurers to more effectively design benefits or steer patients to higher-value providers.

4. State Efforts to Regulate Consolidation and Promote Competition

Like transparency, competition is essential to the functioning of capitalist markets, and as a result, antitrust law has come to play a pivotal role in health care. Absent competition, the market will allow prices to increase and quality to decrease without correction. As a result, state and federal antitrust laws play a pivotal role in safeguarding health care markets, protecting consumers and market participants from competitive harms, such as price increases and quality reductions, and restoring competition when it has been lost.

States have an essential role to play in preventing further consolidation in the health care markets and vigorously enforcing state and federal antitrust laws to avoid abuses of existing market power. This section provides an overview of state and federal antitrust law, enforcement authority, and remedies and then explores the scope of state attorney general authority in health care markets, state premerger review, the role of consent decrees and certificates of public advantage when structural remedies fail, and the balance between litigation and legislation of anticompetitive behavior.

Overview of Antitrust Laws, Enforcement Authority, and Remedies

State and federal antitrust laws work in concert to promote competition. Furthermore, state attorneys general (AGs) share authority with federal regulators in enforcing both state and federal statutes.

State and Federal Antitrust Laws

Three key federal antitrust laws govern competition: the Sherman Antitrust Act,⁵⁰ the Clayton Antitrust Act,⁵¹ and the Federal Trade Commission Act (FTCA).⁵² Section 1 of the Sherman Antitrust Act prohibits contracts, combinations, and conspiracies “in restraint of trade,”⁵³ which in health care often occur in contracts between providers and insurers. These types of anticompetitive behaviors will be discussed in Chapter 4, section, Anticompetitive Behavior and Consolidated Markets. Section 2 of the Sherman Antitrust Act prohibits monopolization, attempted monopolization, or conspiracy to monopolize.⁵⁴

Unlike section 1, monopolization or attempted monopolization is typically unilateral and involves the possession of monopoly power and the willful acquisition or maintenance of that power. Section 7 of the Clayton Act prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly.⁵⁵ States and federal merger review will be discussed in Chapter 4, section Review of Proposed Merger and Acquisitions. Finally, section 5 of the FTCA prohibits “unfair methods of competition,” which include all violations of the Sherman and Clayton acts, and “unfair or deceptive acts and practices.”⁵⁶

Nearly all states have passed legislation that closely mirrors the language of the federal antitrust laws, but may deviate in small, but important, ways. While federal antitrust enforcers may file suits to enforce the federal antitrust laws, state attorneys general can sue to enforce both the state and federal antitrust laws.

Antitrust Enforcement Authority

At the federal level, the DOJ and the FTC (the “federal antitrust agencies”) have joint oversight over antitrust enforcement, but each agency has taken the lead in particular areas. For instance, the DOJ has taken primary responsibility for overseeing health insurance mergers, while the FTC primarily oversees health care provider mergers.⁵⁷ However, with respect to anticompetitive behavior by entities that already possess market power, the DOJ and state attorneys general must enforce the law for most health insurance and health care provider organizations, because the FTC has limited authority to oversee the practices of nonprofit health care organizations (Slaughter 2019).⁵⁸

Gaps in federal enforcement authority and capacity leave significant opportunities for state attorneys general to expand antitrust enforcement. Furthermore, state attorneys general have a differentiated and significant role to play in overseeing health care consolidation, the functioning of health care markets, and the cost of care. Unlike federal antitrust enforcers, state attorneys general can examine the impact of health care entities’ behavior on more than just competition, including considerations of charitable trust doctrine, consumer protection, and the public interest.⁵⁹ This broader authority provides state AGs both a more comprehensive understanding of health care market activities and a wider array of enforcement options. In addition, because of the Hart-Scott-Rodino filing threshold,⁶⁰ the federal antitrust agencies receive notification of only a small percentage of health care industry mergers, creating significant demand for state-level oversight and merger review.

Antitrust Enforcement Remedies

State and federal antitrust enforcers oversee market function by reviewing mergers and acquisitions for the potential to harm competition, challenging proposed mergers that will substantially lessen competition, imposing conditions on allowed mergers that offer benefits but pose some risk to competition, and enforcing laws prohibiting anticompetitive behavior. Historically in health care, judges and antitrust enforcers left many mergers unchallenged, often viewing the procompetitive justifications provided by hospitals or other providers favorably (Greaney and Richman 2018). In addition, federal antitrust enforcers lost a series of merger challenges beginning in 1992 that resulted in a nearly 15-year lull in hospital merger enforcement.⁶¹ However, growing recognition that consolidation drives health care price increases and improved merger analysis tools have led antitrust enforcers to more critically review and challenge proposed mergers and potentially anticompetitive behavior.

In these activities, state and federal antitrust enforcers have the ability to use structural and conduct remedies. Antitrust enforcers have traditionally preferred to use “structural remedies,” which would prevent a proposed merger, undo a recent merger, or require a divestiture or other structural change to restore or maintain competition (Antitrust Division 2004; Slaughter 2019). While common and favored in premerger challenges for their clean results that avoid governmental entanglements and oversight commitments, structural remedies often prove elusive once a merger has been executed.⁶² Antitrust experts commonly assert that in the context of health care provider mergers, it is hard to “unscramble the eggs.”⁶³ Merged health care entities often claim that they have become too administratively and clinically integrated to simply unwind the merger and that doing so would harm patient care.⁶⁴ Yet, Fuse-Brown and King challenged this complacent attitude, arguing that abuses of accumulated market power could be challenged under section 1 of the Sherman Act or monopolization and attempted monopolization claims under section 2 of the Sherman Act (Fuse Brown and King 2019, 87). As a result, while no court has broken up a major health care system, in today’s highly concentrated health care markets, state attorneys general could consider the use of structural remedies, including unwinding the merger or requiring divestiture of components of the system, in egregious cases.

In lieu of blocking a proposed merger or seeking another structural remedy, antitrust enforcers may also impose conduct remedies, which would allow the consummation of a proposed merger or a merged entity to remain intact subject to conditions that will remain in place for a specified term and overseen by the antitrust enforcer. Antitrust enforcers have historically disfavored conduct remedies because they require state entanglement in the market, with resource-intensive monitoring of the merged entity (Antitrust Division 2004; Greaney 2017; Kwoka and Moss 2012). Furthermore, as applied in the past, the short-term nature of conduct remedies has meant that they prevent anticompetitive behavior only

for a limited amount of time, enabling patient health care entities to reap the significant benefits of an increase in market power after a brief period of restraint.

However, conduct remedies can be used effectively, serving specific purposes in particular circumstances. In the case of a merged entity engaging in anticompetitive behavior, an antitrust enforcer could impose a conduct remedy, such as a prohibition on the enforcement of an anticompetitive contract term in a provider-insurer contract, to attempt to restore competition, rather than institute a structural remedy to break apart the provider organization (Fuse Brown and King 2019, 86).⁶⁵ In merger cases, however, consent decrees, a form of conduct remedies, would allow a merger to proceed while guarding against potential anticompetitive behavior or communal losses if the merger provides additional market power to the merged entity (Antitrust Division 2011). Federal antitrust enforcers tend to rely on consent decrees with specific conduct provisions in vertical merger cases, because of the possibility efficiencies arising from consolidation in the supply chain (Antitrust Division 2011). Consent decrees can also be important tools in cases where the merger challenge case is weak, when the state has limited resources to challenge the case, or when a merger is necessary to save a failing hospital that provides essential services to a community. Specifically, in the context of hospital mergers, consent decrees may require that a hospital negotiate with health plans in certain ways or be prohibited from raising their negotiated prices above a certain percentage or threshold.⁶⁶ We provide a taxonomy of commonly used consent decree provisions in Chapter 5, section Continued Oversight as a Condition of Merger Approval or Acquiescence.

The historical reluctance to use of structural remedies to unwind health care mergers reasonably suggests that the antitrust enforcement community should more critically examine proposed mergers and impose structural remedies premerger, while expanding the use of conduct remedies (and in some cases, structural remedies) to restrain anticompetitive and monopolistic behavior by merged entities. Specifically, antitrust authorities have leverage both to impose conduct remedies to limit future acquisitions, prevent certain anticompetitive behaviors, including providers' ability to obtain supra-competitive payment rates, and gain commitments from the merged entity to provide additional public benefits they otherwise would not have considered on their own. To do so, state attorneys general will need to exercise more than just their antitrust authority in reviewing anticompetitive behavior.

The Scope of State Attorney General Authority to Oversee Health Care Markets

Depending on the state, attorneys general derive their authority from constitutional, statutory, and common law (Committee on the Office of Attorney General 1975). Attorney general authority is most commonly based in statute, yet those statutes can also codify or supplement common law powers. For instance, in Pennsylvania, the Commonwealth Attorneys Act grants the Pennsylvania attorney general a wide array of powers, including the ability to enforce state and federal antitrust law, state consumer protection law, and state charitable trust law.⁶⁷ The Pennsylvania attorney general, like many other state attorneys general, also maintains the ability to protect citizens via the state *parens patriae* power, which arises from the state's common law ability to protect its citizens from harm and can also be granted to the attorney general via statute (Committee on the Office of Attorney General 1975). State attorneys general have used *parens patriae* to justify intervention into a diverse assortment of legal actions, including antitrust enforcement and preventing inappropriate transfers of nonprofit charitable assets to for-profit entities (Committee on the Office of Attorney General 1975).

Initially, most states oversaw health care entity behavior and mergers through a division or section of the attorney general's office, frequently the Charities Division, the Antitrust Division, or the Consumer Protection Division. Charities Divisions oversee the actions of nonprofit entities within the state. Many states require notice of any proposed merger or acquisition of a nonprofit entity, enabling the attorney general to ensure that the charitable assets of the organization continue to be used for the stated purpose and mission of the organization following the merger or acquisition. Given the rise in health care mergers and acquisitions, and that the majority of hospitals are nonprofit entities,⁶⁸ Charities Divisions often play important roles in antitrust enforcement by both identifying nonprofit health care mergers and analyzing their potential impact on health care quality, access, and cost. Antitrust Divisions, on the other hand, enforce state and federal antitrust laws and focus entirely on the impact of health care entity behavior on market competition. Finally, Consumer Protection Divisions safeguard the public from unfair, misleading, or deceptive business practices. Each of these areas of attorney general oversight—charitable trust, antitrust, and consumer protection—can play an essential role in aiding the state to protect health care markets and contain health care spending.

The Structure of State AG Offices Impacts Oversight of Health Care Markets

State attorneys general can structure the divisions and sections of their offices in various ways, which can directly promote or hinder oversight of the health care system. Specifically, siloed divisions within AG offices may stifle information sharing and communication in ways that limit the reach of attorney general oversight and enforcement. In the last two decades, however, a handful of states created specialized health care divisions within the attorney general's office to combine the expertise and perspectives of these divisions with knowledge specific to the health care industry in that state, allowing the AG to better address the particular challenges and complexities associated with health care that one division cannot address in isolation. More recently, innovative states have begun to tear down the divisional silos of the past by integrating their charitable trust, antitrust enforcement, and consumer protection divisions to enhance their oversight and enforcement in health care.

This integration allows state attorneys general to look beyond price effects to evaluate the full scope of consumer and societal implications that may arise from a potential merger, enabling them to craft more holistic solutions to a merger query. Currently, the AG offices in Massachusetts and Pennsylvania both operate specific Health Care Divisions that work closely with other divisions to ensure effective oversight of health care markets. Following the passage of the Massachusetts Health Care Reform Plan in 2007, the Massachusetts attorney general formed the Health Care Division, with the explicit intent that it would engage directly in matters of health care policy and markets. The Massachusetts attorney general gave the Health Care Division a broad mandate to enforce the health care laws and provide expertise needed to address challenges associated with the health care industry. The Health Care Division's expertise offers depth and context to antitrust, charitable trust, and consumer protection analyses, and facilitates collaboration between the divisions. Further, the Health Care Division served as a prototype for and was instrumental in the creation of the Health Policy Commission, which was later founded in 2012.⁶⁹ Currently, members of the Health Care Division work closely with the Health Policy Commission on merger review, policy goals, and the production of biannual reports on cost trends and drivers.⁷⁰

In addition, Massachusetts attorney general Maura Healey recently restructured the Attorney General's office by establishing the Bureau of Health Care and Fair Competition, which now houses the Non-Profit Organizations and Public Charities Division, the False Claims Division, the Antitrust Division, the Medicaid Fraud Division, and the Health Care Division.⁷¹ This restructuring allows the bureau to examine health care mergers and the behavior of health care entities through a variety of

lenses and multiple points of view and thereby, see a broader range of the potential impacts from an expanded palette of legal, economic, and policy perspectives. The attorney general's office used this level of coordination in the recent Beth Israel Deaconess-Lahey Health merger to negotiate a consent decree with significant conditions, largely by using the threat of an antitrust challenge to garner both systemwide price caps as well as substantial commitments to providing health care to low-income and underserved communities in the state.⁷² Because the conditions related to maintaining access to critical services, participation in MassHealth, and investments in health care for low-income individuals fall outside typical antitrust remedies, the Massachusetts attorney general's integrated approach to health care oversight and enforcement led to a more coordinated, well-rounded response to a variety of concerns not typically touched in a federal enforcement action.

In Pennsylvania, the Health Care Division fields a wide range of consumer complaints, including data breaches, insurance coverage denials, and inability to access services. While it does not have a direct role in health care merger review or antitrust enforcement, the Health Care Division provides notice to the Antitrust Division regarding complaints or concerns related to proposed mergers or anticompetitive behavior, as the state does not require merging entities to provide direct notice to the Antitrust Division. More recently, the Pennsylvania attorney general successfully integrated the sections that oversee health care in the Public Protection Division, including the Antitrust, Consumer Protection, Charitable Trusts and Organizations, and Health Care Sections. While historically distinct, the sections in the Public Protection Division have begun to work more closely by sharing information and coordinating their enforcement actions, which has enabled them to develop broader-reaching enforcement strategies. Case studies of these states that effectively integrated the AG's office could provide guidance on how these unified groups addressing consolidation in health care can be most effective and provide best practices for other states looking to increase the collaboration between divisions in their AG offices.

BOX 1

University of Pittsburgh Medical Center and Highmark Health Consent Decree

In a recent dispute with the University of Pittsburgh Medical Center (UPMC) and Highmark Health, a leading insurance company in the Pittsburgh area, the Pennsylvania attorney general successfully leveraged charitable trust law to address traditionally anticompetitive behavior. The attorney general alleged that UPMC had driven up the cost of health care in the region by engaging in a range of activities, including excessive balance billing for out-of-network patients and a refusal to treat any of Highmark's Medicare Advantage plans after the expiration of a previously-agreed-to consent decree. The structure of the Pennsylvania AG's office encouraged close cooperation between the different sections within the Public Protection Division and enabled the Pennsylvania attorney general to file a complaint alleging that UPMC violated its charitable trust obligations rather than bringing the case under antitrust law.

Challenges of anticompetitive behavior under the Sherman Act §1 for unreasonable restraint of trade can be difficult to prove and require significant economic and market-based expertise. In a novel use of charitable trust law, the AG alleged UPMC's refusal to contract with Highmark's Medicare Advantage plans violated its stated charitable purpose to provide "a high quality, cost effective and accessible health care system" for the Pittsburgh community. Bringing the action under charitable trust law brought all parties to a joint resolution that included a 10-year contract between Highmark Health and UPMC.

Overall, greater integration and collaboration between the different divisions in the attorney general's office as well as the cultivation of health care industry expertise can allow a state to develop novel strategies for addressing anticompetitive behavior and anticompetitive mergers.

Review of Proposed Mergers and Acquisitions

Effective antitrust enforcement begins with ensuring competitive markets by critically reviewing proposed mergers. As noted above, merger review can occur at both the federal and the state level. Section 7 of the Clayton Antitrust Act permits both federal antitrust agencies and state attorneys general to review and challenge any merger where the effect may be "substantially to lessen competition" or "to tend to create a monopoly."⁷³ As noted above, the federal antitrust agencies have joint oversight over health-related antitrust enforcement, yet they tend to divide merger reviews based on their areas of expertise, such that the FTC reviews provider mergers, such as the St. Lukes-Saltzer merger in Idaho,⁷⁴ and the DOJ reviews insurance mergers, like the attempted Aetna-Humana merger.⁷⁵ By one estimate, nearly half of all FTC merger challenges between 2010 and 2018 involved health care

entities (Wilson 2019), a significant portion of which centered on hospitals (Meier, Albert, and Monahan 2019).

The Hart-Scott-Rodino Act requires merging entities to notify the federal antitrust agencies of all mergers and acquisitions that exceed the act's filing threshold—which, as of April 2019, reached \$90 million—and wait 30 days from the filing date to consummate the merger.⁷⁶ The act also permits federal antitrust agencies to compel document production and testimony from the merging entities.⁷⁷ While the federal antitrust agencies have the authority to challenge any merger they perceive to be anticompetitive, the \$90 million filing threshold allows many health care mergers and acquisitions, especially those of provider groups, to escape federal review (Capps, Dranove, and Ody 2017). In a recent study from the University of Chicago, Thomas Wollman referred to this phenomenon as “stealth consolidation” and noted its potential to have a large cumulative effect on market consolidation (Wollmann 2018). The study found that unreported mergers represented approximately \$50 billion in US output since 2000, with health care transactions making up a disproportionate share of all exempt transactions over this period (Wollmann 2018). Furthermore, FTC commissioner Rebecca Kelly Slaughter recently noted that “merger activity and merger enforcement resources have been moving in opposite directions...we have more mergers to review and fewer resources with which to review (and challenge) them” (Slaughter 2019).

As a result, states' merger enforcement is more important than ever, especially in the area of provider mergers. Under sections 4c and 16 of the Clayton Act, state attorneys general have the authority to enjoin any merger.⁷⁸ In recent years, state attorneys general have increasingly challenged mergers both alongside federal antitrust enforcers and independently, demonstrating their ability to significantly limit future consolidation (Goldfein and Hoffman Lent 2018). State-based challenges should not be underestimated, as “any of the fifty state attorneys general can challenge and possibly block a multi-billion dollar transaction, even if the Federal Trade Commission, the Department of Justice, and the forty-nine other state attorneys general desire for it to proceed” (Lande 1990, 1061). The only check on state attorney general power to oppose a national transaction is whether the merger will detrimentally affect the state, its citizens, or its economy (Lande 1990, 1062). States allocate merger review to different agencies and divisions in the attorney general's office depending on the type of entities involved in the deal. We discuss the merger review process for provider mergers below.

Health Care Provider Mergers

States have not historically required organizations to notify the Antitrust Division of the attorney general's office of a proposed merger or acquisition. When for-profit health care entities merge, the states typically follow traditional norms of corporation law, which impose minimal requirements on merging entities that are largely unrelated to competition. Many states do require non-profit organizations to notify the attorney general's Charities Division or other subdivision that enforces charitable trust law, of any material change, including a merger or acquisition,⁷⁹ and then rely on the Charities Division to notify the Antitrust Division of potentially anticompetitive mergers.⁸⁰ However, this lack of direct merger notification to state antitrust entities can create gaps in enforcement, exacerbating the negative effect of the increased federal Hart-Scott-Rodino reporting threshold.

In recent years, some states have started to grant their attorneys general greater authority to oversee health care provider mergers. In 2014, Connecticut passed a first-of-its-kind law that required hospitals and group medical practices to provide the attorney general 30 days' notice before consummating any merger or affiliation agreement if the transaction involves eight or more physicians or if a hospital acquires any group practice.⁸¹ The Connecticut legislature designed the filing threshold to capture significantly more transactions than the federal Hart-Scott-Rodino threshold to enable the state to better monitor all forms of health care consolidation. In May 2019, Washington passed HB 1607, which requires health care entities licensed and operating in Washington to notify the attorney general at least 60 days before the effective date of any "material change."⁸² The law defines "material change" to include a merger, acquisition, or contracting affiliation between two or more hospitals, hospital systems, or provider organizations.

Furthermore, Washington requires any provider doing business in the state that files a federal Hart-Scott-Rodino premerger notification to also provide a copy of that filing to the state attorney general. Washington's inclusion of provider mergers in its notice requirements acknowledges the importance of nonhorizontal mergers and acquisitions in the overarching health care market. In total, HB 1607 ensures that the Washington attorney general will have the information necessary to evaluate all proposed health care mergers for potential harms to consumers and competition. The statute does not require attorney general approval for merger consummation; instead it acknowledges the right of the attorney general to challenge any merger on antitrust or consumer protection grounds.

State laws could go even further to mirror the types of requirements imposed at the federal level by Hart-Scott-Rodino, including notification, a waiting period, and the ability to compel document production, to grant state enforcers the time and information they need to fully analyze the implications

of a proposed merger. Further, charging adequate filing fees can provide the necessary resources to conduct the review, easing burdens to the state of doing the analysis. Future studies could show what kind of notification or review is most effective at mitigating stealth consolidation.⁸³

Nonhorizontal Mergers

Historically, the courts and enforcement agencies have been reluctant to oppose nonhorizontal health care acquisitions, which include vertical⁸⁴ and cross-market⁸⁵ mergers, such as a hospital system acquisition of a physician group. While nonhorizontal mergers can offer potential efficiencies, including integrating patient care, reducing the administrative burden of care coordination, and minimizing duplicative testing and care, their potential for anticompetitive harm remains substantial. Specifically, nonhorizontal mergers may cause economic harm if the increased market power for the integrated hospital system prevents physicians from referring patients to rival facilities or if the health system gains market power from the acquisition sufficient to increase payment rates. Yet, physician acquisitions by health systems continue, and the percentage of physicians employed by hospitals rose from 26 percent to 44 percent between July 2012 and January 2018 (PAI 2019).

Numerous academics have criticized federal antitrust enforcement approaches that broadly assume that vertical mergers create efficiencies and cross-market mergers do not affect competition, even in the face of evidence to the contrary (Dafny, Ho, and Lee 2019; Fuse Brown and King 2016; Gaynor and Town 2012; Greaney 2018; King and Fuse Brown 2017; Vistnes and Sarifides 2013). For vertical mergers, Capps, Dranove, and Ody found that physician prices increased following acquisition by a hospital, and Baker, Bundorf, and Kessler found that hospital prices also increased following acquisition of a physician group (Baker, Burndorf, and Kessler 2014; Capps, Dranove, and Ody 2018). Furthermore, Short and Ho found vertical health care mergers had a limited effect on a small number of quality indicators (Short and Ho, 2019). These studies suggest that the quality improvements and cost-saving efficiencies frequently claimed as justification for allowing a vertical merger to proceed do not always manifest in the predicted ways. Furthermore, Lewis and Pflum and Dafny, Ho, and Lee found that cross-market mergers were associated with 7 to 17 percent increases in prices for independent hospitals purchased by an out-of-market health system (Dafny, Ho, and Lee 2019; Lewis and Pflum 2017). Overall, these findings alone should raise significant questions regarding the applicability of common assumptions about nonhorizontal mergers in the health care context.

Current versions of antitrust legal theory and economic modeling of health care markets do not capture these emerging phenomena well (Argue and Stein 2015, Vistnes and Sarifides 2013). Despite

rapid consolidation and empirical evidence demonstrating price increases and little to no quality improvements, the FTC challenged very few acquisitions of physician groups by hospital systems and has so far based its challenges primarily on horizontal grounds.⁸⁶ No cross-market mergers have been challenged. The difficulty faced by federal antitrust enforcement agencies using broad and outdated nonhorizontal merger guidelines increases the importance for state attorneys general to expand their health care merger review. As asserted by antitrust legal experts Thomas Greaney and Barak Richman, “[g]iven the many alternative methods of achieving the benefits of clinical and economic integration, the risks associated with turning a blind eye to vertical mergers is apparent, and the urgency of developing robust theories and aggressive enforcement actions against vertical linkages is growing” (Greaney and Richman 2018). Given that a large percentage of health care consolidation now occurs through nonhorizontal mergers (Dafny, Ho, and Lee 2019), more research is imperative to understand the market impact of these types of mergers and how to evaluate them for purposes of antitrust enforcement.

Continued Oversight as a Condition of Merger Approval or Acquiescence

Regardless of the entity in charge of reviewing the merger, state antitrust enforcers may decide to allow a merger to proceed that poses some risk of competitive harm for a variety of reasons. In some instances, enforcers may believe that the procompetitive benefits of the merger outweigh the risk of anticompetitive harm. In others, the state may opt to regulate a merged entity that enforcers view as anticompetitive to promote other priorities of the state. In that instance, the state can exercise the state action doctrine, which will free the merged entity from federal antitrust enforcement, to create a certificate of public advantage (COPA) (Garland 1987). Both consent decrees and certificate of public advantages would require state entities to monitor the activities of a merged entity for some period of time for anticompetitive behavior.

Consent Decrees

The nature of consent decrees has evolved over time, especially in the health care context. Historically, they have included conditions aimed at preventing competitive harms, such as price increases, quality decreases, or foreclosure of competitors. Most commonly, consent decrees in health care mergers aim to ensure that the newly formed entity does not use its leverage to negotiate unreasonable prices.

However, in recent years, states have begun including conditions focused on patient access to care and the provision of charity care.

Postmerger price increases often pose the largest threat to consumer welfare following a merger, making them a natural target for antitrust oversight. For example, as far back as 1994, the Pennsylvania AG's office agreed to permit Providence Health System's acquisition of North Central, subject to certain conditions, including the requirement that the merged entity pass any savings generated through to consumers in the form of discounted or free community health programs.⁸⁷ Shortly thereafter, Wisconsin issued a consent decree permitting a merger between Kenosha Hospital and Medical Center on similar terms.⁸⁸

In recent years, states have also incorporated explicit commitments for the merged entity to provide services to the community to ensure proper investment in local services. In 2013, the New York AG approved a hospital merger between Faxton-St. Luke's Healthcare and St. Elizabeth Medical Center (one secular and one Catholic, respectively), arguing that the union was necessary for the hospitals' survival. The consent decree contained conduct provisions to ensure that the secular hospital continued to offer certain reproductive health services postmerger.⁸⁹

In 2018, the Massachusetts AG approved a merger between Beth Israel Deaconess Medical Center and Lahey Health with conditions to address potential access barriers. The consent decree required that the newly formed health system make "good faith efforts" to enroll Medicaid and CHIP beneficiaries, as well as make over \$70 million in investments to support vulnerable populations, including providing financial support to affiliated community health centers and safety net hospitals, making additional investments in mental health and substance use disorder treatment, and allocating funds to increase access to care for communities of color and low-income individuals.⁹⁰ States' broader use of consent decrees is a notable change in antitrust enforcement and one that enables state attorneys general the opportunity to leverage their different oversight functions to protect their constituents when mergers go through.

We reviewed a number of consent decrees negotiated in the past two decades in various states, including Massachusetts, New York, Pennsylvania, West Virginia, and Wisconsin, and interviewed staff in state AG offices to identify typical consent decree provisions for the purpose of developing a typology of consent decrees (see textbox). Broadly considered, the provisions address pricing concerns by either directly or indirectly seeking to substitute other price control mechanisms to compensate for the reduction in market forces that the merger produces. In addition to typical antitrust conduct

remedies, some consent decrees required the merged entity to address specified public benefits and adopt additional consumer protections.

BOX 2

A Typology of Consent Decrees

1. Private insurer-hospital payment rate negotiations with backstops require that future payer contracts be negotiated “in good faith”—dealing honestly and fairly, without malice or intent to defraud. This provision can prevent merged hospitals from negotiating deceptively or stonewalling in response to insurers, legitimate offers. Some consent decrees require that insurers be allowed to submit their rejected offers to binding arbitration, such as “best-final-offer” (“baseball”) arbitration, where arbitrators must rule in favor of the more reasonable position, rather than splitting the difference.

2. Publicly overseen limitations on prices, costs, or margins require merging partners to deliver on a specified set of merger-related efficiencies, forcing them to document savings to the satisfaction of the designated overseer. States have also limited growth in hospital rates, costs, or operating margins to some specified benchmark (with public oversight to assure compliance) required an acquired hospital to continue billing at its current negotiated rate, or prohibited the hospital from increasing outpatient hospital rates for previously independent physicians through the site-of-service differential.

3. Prohibit or require particular contract provisions to prevent anticompetitive behavior or promote competition-enhancing behavior. Component contracting requires a merged health system to allow payers to negotiate separate agreements with specific components of the overall system to avoid pricing leverage based on size or the possession of “must-have” provider entities. Similarly, consent decrees can prohibit the use of anticompetitive contract terms, such as antisteering or antitiering provisions, most-favored-nations provisions, and all-or-nothing provisions that have not already been prohibited through state legislation. In the next section of this report, we discuss opportunities for litigation challenging and legislation prohibiting these and other anticompetitive contract provisions.

4. Prohibit or require other conduct. A consent decree may obligate or prohibit the merged entity from engaging in certain behaviors, such as requiring the merged entity to release terminated employees from any noncompete provisions in their employment contracts, or, when a hospital acquires another hospital, to allow the acquired physicians or physician group practice the opportunity to leave. Another remedy is to ban a merged hospital from opposing certificate of need applications from new market entrants or competitors seeking service expansion approval. Similarly, hospitals owning an insurer may be barred from requiring enrollees from purchasing certain ancillary services from the merged hospitals affiliated firms.

5. Commitments to enhance community services or assure unique patient-oriented services with an emphasis on underserved communities. These provisions require merged entities to invest in charity care (providing free or discounted services for vulnerable populations), participate in Medicaid programs, finance medical education and research, or devote funds to community programs related to

health and health care improvement. Consent decrees can specify investment amounts to support the provision of these services.

Although, in theory, consent decrees aim to assuage concerns about sanctioning a merger, practical concerns include (1) failure of the state to vigilantly monitor compliance with the terms of the agreement over time, perhaps because of high administrative costs that typically must be borne only by the office of the state AG; (2) lack of requisite expertise, which can be ameliorated by contracting with a third party but at a commensurately high cost; (3) creation of market power that can be exercised once the provisions that restrict conduct expire, as typically occurs; and (4) inability to adjust the terms of the agreement for changed marketplace circumstances. Health care entities in fact may find it financially rewarding to consolidate and accept the terms of the consent decree in the short term to obtain greater market leverage in the future (Fuse Brown and Kin 2016). Future studies could assess the efficacy of different types of consent decrees on controlling costs and promoting community benefits, as well as the market dynamics following the expiration of a consent decree.

Certificates of Public Advantage

Instead of negotiating a consent decree, states, wishing to approve a merger with conditions, can also issue a *certificate of public advantage*, a legal mechanism by which the state approves a health care merger and shields it from federal antitrust enforcement by committing to state oversight and supervision of the merged entity's prices and conduct (Fuse Brown 2019). In *Parker v. Brown*, the Supreme Court held that via the "state action immunity" doctrine, a state can prioritize other values or state interests over protecting competition and, in doing so, insulate the actions of the state or specific private entities from federal oversight.⁹¹

The 1980 Supreme Court decision in *MidCal* created a two-part test for states seeking to offer state action immunity to shield a merged entity from federal antitrust enforcement.⁹² First, the state must provide a "clear articulation" that the state has adopted an alternative policy to competition in the specific situation. Second, the state must provide "active supervision" of actions pursuant to the alternative policy (Havighurst 2006). In the case of a health care COPA, state legislatures have to enact enabling legislation to guide the process of negotiating the terms of the COPA. Often, COPA terms closely resemble those included in consent decrees, as described above. States use consent decrees more frequently than COPAs, because COPAs often require the involvement of multiple state agencies and require the state to pass legislation clearly articulating its purposes.

Two recent COPAs required merged entities to make commitments to the community, in addition to providing more typical conduct remedies. In West Virginia, the state passed a COPA in 2016, allowing Cabell Huntington and St. Mary's Medical Center to merge. Specifically, the COPA requires the merged entity to implement community wellness programs to connect with underserved communities; requires the hospitals to develop quality and population health goals, as well as implement community health needs plans and conduct assessments to ensure they are meeting the needs of the community; calls for enhancements to medical education and research opportunities; and necessitates improvements in health equity.⁹³

The Tennessee-Virginia COPA (Ballad Health), implemented in 2018, includes similar commitments. The Ballad COPA requires that the merged entity invest over \$300 million to expand access to behavioral health care by creating new capacity for residential addiction and recovery services; allocate funds to support academics and medical research; address population health needs specific to the community (e.g., diabetes and infant mortality); and direct funds toward children's and rural health services. The entity must also adopt a policy for charity care to ensure that the states' vulnerable populations are not adversely affected by the COPA.⁹⁴

Federal antitrust enforcers have recently expressed special concern about COPAs, raising the specter that the two recently adopted COPAs in West Virginia and Tennessee-Virginia acting together would lead to a "resurgence" of COPAs – the FTC points to three new COPAs as the resurgence -- fundamentally undermining the purpose of the federal antitrust statutes.⁹⁵ Specifically, the FTC vigorously opposed the issuance of the two COPAs, asserting that the Ballad Health merger of two previously competing hospital systems "will eliminate competition and likely lead to higher prices, lower quality (Fuse Brown 2019), and reduced availability of health care services in Northeast Tennessee and Southwest Virginia."⁹⁶

COPAs can align state agencies and interests behind a single organization, but they raise significant risks if not properly overseen. First, states introducing a COPA design the enacting legislation to grant state-action immunity to the merging entities and avoid scrutiny from federal regulators. Furthermore, state COPA laws require state officials to consider numerous and conflicting factors that may be impossible to analyze empirically.⁹⁷ Critics have argued that "[b]eyond the sheer volume of information necessary to address such complex policy considerations, weighing them against competitive harm is an intractable task.... In short, there is little reason to have confidence that COPA proceedings can ascertain when consolidations will generate benefits that outweigh costs to competition and, given the weighty evidence that provider consolidations impose significant economic harm, they frequently amount to evasions of needed FTC scrutiny" (Greaney and Richman 2018). Future studies are crucial to

assess whether and what type of state COPA oversight can ensure that the state interests outweigh any anticompetitive effects or whether alternative mechanisms could allow states to achieve those goals in ways that do not override federal oversight.

Conclusion

When circumstances deem it prudent, state enforcers turn to conduct remedies, contained in consent decrees and COPAs, to guard against potential harms to competition and the community that may arise from the accumulation of market power. In contrast, federal antitrust enforcement policy generally has been hostile to reliance on conduct remedies in virtually all circumstances.⁹⁸ As discussed in Chapter 4, section Review of Proposed Mergers and Acquisitions, state AGs' attitudes may differ from those of federal enforcers when it comes to health care merger review, as elected state AGs represent the affected communities and have explicit responsibilities that stretch beyond competition concerns to encompass consumer protection and preservation of charitable trusts. For instance, state AGs may experience more acutely the risks of a local hospital closing if not acquired by a larger health care system, including loss of access and jobs. This proximity to the risks can cut both ways in terms of state use of conduct remedies in premerger review. Yet, states that allow anticompetitive mergers to consummate or fail to monitor and enforce their consent decrees and COPAs will potentially find themselves addressing the anticompetitive behavior of those merged entities in the not-too-distant future.

Anticompetitive Behavior in Consolidated Health Care Markets

While strong merger review remains essential, over 90 percent of health care provider markets are already highly concentrated, which means that antitrust enforcers must address the anticompetitive behavior by entities that already possess market power (Fulton 2017). State attorneys general can bring a lawsuit for both specific and general deterrence purposes.

Unlike federal antitrust enforcers, state attorneys general have the ability to challenge anticompetitive behavior by nonprofit entities using both federal and state antitrust law. The Sherman Antitrust Act governs anticompetitive behavior at the state and federal level by prohibiting “every contract, combination, or conspiracy in restraint of trade,” and “monopolization, attempted monopolization, and the conspiracy or combination to monopolize.”⁹⁹ Furthermore, most states enacted

antitrust statutes that replicate or closely resemble the federal law and, in some instances, may be broader. For example, California's Cartwright Act prohibits any person or commercial entity to make any lease, sale, or contract that may substantially lessen competition or tend to create a monopoly.¹⁰⁰ Under the Cartwright Act and other similar state provisions, the state attorneys general can challenge a wide range of anticompetitive behavior, including using anticompetitive contract terms, fixing prices, boycotting competitors, foreclosing competition, or attempting to create or creating a monopoly.

Interestingly, in contrast to its primary role in reviewing nonprofit mergers, the FTC is prohibited from enforcing antitrust laws against nonprofit entities for anticompetitive behavior. Approximately two-thirds of all private US hospitals are nonprofit entities, and in some states, like Connecticut, North Dakota, and Vermont, the percentage is close to 100 percent.¹⁰¹ As a result, the FTC, which has garnered significant expertise in the last several decades through its oversight of health care provider mergers, cannot work with the DOJ and state attorneys general to challenge anticompetitive practices by over two-thirds of all private hospitals in the US and other nonprofit health-related entities.¹⁰²

Addressing Anticompetitive Contract Terms

In recent years, anticompetitive contract provisions between insurers and providers have received increasing attention from federal and state antitrust enforcers for their ability to entrench anticompetitive behavior and market power. At the federal level, the Lower Health Care Costs Act,¹⁰³ referenced in Chapter 3, section Limitation of State-based Transparency Efforts, which would put limits on out-of-network "surprise bills," also would ban gag clauses and several anticompetitive contract terms between health care providers and payers, but the bill remains under congressional review. While waiting for federal action, states have used both antitrust litigation and legislation to prevent the use of contract clauses in anticompetitive ways.

Provider market consolidation has enabled some dominant providers to demand terms in their contracts with health care payers and third-party administrators working on their behalf ("payers") that facilitate their ability to demand supracompetitive pricing that preserves and enhances their dominant market share. The four contract clauses that have raised the most concern among antitrust enforcers and lawmakers are most-favored-nation (MFN) clauses, all-or-nothing contracting clauses, anti-incentive provisions (including antitiering and antisteering provisions), and nondisclosure requirements (gag clause provisions). In the health care context, MFN or pricing-parity clauses generally guarantee that a buyer of goods or services (i.e., an insurer) receives terms from a seller (i.e., a hospital or provider) that are at least as favorable as those provided to any other buyer. Dominant providers can offer an

MFN to an insurer in exchange for supracompetitive reimbursement rates to allow them to ensure that no other insurer will negotiate a lower rate. To retain a dominant market position, insurers often do not need to negotiate a “low” reimbursement rate from providers; they simply need to negotiate the lowest rate among their competitors (Dafny 2015, 2019). MFN provisions allows insurers to accomplish that goal, while meeting the demands of the dominant or must-have provider.¹⁰⁴ As demonstrated below, dominant insurers can also demand MFN provisions to thwart competitors or prevent market entry.

All-or-nothing contracts require that if an insurer wants a contract with any provider or affiliate in a particular provider organization, it must contract with all providers in the system. Provider organizations typically use all-or-nothing provisions to leverage the status of their must-have providers in a highly concentrated market to demand supracompetitive payment rates for the entire provider organization, including those providers in more competitive areas and specialties.

Anti-incentive provisions typically require that an insurer place all physicians, hospitals, and other facilities associated with the dominant provider in the most favorable tier of providers (antitiering) or at the lowest cost-sharing rate to avoid steering patients away from that network (antisteering), even if providers in that network are more expensive or are of lower quality than other providers in the area. Anti-incentive provisions prevent patients from experiencing the price differential between providers and prevent an insurer from signaling a preference for providers by placing them in the most-favored tier or with the lowest copay. As a result, these provisions artificially inflate use of high-priced, market-dominant providers.

While some economists note the potential for some of these provisions to be used procompetitively in some industries (Chen and Liu 2011; Gurkaynak et al. 2016), they can be particularly problematic in consolidated health care markets (Scott-Morton 2012). Clark Havighurst, a leading antitrust scholar, argued that “U.S.-style health insurance greatly enhances the pricing freedom of firms possessing market power in health care markets, which results in much larger monopoly profits and much greater redistributions of wealth than would result from comparable monopoly power in markets where consumers face prices” (Havighurst and Richman 2011). As a result, dominant health care firms have greater ability to use contract terms to entrench market power and charge supracompetitive prices.

Antitrust enforcers filed three recent lawsuits alleging the use of certain terms in contracts between health care providers and insurers amounted to illegal anticompetitive conduct. First, in 2010, the DOJ filed an antitrust lawsuit against Blue Cross Blue Shield of Michigan (BCBSM), alleging BCBSM used MFN clauses to ensure that no other insurer could negotiate lower prices with hospitals, thereby preventing other insurers from entering and competing in local markets.¹⁰⁵ The DOJ dropped the

lawsuit after the Michigan insurance commissioner issued an order prohibiting MFN clauses in contracts with providers.¹⁰⁶ The Michigan legislature soon passed a law prohibiting MFNs in any health care provider contracts, and 20 states now ban MFNs in some contracts between insurers and providers.¹⁰⁷

Second, in 2016, the DOJ and North Carolina's AG argued that Atrium Health, a dominant hospital system in the Charlotte area, used anticompetitive, illegal antisteering clauses in its contracts with insurers, which prohibited commercial health insurers from offering patients financial incentives to choose health care services from less-expensive providers.¹⁰⁸ The two sides settled the case when Atrium agreed to not use or enforce any contract terms that prevent insurers from disclosing costs to patients or designing benefit plans to steer patients to cost-effective providers.¹⁰⁹

Third, the California attorney general recently settled a lawsuit against Sutter Health, alleging that the health system's market power allowed it to use a combination of contract terms, including all-or-nothing, anti-incentive, and gag-clause terms, to inflate prices for health care services.¹¹⁰ Since these contract terms precluded other providers from gaining market share through lower prices or higher quality, the California attorney general asserted that the contract terms used by Sutter drove up costs for all health care services in Northern California as other providers increased their rates in response to Sutter's increases. These lawsuits have brought a great deal of attention to the anticompetitive nature of certain contract terms, which may discourage their use by other provider organizations.

Potential Antitrust Remedies in Anticompetitive Conduct Cases

Although many of these cases settle, state AGs, when bringing these suits, can seek equitable (non-monetary) and monetary relief. Equitable relief can come in many forms, including an injunction preventing anticompetitive behavior from continuing, a structural remedy requiring a merged entity to divest certain portions of its business, or a conduct remedy requiring the merged entity to engage in or refrain from certain behavior. Finally, state AGs can seek monetary damages for financial losses experienced by any state agency or political subdivision on behalf of a larger class of plaintiffs. Most states have civil antitrust statutes that enable the state attorney general to seek treble (or triple) damages on behalf of state residents, agencies, and political subdivisions.

Two recent case filings exemplify the types of relief state AGs can seek when challenging anticompetitive behavior. In its recent case against Franciscan Health System, the Washington State AG sought a rare structural remedy by asking the District Court to undo Franciscan Health System's acquisition of a physician group and affiliation with a multispecialty physician practice because of

violations of section 1 of the Sherman Act, section 7 of the Clayton Act, and the Washington Consumer Protection Act.¹¹¹ However, the District Court dismissed Washington's case involving the acquisition of the physician group, which led to a settlement between the state and Franciscan Health System, in which the parties agreed to a significant payment to the state and a set of conduct remedies, which have not been made public.

Before settlement, the California AG sought conduct remedies for anticompetitive behavior in the case against Sutter Health discussed above, including (1) staggering reimbursement negotiations for inpatient, outpatient, ancillary care, and physician services to avoid all-or-nothing contracting; (2) maintaining different negotiating teams for different services separated by firewalls; (3) agreeing to arbitration in a range of circumstances; (4) limiting reimbursement rates to preacquisition or preaffiliation levels following a recent acquisition for a certain amount of time; (5) avoiding retaliation against the state or private plaintiffs; (6) enhancing transparency; and (7) agreeing to the appointment and payment of a trustee to ensure compliance with the equitable remedies provided by the court.¹¹² Conduct remedies, like those sought in the Sutter case, can grant a state significant authority to regulate and oversee the operations of dominant health systems that have engaged in anticompetitive behaviors, including restricting their contracting practices and their reimbursement rates.

In a tentative settlement announced in December 2019, Sutter agreed to pay \$575 million to settle claims of anticompetitive behavior with the private plaintiffs and the California Attorney General.¹¹³ The settlement will also prohibit Sutter from engaging in certain practices the plaintiffs argued Sutter used to maintain its dominance, including all-or-nothing contracting. The tentative settlement awaits final approval by Judge Anne-Christine Massullo of the San Francisco Superior Court. Further, Sutter still faces a federal suit on these issues.

Legislate or Litigate?

A major question states face is whether to pursue litigation or legislation to address anticompetitive contract terms. Historically, states have been hesitant to ban contract clauses, other than MFNs, through legislation. While a few states have considered bills to ban these terms,¹¹⁴ only Massachusetts bans all-or-nothing provisions, and it does so only within specific plans, as opposed to across all plans.

States may think strategically about whether to combat anticompetitive contract terms through legislation, litigation, or both. Legislation is the most effective way for states to broadly prohibit the use of terms that consistently harm health care markets. For antitrust enforcers and market participants, legislation makes use of a *per se* violation of state law, thereby eliminating any ambiguity as to the

legality of its use and significantly simplifying enforcement actions. However, passing legislation can prove challenging, especially in states with highly powerful health care systems that have both market and political power. As a result, legislatures may spend a great deal of time and resources attempting to pass legislation that does not succeed. For example, in 2018, the California legislature considered SB 538, which would have prevented contracts between hospitals and insurers that allow hospitals to set rates for affiliates or require that the insurer also contract with any other affiliate of the hospital.¹¹⁵ The bill also banned any contract clause requiring the plan or insurer to keep any contract payment rates confidential from any payor that may become financially responsible for services. The bill, however, failed to pass, despite multiple hearings. Other states may find similar legislation difficult to pass. Furthermore, legislation without sufficient oversight may open the door to providers and insurers agreeing orally or via other means to terms not explicitly written into the contract.

Challenging the use of anticompetitive contract terms in court offers alternative advantages and disadvantages. Litigation can provide key information for policymakers as they demonstrate how the use of these contract provisions prevents proper market function and raise prices for consumers. It also allows antitrust enforcers to target a broader range of alleged anticompetitive conduct by a specific provider organization without being limited to actions expressly prohibited by legislatures. When states want to allow businesses more leeway in their practices, litigation allows the court to explore the procompetitive and anticompetitive effects in a particular case through a rigorous *rule of reason* analysis to determine whether, on balance, use of a particular contract term was anticompetitive.¹¹⁶ Because of the detail needed to conduct such an analysis, *rule of reason* cases can demand significant time and financial resources to conduct.¹¹⁷

Whether a state pursues litigation or legislation to combat anticompetitive contract terms should depend on the likelihood of success of legislation, the number of provider organizations with sufficient market power to use anticompetitive contract terms, the level of oversight feasible, and the resources available for enforcement activities. As Emilio Varanini, a California deputy AG, articulated, “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.... [C]ourts, proceeding on a case-by-case basis, must act prudently in each individual case to ensure that they are not inappropriately second-guessing individual business decisions. Legislation does not suffer from that same need as it reflects public value judgements on the utility of business conduct as a general matter” (Varanini 2017). Overall, passing legislation to prohibit certain anticompetitive contract terms clarifies and streamlines enforcement by creating a *per se* violation. Whereas litigation allows courts to carefully weigh the benefits and detriments to competition in a specific case through a rigorous *rule of reason* analysis, which

provides more nuance in business but also adds significant ambiguity to enforcement actions. However, litigation also depends on the state having adequate resources for enforcement, as well as risks the parties settling the case so that it cannot serve as clear precedent for future cases. Overall, states must select the most applicable policy option for their particular goals.

Adding Competitive Options: State Public Option Bills

States can also enhance competition by adding competitors to a consolidated market. Nearly 37 percent of counties in the US have only one insurer offering coverage on the ACA Marketplaces, which thus have no business reason to negotiate for lower provider rates. As a result, many state legislatures have considered creating a public option plan, a health plan managed or regulated by the state government that would compete with private health plans in the individual, small group, and in some cases, large group markets. Over the past eight years, 15 states have considered public option bills, and many more states have considered or passed bills to study the implications of a state public option plan.¹¹⁸ In addition, two cities—New York City and Los Angeles—offer public option plans based on the states' Medicaid plans.

Public option plans seek to offer comprehensive and affordable coverage to at least some portion of the state population, but they vary significantly in plan design and eligibility. Many of these plans have cost control provisions, such as premium savings targets¹¹⁹ or caps on provider payment rates. Furthermore, public option plans also may have spillover effects. The competition from a public plan with cost control provisions provides private insurers the impetus to control costs more effectively to remain competitive and enhances their negotiating power vis-à-vis providers. Specifically, if private plan premiums and cost-sharing substantially exceed those of the public option, those plans may not remain competitive. However, providers may prefer to keep private plans in the market and lower their payment rates somewhat to maintain their viability. As a result, the mere existence of a public option, and its lower rates, may encourage private plans to offer improved benefit design and cost control measures, even if the number of enrollees in the public option remains relatively small.

State Public Option Plans

States can use public option plans to serve a range of policy goals, including increasing the number of insurance plan options in counties or other areas where few insurers offer coverage, generating a lower-cost plan to encourage price competition within the private market, or prototyping government-

run plans intended to evolve into a single-payer system. The variation in design of state public option plans reflects these differing policy goals. For example, state legislators seeking to improve insurance options in “bare counties” might offer a Medicaid buy-in or state-sponsored plan on the exchanges to all state residents. States seeking to improve competition by offering a lower-cost option to residents may offer a plan based on coverage in the state employee benefits plan and attempt to limit provider payment rates. Finally, some states may use a comprehensive public option, sold on the individual, small group, and large group markets, to expand the use of public insurance, while promoting competition and lowering costs in both the private and public health insurance markets.

For states wishing to target specific populations that lack coverage, a Medicaid buy-in public option may allow the state to assist individuals who cannot afford the cost-sharing required in employer plans and the individual market (Neuman, Pollitz, and Tolbert 2018). In the past three years, Iowa, Minnesota, Nevada, New Mexico, and Wyoming considered bills to allow individuals to buy into the state Medicaid program, but no state has yet passed such a bill.

States with broader policy goals, including improving market function in consolidated markets and universal coverage, may consider other coverage options as the basis for their public options. For example, some states, including Connecticut¹²⁰ and Maine,¹²¹ considered, but did not pass, bills that would allow state residents to purchase insurance through the state employee health benefit plans (SEHBP). While risk-pooling and ERISA-preemption issues may make it difficult for states to allow small businesses to purchase coverage through the SEHBP, states may consider creating a new public option plan with coverage based on the SEHBP.

Other states considered requiring private insurers offering coverage on the Marketplaces to also offer a public plan that satisfies the states’ public option requirements. In May of 2019, Washington became the first state to pass a law to create such a public option.¹²² Washington’s law tasks the State Health Care Authority (HCA)—a state agency that purchases health care for more than 2 million state residents, including state Medicaid enrollees and public employees—to contract with one or more health carriers to offer at least three qualified health plans at each metal tier (bronze, silver, and gold) on the Washington health benefit exchange beginning in plan year 2021. Similarly, Colorado released a draft report in October 2019, detailing a public option for Colorado that would require every insurer above a to-be-determined market share or membership size to offer a public option plan in addition to their other insurance plans (Colorado Departments 2019). This draft report requires insurers to offer the public option plans both on the exchange and in the traditional individual market. As the only two states to pass legislation to create a public option, the lessons learned from experiences in Colorado and Washington should prove invaluable to other states seeking to implement public option.

From the outset, the plans have numerous similarities and differences that provide important points for comparison. Notably, the public option plans in both states will be sold on the state exchanges. But in Colorado, public option plans also will be offered on the individual and small group commercial insurance markets. Both plans include caps on provider payments. The Washington plan caps payment rates for all participating providers (excluding pharmacy benefits) to 160 percent of Medicare rates. The law also establishes minimum payment rates for primary care providers and pediatricians at 135 percent of Medicare rates and for rural and critical access hospitals of 101 percent of Medicare rates.¹²³ Colorado recommends that provider payments from state option plans not exceed 175 to 225 percent of Medicare rates (Colorado Departments 2019, 14). Both states acknowledge that providers may refuse to participate in the public option at these rates, but they offer different solutions.

Specifically, the Washington law allows the insurance commissioner to lift the caps on provider reimbursement rates, if the insurer can do so without raising premiums or is unable to create a sufficient provider network at the given rates.¹²⁴ Whereas Colorado encourages negotiation with providers by stating that “a key concern with all policies that focus on coverage affordability is ensuring a robust network of providers willing to participate...[state officials] seek an open dialogue with providers and carriers in order to achieve this goal” (Colorado Departments 2019, 15). While some have argued that these provisions give providers an incentive to not join the provider network for the public option,¹²⁵ allowing state agencies to increase provider payment amounts, if needed and under certain conditions, permits the state to refine the program to best balance the needs of both providers and enrollees in the state.

Finally, states considering comprehensive public option bills, those that would be accessible to residents in the individual, small group, and large group markets, should be aware that political challenges may come from a variety of sources. For instance, in 2019, the Massachusetts legislature proposed offering a comprehensive public health insurance option in the individual, small group, or large group markets, which would enable nearly every state resident to purchase a public option plan.¹²⁶ As of this writing, however, the bill remains in the State Joint Committee on Health Care Financing and appears unlikely to pass, because support among Democrats for a single-payer plan overshadows the consideration of a public option.

In Connecticut, the legislature considered creating a public option through the ConnectHealth Program. This bill required insurers seeking to offer insurance products for sale on the exchange to also offer the public option. This bill had strong gubernatorial support and appeared poised to pass, when a major insurer reportedly threatened to move its headquarters out of state if the bill succeeded.¹²⁷ In response, the legislature revised the bill but failed to pass it before it adjourned. State legislators will

need to carefully examine the political and market power forces at work and develop strong stakeholder alliances to successfully implement significant health reforms, like a comprehensive public option.

Overall, public option plans can address a range of policy goals from providing additional insurance options in areas with few possibilities to a comprehensive program intended to move the state toward broad public coverage. The design of the public option, including whether the coverage mirrors that of Medicaid, the SEHBP, or a more comprehensive approach, should reflect those policy goals. The experience gained by Washington and Colorado may offer meaningful lessons to other states considering creating a public option. Nonetheless, future research is needed to ascertain the legal requirements and waivers necessary for states to implement the variety of alternatives in public option plans. In addition, research should assess the effects of a public option on provider rates and market functioning, both in the market segment with a public option (e.g., the individual or exchange plans) and in other markets to determine whether the public option permits cost-shifting to other private plans.

Concluding Thoughts on State Options to Regulating Consolidation and Promoting Competition

Health care provider organizations have been allowed to consolidate with little restraint for several decades, and such consolidation has produced overwhelming price increases with little to no quality improvements to the detriment of citizens, employers, and states throughout the country. Competition in the US health care system is dwindling. While rigorous state merger review can slow future consolidation, antitrust laws must more effectively address the anticompetitive potential of non-horizontal mergers, which compose the majority of modern health care mergers. Regulatory tools, like conduct remedies, can offer states greater regulatory oversight over health care organizations with market power and community benefits, but these tools are limited by state resources and time. States can use litigation and legislation to address specific anticompetitive behaviors by individual actors and throughout the market, but these efforts do little to address the comprehensive effects of consolidation. Finally, public option plans can inject competition into highly consolidated markets to target specific or comprehensive populations, yet their effectiveness and political feasibility remains largely untested.

Future research should examine the following issues: (1) the medical, legal, and financial implications of using structural remedies to break up large health care systems that abuse their market power; (2) how to develop the appropriate legal and economic assessment tools to evaluate the

potential harm to competition from nonhorizontal mergers for purposes of merger review; and (3) the effects of state public option plans on health care spending and private health plan premiums in the state. In sum, while specific efforts to promote competition can help lower costs, the broad failure of competition in many American health care markets requires consideration of regulatory approaches to complement and supplement market-based approaches.

5. State Options for Overseeing and Regulating Prices

In the Introduction, we documented that the inexorably-increasing concentration of providers and insurers in most markets represents market failure, making the possibility of price competition among hospitals and other providers as the dominant approach to reward providers for efficient production of care problematic. Simply, hospitals and, to a somewhat lesser extent, physicians have organized into horizontally and vertically consolidated must-have¹²⁸ organizations that can exert market power to raise prices and resist payer contract provisions intended to constrain their exercise of market power. Conversely, as discussed earlier, insurance market concentration fails to provide a sufficient counterweight to provider market power because dominant insurers lack an incentive to negotiate low rates (Dafny 2010; Dafny, Duggan, and Ramanarayanan 2012).

Most competition theory assumes that price regulation is antithetical to market competition. Health care may be the exception. More than two decades ago, health economists Paul Ginsburg and Kenneth Thorpe argued that “rate setting can be highly compatible with the most important aspects of competitive approaches, but only if designed to be so” (Ginsburg and Thorpe 1992). A real-world example demonstrating the compatibility of price regulation and competition over other important objectives of health delivery, including quality, service, innovation and access, can be found in Medicare. For example, research has demonstrated that Medicare Advantage (MA) plans actively compete with each other and the traditional Medicare program primarily because the Medicare statute prohibits MA insurers from billing patients more than traditional Medicare allowed charges (Berenson et al. 2015).

Although designed to protect Medicare beneficiaries from the exorbitant charges that often take place in commercial insurance markets, especially for out-of-network services, this prohibition on excessive-balance billing alters plans’ negotiating leverage with providers. In short, hospitals can be in-network at Medicare rates or out of network at the same rates. Therefore, most providers accept Medicare rates in their contracts with MA plans—and the plans then compete on the other important factors that beneficiaries value, not which insurer obtains the best rates from hospitals and physicians. In this example, Medicare’s administered prices and accompanying beneficiary protections have served to promote competition and provide more consumer choice than what would be possible without such limitations.

In this section, we explore forms of state regulation that could directly or indirectly affect provider prices. We first address certificate of need (CON) laws and regulations that about half of states maintain to control hospital capacity, including availability of beds. We examine the proposition asserted by many proponents of market competition that CON presents a fundamental barrier to market entry and, therefore, importantly contributes to market concentration and the lack of effective price competition. We also explore the possibility that CON regulations limiting provider capacity and expansion can be compatible with efforts to increase provider competition.

We next review developments on four approaches that some states have adopted to more directly control prices. These include (1) the authority of state-based commissions to examine, among other things, the drivers of health care cost increases, focusing on how commissions can influence or directly regulate prices; (2) insurance rate review with authority to deny rate increases insurers negotiate with hospitals and other providers; (3) the use of provider price limits by public employee insurance programs; and (4) hospital rate review through both “lighter” approaches to hospital rate setting and the more well established, all-payer rate-setting approaches that Maryland pioneered in the 1970s and has evolved into budget setting.

A challenge in presenting the information is that states can perform similar functions through different organizational mechanisms, sometimes with a commission with representation from stakeholders, as well as the public, and sometimes through an established government agency. For example, Oregon has vested its Health Policy Board within the Health Authority to perform analyses and propose recommendations to the legislature, as commissions in other states are asked to do. In short, the lines between the topics related to setting cost and rate limits are not distinct. Our discussion will reflect these areas of overlap.

Certificate of Need Laws

It is an article of faith among pro-market-competition advocates that state certificate of need (CON) programs are anticompetitive, preventing market entry of potential hospital competitors and therefore contributing to market concentration and high hospital prices. Thus, CON critics typically advocate repeal of state-based CON laws. The Trump administration articulated this viewpoint in its 2019 report on reforming America’s health care system, asserting that “the evidence to date...suggests that CON laws are frequently costly barriers to entry for healthcare providers rather than successful tools for controlling costs or improving healthcare quality.”¹²⁹ In this section, we explain that the evidence, in fact, does not support this conclusion. A recent study actually found the opposite, that CON actually

reduces market concentration, suggesting a potential beneficial effect on competition (Paul, Ni, and Bagchi 2019).

The rationale for CON in the 1960s was the broad acceptance of Roemer’s Law, which states that in an insured population, “a hospital bed built is a filled bed.” The law—attributed to Milton Roemer, then a professor at the UCLA School of Medicine—implicated supplier-induced demand for health care services (Shain and Roemer 1959). CON laws, first promoted and financially supported by the National Health Planning and Resources Development Act of 1974, established quasi-independent commissions or vested authority in state agencies to determine the need for expansion of hospital capacity, responding to the phenomenon in the hospital sector of nonprice competition, characterized as a “medical arms race” (Robinson and Luft 1987). CON requires state approval for new beds or services, in essence, to prevent too much hospital capacity that increases costs through supplier-induced demand. All states except Louisiana enacted CON laws. Subsequently, supporters also emphasize the “volume-outcome effect, that demonstrates a positive correlation between the number of times a hospital performs a procedure and the likelihood of good patient outcomes for many but not all procedures (Dobson et al. 2007; Gaynor, Seider, and Vogt 2005; Morche, Mathes, and Pieper 2016).

CON critics have long asserted that CON laws have backfired by empowering incumbent hospitals to prevent market entry of potential competitors and, importantly, reducing competition for traditional hospital services. They point to the reality of “regulatory capture”—when a body created in the public interest, instead, succumbs to the interests of the stakeholders it regulates, such as when the CON agency does not approve the application of a physician-owned ambulatory surgery center that would compete with a hospital’s outpatient surgery facility. They also point to high compliance costs and delays associated with the review process as factors interfering with a responsive competitive market (Dobson et al 2007; HHS, n.d.; Paul, Ni, and Bagchi 2019).

Reflecting broad interest in deregulation in the Reagan presidency, Congress in 1982 lowered state funding for CON and repealed the CON mandate in 1987. Yet, 36 states and the District of Columbia (DC) maintain some form of their CON laws, although we calculate that only 26 states and DC apply CON for short-stay, acute-care hospitals.¹³⁰

The Empirical Evidence of Market Effects of CON Laws

Little appreciated about CON regulations is that they might also be procompetitive, primarily by preventing predatory behavior of established hospital systems seeking to expand their own capacity for specialized services lines, such as cancer care and cardiac surgery, by limiting excessive expansion from

incumbent hospitals while preempting the potential entry of would-be competitors. In short, CON laws may theoretically have both beneficial and harmful effects on competition (Paul, Ni, and Bagchi 2019), and their effects may vary across states based on how states implement CON regulations. Thus, the net effect of CON on marketplace competition remains an empirical question, which we sought to examine through an updated literature review of peer-reviewed studies.

Some states, including Florida, Georgia, North Carolina, and Virginia, now require the state's CON entity to consider, among other factors, whether the new service or facility being proposed fosters competition. And some states' statutes explicitly require the approving entity to consider the anticipated effects of an approval on quality. In 2017, Massachusetts modified its determination of need (DON) regulations to incorporate "public health and community principles" into its assessment of "need," requiring commitments from new entities to control costs, ensure access to care, and address health equity.¹³¹ Further, Massachusetts has found that even vigorous antitrust enforcement, on services for which there is competition, does not address tertiary and quaternary care provided by a single system and has found that having a DON program is desirable and complementary to the AGs efforts to promote competition.

Despite strongly held views about the presumed effects of CON on market competition, the ongoing studies on the association of CON laws with important outcomes such as state per capita costs, quality and service use, and, for our purposes, the impact of CON programs on market competition and hospital prices, mostly have been overlooked or misunderstood by policymakers.

The FTC and DOJ have presented what they describe as an "evidence review," finding that studies point to negative consequences of CON on important outcomes, including comparative state costs per capita and measures of quality (DOJ and FTC, n.d.). As mentioned above, the Trump administration, citing the FTC-DOJ evidence summary, consistently asserts that CON laws lead to provider market concentration and ever higher provider prices and should be repealed. The agencies rely on their brief review when providing advice to states advocating repeal of CON in the states that maintain CON programs. Such conclusions are unwarranted based on an objective reading of the recent literature. We briefly summarize two studies, one of which includes a detailed literature review of studies published before 1998. The other, published after the FTC-DOJ evidence review, counters the assumption that CON compromises market competition.

In 1998, two Duke University researchers, Christopher Conover and Frank Sloan, examined the association between state certificate of need laws and various outcomes, including acute care spending per capita (Conover and Sloan 1998). Despite a statistically significant reduction by mature CON

programs on short-stay hospital spending per capita (5 percent) and bed supply (2 percent), there was no corresponding reduction in total per capita spending, because of an offsetting increase in post-acute care spending, such as in skilled nursing facilities (Conover and Sloan 1998). Importantly, for our interest in competition, they found neither a surge in beds and expenditures after states lifted CON requirements nor a decrease in costs over time from a more competitive market permitted by removing the supposed CON restraint on market entry. The researchers found no increase in bed supply following removal of CON, even many years later. Conover and Sloan did find that health maintenance organization (HMO) market share, rather than CON regulations, was associated with substantially lower hospital bed supply, lower expense per adjusted admission, and lower diffusion of open-heart surgery units, holding other factors constant (Conover and Sloan 1998).

Reviewing the conclusions of published studies through 1997, Conover and Sloan concluded that the empirical evidence of CON as a cost-containment mechanism was mixed, with a range of findings and no consistent patterns (Conover and Sloan 1998). They concluded that “the record for CON as a cost-containment mechanism appears mixed at best” and that four of six reviewed studies did not demonstrate that CON reduced bed supply, an essential element of CON detractors’ criticism that CON leads to hospital market concentration. They also found that few studies examined the impact of CON on market structure (Conover and Sloan 1998).

One recent study did have decisive findings, opposite to the prevailing viewpoint that CON leads to market concentration, thereby reducing hospital market competition. Paul and colleagues in 2017 found that CON laws are associated with a **32 percent decrease** in market concentration, as measured by the Herfindahl-Hirschman Index. The effect was even greater in states with more stringent (lower dollar threshold for review and approval) CON programs. The authors suggest that these results are consistent with the proposition that CON laws do more to prevent incumbents from expansion and predatory behavior to keep out competitors than to prohibit market entry of competitors (Paul, Ni, and Bagchi 2019).

In addition, we reviewed the broad range of CON impact studies published since 1998, finding they present inconsistent, often contrary findings. Nevertheless, most did not find a markedly positive or negative association between CON laws and outcomes of interest. Even statistically significant results—positive or negative to the impact of CON—were of small magnitudes in the low, single-digit range. Research for the most part has not examined the likely variation in the effects of CON programs across the states, such as the extent to which states succumb to regulatory capture. Little is known about how states with various mandates, such as those that require approved applications to “foster competition”

or promote public benefits, attempt to ensure compliance while carrying out the direct responsibility to limit oversupply.

Conclusion

About half of states retain certificate of need requirements for short-stay, acute care hospitals, yet there is little consensus about the impact of CON programs or, conversely, on the impact of repealing CON. Researchers continue to conduct studies of the impact of CON on a range of outcomes, but for the most part, the results of these studies remain within the domain of the researchers themselves and are not influencing policymakers. Further, studies have not examined the likely substantial variations in how different implementation of state CON administration affects outcomes, for example, the extent to which different state programs have been “captured” by the interests of the incumbent hospitals in some states but not others and what can be done to prevent capture. Such research might show that the large variations in prices across states in the recent RAND study (White and Whaley 2019) depend to a meaningful extent on how the CON programs function in relation to incumbent hospital interests.

As a next step, we recommend that a definitive, high quality literature review of the range of recent CON studies is needed to bring facts to what otherwise has become a largely ideological position that CON needs to be repealed to promote provider market competition, even as half the states maintain these programs. Given the recent ability to present data showing the mean and variations in hospital prices at the individual state level, relying on the increasingly wide use of APCDs and other sources of claims data (White and Whaley 2019), it is now possible to assess directly the effect of CON on hospital prices in commercial insurance markets to explore directly the association of CON and hospital prices. Finally, given the broad range of potential CON effects, including outcomes related to costs, quality, and access, qualitative research, including case studies on apparently successful and unsuccessful CON programs, might provide a valuable adjunct to additional quantitative studies.

State Commissions

Several states have established commissions to study and, in most cases, make recommendations for state action to address the drivers of high health care spending. As their initial explorations proceeded, it became apparent for some commissions that prices and price increases are a leading contributor to health care spending growth. Accordingly, among their main activities, state commissions have focused on exposing these price variations, implementing cost controls meant to contain prices, or overseeing

provider market consolidation that raises prices and exacerbates price differences across providers, particularly hospitals.

States may establish commissions through statute, rather than relying on government agencies to address a challenging issue like health care spending. In contrast to state agencies, commissions are not subject to supervision or control by the executive branch and, thus, can carry out their activities independently and may be in a better position to obtain buy-in from the range of stakeholders represented.^{132,133} Commissions usually are designed to solicit the participation of nongovernmental expertise and take advantage of the diverse perspectives of commission members, allowing for creative thinking that is not necessarily in the purview of day-to-day state business.^{134,135} Often, commissions are charged with carrying out legislative functions, such as fact finding and initial policy recommendations, with implementation assigned to an established governmental agency. In that way, commissions often are established to study and make recommendations in policy areas that do not fall within the established confines of government agencies.

Some commissions are entrusted regulatory powers, serving as a quasi-governmental operating agency; for example, the long-standing Maryland Health Services Cost Review Commission (HSCRC) has had regulatory authority to set all-payer payment rates and, now, to set hospital budgets (Fuse Brown and King 2016). However, commissions with more authority can be subject to regulatory capture, where the regulated entity influences commission members or lobbies the legislature to limit their authority. Nevertheless, the commission's independence, diverse representation, and the evidence it accumulates may facilitate a stronger policy consensus that could be carried out through legislative action.

Seven State Commissions Addressing Health Care Costs

To date, seven states have established commissions: Colorado, Delaware, Maryland, Massachusetts, New York, Pennsylvania, and Virginia.¹³⁶ The Massachusetts Health Policy Commission (HPC), which has received recent prominence, has been granted some regulatory authority, as discussed below. The Maryland HSCRC, established in 1971, and the Vermont Green Mountain Board¹³⁷ limit prices through rate setting or global budgets, which we review in Chapter 5, section Hospital Rate Setting.

Some commissions have exposed price variation across the state and made recommendations to closely monitor and provide information to the public about health care prices. For example, by analyzing the states' APCDs, the Colorado Commission on Affordable Health Care and the Pennsylvania Health Care Cost Containment Council identified significant price variations across their

states and recommended continued oversight of health care prices and made price information available to consumers in the form of a public website.^{138,139}

The HPC also concluded that increasing prices and upcoding drove spending growth within the state. They found that from 2013 to 2018, commercial inpatient spending grew 10.7 percent in Massachusetts, while volume decreased by 12.8 percent (MHPC 2019),¹⁴⁰ supporting their efforts to focus their work on high and varying prices within the state. The HPC has the legislative authority to review proposed mergers, acquisitions, or expansions and provide an assessment of its potential impact on prices to the office of the state attorneys general (see box 3).

To contain costs, the state commissions in Massachusetts and Delaware—the Delaware Health Care Commission, established in 1990—have established all-payer, statewide cost growth benchmarks, which serve as a signal for state payers and providers to control expenditures. Generally, states set their benchmarks to reflect forecasted growth in per capita gross state product (GSP) to bring spending in line with growth in the states’ overall economy. The commissions, with the help of other state entities, use state APCDs to assess payer expenditure growth against the benchmark.

In Massachusetts, for example, the benchmark does not apply directly to hospital prices because it requires a “captive” patient population to calculate spending growth. The benchmark may, however, encourage insurers and primary care providers to avoid high-priced hospitals or negotiate more aggressively over price with such hospitals to comply with the growth limit. Hospitals themselves might voluntarily try to comply with the cost increase limitation; restraining their requests for price increase might be the simplest approach they can take. Oregon has also implemented a per capita growth limit modeled after Massachusetts—3.4 percent for state employee health benefit plans and is implementing a similar approach for the private sector—via its Authority, rather than through a commission.¹⁴¹

BOX 3

Massachusetts Health Policy Commission Authority

An essential activity of the Health Policy Commission (HPC) has been to explicate the details of high prices charged by some health systems and the major price variations between large academic health centers and local community hospitals, with recommendations about how to address the variations to protect the community hospitals.

The HPC has also become central for policy making in Massachusetts both because of its explicit authority and its broad influence. For instance, in 2013, the HPC warned the AG that Partners Healthcare's acquisition of three hospitals could raise health spending per year substantially. HPC's analysis also helped inform a decision by the Superior Court to block the merger, despite a negotiated consent judgment between Partners and the state AG.

The commission also contributed to the state AG's recent review of the proposed merger between Beth Israel Deaconess Medical Center and Lahey Health. HPC determined that the merger would likely have a significant impact on costs and market functioning in Massachusetts, recommending that the AG conduct further review of the proposed transaction to attempt to mitigate negative effects, such as price increases or access issues for the underserved. The AG agreed to allow the parties to merge, subject to specific conduct remedies via a consent decree discussed in Chapter 4, section Continued Oversight as a Condition of Merger Approval or Acquiescence. In addition to obtaining commitments to limit growth in hospital prices and certain other behaviors, the consent decree required the merged health system to make investments to improve population health and boost access to health care for communities of color and low-income populations.

The HPC also has the authority to regulate capital expansion where the AG does not have purview. For example, Boston Children's Hospital planned to expand its facility through building another hospital wing, which does not warrant AG review. The HPC is allowed, through statute, to review and comment on any determination of need application. The HPC produced a detailed analysis finding that the expansion would likely increase the state's health care spending. The Department of Health ultimately approved the expansion.

The HPC also invests in delivery reform models and certifies accountable care organizations and patient-centered medical homes to promote efficient, high-quality health care.

Sources: Review of Partners HealthCare System's Proposed Acquisition of South Shore Hospital and Harbor Medical Associates.; 2013. <https://www.mass.gov/files/documents/2016/07/qh/hpc-preliminary-review-of-phs-ssh-harbor-12-18-2013.pdf>.; Commonwealth vs. Partners Healthcare System, Inc & others: Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgement by Consent. 2015. Pages 2 & 22-30. <https://www.crowell.com/files/MCLW-Commonwealth-of-Massachusetts-v-Partners-Healthcare-System-Inc-et-al.pdf>; Massachusetts Health Policy Commission Review of the Proposed Merger.; 2018. [https://www.mass.gov/files/documents/2018/09/27/Final CMIR Report - Beth Israel Lahey Health.pdf](https://www.mass.gov/files/documents/2018/09/27/Final%20CMIR%20Report%20-%20Beth%20Israel%20Lahey%20Health.pdf); Bannow T. FTC hears concerns about Ballad Health merger. Modern Healthcare. <https://www.modernhealthcare.com/mergers-acquisitions/ftc-hears-concerns-about-ballad-health-merger>. Published 2019. *Boston Children's Hospital Determination of Need Project Number 4-3C47*. <https://www.mass.gov/files/documents/2016/09/xv/hpc-childrens-don-comment.pdf>

Conclusion

Some states have established commissions to explore the problem of high and rising health care spending, not only for those individuals the state has direct responsibility for, including public employees and Medicaid beneficiaries, but also for all other residents in the state. When commissions examine the causes of high health care spending, they commonly identify market concentration and the resultant provider market power as key drivers of prices and, thus, health expenditures. Thus far, some commissions are only allowed to make an issue of prices but lack authority to do anything about it. Others have followed the lead of Massachusetts to set cost growth updates that serve as a voluntary target that the state encourages all stakeholders to comply with. While Massachusetts appears to be successful, it is unclear whether the approach will work in other states. It has also proved difficult to convert a statewide spending update target into specific approaches to limit price increases or set ceilings on provider rates. Nevertheless, the broad-based stakeholder representation on the commissions and the evidence accumulated arguably may make it easier to develop a policy consensus for more concrete action the legislature might authorize, whether in the commission or through another channel.

When given some regulatory authority that extends beyond fact-finding, an important challenge is making sure the commission coordinates with other existing government agencies and does not simply add another regulatory body to the mix. To be effective, a commission should closely communicate with the APCD authority, the state AG, the Department of Insurance, certificate of need authorities, and others. Although it can be extremely valuable for a state to have an expert, independent commission to analyze APCD data, make policy recommendations, and shine a light on high and variable prices, the most effective model of a commission may need to be vested with meaningful regulatory and enforcement authority, as long ago adopted in Maryland and more recently in Massachusetts.

Review of Insurance and Provider Rates

The rise of health care spending has also motivated states to empower their administrative agencies to control health care expenses. Nearly all states grant the Department of Insurance the ability to review health insurance premiums before they go into effect. Over half require the Department of Insurance to review and approve certain types of rate changes, and several states, including Massachusetts, Oregon, and Pennsylvania, grant the Department of Insurance comprehensive rate review, which enables them to review and approve rates for all health insurance plans sold in the state.¹⁴² So far, however, only two states, Rhode Island and more recently Colorado, have charged the insurance commissioner with

maintaining the affordability of health insurance, which resulted in the commissioner having the ability to review and approve not only health insurance rates but certain hospital rate increases in contracts with commercial insurers (Baum et al. 2019). This ability enables the commissioner to ensure that hospitals and health systems with market power do not demand high increases, while limiting reimbursement rates of their competitors. Below, we discuss the experience of the Rhode Island insurance commissioner in implementing the Affordability Standards, as Colorado's remain in development.

Review of Provider Rates in Insurance Contracts

Traditionally, insurance commissioners have focused on ensuring health plan solvency and fair treatment of consumers. In 2004, the Rhode Island legislature removed health insurance regulation from the Department of Business Regulation and created the Office of the Health Insurance Commissioner. In doing so, the legislature expanded the new health insurance commissioner's role by charging him with holding health insurers accountable for the fair treatment of providers and promoting improved accessibility, quality, and affordability for health insurance sold in the state.¹⁴³ The legislature's explicit direction that the health insurance commissioner shall address the "affordability" of health insurance distinguished the authority of the Rhode Island health insurance commissioner from those in other states (Koller, Brennan, and Bailit 2010). The Rhode Island health insurance commissioner also possessed the authority to review the rates of all insurance plans in the commercial market, including large group plans, which was also uncommon. Placing this authority with the insurance commissioner also saved the Affordability Standards from ERISA preemption, because they were part of a state insurance law.

As a result of these factors, in 2010, the Rhode Island health insurance commissioner issued new regulations designed to improve the affordability of insurance by increasing the supply of primary care providers and reducing hospitalizations, emergency room visits, and premium increases for commercial insurance.¹⁴⁴ The commissioner designed the Rhode Island Affordability Standards to minimize growth in commercial insurance premiums by targeting the joint drivers of health care spending: utilization and prices. The Affordability Standards attempt to decrease utilization by increasing spending on primary care¹⁴⁵ and control costs by requiring insurer-hospital contracts to move toward bundled payments and value-based payment models.

Furthermore, the Affordability Standards require insurer-hospital contracts to include explicit statements of the provider payment rates and quality incentive payments for the commissioner to

review. The health insurance commissioner must review the hospital-insurer negotiated rates under two circumstances: (1) if the average provider rate increase, including quality incentive payments, exceeds the US Consumer Price Index for All Urban Consumers (CPI-Urban) percentage increase; or (2) if less than half the average rate increase is used for expected quality incentive payments. In either case, the commissioner must review the negotiated hospital rates to determine whether the rate increases are in the interest of the states' health insurance consumers. If the commissioner finds they are not, he or she has the ability to deny the negotiated hospital rate. As a result, Rhode Island now has the ability to limit excessive growth in provider payment rates based on authority already vested in its Department of Insurance, and without passing legislation.

In 2019, Baum and coauthors conducted a study examining the impact of the Rhode Island Affordability Standards (Baum et al. 2019). The study examined changes in health care spending, utilization, and quality in Rhode Island as compared with matched individuals in other states. Overall, Baum and colleagues found that the Affordability Standards reduced both inpatient and outpatient quarterly fee-for-service (FFS) spending by \$76 per enrollee, while utilization and quality levels remained the same. While quarterly non-FFS payments increased \$21 per enrollee because of increases in primary care spending, both overall health care spending and consumer out-of-pocket spending declined. As a result, the overall savings in the program resulted from slower price growth rather than from changes in utilization or quality.

One limitation of the CPI-Urban +1 percent increase threshold is that it examines only percentage increases in provider rates and fails to address inequities in payment that already exist because of varying levels of market power. Another potential risk of a regulation-based approach arises from the potential for agency capture. However, in this instance, hospitals and provider organizations are less likely to have influence over the health insurance commissioner than they would a regulatory agency more directly focused on providers, because providers have less direct contact and relationships with the insurance commissioner. The long-term impacts of the Affordability Standards may become more apparent as the health insurance commissioner continues to monitor their efficacy and other scholars analyze the findings.

In addition to controlling health care costs, Rhode Island's insurance rate review process also provides key protections that promote price transparency. In reviewing contracts between insurers and hospitals, the insurance commissioner has access to a wide range of negotiated health care prices, contract terms, and other information that health care providers and insurers have tried to keep confidential through gag clauses and claims of trade secret protections. The Rhode Island insurance commissioner guarded against these claims by explicitly stating that all commercial insurance contracts

must include terms relinquishing the right by any party to contest the public release of information demonstrating compliance with the affordability standards. However, the insurer or other affected party have the right to request the commissioner to keep certain contract provisions confidential, which depends on whether the commissioner's legal and factual analysis justifies the claim of confidentiality.

Conclusion

The lessons from Rhode Island's health insurance commissioner demonstrate the viability of explicitly charging state insurance commissioners with maintaining the affordability of health insurance and granting them comprehensive rate review and approval authority that can extend to the negotiated provider rates in insurance contracts. Rhode Island's Affordability Standards provide a strong framework for other states to build upon in terms of controlling costs. However, states interested in this option should consider how to avoid allowing it to entrench existing payment inequities created by market power. In some instances, administrative agency regulations offer states a viable option for controlling costs without the direct need for legislation or litigation. Future research could determine the applicability of this affordability standard beyond Rhode Island and Colorado and determine whether administrative agency regulations offer states a viable option for controlling costs without the direct need for legislation or litigation.

Imposing Price Limits for State Employee Health Benefit Plans

In the face of high and ever-increasing health care expenditures, states have a primary interest in reducing the costs for state employee and retiree health benefits. Two state employee health benefit plans (SEHBP)—in Montana and Oregon—have been established, and North Carolina has attempted to implement payment limits for hospitals, supplanting the rates that their third-party administrators (TPAs) have negotiated with hospitals and other providers. However, none of the states are making pricing information available on a publicly identified, facility basis, as a few APCDs do. In short, these SEHBPs have direct incentives to control their own health care spending and use their own clout, as a government purchaser with substantial numbers of employees, to set payment caps.¹⁴⁶ By setting payment caps, state employee benefit plans can both target outlier providers that have negotiated the highest rates with private payers while producing modest savings for the state.

As one of the largest health care purchasers in any state, public employee plans wield more negotiating power than they have used. The public employee plans in Montana, Oregon, and North Carolina represent about 7, 15, and 16 percent of the employer-sponsored insurance state population, respectively.¹⁴⁷ Currently, states typically contract with TPAs to manage the public employees plan. Although some insurers and TPAs may have even more covered individuals than state employee plans, they lack strong incentives to aggressively negotiate with hospitals over price because they do not face effective competition themselves. Although evidence demonstrates that while dominant insurers have market power to negotiate somewhat lower rates in contracts with hospitals, when those same entities act as TPAs providing administrative services rather assuming insurance risk, they lack incentives to do so. Even when functioning as risk-bearing insurers, they have no need to pass through savings from negotiating for lower prices to the employers who contract for them. In short, dominant insurers that act as TPAs do not need to negotiate low rates, just rates more favorable than their competitors obtain (Dafny 2015; Dafny, Gruber, and Ody 2014; Dafny and Ramanarayanan 2012).

On the other hand, several factors support SEHBP initiatives to cap payment rates to hospitals and possibly physicians. In contrast to the situation with TPAs, self-funded public employee plans would directly retain any savings from applying claims-based upper limits on directly negotiated rates for hospitals and health professionals. SEHBPs also represent a substantial book of business for providers. In addition, providers may feel it is particularly prudent to serve SEHBP members to avoid a public relations “black-eye,” if they did not agree to serve public employees. Further, SEHBPs maintain anonymity of providers, which may improve the plans’ ability to implement rate limits, but it sacrifices the desired transparency of informing the public. Overall, states have significant incentives for limiting SEHBP payment rates, including to significantly reduce payments to outliers. Nevertheless, some hospitals may retain market power to resist state attempts to limit rates, and hospitals as a powerful interest group may have political power to resist such efforts by SEHBPs. We review the experience in the three states that have tried to impose such upper price limits.

How Do SEHBPs Determine the Price Limits?

Provider price variation across and within states demonstrates the need for tailored approaches. Montana, North Carolina, and Oregon have set or attempted to set different limits for inpatient and outpatient services, by using internal claims-based data to identify what they believe are reasonable rates that would generate savings, yet do not create a major backlash from most hospitals.

They have chosen to set payment ceilings for inpatient and outpatient hospital services—and, in North Carolina, physician services—as a percentage above the commonly used Medicare yardstick.¹⁴⁸ By setting ceilings as a fairly high percentage above Medicare but below the current payment mean (which also happens to be above the negotiated rates agreed to by many hospitals) the state-applied ceilings disproportionately affect a subset of particularly high-priced providers, rather than all providers.¹⁴⁹ This empirically based approach, involving publication and analysis of the public employee plan’s own claims experience, adds credibility while presumably reducing opposition from the hospitals whose rates are below the new state plan ceilings.

The three states that have adopted upper limits on average provider payment rates have set their ceilings modestly below the average payment rates negotiated by their TPAs (see table 1). The states appear to set payment ceilings that generate modest savings while directly targeting high-priced outliers, thereby attempting to forestall a general provider backlash to the price limits. Nevertheless, in each case, providers challenged the limits that the states originally proposed. In North Carolina’s case, the state was not successful in securing providers to participate in the plan (see textbox 4).

TABLE 1

State Employee Health Benefit Plan Rates and Proposed Rate Limits

State	Rate limits	Mean			Maximum		
		Inpatient	Outpatient	Professional	Inpatient	Outpatient	Professional
Montana*	234% of Medicare (composite)	259% of Medicare	319% of Medicare	NA	322% of Medicare	611% of Medicare	NA
North Carolina**	196% of Medicare (composite)	158% of Medicare	291% of Medicare	126% of Medicare	318% of Medicare	391% of Medicare	994% of Medicare
Oregon***	200% of Medicare (composite) for in-network 185% of Medicare (composite) for out-of-network	237% of Medicare (inpatient & outpatient combined)		NA	672% of Medicare (inpatient & outpatient combined)		NA

*Bartlett M. Contracted Reference Based Pricing Discussion. 2018.

** This was the final proposal but not implemented. Folwell D, Jones D. Letter of Intent (Letter) to offer provider reimbursement rates based on a percentage of Medicare for health care services provided to members of North Carolina State Health Plan for Teachers and State Employees (Plan). 2018; NC State Health Plan Network Increases Payments to Hospitals and Reopens Sign-Up Period. 2019

*** SB 1067 A Staff Measure Summary: Joint Committee On Ways and Means. 2018.

[https://www.oregon.gov/oha/PEBB/docs/OEBB-PEBB Innovation Workgroup/20181016/IW Attachment 4c-SB106-HB3418 summaries and testimony.pdf](https://www.oregon.gov/oha/PEBB/docs/OEBB-PEBB%20Innovation%20Workgroup/20181016/IW%20Attachment%204c-SB106-HB3418%20summaries%20and%20testimony.pdf).

Whether hospitals and health plans will respond to the rate caps for state employees by shifting costs to other private payers remains unknown because of the recency of their implementation. A body of literature studying hospital responses to restrained Medicare payment updates suggests that in recent years, hospitals have responded primarily by reducing their own costs, rather than shifting the costs to other payers (Cooper et al. 2017; White 2013).¹⁵⁰ Whether a comparable behavioral response to price maximums set by public employee plans would occur is speculative. However, the ceilings the three states have adopted are far above Medicare levels and guided by the state analysis of their current TPA-negotiated rates; again, the payment limits seem focused as much on reducing payments to particularly high-priced hospitals as on achieving substantial savings from all hospitals. Whether other large self-funded purchasers, either directly or via TPAs, would try to emulate the state plan ceilings by aggressively seeking lower rates for their own employees and covered dependents also remains unknown.

BOX 4

Example of Provider Pushback in North Carolina

In North Carolina, the state treasurer proposed a resolution in October 2018 to launch a payment strategy that would provide transparency into hospital pricing practices and address price variation for the State Health Plan. The State Health Plan found that it was paying up to three times Medicare for inpatient services, as much as eight times Medicare for outpatient services, and up to nine times Medicare for physician services. The treasurer originally proposed to set inpatient rates at 155 percent of Medicare, outpatient rates at 200 percent of Medicare, and professional rates at 160 percent of Medicare, with higher amounts for critical-access hospitals. The treasurer estimated these limits would generate approximately \$300 million in savings to the plan and about \$216 per year per beneficiary.

Provider attempts to stymie the proposal resulted in the state raising the proposed limits. To slow the plan's momentum, the state House of Representatives passed a bill to create a committee to study and release a report on approaches to address costs for the State Health Plan. Further, the affected hospitals engaged in an aggressive public relations campaign to oppose the proposed action.

In the face of the hospital pushback, the treasurer agreed to increase the average inpatient and outpatient rate to 196 percent of Medicare to encourage participation, but still below the current average rates paid by the state. Ultimately, only some providers, including one major hospital system, agreed to the arrangement by the state's established deadline. The state allowed providers that failed to sign up to keep their existing arrangements for 2020 to ensure state employees did not face access issues. Therefore, the State Health Plan could not reduce premiums for state employees for 2020, a central goal of the plan. However, the State Health Plan plans to continue its efforts to set rate limits, seeking to highlight providers that seek transparent contracting and attempting to acquire lower rates next year.

Sources: State Health Plan Clear Pricing Project. NC State Health Plan. <https://www.shpnc.org/state-health-plan-clear-pricing-project/>; Folwell D, Jones D. Letter of Intent (Letter) to offer provider reimbursement rates based on a percentage of Medicare for health care services provided to members of North Carolina State Health Plan for Teachers and State Employees (Plan). 2018.; Hoban R. Treasurer moves forward with health care pricing plan despite uncertainty. North Carolina Health News. <https://www.northcarolinahealthnews.org/2019/05/17/folwell-state-health-plan-pricing-changes-uncertainty/>. Published 2019.; House Bill 184 2019-2020 Session - North Carolina General Assembly. [https://www.ncleg.gov/BillLookUp/2019/HB 184](https://www.ncleg.gov/BillLookUp/2019/HB%20184).; Roberts J. UNC Health says payment to dark money group was a mistake. The Locker Room. <https://lockerroom.johnlocke.org/2019/06/25/unc-health-says-payment-to-dark-money-group-was-a-mistake/>. Published 2019.; Stoogenke J. Atrium, Novant will be in network for state health plan members next year. <https://www.wsocvtv.com/news/action-9/more-than-700-000-people-caught-in-middle-of-state-health-plan-fight/971617634>. Published 2019.; <https://nsjonline.com/article/2019/08/hybrid-deal-brings-state-health-plan-fight-to-an-end/>; Dillion A. "Hybrid deal brings State Health Plan fight to an end." *North State Journal*. 2019. <https://nsjonline.com/article/2019/08/hybrid-deal-brings-state-health-plan-fight-to-an-end/>; Havlak J. "Hospitals force Folwell to back off State Health Plan reforms." *Carolina Journal*. 2019. <https://www.carolinajournal.com/news-article/hospitals-force-folwell-to-back-off-state-health-plan-reforms/>; 2020 Open Enrollment Decision Guide. *North Carolina State Health Plan*. 2019. <https://files.nc.gov/ncshp/documents/open-enrollment-documents/2020/DecisionGuides/SHP302-Active.pdf>

Conclusion

As prudent purchasers, state-run public employee plans have the opportunity to reduce spending of public funds by establishing state-specific upper payment ceilings on hospital and, possibly, physician payment rates. Policymakers can speculate on whether setting price limits for public employee plans would produce cost-shifting to other employers or, alternatively, serve as a guidepost that might lead other payers to emulate these ceilings within their own book of business. Researchers should examine these natural experiments in coming years to gauge the impact not only on the costs of the public employee plans but on the spillover effect on other payment rates in the private insurance sector.

Oregon has established a firm intent to start with price ceilings for public employees but to shortly follow with overall price ceilings on all rates negotiated between hospitals and health plans to avoid the possibility of cost-shifting and to save money throughout the health care system. (see section, Hospital Rate Setting below). Although setting an upper limit on average rates seems operationally straightforward, calculating the average payments across a myriad of services and payments to assure compliance is not. Starting with the captive data that public plans have as a self-funded employer seems a logical way to get into this form of price regulation. It is also not clear why the states would not identify the rates they are paying hospitals, and potentially physicians, as APCDs do.

Hospital Rate Setting

States are not limited to capping provider rates in their SEHBPs. As sovereign entities, they can directly set provider payment rates, not only for Medicaid and other state-directed programs but for private insurers' payments to providers. In 1995, in *Blue Cross & Blue Shield v. Travelers Insurance Co.*, the Supreme Court found that ERISA does not expressly preempt state laws that govern health care providers and only incidentally effect ERISA plans (Jordan 1996). That decision gives Maryland—and potentially other states—the power to limit commercial insurer payments to providers and establish all-payer rates or global budgets for health care spending throughout the state.

State hospital rate setting initially took off in the early 1970s. By 1980, at least 27 states had implemented programs to review or directly regulate hospital rates. However, of the 27, only 7 states, mostly in the Northeast, directly regulated the rates that private insurers would pay hospitals (Murray and Berenson 2015). With the exception of West Virginia's program, the other state programs that actually regulated rates were "all-payer," meaning they included all private insurance hospital payments, payments from individuals paying out of pocket, Medicaid, and Medicare. Including Medicare

in a state-based, all-payer program requires a federal waiver permitting the state to replace national Medicare payment rules and payment amounts with its own, as part of a broader regulatory approach.

The performance of hospital rate setting was mixed. Overall, states that implemented all-payer rate setting had a reasonably strong record of cost control in their initial years but ultimately failed and were dismantled for various reasons, including administrative complexity, regulatory capture by the hospitals subject to the rate setting, and growing political opposition by various stakeholders—all of this taking place at a time when the Reagan Administration, initially, and diverse policymakers, increasingly, advocated marketplace solutions to contain health care costs. The prospect of competition among rapidly growing health maintenance organizations was seen as one potentially successful deregulatory alternative to hospital rate setting.¹⁵¹ By the late 1990s, five of the seven states had abolished their rate-setting systems, all except for Maryland and West Virginia.¹⁵² The state legislature terminated the West Virginia program in 2016.¹⁵³

New Approaches to Hospital Rate Setting

Given the checkered record of all-payer rate setting and persisting opposition from hospitals and other stakeholders outside of Maryland, state policymakers in recent years have explored approaches to limiting private-sector provider payment rates that involve much less regulatory infrastructure, rather than regulating hospital rates for all payers. The two most commonly considered, less intrusive approaches include limiting annual price updates (while leaving base rates alone) and placing a ceiling—an upper dollar limit—on how much a negotiated rate can exceed Medicare payment amounts for the same services. The latter approach would resemble the payment rate ceilings used by the three states above for their SEHBPs but broaden it out to the commercial market. To date, both approaches are mostly in the discussion stage, and both also generate significant opposition from hospitals. Further, even though they are conceptually much simpler to operationalize than actually setting rates or establishing and adjusting budgets, as Maryland now does (see below), both of these approaches require some level of state oversight to assure technical compliance with the pricing limits being imposed.

Under the first approach, a state authority would establish update percentages or absolute dollar amounts that would be added each year to current base rates that hospitals have negotiated for both inpatient and outpatient services. Most of these proposals would establish a common update factor applicable to private insurance payment rates, (e.g., 2 percent), similar to how Medicare increases hospital payments annually, for all hospitals in the state.¹⁵⁴ States may choose to reflect annual payment

rate updates that Medicare provides by statute and regulations in their decisions to set update factors for hospitals in the commercial sector.

Hospitals could be tiered into categories based on relative costliness in their commercial rates for comparable patients, generating differential updates based on which tier they were in. Over time hospital price variations would decrease, as the relatively low-priced hospitals received greater updates than the higher-priced tiers. In 2017, Massachusetts Governor Baker proposed to assign hospitals into three tiers, given differential rate updates, in an effort to address the observed substantial baseline price variations displayed by large, relatively highly paid health care systems and low-paid community hospitals. Under Governor Baker's proposal, the state would not place a cap on the lowest-price providers' rate increase (tier 1); limit the rate increase of moderate-price providers to less than one percent (tier 2); and prohibit any rate increases by high price providers (tier 3) (Executive Office 2017).¹⁵⁵ The legislature considered the proposal but faced opposition from the most negatively affected hospital systems, resulting in a legislative stalemate.

A more sophisticated approach—likely requiring a government infrastructure—would provide for exceptions. For example, safety net hospitals and rural hospitals might be provided a minimum update guarantee because these hospitals typically lack leverage in their negotiations and might not do well relying on market negotiations to determine their updates.

Under the second approach—setting a ceiling on negotiated rates as a percentage above Medicare—states would adopt state-specific provider rate limits appropriate to the prevailing market characteristics and the existing levels of commercial rates in relation to the Medicare yardstick, rather than accepting a national limit. In one recent study, 2017 average aggregated inpatient and outpatient rates in Michigan were 156 percent of Medicare, whereas they were 311 percent in Indiana (White and Whaley 2019). Presumably, Indiana's upper limits would be higher initially and be lowered over a more extended time period than Michigan's.

The lower the ceiling, the more hospitals it would affect, producing more system savings but commensurately raising concerns about disruption in hospital services and hospital employment when revenue shortfalls inevitably occur. Hospitals that have received generous private insurance payments over many years have built capacity that now requires continued generous payments to support. To mitigate immediate disruptions in care and employment, payment ceilings could be gradually reduced in stages to permit time for high-cost hospitals to adjust.

As we noted earlier, there can be substantial savings from setting a payment ceiling. In an analysis of payment variation in Colorado, the Center for Improving Value in Health Care (CIVHC) calculated that

commercial payers could save \$49 million if they standardized their rates to the commercial state median or \$178 million if standardized to 150 percent of Medicare (CIVHC 2018).

States could also take into account that the hospitals most likely to be affected by ceilings on negotiated rates may have substantial sources of revenues other than through services provided, especially investment income and contributions. As noted in the introduction, some major health care systems have accumulated invested reserves in the billions of dollars,¹⁵⁶—available to cushion the transition to lower rates produced by both ceilings on negotiated rates as a percentage above Medicare and on establishing limits on rate updates.

The State of State-Based Hospital Rate Setting

The historic approach, all-payer rate setting, has the advantages of eliminating the possibility of cost-shifting from relatively low-payment payers to more generous ones and, by extension, reducing economic reasons for the hospitals to favor some patients over others. Because all-payer models apply to all payments (with some exceptions, such as for foreign nationals obtaining care in a US hospital), hospitals can better approximate a realistic budget that can guide their activities, thereby enhancing overall cost control. All-payer rate-setting systems improve payment equity and reduce price discrimination, finance uncompensated care, and may help states reduce their Medicaid budgets (Murray and Berenson 2015). Of seven states that regulated payment rates in the 1970s and 1980s, as noted above, all but West Virginia were all-payer.

Maryland is the only surviving program in place today, partly because of its support from the state's hospital community resulting partly from continuation of high payments from Medicare. Under the terms of the initial Medicare waiver in 1977, continued under the 2014 demonstration that allowed the all-payer approach to continue using a modified payment method, Medicare pays Maryland hospitals substantially higher payments, on the order of \$2 billion per year, for Medicare patients than Medicare would have paid on its own (Murray and Berenson 2015). This financial “bonus” helps maintain hospital support for the regulatory program, an advantage unlikely to be extended to other states seeking Medicare demonstration authority to engage in all-payer rate or budget setting. At the same time, Maryland hospitals, long accustomed to the Health Services Cost Review Commission's (HSCRC) role in setting rates, has supported the demonstration's new payment approach to move to global hospital budgets to replace individual service rate setting.

The long-term performance of Maryland's rate-setting approach has been mixed. Maryland successfully reduced the average hospital cost per admission, which was about 25 percent above the

national average in 1977, and 20 years later dropped to about 6 percent below (McDonough 1997). However, by the early 2000s, hospitals had begun to increase admissions, including readmissions, because the system contained only costs per admission and not overall hospital spending. By 2013, Maryland's readmissions rate for the total population was substantially higher than the national average, implying that it would be substantially higher with an apples-to-apples comparison for a Medicare population that included seniors and disabled individuals (Murray and Berenson 2015).

In 2014, Maryland negotiated the new agreement with CMS for all the state's hospitals, replacing Maryland's statutory waiver with a Center for Medicare and Medicaid Innovation (CMMI) demonstration waiver. Partly because of the increase in potentially avoidable hospitalizations that may have been induced by the all-payer price limits, the HSCRC—responsible for administering the program—and state officials recommended to move all Maryland hospitals to global budgets, based to some extent on a successful approach to providing all-payer budgets for 10 relatively isolated rural hospitals.

In theory, global budgets create an incentive for hospitals to constrain overall costs, particularly if the budgets include all payers, by making hospitals responsible for both the costs per case and the volume of cases they serve. CMS and others are conducting formal evaluations of this modified all-payer program in Maryland. As this demonstration has received a lot of attention, readers are referred elsewhere for additional findings from the early experience with the new approach to all-payer hospital payment (Bell et al. 2019; Pines et al. 2019).

While there is inherent appeal in holding hospitals accountable for spending against a budget, many European countries have actually abandoned the use of global budgets for hospitals because of concern that with the assurance of a preset budget, hospitals can become complacent, leading to reduced responsiveness to patients and sometimes leading to queues for elective services. Countries abandoning reliance only on hospital budgeting have emphasized the need for “pay-for-activity” approaches to address the perceived complacency that hospital budgets seem to promote (Busse and Riesberg 2004). The HSCRC is aware of concerns that fixed hospital budgets may lead to complacency and has incorporated a volume adjustment, modifying the budget to reflect unusual or warranted changes in volume (e.g., a bad flu season) while also not adjusting for unnecessary services (Berenson 2015b). The HSCRC's ability to appropriately adjust budgets for changes in volume will be a test of the success of budget setting in an environment in which hospitals still compete for patients.

In summary, hospital budgets provide inherent incentives for cost control and predictable spending, eliminate payment variations that accompany people with different insurance or without insurance, and

reduce administrative complexity associated with claims management. However, without a sophisticated and successful approach to adjusting budgets for patient volume changes, problems can arise from demand shocks, such as a bad flu season, and can reduce incentives to innovate and become attractive sources of care in a still-competitive marketplace.

Two other states adopted all-payer budget approaches similar to that in the Medicare demonstration with Maryland (but without the higher Medicare payment rates that the Maryland demonstration enjoys). Vermont's delivery system reorganization is based around the development of a statewide accountable care organization (ACO) that includes most of the hospitals in the state, making competition among hospitals problematic, as they collaborate as partners in the same ACO; with this form of state-sanctioned consolidation, all-payer rate or budget setting to protect the commercial payers and the public against monopoly market power is a logical approach.

In Pennsylvania, several of the state's rural hospitals are experiencing financial pressures to cut services or close. Global budgets may be more realistic in counties with a single hospital, as the hospital does not face local competition for patients. Successful budgeting programs for rural hospitals should be able to account for out-migration of patients to urban hospitals, a common occurrence. Building on Maryland's experience with 10 relatively isolated rural hospitals, Pennsylvania began a Rural Health Model demonstration with CMMI in 2019. The state is implementing global budgets with at least five rural hospitals that will be paid by all payers (Global Health Payment 2018). The state hopes the hospital global budgets will help the its rural facilities stay afloat with more predictable revenues.

Conclusion

The legacy of all-payer rate setting continues to discourage states from seriously considering reprising those approaches, despite Maryland's continued program and Vermont's and rural Pennsylvania's ventures through Medicare demonstration. States including Oregon and Massachusetts are considering what likely are simpler—but not simple—approaches of focusing on either capping negotiated rates at a percentage of Medicare or limiting the annual payment rate updates for hospitals. These approaches likely would require a much smaller governmental or commission infrastructure than all-payer rate-setting or budget-setting approaches to operationalize to assure compliance, and they would focus price constraints mostly on the highest-priced hospital systems. In essence, these approaches apply brakes on outlier prices while leaving most negotiated rates to market negotiations.

Phasing these approaches in overtime should help avoid the possibility of severe dislocations to patients and staff that could result from prompt movement toward Medicare or Medicare + rates, as

recommended under Medicare for All proposals. States could tailor their approaches to the realities on the ground in their own states, recognizing that some health care systems have engaged in aggressive capital expansion facilitated by the overly generous payment rates their growing market power afforded them. If they have the political will, states can initiate moderate approaches to rate setting that can definitively change the trajectory of health care spending, while avoiding serious dislocations in health delivery and compromising the stability of important health care institutions.

6. Conclusion

As this report details, states have myriad options to address rising health care costs. State legislators and regulators can learn from these examples to implement and refine solutions that address the market conditions and political ideologies specific to their state. Nonetheless, to tailor responses to rising health care expenditures, states need data to understand how market forces like consolidation affect prices in their state. Transparency efforts may foster a more competitive market and allow policymakers to target interventions to underlying market forces in their state. Competition and regulation, once seen as opposing solutions, must work conjointly to ensure high functioning health care markets. Especially in states with highly concentrated provider markets, regulation provides an important tool to stimulate competition and reduce prices.

Consolidation in health care provider markets has continued unchecked for decades, and the states are uniquely poised to address the growing concerns associated with health care prices and lack of competitive markets. State Attorneys General have a broader mandate to oversee mergers and anticompetitive behaviors, especially for non-profit hospitals, and are better positioned than federal antitrust authorities to address stealth consolidation, such as increases in vertical and cross-market mergers. While antitrust enforcement still has an important role to play, the consolidation that has occurred over the last decades has left some markets with no meaningful competition. In these markets, patients and consumers depend on oversight by the government to regulate competition or provide a counterweight to supracompetitive pricing by monopolistic firms. As a result, while states can adapt a multitude options, including those detailed here, they have both the opportunity and the obligation to act to address the ever-growing burden of health care prices.

Notes

- ¹ Centers for Medicare and Medicaid Services, National Health Expenditure Accounts, Historical NHE tables, 2019.
- ² Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; long-term acute care; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries. See “Fast Facts on U.S. Hospitals, 2019,” American Hospital Association, accessed November 21, 2019, <https://www.aha.org/statistics/fast-facts-us-hospitals#community>.
- ³ Alanna Moriarty, “How Many Hospitals Are in the US?” Definitive Healthcare blog, February 27, 2019, <https://blog.definitivehc.com/how-many-hospitals-are-in-the-us>.
- ⁴ Scott Allen and Marcella Bombardieri, “A Handshake That Made Healthcare History,” *Boston Globe*, December 28, 2008, <https://www.bostonglobe.com/specials/2008/12/28/handshake-that-made-healthcare-history/QiWbywqb8olJsA3IZ11o1H/story.html>; and Thomas Greaney, “New Health Care Symposium: Dubious Health Care Merger Justifications—the Sumo Wrestler and ‘Government Made Me Do It’ Defenses,” Health Affairs blog, February 24, 2016, <https://www.healthaffairs.org/doi/10.1377/hblog20160224.053297/full/>.
- ⁵ “2017 Health Care Cost and Utilization Report,” Health Care Cost Institute, February 11, 2019, <https://www.healthcostinstitute.org/research/annual-reports/entry/2017-health-care-cost-and-utilization-report>.
- ⁶ Alex Kacik, “Price Hikes, Upcoding Drive Massachusetts Inpatient Spending,” *Modern Healthcare*, September 12, 2019, <https://www.modernhealthcare.com/operations/price-hikes-upcoding-drive-massachusetts-inpatient-spending>.
- ⁷ Harris Meyer, “Why Does the US Spend So Much More on Healthcare? It’s the Prices,” *ModernHealthcare*, April 7, 2018, <https://www.modernhealthcare.com/article/20180407/NEWS/180409939/why-does-the-u-s-spend-so-much-more-on-healthcare-it-s-the-prices>; Kacik, “Steady Executive Pay Hikes Eclipse Cost-Containment Concerns,” *Modern Healthcare*, August 4, 2018, <https://www.modernhealthcare.com/article/20180804/NEWS/180809985/steady-executive-pay-hikes-eclipse-cost-containment-concerns>.
- ⁸ Aggregate average operating margin is effectively a weighted average, where hospitals with larger denominators have more influence over the resulting measure. MedPAC uses the aggregate average margin while others use the median or a simple average, not accounting for differences in the size of the denominator.
- ⁹ Nancy Kane, Adjunct Professor of Management, Department of Health Policy and Management, Harvard T.H. Chan School of Public Health, personal communication, October 3, 2019.
- ¹⁰ *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).
- ¹¹ Mergers between hospitals.
- ¹² Where hospitals either own the physician practices or employ physicians directly.
- ¹³ 29 U.S.C. § 1144(a) (2012).
- ¹⁴ ERISA § 514(a) (2012); 29 U.S.C. § 1144(a) (2012).

- ¹⁵ *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997); *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995); *Carpenters Local Union No. 26 v. U.S. Fid. & Guar. Co.*, 215 F.3d 136, 140 (1st Cir. 2000).
- ¹⁶ *Pharm. Care Mgmt. Ass'n v. Gerhart* 852 F.3d 722, 728 (8th Cir. 2017) (quoting *Gobeille v. Liberty Mut. Ins. Co.*, 136 S.Ct. 936, 943 (2016)).
- ¹⁷ *PCMA v. Gerhart*, 852 F.3d 728 (8th Cir. 2017).
- ¹⁸ ERISA § 514(b)(2)(A); 29 U.S.C. § 1144(b)(2)(A); *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329, 338-39 (2003).
- ¹⁹ “2017 Employer Health Benefits Survey, Section 10: Plan Funding,” Kaiser Family Foundation, accessed November 22, 2019, <https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/>.
- ²⁰ L.D. 1504, 129th Maine Leg., (Me. 2019).
- ²¹ *PCMA v. Gerhardt*, 852 F.3d 722 (8th Cir. 2017); *PCMA v. Rutledge*, 891 F.3d 1109 (8th Cir. 2018).
- ²² *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-16 (1997); *Travelers*, 514 U.S. at 658-59; *Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 191 (4th Cir. 2007) (citing *DeBuono* and *Travelers* to conclude, “States continue to enjoy wide latitude to regulate healthcare providers”).
- ²³ *Gobeille v. Liberty Mut. Ins. Co.*, 136 S.Ct. 936 (2016).
- ²⁴ Lower Health Care Costs Act, S. 1895 116th Cong. (2019).
- ²⁵ See Assem. Bill 1611 2019-2020 Reg. Sess. (Cal. 2019) (Amended June 27, 2019) and S.P. 466, L.D. . 1504, 129th Leg., 1st Reg. Sess. (Maine 2019).
- ²⁶ Assem. Bill 1611 2019-2020 Reg. Sess. (Cal. 2019) (Amended June 27, 2019).
- ²⁷ Assem. Bill 1611 2019-2020 Reg. Sess. (Cal. 2019) (Amended June 27, 2019).
- ²⁸ Cal. Health & Safety Code § 1367.49(a)-(b) (ability of healthcare service plan to furnish information to subscribers or enrollees concerning cost range of procedures or quality of services at hospital or facility; contractual provisions; statement posted on Internet website); Cal. Health & Safety Code § 1367.50 (defining a “qualified entity,” pursuant to 42 USC 1395kk, as a public or private entity “that is qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use”). To be certified as a qualified entity, an organization— “either a single public or private entity, or a lead entity and its contractors”—must submit to CMS an application package that includes information demonstrating that the applicant will satisfy the requirements specified in 42 CFR § 401G (401.700–.721), as well as other criteria determined by CMS.
- ²⁹ “Compare Health Costs and Quality of Care in New Hampshire,” New Hampshire Insurance Department, accessed November 22, 2019, <https://nhhealthcost.nh.gov/>. See also the website for CompareMaine at <https://www.comparemaine.org/>.
- ³⁰ See the website for the APCD Council at <https://www.apcdouncil.org/>.
- ³¹ States with active, mandatory APCDs are Arkansas, Colorado, Connecticut, Delaware, Florida, Hawaii, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. States in the process of studying or implementing APCDs are Alaska, California, Idaho, North Carolina, New Jersey, New Mexico, Montana, Tennessee, Pennsylvania, West Virginia, and Wyoming.
- ³² “Compare Health Costs and Quality of Care in New Hampshire,” New Hampshire Insurance Department, accessed November 22, 2019, <https://nhhealthcost.nh.gov/>.

- ³³ Shoppable services” as those that can be scheduled in advance, as those that many patients find interchangeable, like laboratory tests. See [Medicare Program: Proposed Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs](#), 84 Fed. Reg. 39398 (August 9, 2019) (requiring hospitals to list prices for 300 shoppable services). See also Chernew et al. (2018).
- ³⁴ Josh Archambault and Nic Horton, “Right to Shop: The Next Big Thing In Health Care,” *Forbes*, August 5, 2016, <https://www.forbes.com/sites/theapothecary/2016/08/05/right-to-shop-the-next-big-thing-in-health-care/#31bda24b4f60>.
- ³⁵ See e.g. Utah Ann. Code §31A-22-647 (2018); Sec. 1.22 MRSA §1718-B, sub-§2 (2017). See also Julie Appleby, “Need a Medical Procedure? Pick the Right Provider and Get Cash Back,” *Kaiser Health News*, March 5, 2018, <https://khn.org/news/need-a-medical-procedure-pick-the-right-provider-and-get-cash-back/>.
- ³⁶ Archambault and Horton, “Right to Shop.”
- ³⁷ Archambault and Horton, “Right to Shop.”
- ³⁸ Utah Ann. Code §31A-22-647 (2018); Tenn. Code Ann. 56-7-3501 et seq.(2019), Neb. Rev. Stat. §44-1402 et seq., 627.6387, 627.6648, and 641.31076 Fla. Stat. Ann (2019) Va. Code Ann. § 38.2.3461-38.2.3464 (2019), and 22 MRSA §1718-B, sub-§2 (2017).
- ³⁹ Archambault and Horton, “Right to Shop.”
- ⁴⁰ But see Chernew et al. (2018) (finding that patients did not use consumer transparency shopping tools for one of the most shoppable services, the MRI, instead they relied on physician referral).
- ⁴¹ In this instance, CIVHC calculated the total expense if all providers were paid the median rate for each service, such that prices on the low end would increase to the median and prices on the high end would decrease to the median.
- ⁴² In this instance, CIVHC calculated the total expense if all providers were paid the median rate for each service, such that prices on the low end would increase to the median and prices on the high end would decrease to the median.
- ⁴³ “2017 Employer Health Benefits Survey, Section 10: Plan Funding,” Kaiser Family Foundation, accessed November 22, 2019, <https://www.kff.org/report-section/ehbs-2017-section-10-plan-funding/>.
- ⁴⁴ Lower Health Care Costs Act, S. 1895 116th Cong. (2019) .
- ⁴⁵ Lower Health Care Costs Act, S. 1895 116th Cong. (2019) § 303 (h).
- ⁴⁶ Exec. Order No. 13,877, 84 F.R. 30849 (2019).
- ⁴⁷ See, Final Rule 45 CFR 180.20. The American Hospital Association expressed opposition to the proposed rule and said that they have “been working to overturn this rule through legal action and by working with the Congress.” See Rick Pollack, “AHA Statement on Proposed CY 2020 Opps Rule,” Press Release, American Hospital Association, July 29, 2019, <https://www.aha.org/press-releases/2019-07-29-aha-statement-proposed-cy-2020-oppo-rule>.
- ⁴⁸ *O’Grady v. Superior Court*, 139 Cal. App. 4th 1423 (Cal. Ct. App. 2006) at 1475–76.
- ⁴⁹ US Dept. of Justice (DOJ) and Federal Trade Commission (FTC), *Statements of Antitrust Enforcement Policy in Health Care*, August 1996, 50.
- ⁵⁰ Sherman Antitrust Act, 15 U.S.C. §1-7.
- ⁵¹ Clayton Antitrust Act, 15 U.S.C. §12-27.
- ⁵² Federal Trade Commission Act, 15 U.S.C. §41-58.

- ⁵³ 15 U.S.C. §1.
- ⁵⁴ 15 U.S.C. §2.
- ⁵⁵ 15 U.S.C. §18.
- ⁵⁶ 15 U.S.C. §45(a)(1).
- ⁵⁷ While both agencies maintain the authority to review both insurance and provider mergers, the agencies have typically divided merger review in this manner.
- ⁵⁸ FTC Act §5 (15 U.S.C.A. § 44). The FTC Act only covers corporations “organized to carry on business for its own profit or that of its members.
- ⁵⁹ See Committee on the Office of Attorney General (1975) (discussing a wide array of powers including *parens patriae* and charitable trusts) and Varanini (2017, 8).
- ⁶⁰ Premerger Notification Office Staff, “HSR Threshold Adjustments and Reportability for 2019,” *Competition Matters* (blog), March 7, 2019, <https://www.ftc.gov/news-events/blogs/competition-matters/2019/03/hsr-threshold-adjustments-reportability-2019> (set at \$90 million in 2019).
- ⁶¹ “Enforcement: Federal,” The Source on Healthcare Price and Competition, accessed November 21, 2019, <https://sourceonhealthcare.org/federal/>.
- ⁶² The most famous structural remedy resulted in the breakup of AT&T’s monopolistic Bell System into the “Baby Bells,” including Bell South, Atlantic Bell, and NYNEX.
- ⁶³ “Guide to Antitrust Laws: Mergers,” Federal Trade Commission, accessed November 22, 2019, <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers>.
- ⁶⁴ “Divesting Highland Park after seven years of integration would be a complex, lengthy, and expensive process” (Majoras, n.d., 90).
- ⁶⁵ See also Atrium health care settlement that prohibits the enforcement of antisteering provisions.
- ⁶⁶ Alex Kacik, “Beth Israel Deaconess and Lahey Health Complete Merger,” *Modern Healthcare*, March 1, 2019 <https://www.modernhealthcare.com/mergers-acquisitions/beth-israel-deaconess-and-lahey-health-complete-merger>; Alec Kacik, “Beth Israel-Lahey Health Merger Clears Final Approval with Conditions,” *Modern Healthcare*, November 29, 2018, <https://www.modernhealthcare.com/article/20181129/NEWS/181129916/beth-israel-lahey-health-merger-clears-final-approval-with-conditions>; Office of Attorney General Maura Healey, “AG Healey Reaches Settlement With Beth Israel, Lahey Health Over Proposed Merger,” press release, November 29, 2018, <https://www.mass.gov/news/ag-healey-reaches-settlement-with-beth-israel-lahey-health-over-proposed-merger>; Ober Kaler, “Recent State Attorney General Merger Enforcement: Charting a Different Path from the Feds—or Not?” *Lexology*, October 29, 2014, <https://www.lexology.com/library/detail.aspx?g=a2b2048f-475b-468f-9224-96d6e5dcef32>.
- ⁶⁷ Commonwealth Attorneys Act. P.L. 950, No. 164 (PA 1980).
- ⁶⁸ See “Fast Facts on U.S. Hospitals, 2019,” American Hospital Association, accessed November 21, 2019, <https://www.aha.org/statistics/fast-facts-us-hospitals#community>. Showing that in 2017, 56 percent of nonfederal short-term general, and other specialty hospitals in the US were nonprofit.
- ⁶⁹ For an in-depth discussion of the Massachusetts Health Policy Commission, see the subsection on State Commissions.
- ⁷⁰ See “Reports on Health Care Cost Trends and Cost Drivers,” *Mass.gov*, accessed November 22, 2019, <https://www.mass.gov/lists/reports-on-health-care-cost-trends-and-cost-drivers>.

- ⁷¹ Learn about the Attorney General’s Health Care and Fair Competition Bureau,” Mass.gov., accessed November 22, 2019, <https://www.mass.gov/service-details/learn-about-the-attorney-generals-health-care-and-fair-competition-bureau>.
- ⁷² Alex Kacik, “Beth Israel Deaconess and Lahey Health Complete Merger,” Modern Healthcare, March 1, 2019 <https://www.modernhealthcare.com/mergers-acquisitions/beth-israel-deaconess-and-lahey-health-complete-merger>; Alec Kacik, “Beth Israel-Lahey Health Merger Clears Final Approval with Conditions,” Modern Healthcare, November 29, 2018, <https://www.modernhealthcare.com/article/20181129/NEWS/181129916/beth-israel-lahey-health-merger-clears-final-approval-with-conditions>; Office of Attorney General Maura Healey, “AG Healey Reaches Settlement With Beth Israel, Lahey Health Over Proposed Merger,” press release, November 29, 2018, <https://www.mass.gov/news/ag-healey-reaches-settlement-with-beth-israel-lahey-health-over-proposed-merger>;
- ⁷³ Clayton Antitrust Act, 15 U.S.C. §18 (2019).
- ⁷⁴ Federal Trade Commission. 2017. “St. Luke’s Health System, Ltd, and Saltzer Medical Group, P.A.,” <https://www.ftc.gov/enforcement/cases-proceedings/121-0069/st-lukes-health-system-ltd-saltzer-medical-group-pa>.
- ⁷⁵ US Department of Justice, Office of Public Affairs, “U.S. District Court Blocks Aetna’s Acquisition of Humana: Merger Would Harm Seniors Relying on Medicare Advantage and Low-Income Families and Individuals Obtaining Insurance on Public Exchanges,” news release, January 23, 2017, <https://www.justice.gov/opa/pr/us-district-court-blocks-aetna-s-acquisition-humana>.
- ⁷⁶ Premerger Notification Office Staff, “HSR Threshold.”
- ⁷⁷ Premerger Notification Office Staff, “Resetting Our Views on HSR Items 4(c) and 4(d),” *Competition Matters* (blog), November 28, 2016, https://www.ftc.gov/news-events/blogs/competition-matters/2016/11/resetting-our-views-hsr-items-4c-4d?utm_source=govdelivery.
- ⁷⁸ Clayton Act, §§ 4C(a)(1), 16 as amended 15 U.S.C.A. §§ 15c(a)(1), 26.
- ⁷⁹ This notice enables the Charities Division to review the proposed merger to determine whether the postmerger entity will continue to use the assets of the nonprofit organization in accordance with its stated charitable purpose.
- ⁸⁰ See American Health Lawyers Association, Antitrust Practice Group Spotlight Interview Series, Questions for Kathleen Foote, Senior Assistant Attorney General at the California Department of Justice at 2 (2016).
- ⁸¹ Conn. Pub. Act. 14-168 (2019).
- ⁸² Washington, Substitute House Bill 1607, 66th Leg. 2019 Reg. Sess.
- ⁸³ Researchers at UC Hastings and the Petris Center at UC Berkeley have already begun a project funded by Arnold Ventures that examines the impact of different forms of state notification and merger review on insurance premiums and health care concentration.
- ⁸⁴ A typical vertical merger involves the acquisition of another entity in a supply chain by another entity in the same supply chain. In the health care context, scholars often refer to a hospital acquisition of a physician group as a vertical merger. In some ways, the analogy of a hospital acquiring a physician group is a strained example of a vertical merger, as providers are not always directly linked to the hospital in terms of supplying patients. This strain has caused some legal scholars, including William Sage, to refer to these mergers as “diagonal mergers”. However, we will refer to them as vertical to preserve the language used by the majority of the health care antitrust community.

- ⁸⁵ In a cross-market merger, two entities merge that are not direct competitors, nor do they operate in the same geographic supply chain. So for instance, a hospital system in northern California acquiring a hospital in southern California would constitute a cross-market merger. See Vistnes and Sarafides (2013) and Argue and Stein (2015).
- ⁸⁶ In 2012, the FTC's first challenge to the acquisition of physician groups by a health system occurred when the largest hospital system in metropolitan Reno, Nevada acquired two cardiology physician groups. While this merger involved the acquisition of physicians by a large hospital system, the FTC challenged the merger on horizontal grounds because the merged entity employed 88 percent of the active cardiologists in the area. The consent decree negotiated in this case prohibited the merged entity from enforcing anti-compete provisions of any contracts with cardiologists. <https://www.ftc.gov/enforcement/cases-proceedings/1110101/renown-health-matter>; <https://www.ftc.gov/sites/default/files/documents/cases/2012/12/121204renownhealthdo.pdf>;
- ⁸⁷ *Pennsylvania v. Providence Health Sys., Inc.*, No. 4:CV-94-772, 1994 WL 374424 (M.D. Pa. May 26, 1994).
- ⁸⁸ *Wisconsin v. Kenosha Hosp. & Med. Ctr.*, No. 96-C-1459, 1996 WL 784584 (E.D. Wis. Dec. 31, 1996).
- ⁸⁹ Office of the Attorney General, "A.G. Schneiderman Announces Settlement with Utica Hospitals to Address Competitive Concerns," news release.
- ⁹⁰ Office of the Attorney General, "A.G. Schneiderman Announces Settlement." Kacik, "Beth Israel-Lahey Health Merger Clears Final Approval"; Kacik, "Beth Israel Deaconess and Lahey Health Complete Merger."
- ⁹¹ Merrick B. Garland. 1986. "Antitrust and State Action: Economic Efficiency and the Political Process, Yale L. J. 96: 486-519, 488.
- ⁹² *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 100 S. Ct. 937, (1980).
- ⁹³ In Re: Cabell Huntington Hospital, Inc., Cooperative Agreement No.16-2/3-001: Decision. <http://hca.wv.gov/About/Documents/Decision.pdf>.
- ⁹⁴ "Certificate of Public Advantage (Tennessee) & Cooperative Agreement (Virginia)," Ballad Health, accessed November 22, 2019, <https://www.balladhealth.org/copa>.
- ⁹⁵ "FTC Staff Notice of COPA Assessment: Request for Empirical Research and Public Comments," Federal Trade Commission, last updated March 27, 2019, https://www.ftc.gov/system/files/attachments/press-releases/ftc-staff-seeks-empirical-research-public-comments-regarding-impact-certificates-public-advantage/copa_assessment_public_notice_11-1-17_revised_3-27-19.pdf.
- ⁹⁶ "A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets," Federal Trade Commission, November 22, 2019, <https://www.ftc.gov/news-events/events-calendar/health-check-copas-assessing-impact-certificates-public-advantage>; Tara Bannow, "FTC Hears Concerns about Ballad Health Merger," *Modern Healthcare*, June 18, 2019, <https://www.modernhealthcare.com/mergers-acquisitions/ftc-hears-concerns-about-ballad-health-merger>.
- ⁹⁷ See e.g., W. Va. Code §16-29B-28(c) (requiring that the board consider evidence that a consolidation will improve quality of care, ensure the affordability of care, increase patient access to providers, enable consolidating parties to achieve cost savings, and improve the health status of the community).
- ⁹⁸ See Antitrust Division (2004, 2011). The Department of Justice exemplified this viewpoint in the 2004 Federal Guide to Merger Remedies, stating that the enforcement agencies strongly preferred structural remedies to conduct remedies and highlighting the costs associated with conduct remedies and their potential to restrain pro-competitive behavior. Some observers saw the 2011 guide as friendlier to conduct remedies, which stated that they can be useful in the case of vertical mergers.
- ⁹⁹ Sherman Antitrust Act, 15 U.S.C. §1-2 (2019).

- ¹⁰⁰ Cartwright Act, Ca. Bus. & Prof. Code §16720 et seq.
- ¹⁰¹ See “Hospitals by Ownership Type,” Kaiser Family Foundation, accessed November 22, 2019, <https://www.kff.org/other/state-indicator/hospitals-by-ownership/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> (citing data from 2017 and estimating the nonprofit hospital percentage to be 54.6 percent); and “Fast Facts on U.S. Hospitals, 2019,” American Hospital Association, accessed November 21, 2019, <https://www.aha.org/statistics/fast-facts-us-hospitals#community> (citing data from fiscal year 2017 and estimating the nonprofit hospital percentage to be close to 48 percent).
- ¹⁰² See Slaughter (2019). Note that the difference in percentages reflects that Commissioner Slaughter examined all hospitals, and we include information on private hospitals only.
- ¹⁰³ Lower Health Care Costs Act, S. 1895 116th Cong. (2019) .
- ¹⁰⁴ Must-have providers include either a hospital or provider group that has monopoly status in a particular area or a hospital or provider group that is required to meet state network adequacy laws, such that an insurer cannot meaningfully construct a network without including those providers.
- ¹⁰⁵ United States v. Blue Cross Blue Shield of Michigan, 809 F. Supp. 2d 665 (E.D. Mich. 2011).
- ¹⁰⁶ US Department of Justice, Office of Public Affairs, “Justice Department Files Motion to Dismiss Antitrust Lawsuit against Blue Cross Blue Shield of Michigan after Michigan Passes Law to Prohibit Health Insurers from Using Most Favored Nation Clauses in Provider Contracts,” news release, March 25, 2013, <https://www.justice.gov/opa/pr/justice-department-files-motion-dismiss-antitrust-lawsuit-against-blue-cross-blue-shield>.
- ¹⁰⁷ Alaska Stat. § 21.07.010 (b)(3); Ark. Code Ann. § 23-99-1204; Conn. Gen. Stat. Ann. § 38a-479b(d); Ga. Comp. R. & Regs. 120-2-20-03; Idaho Code Ann. § 41-3927 and §41-3443; Ind. Code Ann. § 27-8-11-9; Ken. Stat. Ann. § 304.17A-560; Maine Rev. Stat. Ann. 24-A, § 4303(17); Md. Ins. Code Ann. § 15-112 (2009); Mass. Gen. Laws 176D, § 3 and 176O § 9A.; Mich. Comp. Laws Ann. § 500.3405a and § 550.1400; Minn. Stat. § 62A.64; N.H. Rev. Stat. Ann. §417:4; N.J. Admin. Code § 11:24C- 4.3(c)(2) and § 11:24B-5.2(c)(8); N.C. Gen Stat. § 58-50-295; N.D. Cent. Code § 26.1-04-03(19); Ohio Rev. Code Ann. § 3963.11; R.I. Gen. Laws § 23-17.13-2, 3 and § 27-18.8-3 (d)(8); Vt. Stat. Ann. tit. 18, § 9418e; and Wash. Admin. Code 246- 25-045. In addition, New York requires that the Insurance Commissioner review and approve any contract that includes an MFN between a provider and a managed care organization.
- ¹⁰⁸ United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720 (W.D.N.C. 2017).
- ¹⁰⁹ Final Judgement, United States of America and the state of North Carolina v. the Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System , No. 3:16-cv-00311-RJC-DCK (W.D. NC Apr. 24, 2019). <https://www.justice.gov/atr/case-document/file/1157461/download>
- ¹¹⁰ Becerra Complaint, People of the State of California ex rel Xavier Becerra v. Sutter Health., CGC 18-565398 (Cal. Super. Ct. S.F. City and Cnty. 2019).
- ¹¹¹ Complaint, State of Washington v. Franciscan Health System, No. 3:17-cv-05690 (W.D. WA Aug. 31, 2017).
- ¹¹² Complaint, State of California v. Sutter Health, No. CGC-18-565398 (Cal. Super. Ct. S.F. City and Cnty. Mar 20, 2019).
- ¹¹³ Katie Thomas, “Sutter Health to Pay \$575 Million to Settle Antitrust Lawsuit,” New York Times, December 20, 2019, <https://www.nytimes.com/2019/12/20/health/sutter-health-settlement-california.html/>.
- ¹¹⁴ S. 1008 and A. 3047 2018-2019 Leg., Reg. Sess. (N.J. 2018); S.B. 538 2017-2018 Reg. Sess. (Cal. 2018).
- ¹¹⁵ S.B. 538 2017-2018 Reg. Sess. (Cal. 2018).

- ¹¹⁶ See *In re Cipro Cases I & II*, 61 Cal. 4th 116, 348 P.3d 845 (2015) and *Ohio v. Am. Express Co.*, 138 S. Ct. 2274, 201 L. Ed. 2d 678 (2018)
- ¹¹⁷ For instance, in the *Sutter* case discussed above, the judge anticipated that the trial would last 60 to 90 days, and discovery included hundreds of thousands of pages of evidence. *People of the state of California ex rel Xavier Becerra, v. Sutter Health*, 2018 WL 1584066 (Cal.Super.) (author’s note from attending hearing).
- ¹¹⁸ H.B. 19-1004 72nd Gen. Assembl. (Colo. 2019); H.B. 7267, 2019 Gen. Assembl. Jan. Sess. (Conn. 2019); S.F. 2305, 86th Gen. Assembl. (Iowa 2017); H.B. 5733, 98th Gen. Assembl. (Ill. 2014); H.B. 1228, 187th Gen. Ct. (Mass. 2011); S.B. 514 188th Gen. Ct. (Mass. 2013); H.B. 1033 189th Gen. Ct. (Mass. 2015); S.B. 638, 190th Gen. Ct. (Mass. 2017), and S.B. 697, 191st Gen. Ct. (Mass. 2019); H.P. 91, 128th Leg., 2d Reg. Sess. (Me. 2019); H.B. 6285, 2017-2018 Leg. Sess. (Mich. 2018); S.F. 58 90th Leg. Sess. (Minn. 2017); A.B. 4211 217th Leg. Sess. (N.J. 2016); A.B. 1343, 218th Leg. Sess. (N.J. 2018); H.B. 416 54th Leg., 1st Sess. (N.M. 2019); A.B. 374 79th Leg. Sess. (Nev. 2017); S.B. 2019 Reg. Sess. 867 (Or. 2019); H.B. 146 and S.B. 109, 2011-2012 Leg. Reg. Sess. (Vt. 2011); H.B. 88, 2015-2016 Leg. Reg. Sess. (Vt. 2015); H.B. 28 2017-2018 Leg. Reg. Sess. (Vt. 2017); H.B. 1104, S.B. 5222, and S.B. 5526, 66th Leg. 2019 Reg. Sess. (Wash. 2019); S.F. 88, 2018 Budget Sess. (Wyo. 2018).
- ¹¹⁹ H.B. 7267, 2019 Gen. Assembl. Jan. Sess. (Conn. 2019).
- ¹²⁰ S.B. 1004 2019 Gen. Assembl. Sess. (Conn. 2019)
- ¹²¹ H.P. 91, 128th Leg., 2d Reg. Sess. (Me. 2019).
- ¹²² S.B. 5526, 66th Leg. 2019 Reg. Sess. (Wash. 2019).
- ¹²³ S.B. 5526, 66th Leg. 2019 Reg. Sess. (Wash. 2019) §3(h) and §3(i).
- ¹²⁴ S.B. 5526, 66th Leg. 2019 Reg. Sess. (Wash. 2019) §4.
- ¹²⁵ Billy Wynne, “Public Option 1.0: Washington State Takes an Important Step Forward,” Health Affairs blog, May 1, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20190430.353036/full/>.
- ¹²⁶ S.B. 697, 191st Gen. Ct. (Mass. 2019) § 2(a).
- ¹²⁷ Dylan Scott, “Report: Cigna Threatened to Leave Connecticut If It Passed a Public Option,” Vox, May 30, 2019, <https://www.vox.com/policy-and-politics/2019/5/30/18645790/cigna-connecticut-public-option-medicare-for-all>.
- ¹²⁸ “Must have” providers either include a hospital or provider group that has monopoly-status in a particular area or a hospital or provider group that is required to meet state network adequacy laws, such that an insurer cannot meaningfully construct a network without including those providers.
- ¹²⁹ Alex M. Azar II, Steven T. Mnuchin, and Alexander Acosta, “Reforming America’s Healthcare System through Choice and Competition,” press release, December 3, 2018, <https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html>.
- ¹³⁰ See APHA (2016). States continue to repeal or reinstitute CON programs; New Hampshire repealed its program in 2016.
- ¹³¹ Andrew Levine and Crystal Bloom, “DPH Adopts New Determination of Need Regulations,” Barrett and Singal, January 16, 2017, <https://barrettsingal.com/news/dph-adopts-new-determination-of-need-regulations>.
- ¹³² Mass. Gen. Laws ch. 6D, § 2; Del. Code Ann. § 9902. Delaware Health Care Commission.
- ¹³³ For example, the Massachusetts Health Policy Commission is required by statute to include a diverse mix of perspectives, such as a primary care physician, a health plan administrator, a health economist, and a health care consumer advocate. (Mass. Gen. Laws ch. 6D, § 2)

- ¹³⁴ “What Is the Delaware Health Care Commission?” Delaware.gov, accessed November 22, 2019, <https://dhss.delaware.gov/dhcc/about.html>.
- ¹³⁵ The governor or other state leaders (e.g., speaker of the House, attorney general) appoint citizens and public officials with health care expertise and diverse backgrounds as members of the commission. In most cases, legislators do not serve as commission members. Commission statutes usually include requirements for the political composition of the commission to prevent the governor from appointing members of his or her party only. Members also typically serve for a specified number of years but are usually eligible for reappointment.
- ¹³⁶ Although they serve some of the same functions, Oregon, Rhode Island, and Vermont have regulatory authority over hospital rates or budgets and do not have state commissions, but boards or authorities, so we have described their activities elsewhere.
- ¹³⁷ While the Vermont Green Mountain Board does not traditionally meet the definition of a commission because all board members must be state employees, it functions similarly to a commission as an independent board with the charge to promote the general good by overseeing the state’s accountable care organization.
- ¹³⁸ “Search Prices for Common Health Care Services,” Center for Improving Value in Health Care,” accessed November 22, 2019, <https://www.civhc.org/shop-for-care/>.
- ¹³⁹ See the website for the Pennsylvania Health Care Cost Containment Council at <http://www.phc4.org/>.
- ¹⁴⁰ See also Kacik, “Price Hikes, Upcoding.”
- ¹⁴¹ “Health Care Cost Growth Benchmark Program,” Oregon Health Authority, accessed September 19, 2019, <https://www.oregon.gov/oha/HPA/HP/Pages/Health-Care-Cost-Growth-Benchmark-Program.aspx>; Oregon Health Authority, “Oregon Passes Bipartisan Legislation to Slow Rising Cost of Health Care and Increase Transparency for Consumers,” news release, June 19, 2019, <https://www.oregon.gov/oha/ERD/Pages/OregonPassesBipartisanLegislationToSlowRisingCostOfHealthCareAndIncreaseTransparencyForConsumers.aspx>. See also Task Force (2018).
- ¹⁴² “State Approval of Health Insurance Rate Increases,” National Conference of State Legislatures, accessed November 23, 2019, <http://www.ncsl.org/research/health/health-insurance-rate-approval-disapproval.aspx>.
- ¹⁴³ Rhode Island General Law 42-14.5-2 (2019).
- ¹⁴⁴ 230 R.I. Code R. 20-30-4.10.
- ¹⁴⁵ The regulations specified that insurers must increase the percentage of spending on primary care spending to increase by 1 percent annually between 2010 in 2014. As of 2014, the state required health insurers to maintain the 2014 level by spending at least 9.7 percent of their annual medical expenses on direct primary care and at least 1 percent on indirect primary care (for a total of 10.7 percent). R.I. Code R. § 32-1-2:10(b)(1)(A)
- ¹⁴⁶ For states that have trust funds, rising prices threaten plan solvency. This one of the reasons that Montana implemented price ceilings.
- ¹⁴⁷ Montana’s Employee Health Plan includes 31,000 total individuals (Marshall Allen, “A Tough Negotiator Proves Employers Can Bargain Down Health Care Prices,” NPR, October 2, 2018, <https://www.npr.org/sections/health-shots/2018/10/02/652312831/a-tough-negotiator-proves-employers-can-bargain-down-health-care-prices>). Oregon’s Public Employees Benefit Board and Oregon Educators Benefit Board include 140,000 public employees and almost 150,000 state teachers (“OEBB Overview,” Oregon Health Authority, accessed November 23, 2019, <https://www.oregon.gov/oha/OEBB/Pages/Overview.aspx>; “Public Employees’ Benefit Board: About Us,” Oregon Health Authority, accessed November 23, 2019, https://www.oregon.gov/oha/PEBB/Pages/About_Us.aspx). North Carolina’s State Health Plan for Teachers and State Employees includes more than 720,000 teachers, state employees, retirees and their dependents (“Who We Are,” North Carolina State Health Plan for Teachers and State Employees, accessed November 23, 2019,

<https://www.shpnc.org/about-us/who-we-are>). Denominators come from Kaiser Family Foundation, Health Insurance Coverage of the Total Population.

- ¹⁴⁸ The mean rate could be calculated using an aggregate average (or weighted average), accounting for the different shares of the plan's book of business, or a simple mean, averaging relative prices considering each provider contract equally regardless of the share of the plan's enrollee population. The three states do not report their method; we presume that they use the aggregate approach in their calculations of means and projected savings.
- ¹⁴⁹ The aggregate average amount is presumably based on actual spending, which gives more weight to high-volume, high-price hospitals. By setting the rate below this target, the states can target their policy to the high-volume, high-price hospitals and leave most hospitals unaffected.
- ¹⁵⁰ See also Austin Frakt, "Hospitals Are Wrong about Shifting Costs to Private Insurers," *New York Times*, March 23, 2015, <https://www.nytimes.com/2015/03/24/upshot/why-hospitals-are-wrong-about-shifting-costs-to-private-insurers.html>.
- ¹⁵¹ As we noted in the The Empirical Evidence of Market Effects of CON Laws in Chapter 5, Conover and Sloan found that HMO market share was associated with substantially lower hospital bed supply, lower expense per adjusted admission, and lower diffusion of open-heart surgery units (Conover and Sloan 1998; Zwanziger and Melnick 1996).
- ¹⁵² West Virginia adopted a rate-setting approach that applied only to private insurers, in effect establishing ceilings and floors on negotiated payment rates, which could vary across private insurance payers and hospitals.
- ¹⁵³ "Rate Review History," West Virginia Health Care Authority, accessed November 23, 2019, https://hca.wv.gov/ratereview/Pages/RR_History.aspx.
- ¹⁵⁴ Percentage increases advantage high-cost hospitals because the same percentage increase produces absolute dollars. Alternatively, a fixed-dollar update, as Medicare provides to accountable care organizations, would address the challenges with the percentage approach.
- ¹⁵⁵ See also Barbara Anthony, "Governor's Plan to Cap Healthcare Provider Prices Misses the Mark," Pioneer Institute, March 2, 2017, <https://pioneerinstitute.org/news/governors-plan-cap-healthcare-provider-reimbursement-rates-misses-mark/>.
- ¹⁵⁶ Nancy Kane, Retired Professor of Management in the Department of Health Policy and Management, personal communication, October 3, 2019.

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