Bigger, Not Better:

The High Cost of Healthcare Consolidation

February 2021

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I. Introduction

In Oregon, we believe that everyone deserves to be healthy. Guaranteeing access to high-quality, affordable care is key to delivering on this shared vision. Yet despite some progress, the cost of care continues to skyrocket in our state, making healthcare increasingly unaffordable and out-of-reach.

Now COVID-19 is forcing more families, communities and small businesses to cope with job losses or reductions in income. Without action, the burden of higher healthcare premiums, deductibles, copays or other costs will only get worse. These impacts will be felt deeply by Black, Indigenous and People of Color (BIPOC) communities, whose health and economic stability has been disproportionately impacted by the pandemic — and further exacerbate health inequities in our state.

While Oregon is currently pursuing important efforts to control costs, one significant cost driver that has yet to be tackled looms large on the horizon: consolidation. The evidence is clear that consolidation in healthcare leads to higher prices, does not necessarily improve quality, and can lead to reductions in services in underserved areas and even the denial of care for marginalized groups. However, over the last decade, healthcare mergers, acquisitions, and other partnership arrangements have taken place at a rapid clip. Experts predict that COVID will further accelerate this trend, as independent providers continue to suffer losses and become vulnerable to acquisition by large, more financially secure health systems.

Given that federal oversight of these deals is severely lacking, states — including California, Massachusetts and Washington — are taking action on healthcare consolidation. In Oregon, the systems currently in place to address these issues are limited, allowing potentially harmful deals to proceed unchecked. If we care about ensuring health equity and controlling costs for consumers and businesses in our state, we must establish a comprehensive process for examining whether proposed deals match these ideals.

> "The economic collapse sparked by the pandemic is triggering the most unequal recession in modern U.S. history, delivering a mild setback for those at or near the top and a depression-like blow for those at the bottom."
>
> *Washington Post*, The COVID-19 Recession is the Most Unequal in Modern US History, October 2020

II. Oregon Has a Price Problem

In just four short years, the amount Oregonians paid for their healthcare increased nearly 29 percent – faster than the rest of the nation and outpaced inflation at a disturbing rate.[1]

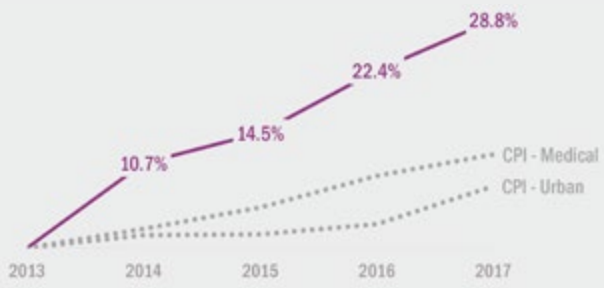
Unaffordable Co-Pays and Deductibles Force Individuals to Go Without Care

Rising prices are forcing a growing number of patients to forgo necessary medical care because they simply cannot afford it. From 2016–2018, Oregon was one of only 15 states in which the percentage of adults who went without care because of cost went up.[2] In addition, though a large share of Oregonians have insurance, more and more individuals are likely becoming "functionally uninsured" – meaning they can't afford to use their coverage because of rising co-pays and deductibles.[3]

Rising Prices Exacerbate Health Inequities

These price increases hit families with the lowest incomes the hardest, as healthcare costs crowd out wages. Now, COVID-19 has made this issue even more urgent, as many have lost work or experienced drastic reductions in income.[4] In a recent national survey, one in four adults reported that their family's financial situation was worse in September 2020 than it was at the beginning of March 2020. However, the financial situations of BIPOC and low-income individuals have become even more precarious: More than one-third of Hispanic adults, nearly 3 in 10 Black adults, and more than 4 in 10 adults with pre-pandemic incomes below the federal poverty level reported that they were worse off financially in September than they were in March.[5] Without action, the burden of higher healthcare prices will only get worse.

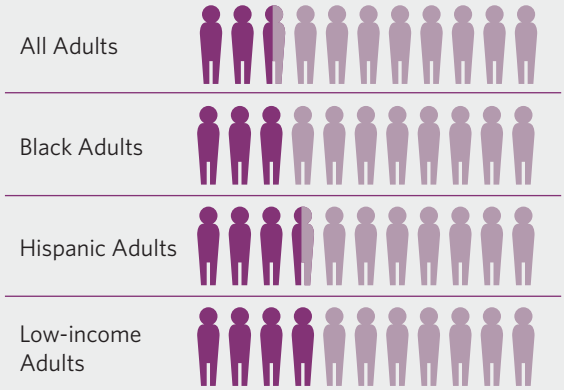
Healthcare Prices in Oregon Are Growing Rapidly



Source: All Payer All Claims Data. Analysis conducted by the Oregon Health Authority.

Pandemic's Financial Burden Not Shared Equally

US adults reporting the pandemic worsened family finances



Source: Urban Institute's Coronavirus Tracking Survey, Uneven Recovery Leaves Many Hispanic, Black, and Low-Income Adults Struggling, October 2020.

III. Healthcare Consolidation Is on the Rise

If we want to control skyrocketing healthcare prices, we need to examine why they are so high in the first place. The U.S. spends twice as much per person on healthcare than other wealthy nations ($10,637 vs. an average of $5,527 per year), and the overwhelming majority of the difference – 76% of it – came from spending on inpatient and outpatient care.[6] A recent Urban Institute report noted that, "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."[7]

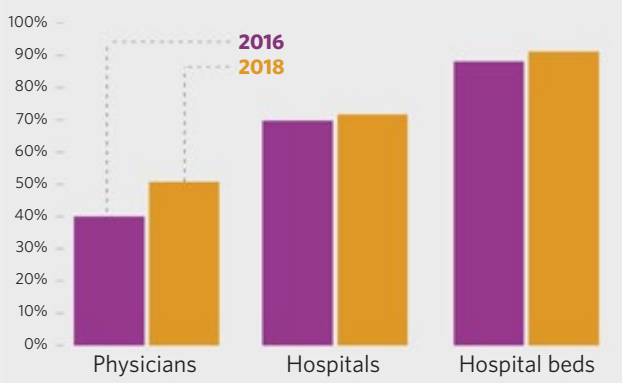
While many efforts are underway in Oregon and across the country to control price increases (including a cost growth cap and move toward value-based payments), there is another factor that has been overlooked: healthcare consolidation. And it's expected to get worse.

National Consolidation Trends

Over the last several decades, the healthcare industry has undergone a radical transformation. It has changed from a relatively segmented sector – with hospitals only operating hospitals, doctors operating independent practices, and insurers the same – to one in which large, national systems have gained significant market share across all of these lines of business. In 2018, more than half of all physicians and 91 percent of hospital beds in the U.S. were affiliated with a health system.[8] And this trend is accelerating – in just two years (2016-2018), the share of physicians affiliated with health systems grew by more than 27%.[9]

National Healthcare Consolidation Across Sectors Increased Substantially from 2016 to 2018

Percentage Affiliated with a Health System



Source: Health Affairs, August 2020. "Consolidation Of Providers Into Health Systems Increased Substantially, 2016–18."

> "Over the past decade mega health systems across the country have gobbled up smaller practices, becoming larger and more financially integrated."
>
> *Healthcare Dive*, For-profits, church-run health systems dominated M&A growth from 2016 to 2018, August 2020

Health systems themselves are merging too — a recent study published in *Health Affairs* found that there were 50 mergers or acquisitions of systems by other systems from 2016 to 2018. Most of the systems that were acquired were relatively small (with median numbers of 2 hospitals and 148 physicians), whereas the acquirers were larger, offered more services, and were more likely to operate in multiple states.[10]

In addition, providers have begun developing their own insurance offerings, and so called "payvider" deals (in which insurers buy or partner with medical groups and other providers) have exploded in 2020, a trend that is predicted to continue. One mergers and acquisitions expert noted, "The line between providers and payers is getting blurrier and blurrier over the course of time with major payers taking significant positions in the provider space."[11]

COVID's Potential Impact on Consolidation

COVID-19 has exposed the widening gap between large wealthy systems and smaller, independent providers — causing experts to predict a wave of consolidation.[12]

The Pandemic is Likely to Accelerate Healthcare Mergers and Acquisitions

Hospitals and health systems that were succeeding before the pandemic have amassed billions in reserves that enable them to weather financial uncertainty. On top of this, they received a disproportionate share of federal pandemic relief funds. Kaiser Family Foundation found that hospitals with the highest share of private insurance revenue received an average of $44,321 in CARES Act relief funds per hospital bed, compared to just $20,710 for hospitals with the lowest share.[13]

Meanwhile, the pandemic further jeopardized the finances of providers that were already struggling, and many will see affiliations or mergers as the only option to survive. A national survey of more than 100 health system executives conducted in mid-June found that approximately three-quarters expect that physician practices and hospitals will turn to mergers and acquisitions over the next year as a result COVID-19.[14]

> "Absent a fundamental change in federal funding approaches, we can expect a dramatic post-pandemic consolidation of the industry... with the richest institutions growing larger and more powerful at the expense of their smaller, more fragile peers and leaving patients vulnerable to the possibility of higher prices and reduced access to care."
>
> Dr. Bruce Stuart in *Health Affairs*, The Hospital Industry Is In A Financial Mess: We Have A Unique Opportunity To Fix It, August 2020

Unlike some other sectors, the pandemic has not caused a decrease in mergers and acquisitions activity healthcare.[15] Instead, Kaufman Hall analysts found the size of healthcare deals in 2020 have been record-breaking: in the third quarter of 2020 alone, four "transformational transactions" (in which the smaller party, or seller, has annual revenues of more than $1 billion) were announced. This ties the highest number of such transactions ever announced in a single quarter.[16]

COVID's Impact on Oregon Providers

A similar trend has been occurring in Oregon, with some of the largest and wealthiest systems receiving significant cash infusions through federal COVID relief. For example, Providence St. Joseph Health was awarded $1 billion in CARES Act funding, yet recorded $682 million as revenue.[17] Legacy received $93.6 million,[18] and St. Charles received $33.2 million (yet recognized $25.1 million as revenue).[19] Small, rural facilities without substantial reserves or robust investment portfolios received far less help, including Lower Umpqua Hospital District and Harney Hospital District, which only received $4.2 million each.[20]

Oregon's primary care practices are also facing significant financial uncertainty: half of practices surveyed in late May of 2020 didn't know or didn't have access to information on how many weeks or months of financial reserves they had remaining. More than a quarter reported having reserves that would last only three months or less.[21]

IV. The Problem with Consolidation in Healthcare

Consolidation Leads to Higher Prices

Proponents of consolidation often argue it will lead to increased efficiency and higher-quality care. However, research has not supported these claims. Instead, the evidence demonstrates that consolidation generally leads to higher prices with neutral or even negative impacts on patient care.[22] Below, we summarize the evidence for three common types of consolidation: hospitals merging with other hospitals, hospitals buying up clinics and physician practices, and insurer consolidation.

Hospital-Hospital Consolidation

	YES	NO	USUALLY NO
LOWERS PRICES		X	
IMPROVES QUALITY			X

Over the past twenty years, more than 1,500 hospital mergers have taken place across the country;[23] as a result, an astonishing 90 percent of Metropolitan Statistical Areas (MSAs) were considered "highly concentrated" as of 2016.[24] Research has shown that hospital prices in monopoly markets are 12 percent higher than prices in markets with at least four competitors;[25] and hospitals that add other hospitals, in-state, experience price increases of 7–10 percent.[26]

And despite promises of greater quality and efficiencies, the higher prices due to consolidation do not seem to deliver better outcomes. A recent comprehensive analysis concluded that hospital acquisition does not improve the quality of care; in fact, acquisition was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates.[27]

> "'Many presumed that consolidation is a prerequisite for higher value,' said Dr. Michael McWilliams of Harvard Medical School... 'but the only consistent finding from good research is higher prices.'"
>
> *New York Times*, The Downside of Merging Doctors and Hospitals, June 2016

Rising Hospital Prices Caused by Consolidation Decrease Area Wages

Unfortunately, the effects of higher prices extend further into our economy. A recent RAND study found that the price increases that result from consolidation are ultimately passed on to workers in the form of lower wages and less generous benefits. The researchers found that wages for workers who receive employer-sponsored insurance declined by an average of $638 per year after a hospital merger took place in their region.[28] In other words, as healthcare prices increase after consolidation, employers compensate by lowering wages.

Given that research has shown that income is perhaps the most important social determinant of health, these lowered wages ultimately drive down the health potential of many. Worse still, workers of color are more likely to be paid poverty-level wages than white workers. However, most employers set their benefits equally across employees, regardless of salary. Therefore, rising healthcare costs have a disproportionate impact on workers at the lower-end of the wage scale and can contribute to increased inequality.

Hospital-Hospital Consolidation Trends in Oregon

In Oregon, the number of independent hospitals has declined from 28 to 16 since the year 2000. A few recent examples include: OHSU adding Adventist Health Portland to its portfolio in 2018, after adding Tuality Healthcare just a few years before; and Legacy Health affiliating Silverton Hospital into its system in 2016. (See Snapshot: 20 Years of Healthcare Consolidation in Oregon on the following page for additional examples.)

Even if some hospitals do attain efficiencies upon consolidation, savings are not necessarily passed on to payers. Instead, larger systems have more negotiating leverage with payers and can demand higher rates. In fact, Oregon's high prices are due in part to an imbalance in the market — with far more insurers than providers. For example, Deschutes County is served by a single large health system (St. Charles) and six competing insurers. In addition, difficulty getting provider contracts has caused some insurers to drop out of the market entirely — because if one major health system declines to participate, the insurer may fall short of network adequacy requirements.

> "This decade has seen an unprecedented increase in hospital merger and acquisitions 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."
>
> Urban Institute, Addressing Health Care Market Consolidation and High Prices, The Role of the States, January 2020

A recent example in Salem demonstrates this dynamic. While four different insurers serve the Salem area, Salem Health owns the only major hospital, making Salem Health essentially a monopoly in its region. Recently, Salem Health made headlines when it attempted to raise its rates by 30 percent in contract negotiations with health insurer Kaiser Permanente. Kaiser countered by taking out a full-page ad in the *Salem Statesman-Journal* stating, "These overinflated prices (being sought by Salem Health) are unnecessary, and they are not the direction we want to be going regionally and nationally." While they ultimately settled on an undisclosed rate, the stakes were high: an insurer like Kaiser can't hold on to customers in the region without Salem Health on its panel of providers.[29]

Snapshot: 20 Years of Healthcare Consolidation in Oregon

YEAR	DESCRIPTION	SYSTEM INVOLVED
1999	Providence buys Hood River Memorial Hospital.	Providence
2000	Ownership of the Central Oregon Hospital District in Redmond transfers to St. Charles.	St. Charles
2001	Samaritan and North Lincoln Health District sign agreement for Samaritan to operate the hospital through 2030.	Samaritan
2002	Samaritan and Pacific Communities Health District in Newport sign an agreement for Samaritan to operate the hospital through 2031.	Samaritan
2003	McKenzie Willamette Medical Center forms joint venture with Triad Hospitals and becomes for-profit. (Later becomes part of CHS, then Quorum Health.)	Triad
2008	St. Charles enters lease agreement with Pioneer Memorial Hospital in Prineville.	St. Charles
2009	Providence buys Willamette Falls Hospital in Oregon City.	Providence
2012	PeaceHealth and CHI announce plans to merge operations in Oregon and Washington; less than a year later, negotiations were suspended.	PeaceHealth and CHI
2013	Ashland Community Hospital merges with Asante.	Asante
2013	St. Charles merges with Mountain View Hospital, renaming it St. Charles – Madras.	St. Charles
2015	OHSU and Salem Health begin to explore affiliation; the deal was ultimately called off in 2017.	OHSU and Salem Health
2016	Tuality Healthcare in Hillsboro affiliates with OHSU.	OHSU
2016	Legacy affiliates with Silverton Hospital, renaming it Legacy Silverton.	Legacy
2017	Legacy and insurer PacificSource announce partnership.	Legacy
2018	PeaceHealth purchases ZOOM+Care, acquiring 37 clinics in Oregon and Washington.	PeaceHealth
2018	Adventist Health Portland and OHSU form an affiliation.	OHSU
2019	Providence Health Plan announces plans to form a partnership with CareOregon, the state's largest Medicaid provider. CareOregon calls off the deal less than a year later.	Providence

The Portland metro is considered a "highly concentrated" hospital market and, predictably, has correspondingly high prices. In 2017, researchers found that Portland had the 14th highest healthcare prices out of 124 large metros nationally.[31] However, the Portland metro is also arguably the most competitive market in the state. Outside of Portland, not a single community is served by more than two competing health systems. Therefore, even despite its high prices, the Portland area often has some of the lowest cost healthcare in the state, with Southern and Eastern Oregon being far more expensive.

Hospital-Physician Consolidation

	YES	NO	UNCLEAR
LOWERS PRICES		X	
IMPROVES QUALITY			X

A significant body of research has demonstrated that hospitals' acquisition of physician groups drives up prices and spending.[31] First, hospitals can treat formerly independent physicians' offices as "hospital-based outpatient departments" and bill a higher rate that sometimes includes a large facility fee.[32] Second, hospital-affiliated physicians seem more likely, whether under pressure or not, to refer patients to other, generally more expensive, hospital-based facilities.[33] Compounding these effects, one study found that price increases at acquired physicians offices are larger when the acquiring hospital has a larger share of the inpatient market.[34]

> "Yet hospitals continue to roll up practices for one reason: Money. The more doctors that hospitals or private equity companies own, the more market share they capture, the more bargaining power they have with insurers, the more facility fees they can charge (added costs hospitals charge for outpatient services that independent doctors don't), and the more referrals they can be sure to get driven into their systems. This adds up. According to a 2019 report from Merrit Hawkins, hospitals make on average $2.4 million a year net for every doctor they employ."
>
> *Medical Economics*, Employed vs Independent Doctors: Numbers Don't Tell the Whole Story, June 2019

Hospital-Physician Consolidation Trends in Oregon

Oregon's largest hospital systems already operate hundreds of clinics focused on primary care, specialty care, urgent care, occupational and physical therapy, and surgery centers. For example, Legacy Health has more than 70 clinics across Oregon and Washington; Providence has more than 100 in Oregon; Salem Health has more than 25; Samaritan Health Services has 80, and St. Charles has more than 60. In addition, PeaceHealth expanded its footprint by purchasing ZOOM+Care for an undisclosed amount in December 2018, acquiring 37 neighborhood clinics in Oregon and Washington. Over the past 18 months, they have opened an additional 22 neighborhood clinics.[35]

Hospitals and health systems are expanding their outpatient offerings in Oregon at a rapid clip, through acquiring existing practices and opening new clinics across the state. In the Portland metro area, the share of physicians affiliated with health systems grew from 39% in 2016 to 71% in 2018 – an 82% increase. Providence employs the largest share of physicians in Portland (28.7%) and nearly tripled its market share over the same two-year period. In Albany and Corvallis, nearly 60% of doctors are affiliated with a health system, and Samaritan Health Services employs virtually all of them.[36]

Private Equity an Increasing Presence

Private equity investors have also been increasingly entering this space. A study published earlier this year in the *Journal of the American Medical Association* found that while the share of physician practices currently owned by private equity investors is relatively small, acquisitions have increased across specialties in recent years "with unknown implications for care delivery and patient outcomes." Because private equity firms typically expect greater than 20% annual returns, the authors further cautioned that "these financial incentives may conflict with the need for longer-term investments in practice stability, physician recruitment, quality, and safety."[37]

In fact, private equity is already present in Oregon's healthcare landscape. The string of Legacy-branded GoHealth Urgent Care clinics that have sprung up around the Portland metro since 2015 are in fact operated and owned jointly by Legacy Health and Access Clinical Partners LLP.[38] Access Clinical Partners is a TPG Growth portfolio company, specializing in "growth equity and middle-market buyout opportunities". They are an arm of TPG (née Texas Pacific Group), one of the nation's leading private equity firms with over $85 billion in assets currently under management.[39] While the clinics operate under the nonprofit hospital brand, there is no mention of financial or charitable assistance on GoHealth's website.[40]

Insurer Consolidation

	YES	NO	UNCLEAR
LOWERS PRICES			X
IMPROVES QUALITY			X

The health insurance industry is less concentrated than hospital care, with 57–69 percent of markets being highly concentrated nationally.[41] However, compared with the extensive body of research on provider consolidation, far less is known about insurer consolidation's effect on prices and quality of care. In theory, insurer consolidation can offset the negotiating power of powerful providers; however, it is less clear what happens in consolidated markets with large systems that operate in both the provider and payer spaces (as is increasingly the case).

Insurer Consolidation Trends in Oregon

In Oregon, the Department of Consumer and Business Services, which regulates insurance in the state, considers a market "highly concentrated" if the four largest insurers hold 75 percent or more of the market. Under this definition, individual and small-group ACA-compliant, and commercial lines of business are all highly concentrated in our state.

Oregon has the additional market dynamic of many of our insurers also serving as providers. In fact, the state's largest insurers, Providence and Kaiser, are also among the largest hospital and physician providers in the state. Together they control nearly half of the insurance market. Other providers have also gotten into the insurance business: Legacy bought half of PacificSource in 2017 for nearly $100 million; and Samaritan Health Services offers its own insurance products.

Consolidation Can Reduce Access to Care

Troublingly, the impact of consolidation is not limited to higher prices. Consolidation can also reduce access to care in underserved areas, and lead to the denial of services based on religious restrictions.

Reduced Services in Rural Areas After Consolidation

Many independent rural hospitals have struggled financially in recent years, leaving some to see partnering with a larger system as the only option to survive. While keeping doors open and ensuring access to care in underserved areas is critical, recent findings from RAND researchers have shown that affiliations were not associated with improved healthcare quality and instead led to reduced services in these communities.

Following affiliation, rural hospitals were more likely to lose onsite imaging, outpatient nonemergency care, and obstetric and primary care services. Obstetric services alone dropped by 7–14% annually in the five years following affiliation. At the same time, the hospitals in the study saw a significant increase in operating margins (by 1.6–3.6 percentage points within two to five years, compared with –1.6 percent before the affiliation). The study's authors ultimately conclude that, "Given the potentially negative consequences of affiliation, policy makers should support mechanisms that help rural hospitals remain financially viable without it."[42]

> "Hospitals in rural areas are struggling to stay open for a lot of different reasons, but many are looking to health-system affiliation as a way to keep the doors open. But when you give up local control of your hospital to a health system, a lot of things change that may or may not be good for the hospital or its patients."
>
> Clare O'Hanlon of the RAND Corporation, Rural Hospital Acquisitions May Reduce Patient Services, December 2019

Church-Operated Systems are Extending Their Reach — and Restrictions on Care

As more and more healthcare is provided by entities affiliated with the Catholic church, consolidation can also lead to restrictions on services. Catholic health systems are bound by medical care guidelines rooted in religious doctrine. These Ethical and Religious Directives (ERDs) limit access to the full range of healthcare for women, transgender and gender nonconforming people – as well as end-of-life care options authorized under Oregon's Death with Dignity Act. The ERDs have tangible, and in some cases life-or-death, consequences: patients have been turned away while actively miscarrying; denied tubal ligations; and sent home in hospital booties minutes before a gender-affirmation surgery was scheduled to begin.[43]

A recent study published in *Health Affairs* found that, in 2018, while only 8 percent of systems were church-operated, they held 21 percent of hospital beds and 19 percent of system-affiliated providers -- and they are growing at a rapid pace.[44] In Oregon, 30 percent of acute care beds are controlled by systems that restrict access to these services.[45]

In recent years, Catholic systems have been increasingly entering into cooperative ventures with non-Catholic providers, and extending portfolios to include physician practices, urgent care, retail clinics and ambulatory care centers. As these systems grow, it can be challenging for patients to understand what services will be available to them when they arrive. For example, researchers found that "Catholic urgent care centers frequently said they were unable to provide birth control refills or other urgent gynecological services, while non-Catholic centers frequently provided these services."[46]

In addition, despite promises that affiliations with non-Catholic providers will remain "secular," they still often result in restrictions on care.[47] For example, when the secular Swedish Medical Center in Seattle announced its affiliation with Providence in 2012, the system stopped performing elective abortions and other reproductive health services that violate Catholic doctrine "out of respect for the affiliation."[48]

> "Catholic and non-Catholic hospitals are entering into increasingly complex and non-transparent partnerships that make the comprehensive application of the Ethical and Religious Directives difficult for both consumers and advocates to determine."
>
> Community Catalyst, Bigger and Bigger: The Growth of Catholic Health Systems, October 2020

Consolidation Can Exacerbate Health Inequities

Due to the way healthcare is paid for in the U.S., concentrated provider power can perpetuate the market dynamics that ensure that richer, whiter patients continue to be served by state-of-the-art facilities while BIPOC individuals are funneled to under-resourced institutions with lower-quality care.

Healthcare prices in the private insurance market are negotiated between health systems and insurers or other payers, while public insurance (Medicaid and Medicare) prices are set by state and federal agencies. This dynamic allows for more opportunity for negotiation in private insurance prices -- often resulting in these rates being significantly higher than public insurance. In 2018, employers and private insurers paid almost 250% of what Medicare would have paid for the same care at the same facilities.[49] In turn, the patients attached to those higher prices are more sought after.

A recent commentary published by the *New England Journal of Medicine* explored how such price differences exacerbate inequality. The authors assert that when hospitals raise prices in the private insurance market (as is often the case after consolidation), resources are redirected back into facilities that serve the disproportionately white and wealthy populations that can afford private coverage. Meanwhile, Medicaid patients are steered to facilities that are reliant on fixed federal reimbursement rates and don't benefit from inflated payments from private insurers to pay for facility upgrades and additional staff. These patients, who are disproportionately Black and Latinx, are then served by lower-quality facilities with far fewer resources.[50]

This preference for privately insured patients can be observed locally. In 2013, when Legacy Health opened its first clinics in the Portland metro area's west side, the local medical society's newsletter commented on the likely patient population that the clinics would attract: "The locations for the new clinics are in high-income areas, so they will attract many insured patients who have the choice of where they go to be treated and can benefit from some of the deluxe services Legacy Medical Group

> "As hospitals exert pricing power in the private insurance market, their pricing strategy re-directs financial resources to facilities serving Americans with private coverage, a group which is disproportionately white. Those resources pay for staff, facility upgrades and acquisitions to capture more private patients and further augment leverage. This cycle of price discrimination segregates local markets, funneling Medicaid patients—who are disproportionately Black and Hispanic—to hospitals with fewer resources and inferior clinical quality."
>
> *NEJM Catalyst*, Hospital Price Discrimination Is Deepening Racial Health Inequity, December 2020

Cornell offers that seem tailor-made for large county employers such as Nike Inc. and Intel Corp. These include what Legacy calls 'performance evaluations,' such as bicycle fittings and running and golf-swing analyses."[51]

Meanwhile, other patient populations continue to be underserved and overburdened by the high cost of care.

V. Policy Solutions

Combatting the high prices caused by consolidation has historically been the purview of federal antitrust agencies. However, over the last decade, states have begun to step up their own enforcement and develop innovative policy solutions that ensure proposed healthcare mergers and acquisitions are beneficial for consumers – not just health systems' bottom lines.

Federal Oversight, While Important, Has Significant Limitations

The Federal Trade Commission (FTC) primarily focuses on provider mergers, while the U.S. Department of Justice typically oversees health insurance mergers. The U.S. Senate also recently passed legislation with broad bi-partisan support to allow federal antitrust oversight of health insurance companies. These agencies can intervene if they suspect antitrust laws are being broken, such as the use of anticompetitive contract terms, attempted monopolization, and "unfair or deceptive acts and practices."

While important, federal oversight is limited in a variety of ways:

Small Deals Proceed Unchecked

Federal law only requires systems involved in very large deals to notify the FTC about proposed transactions (in 2020, the threshold was $94 million at the time of closing). In effect, this has allowed many smaller deals to proceed unchecked. While these may seem inconsequential on their own, they can add up to dramatic change over time.

Dwindling Resources for Review as Mergers and Acquisitions Speed Up

Federal agencies lack the resources to fully examine every deal, particularly as the pace of healthcare mergers and acquisitions continues to increase. Further complicating oversight efforts, healthcare deals have become more complex over the last decade. In addition to combining assets through mergers or straightforward cash purchases, newer arrangements have emerged that more easily escape oversight. Many have been framed under the broader term of "collaborations" – including increasingly popular clinical affiliations, management service agreements, and joint operating structures -– in some cases potentially because they pose fewer anti-trust consequences.

Lack of Enforcement in Physician Acquisition Deals

While the FTC successfully challenged some high-profile hospital mergers in the last decade, they have largely avoided intervening in physician acquisition deals, which have been expressly linked to price increases. While the FTC released new guidelines for these mergers in July 2020, many experts remain skeptical they will be effective in enforcement; one dissenting FTC Commissioner even noted that the new guidance, "glosses over how these mergers give corporate royalty the power to choke off any potential threat to their throne."[52]

Limited Expertise in Nonprofit Enforcement

While the FTC has significant expertise related to healthcare provider mergers, it is prohibited from enforcing antitrust laws against nonprofit entities for anticompetitive behavior. This limitation is important to note because more than two-thirds of private hospitals in the US are owned by nonprofits[53]; in Oregon, only 2 of our 60 hospitals are owned by for-profit companies.

States Develop Their Own Solutions to Address Consolidation

Recognizing these weaknesses, states have begun to take action on their own – with approaches ranging from ramping up state attorney general oversight and enforcement to passing legislation to ban anti-competitive contract terms outright. Relevant examples from three leading states are presented below:

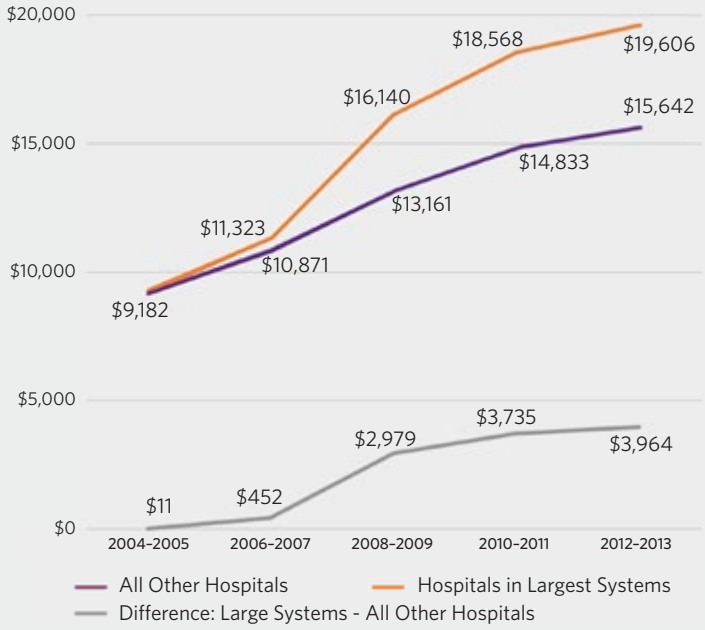
Massachusetts. As part of a 2012 landmark law designed to reduce healthcare spending, Massachusetts charged its newly created Health Policy Commission with reviewing merger proposals, conducting cost and market impact reviews, and referring its findings to the state's attorney general for enforcement. Massachusetts' attorney general's office is also uniquely prepared to review these transactions, as it created a formal Health Care Division that promotes collaboration among the antitrust enforcement, charitable trust, and consumer protection divisions. This structure allows the attorney general to not only examine price effects, but the full scope of consumer and societal implications that may arise from a proposed transaction.

> "There is a growing understanding that comprehensive efforts to control health care costs and improve the quality of care must address the functioning of the markets that undergird the health care system and the prices paid to providers. Ensuring that markets function efficiently is central to an effective health system that provides high-quality, accessible, and affordable care."
>
> Martin Gaynor and colleagues, Making Health Care Markets Work: Competition Policy for Health Care, April 2017

California. California experienced its wave of healthcare mergers and acquisitions much earlier than the rest of the country. As a result of this consolidation, hospital prices grew by more than 75% across all hospitals and all services between 2004 to 2013, and prices at hospitals affiliated with the largest, multi-hospital systems grew significantly more (113%) than prices at all other California hospitals (70%).[54] Recognizing the enormous impact this consolidation has had on prices, California has aggressively pursued legal action against systems for anticompetitive practices and extensively reviewed proposed mergers – denying some and applying conditions on others that were allowed to proceed.

California Experienced Dramatic Price Increases Following Hospital Consolidation, Particularly at Hosptials Affiliated with the Largest Systems

Payment per Admission in Hosptials Affiliated with the Largest Multi-Hospital Systems vs. All Other Hospitals, 2004-2013



Source: Melnick, Glenn A. and Katya Fonkych. "Hospital Prices Increase in California, Especially Among Hospitals in the Largest Multi-Hospital Systems." Journal of Health Care Organization, June 2016.

Washington. In 2019, Washington passed legislation to ensure the state's attorney general is aware of a broad array of transactions that federal antitrust agencies may not be notified about or identify as anticompetitive. Healthcare entities must now notify the attorney general at least 60 days before a "material change" transaction is to take place – with no minimum dollar threshold. "Material change" is defined broadly to capture various forms of consolidation (including mergers, acquisitions, or contracting affiliations) between hospitals, hospital systems, and provider organizations. Washington is also currently considering new legislation that would

establish greater pre-transaction review and post-transaction monitoring.

Oversight of Consolidation in Oregon

Oregon lacks both a comprehensive process for reviewing healthcare mergers and acquisitions and a system for monitoring the impacts of healthcare consolidation. Currently, various state agencies review disparate parts of healthcare transactions, each with its own set of procedures and standards. For example, the Department of Consumer and Business Services reviews insurance mergers and the Office of the Attorney General has the authority to intervene in nonprofit healthcare deals. However, these processes apply only to a small portion of transactions and remain limited in scope. More importantly, they utilize an antiquated rubric based primarily on whether the entities will have enough financial resources to continue operating post-transaction, without evaluating whether the health of Oregonians will be better served.

VI. Conclusion

Oregonians have been struggling with rising healthcare prices for years. Efforts to address skyrocketing costs have never been more urgent, as COVID-19 has pushed many families and businesses to the brink financially -- and disproportionately impacted those who can least afford to pay more for care.

Given the broad consensus among researchers that consolidation is linked to higher prices and can lead to reductions in services, we must take a harder look at mergers and acquisitions before they happen. Intervening before transactions take place is critical, as it virtually impossible to undo these complex and multifaceted deals once they are finalized – and to reverse any associated price increases.

The clear limitations of federal oversight make it all the more imperative that Oregon follow the lead of other states that have developed their own approaches to addressing consolidation. Oregon needs a tool that ensures healthcare deals taking place in our state truly benefit all residents -- by promoting health, access and equity rather than runaway price increases.

> "Due to the unique way in which health care is financed for many Americans, recent changes to health care markets have broad-reaching impacts. Our results suggest Americans doubly feel the effects of rising health care costs – through higher health care prices and slower wage growth."
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Questions?

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