Universal Health Care Commission meeting

December 14, 2023

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Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission
Meeting Materials

December 14, 2023
2:00 p.m. – 4:00 p.m.

Meeting materials

Tab 1

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission

Agenda

Thursday December 14, 2023
2:00 – 4:00 PM
Hybrid Zoom and in-person meeting

Commission members:		
☐ Vicki Lowe, Chair	☐ Estell Williams	☐ Representative Marcus Riccelli
☐ Senator Ann Rivers	☐ Jane Beyer	☐ Megan Matthews
☐ Bidisha Mandal	☐ Joan Altman	☐ Mohamed Shidane
☐ Dave Iseminger	☐ Representative Joe Schmick	☐ Nicole Gomez

Time	Agenda Items	Tab	Lead
2:00-2:05 (5 min)	Welcome & call to order New member introduction • Megan Matthews	1	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:05-2:08 (3 min)	Roll call	1	Mandy Weeks-Green, Manager Health Care Authority
2:08-2:10 (2 min)	Approval of Meeting Summary from 10/24/2023	2	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:10-2:25 (15 min)	Public comment	3	Vicki Lowe, Chair Executive Director, American Indian Health Commission for Washington State
2:25-2:30 (5 min)	FTAC report out • Preliminary Medicaid discussion	4	Pam MacEwan, FTAC Liaison
2:30-3:20 (50 min)	2024 Workplan and prioritization of transitional solutions	5	Liz Arjun, Senior Consultant Health Management Associates
3:20-3:40 (20 min)	Overview of Eligibility under the Washington Health Trust (SB 5335)	6	Andre Stackhouse and Erin Georgen, Whole Washington
3:40-4:00 (20 min)	Overview of the Washington Office of the Insurance Commissioner Preliminary Report on Health Care Affordability • Attorney General Preliminary Report on Health Care Affordability	7 8	Jane Beyer, Senior Policy Advisor Office of the Insurance Commissioner
4:00	Adjournment		

Tab 2

Washington State Health Care Authority

Universal Health Care Commission meeting summary

October 12, 2023

Hybrid meeting held electronically (Zoom) and in-person at the Health Care Authority (HCA)
2–4 p.m.

Note: this meeting was recorded in its entirety. The recording and all materials provided to and considered by the Commission is available on the Universal Health Care Commission webpage.

Members present

Vicki Lowe, Chair
Bidisha Mandal
Dave Iseminger
Senator Emily Randall
Jane Beyer
Joan Altman
Representative Joe Schmick
Representative Marcus Riccelli
Mohamed Shidane

Members absent

Senator Ann Rivers
Estell Williams
Kristin Peterson
Nicole Gomez
Stella Vasquez

Call to order

Vicki Lowe, Commission Chair, called the meeting to order at 2:03 p.m.

Agenda items

Welcoming remarks

Chair Lowe welcomed Commission members to the fourteenth meeting and provided a land acknowledgement.

Meeting summary review from the previous meeting

The Commission members **voted by consensus to adopt the August 2023 meeting summary**.

Washington State Health Care Authority

Public comment

Chair Lowe called for comments from the public.

Judy D'Amore encouraged the Commission to adopt Whole Washington's proposal for universal health care.

Washington's presentation to the Commission at their August meeting is available at timestamp 46:10.

Cris Currie had audio issues and noted that he would submit his comments in writing.

Ronnie Shure, President, Health Care for All – Washington, advocated that the Commission use resources allocated in the 2023 operating budget to hold monthly meetings that extend to three hours (including FTAC meetings).

Raleigh Watts, volunteer, Health Care for All – Washington, encouraged the Commission to use Whole Washington's proposal for universal health care as a starting point for Washington's new system.

Lori encouraged the Commission and FTAC to add Whole Washington's proposal to their respective upcoming meeting agendas.

FTAC updates: Guidance on Employee Retirement Income Security Act of 1974 (ERISA)

Pam MacEwan, FTAC Liaison

FTAC's assessment of options to include ERISA can be found in the ERISA Memo under Tab 4 of the October meeting materials. FTAC agreed that it's not yet clear the best method of capturing employer contributions and incentivizing them to permit their employees to enroll in the universal system.

Legal challenges may be inevitable which would create delays in implementing a universal system. However, a combination of approaches that includes options that are not likely to be challenged could ensure some aspects of reform could be implemented without delay. FTAC agreed that a combination of voluntary employer participation, providing employers a meaningful alternative to what they may already offer, components of provider incentives/regulation, and a funding mechanism should be part of the new system.

FTAC members agreed that this should be revisited once additional elements of the system, such as the benefits and method(s) of provider reimbursement, have been developed by the Commission.

Commission discussion on FTAC's ERISA guidance

Commission members agreed to take under advisement FTAC's guidance, and that ERISA should be revisited once additional elements of the system, such as the benefits and method(s) of provider reimbursement, have been developed by the Commission. Further, a payroll tax on all employers will need to be revisited. Commission members' additional questions and comments in response to FTAC's guidance can be found in the audio recording for the October 12, 2023 meeting here at timestamp 28:40.

Adoption of 2023 legislative report

Chair Lowe

The Commission's work in 2023 was captured in the legislative report. Chair Lowe asked for comments and discussion before adopting the final report. **The Commission members present voted unanimously to adopt the 2023 report.**

Planning for 2024 and continuing transitional solutions discussion

Liz Arjun, Health Management Associates (HMA)

Last year, the Commission outlined three phases of the larger system design. Eligibility (phase one) was selected as the design element of focus in 2023. In 2024, the Commission will build upon this work and continue phase one development on benefits and services, provider reimbursement and participation, and cost containment. These elements will then help identify cost estimates and financing for the new system.

The 2023 legislature also provided additional resources (through Fiscal Year 2025) to support the work of the Commission and FTAC. The Commission discussed how the new resources should be utilized.

The Commission agreed that **a community engagement process should be established once benefits and services are developed**. Commission members will revisit discussion on how the additional actuarial/ modeling funds should be used. Commission members determined that **extending meetings to three hours under the current meeting cadence would be the most effective use of resources.**

Commission members expressed **interest in getting more information (including access to presentation recordings) about projects underway that are focused on health care affordability, equitable access, and quality and how they connect to the Commission's transitional solutions.** The Commission discussed which categories of transitional solutions should be focused on in 2024. **The Commission chose to focus on the following categories in 2024: coverage/enrollment, providers, and purchasing.** More from the Commission's discussion can be found at timestamp 1:39:08.

Adjournment

Meeting adjourned at 3:58 p.m.

Next meeting

December 14, 2023
Meeting to be held on Zoom and in-person at HCA
2–4 p.m.

Tab 3

Washington State Health Care Authority

Public comment

Washington State Health Care Authority

Washington State Health Care Authority

Universal Health Care Commission
Written Comments
Received from September 29

Written Comments Submitted by Email

Additional Comments Received at the October Commission Meeting

- The Zoom video recording is available for viewing here: https://youtu.be/mhSAIg-wlRs?si=9RFB5I6wbj68O1nV

Public comments received since (September 28) through the deadline for comments for the December meeting (November 30)

Submitted by Roger Collier
11/29/2023

November 28, 2023

Dear UHCC Commissioners –

At its October 2022 meeting, the Commission agreed that eligibility for a Washington universal health care plan should be the first consideration for 2023, noting that determining who will be eligible will form a starting place for all other components.

The Commission's work plan identified June 2023 as the point at which a decision on Medicare beneficiaries was to be made, and October 2023 as the point at which a decision on ERISA self-insured plans was to be made.

So far, the Commission and FTAC have had a number of discussions about Medicare and ERISA (and also Medicaid), but no decisions have been made.

Obviously, these are complex issues and decision-making may have suffered from the difficulty of maintaining momentum from one meeting to the next.

The discussions so far have been useful in raising issues, but the need to make eligibility decisions is increasingly urgent if the Commission is to comply with its legislative mandates.

In an attempt to clarify the issues relating to eligibility and – hopefully – accelerate the process, I have prepared the attached paper. I would be happy to discuss it with the Commission.

Thank you

Roger Collier

ROGER COLLIER rcollier@rockisland.com

THREE OBSTACLES TO UNIVERSAL HEALTH CARE

And a Possible Strategy

ROGER COLLIER rcollier@rockisland.com

1. MEDICARE BENEFICIARIES

1.4 million enrollees (estimated)

THE OBSTACLE:

Medicare laws and regulations do not allow the transfer of Medicare beneficiaries to a State Universal Health Care plan.

- There is no feasible waiver process that would allow federal Medicare regulations to be overridden to allow such a transfer.
- Most Medicare beneficiaries are satisfied with their current coverage and would likely oppose a mandated switch to an untested State plan.
- It is highly unlikely that federal administrators would support moving any Medicare beneficiaries to an untested State plan.

POSSIBLE ALTERNATIVE(S)

Some seamlessness between Medicare and a State plan might be achieved if the State plan supplemented Medicare (like a Medigap plan) or treated Medicare as third party coverage (with the State plan rebilling Medicare for Medicare-covered services). A more modest alternative might be to offer the State plan as a Medicare Advantage option. All three approaches have problems.

- Any approach which supplements Medicare is likely to be hugely costly for the State, unless the cost is passed on to Medicare beneficiaries – in which case it is likely to be hugely unpopular with the beneficiaries.
- A Medicare Advantage approach (assuming it is possible to maneuver around federal regulations) will only work if the State plan is much less costly than competing insurer offerings – something that is highly uncertain.

ROGER COLLIER rcollier@rockisland.com

2. SELF-INSURED EMPLOYERS

2.5 million enrollees (estimated)

THE OBSTACLE

The federal Employee Retiree Income Security Act (ERISA) preempts state regulations that "relate to" self-insured employer plans. The US Supreme Court has indicated that an "exorbitant" state tax on such plans would likely be preempted. In other words, an "exorbitant" payroll tax to help fund a universal health plan would not be allowed.

- The Supreme Court's warning about an "exorbitant" tax came in a ruling that *allowed* a 24 percent tax on some hospital claims. However, the Court commented: "*there might be a point at which an exorbitant tax leaving consumers with a Hobson's choice would be treated as imposing a substantive mandate [and would be preempted*]."
- FTAC's expert on ERISA law indicated that a Washington payroll tax would probably not be preempted. However, she failed to recognize today's huge variations in employee benefits that would result in some employers facing a *doubling or more* of their costs if a payroll tax were imposed[1]. It is impossible to know how the courts might decide, but if a 24 percent tax begins to raise red flags, a 100 percent or more cost increase may well be ruled unacceptable.
- Regardless of whether or not a Washington payroll tax is preempted, an employer suit could take as much as four years[2] to reach a final decision – on top of the time for the Commission to make final recommendations and the Legislature and Governor to enact legislation.

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[1] Based on data from the Kaiser Family Foundation national employee benefits survey. Employers with the most generous current benefits would experience lower costs.

[2] Based on the recent City of Seattle case.

POSSIBLE ALTERNATIVE(S)

A play-or-pay model in which employers are required to provide some level of health benefits or pay a tax might avoid the mandatory payroll tax issue (and would not add to the State budget), although this would be contrary to the concept of *universal* health care.

- FTAC's ERISA expert cited two cases in which federal appeals courts ruled that play-or-pay models were not preempted. However, she failed to cite two other cases in which different appeals courts ruled that play-or-pay models *were* preempted.
- Depending on the benchmark benefit level, this could still result in doubling of some employers' benefit costs.
- Whether or not this approach would be preempted, it could still face up to a four or more years' delay in the courts.

Requiring all employers to offer the State plan as an employee option might avoid preemption -- if this did not increase employer benefit costs.

- The implication is that any increased costs would be borne by the employees choosing the State plan – something that would be unpopular with employees and their unions.

A payroll tax much lower than that considered by other states (like Oregon) might reduce the risk of preemption.

- This would leave Washington (which currently has no income tax) with no obvious mechanism for closing the funding gap.
- A much lower taxing level might be used to fund a State catastrophic care plan, although this would be contrary to the concept of a single universal plan.

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MEDICAID (APPLE HEALTH)

2.1 million enrollees (estimated)

THE OBSTACLE

Section 1115 of the Social Security Act allows some waivers of Medicaid regulations, thereby offering a possible path to incorporating Apple Health into a State universal health care plan. However, federal policy requires that waivers be budget neutral to the federal government and initially limited to no more than five years. Most importantly, federal approval is required before waivers are granted.

- Moving more than two million Medicaid enrollees from a functioning system to an untried State plan is unlikely to gain easy federal approval. Federal administrators will be justifiably nervous of the possibility of consolidation resulting in chaos.
- Medicaid advocates will be equally concerned about problems for enrollees, as will providers with numbers of Medicaid patients.
- Moving Medicaid enrollees into a universal system that essentially guarantees coverage creates a problem of federal payment: how will the federal government determine how many Medicaid eligibles it will subsidize if there is no eligibility determination?
- State submittal of a waiver request provides no guarantee of federal approval – ever! Moreover, federal review can take literally years[3] as a state tries to respond to questions and negotiates details.

POSSIBLE ALTERNATIVE(S)

A State plan might be offered to Medicaid enrollees as an alternative to

[3] A recent CMS snapshot of the status of submitted waivers showed eight (out of thirty) still pending after a year. (CMS did not report "worst case" for review time.)

existing managed care options.

- For this to be feasible, the State plan benefits would have to be at least as generous as those of Medicaid, with costs that could be far greater if the State plan imposes few restrictions on provider choice.

It may be possible for the State to simplify the federal subsidy calculation by agreeing to a global cap on federal payments[4].

- This approach would likely put the State at risk for any unanticipated increase in the Medicaid eligible population – as might happen in the case of a future pandemic.

Federal waiver approval will be far more likely if the State has already demonstrated its ability to consolidate some existing programs into a health plan with common benefits – essentially a "mini version" of a full State universal health care plan.

- This could mean, for example, consolidating PEBB, SEBB, Exchange plans, and non-self-insured plans into a single Statewide plan with more than one million enrollees.

[4] As Rhode Island and Vermont have done.

A POSSIBLE STRATEGY

The preceding sections identify major obstacles, substantial uncertainties, and considerable potential delays facing a State universal health care plan. To move forward, decisions must be made, recognizing that these may need to be revisited if things change. The following is proposed as a possible strategy.

Step 1 – Set aside for the foreseeable future any further consideration of including Medicare beneficiaries in a State universal plan.

- As of now, the obstacles to including Medicare beneficiaries are overwhelming.
- Further consideration of this issue will delay analysis of ERISA and Medicaid.
- This would be consistent with Oregon's Task Force decision about Medicare.
- Inclusion of Medicare beneficiaries could be revisited once all other features of the State plan are fully operational.

Step 2 – Discuss further with legal experts the likelihood of ERISA preemption of a plan dependent on payroll taxes. In particular, the State should pursue the question of how a doubling of benefit costs for *some* employers might be viewed by the courts.

- Given that FTAC's ERISA expert has already given her opinion (but without considering the impact of some employers' costs being doubled), it might be appropriate to get a second opinion.
- A second opinion on the risk of preemption of a play-or-pay model, *taking into account all court decisions*, might also be appropriate.

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Step 3 – Design and implement a "mini-version" of the State plan, to include, at a minimum, current enrollees in PEBB, SEBB, Exchange plans, plus other individual and small group insurance.

- This is proposed as the first phase of State plan implementation because it requires no federal approvals other than a Section 1332 waiver for Exchange enrollees (which could be postponed). It will require concurrence (or at least minimal opposition) from public and educational employee groups and some insurers. However, this concern is equally applicable to any more comprehensive State plan proposal.

Step 4 – Plan for inclusion of Apple Health enrollees *after* a "mini-version" of the State plan is fully operational.

- It is highly unlikely that federal administrators will grant a waiver to consolidate a functional Medicaid plan into an *untried* State system.
- Eventual inclusion of Medicaid in a State plan will require rate normalization, and also agreements from all providers to accept Medicaid enrollees.

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Submitted by Nicole Minkoff
11/30/2023

Hi, My name is Nicole Minkoff and I'm a resident of Seattle, a state employee, and my family receives insurance through PEBB. I'm including my previous comments below this email so I can build upon them without repeating. I understand you are meeting (or recently met depending on when I get this sent) about how a move to a system similar to what Whole Washington has been proposing could impact different groups of currently enrolled people.

As someone who receives my health insurance through arguably one of the best employer sponsored plans in the state, I have seen it repeatedly fall short in providing care to my family. In addition to the previous examples I had provided (see my message below), there have been several instances of care falling short:

- In my son's first week of life, his primary care clinic failed to provide the standard of care and this caused the potentially fatal complication that I referred to below. We were locked into the Kaiser network through the next 7 months, which meant our options for my son's care were to return to that clinic or to travel far outside our neighborhood for care, despite the fact that there was a plethora of doctors nearby.
- We switched to the UMP network in 2019 and have appreciated having more control over which providers we see. However, we have had to go out of network for so much care because of Regence's refusal to provide reasonable reimbursement for many types of providers. My physical therapist let me know that they haven't increased reimbursement for PT in over 10 years and PTs in Seattle are struggling to make ends meet if they choose to stay in network.
- Premium costs are rising steeply in 2024, particularly for people who haven't left Kaiser.
- Our family, despite having some of the best insurance in the state, is paying about $12,000 a year for care since my son and I are both disabled and require significant healthcare each year. This year my husband was laid off and this ended up representing about 1/6 of our income for the entire year.

Our tax dollars shouldn't be contributing to corporate insurer profits - they should be focused on providing dignified, excellent care for every person in Washington. The plan proposed by Whole Washington would do an excellent job of improving upon options for those of us with employer-provided insurance currently.

Thank you, Nicole Minkoff

Tab 4

Washington State Health Care Authority

FTAC updates

Medicaid

FTAC's November meeting

Pam MacEwan,
FTAC Liaison

Washington's Medicaid enrollment process

- The Exchange and HCA work to facilitate Medicaid enrollment.
- Potential areas of opportunity
  - Could expand/repurpose *Healthplanfinder* platform for universal health care enrollment

Washington's Medicaid program overview

- Eligibility groups, benefits/services, reimbursement, and service delivery systems
  - TBD - role of managed care organizations (MCOs) in the future
- Lower provider payment rates, though supplemental payments for hospital/health system physicians bring rates close to Medicare.
- May be areas of opportunity through 1115 waivers

More information gathering

- 1115 waivers
  - Limitations, federal barriers and requirements
- Washington's experience with 1115 waivers
- Other states' experience with Medicaid eligibility expansion through 1115 waivers
- Barriers to access and care for Medicaid enrollees (in addition to lower reimbursement rates)

FTAC's January meeting

Pam MacEwan,
FTAC Liaison

- Examine options to include Medicaid
- Assess the pros and cons of each option
- Develop recommendations to the Commission
- Review the Commission's guidance on workplan for 2024

Washington State Health Care Authority

Universal Health Care Commission's Finance Technical Advisory Committee (FTAC) meeting summary

November 9, 2023
Virtual meeting held electronically (Zoom)
2–4 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the **FTAC webpage**.

Members present

Christine Eibner
David DiGiuseppe
Eddy Rauser
Kai Yeung
Pam MacEwan
Robert Murray
Roger Gantz

Members absent

Esther Lucero
Ian Doyle

Call to order

Pam MacEwan, FTAC Liaison, called the meeting to order at 2:02 p.m.

Agenda items

Wecoming remarks

Beginning with a land acknowledgement, Pam MacEwan welcomed members of FTAC to the sixth meeting and provided an overview of the agenda.

Meeting summary review from the previous meeting

One FTAC member offered an amendment on page 4 (timestamp 5:15). The Members present voted by consensus to adopt the September 2023 meeting summary as amended.

Public comment

Cris Currie, volunteer, Health Care for All – Washington, suggested Medicaid Managed Care Organizations (MCOs) be evaluated for their value and that FTAC view background presentations as recordings ahead of meetings.

Lori Bernstein shared personal experience with an MCO requiring prior authorization for a COVID-19 booster, asked if 2024 FTAC meetings would be extended, and for action items from the last meeting to be highlighted.

Roger Collier remarked that while approval of a Section 1115 waiver to transfer Medicaid enrollees to an untested system is unlikely, the federal government may be amenable to such after the future system demonstrates ability to combine programs.

Raleigh Watts mentioned health carriers' reported profits and encouraged FTAC to examine the benefits of a state-administered program (Model A as proposed by the Universal Health Car Work Group) such as the Washington Health Trust.

Kathryn Lewandowsky, Vice Chair, Whole Washington, noted the financial benefit for large employers to be self-insured versus smaller companies struggling to afford employees' benefits from the marketplace.

Commission updates & goals for today

Liz Arjun, Health Management Associates (HMA)

With additional resources allocated to this work, the Commission voted to extend 2024 meetings to three hours. FTAC agreed to add calls on off months for discussion if needed. Today's meeting will provide an overview of Medicaid and will surface opportunities to include Medicaid in Washington's future system. The January 2024 meeting will build off this one and explore topics and themes identified by FTAC for further discussion.

Presentation: Washington's Medicaid enrollment processes

Joan Altman, Director of Gov't Affairs & Strategic Partnerships, Washington Health Benefit Exchange (HBE)
Melissa River, Lead Policy Manager, Office of Medicaid Eligibility & Policy, Health Care Authority (HCA)

The Health Care Authority (HCA) is the Washington state agency for policy and purchasing of Apple Health (Medicaid) programs. The Health Benefit Exchange (HBE) operates Washington's marketplace and Healthplanfinder, a streamlined application for both Medicaid and individual market coverage. Both agencies work together to facilitate Medicaid eligibility and enrollment.

Apple Health is divided into Classic Medicaid (individuals aged 65 and older, or individuals that have blindness or a disability) and modified adjusted gross income (MAGI) -based Medicaid (individuals aged 64 and younger). For MAGI, Healthplanfinder determines eligibility, facilitates plan selection and automatic enrollment, and processes renewals. Healthplanfinder interfaces with state and federal databases to provide enrollees' real-time eligibility. HCA contracts with the Department of Social and Health Services (DSHS) to administer Classic Medicaid and to facilitate eligibility. Apple Health applications are accepted year-round and eligible individuals are approved for a one-year period (exceptions at timestamp 49:55). Information on the renewal timeline can be found at timestamp 53:38. Beginning July 1, 2024, Apple Health coverage will extend to residents who meet income requirements regardless of immigration status (limited enrollment based on current funding levels).

Presentation: Understanding Washington's Medicaid program & opportunities for universal health care

Roger Gantz, FTAC Member

Medicaid is the nation's publicly funded health insurance program for people with low income. For low-income Medicare enrollees, Medicaid also provides wrap-around coverage for services not covered by Medicare. Jointly financed by the federal government and states, Medicaid is administered by states within federal guidelines. States are reimbursed by the federal government for a percentage of Medicaid allowable costs - the federal medical assistance percentage (FMAP). Washington's current FMAP is 50 percent, though certain eligibility groups have higher FMAPs (see timestamp 1:02:20). States must cover certain "mandatory" populations and can receive federal funding to cover "optional" populations (more on population groups at timestamp 1:03:20).

Asset/resource eligibility requirements apply only to certain groups under Classic Medicaid. Timestamp 1:04:50 illustrates the proportion of Medicaid enrollment to expenditures by eligibility group. Washington covers the 15 mandatory benefits under federal law and 28 other optional services.

Washington's Medicaid program does not have any premium or point of service cost-sharing. Generally, Medicaid payment rates are lower than Medicare and commercial payment rates for the same services. However, for certain provider types, e.g., rural health clinics (RHCs), Medicaid payment rates may be higher due to federal payment requirements.

Apple Health is largely administered by MCOs with 1.8 million Apple Health beneficiaries currently enrolled in managed care. Evidence on the impact of MCOs on quality, access to care, and costs is limited.

While Medicaid eligibility is categorical (e.g., income, age, disability status), there may be waiver strategies, e.g., Section 1115 demonstration waivers, to incorporate Medicaid into Washington's universal health care system. Medicaid's breadth of benefit coverage, e.g., dental, hearing, and long-term care and support services, could be treated as supplemental coverage to the universal plan and provided through separate delivery systems.

Discussion

The logistics of retaining the federal match under a 1115 waiver is important, e.g., people could fail to provide necessary eligibility information. ProviderOne, the current program through which the state claims federal match rates, will likely need to stay in place but could be simplified. Healthplanfinder could also be continued, though more information is needed to determine whether asset tests for Classic Medicaid can be worked around. ProviderOne also divides payments based on eligibility groups and assigns the correct match rate and dollar amount the state will draw back.

The assumption is that FMAPs would continue in a universal system, though federal dollars could not be claimed for anyone other than those currently eligible for Medicaid under existing eligibility criteria.

Generally, Medicaid's provider reimbursement rates are lower compared to commercial coverage and Medicare. However, for hospital providers, supplemental payments are added to Medicaid rates bringing them close to, if not at, what Medicare pays. Though, this is not the case for non-hospital physicians, so Medicaid provider rates could be examined more selectively on the assumption that the state could retain access to supplemental dollars. Even selectively increasing Medicaid provider rates would be a state expense and the implications of doing so need to be examined. In a future system, provider rates will need to be standardized. Commercial payment benchmarks are too high and increasing Medicaid rates to match them would subsidize inefficiency.

Members saw value in evaluating whether MCOs are beneficial for quality, access to care, and costs. Commission Member Jane Beyer attended the meeting and suggested looking into Connecticut's experience shifting their Medicaid program away from managed care and back to a fee-for-service model in 2011.

Members agreed that a comparison of benefits between Medicaid, Medicare, the marketplace, and public employees' benefits does not exist. An actuarial analysis comparing these benefits and the respective provider rates would be helpful to anchor the Commission's discussion of a uniform benefit design.

FTAC's next meeting will further examine what surfaced at today's meeting with regards to Medicaid.

Adjournment

Meeting adjourned at 3:57 p.m.

Next meeting

January 12, 2024
Meeting to be held on Zoom
2–4:30 p.m.

Tab 5

Washington State Health Care Authority

2024 Proposed Workplan

What's Changed

- Meetings
  - Commission meetings extended to 3 hours to allow for more deliberation
  - FTAC meetings extended to 2.5 hours to allow for more deliberation
- More focused time on transitional solutions in three key areas:
  - Coverage and enrollment
  - Providers
  - Purchasing
- Regular updates on other relevant areas being addressed in other forums:
  - Affordability and Cost Containment
  - Capacity/Infrastructure
  - Increased subsidies
- Other Priorities
  - Engagement
  - Equity

Organizing Next Year’s Work

Sequencing/Selecting Transitional Solutions Topics for 2024

Coverage/enrollment

- Auto-enroll Medicaid to no-premium or lower-cost plans Exchange
- Codify and fully fund Apple Health expansion
- Increase participation in the Medicare Savings Program
- Uncovered ambulance services
- Services not covered by the Balanced Billing Protection Act

Providers

- Administrative simplification
- Motivate interest in preventative and primary care
- Network adequacy standards
- Standardize claims adjudications
- State provider participation
- Study of provider rate regulatory approaches

Purchasing

- Consolidate and expand state purchasing

Transitional Solution	Anticipated Impact	Resources Required	Potential Magnitude of Impact	Contributes to Universal System
Auto-enroll Medicaid to no-premium or lower-cost plans Exchange	• Continued coverage for people who are no longer eligible for Medicaid • CA and RI are piloting this during the PHE unwind	Medium	++	Promotes seamless coverages across markets
Codify and fully fund Apple Health expansion	• Creates access to coverage for all residents - not subject to budget allocations	High	+++	Fills existing coverage gaps and allocates resources towards coverage
Increase participation in the Medicare Savings Program	• Provide cost-sharing assistance to low-income seniors on Medicare • Addresses underinsurance for a segment of the population	Low	+	Part of the wrap approach to Medicare
Uncovered ambulance services	• Protects individuals with individual and employer-based coverage from unexpected bills for ambulance transport	Low	+	Promotes protection against medical bankruptcy for all
Services not covered by the Balanced Billing Protection Act	• Protects individuals with individual and employer-based coverage from unexpected expenses when providers bill them for what insurance doesn't cover	Low	+	Promotes protection against medical bankruptcy for all
Motivate interest in preventative and primary care	• Increase the number of providers providing primary care in order to meet the need	Low	+	Promotes a focus on prevention and primary care in a new system

Transitional Solution	Anticipated Impact	Resources Required	Potential Magnitude of Impact	Contributes to Universal System
Network adequacy standards	• Network adequacy standards vary across different sources of coverage • Strenthening and aligning would improve access for many and promote similar expectations across coverage sources	Medium	++	Begins alignment across markets
Provider Administrative simplification	• Minimizes and streamlines the reporting and billing processes for providers across coverage sources	High	++	Would promote alignment across existing coverage sources for future integration
Standardize claims adjudications	• Requires common approach to claims across health plans, minimizes burden on providers	Medium	+	Would promote alignment across existing coverage sources for future integration
State provider participation	• Increase participation in publicly-funded programs	Medium	++	Increase access for those in publicly funded programs
Study of provider rate regulatory approaches	• Providing more regulation and alignment on provider rates could improve affordability for individuals in some coverage markets.	Low	+	Could result in improved affordability across coverage markets
Consolidate and expand state purchasing	• Allows the state to leverage its purchasing power collectively across Medicaid, CC, SEBB, PEBB and WAHBE to improve affordability • Allow for “buy-in” to state programs and increased coverage opportunities	High	++	Paves the way for alignment across existing markets

Discussion

Are there natural groupings of topics to address collectively?

For example, administrative simplification, and claims and provider participation?

Prioritization of Transitional Solutions for 2024

Commission Member Vote:

Which topic would the Commission like to address first?

Which topic would the Commission like to address second?

Which topic would the Commission like to address third?

Vicki Lowe, Chair

Universal System Design Areas for 2024

Phase 1: Foundational

- Eligibility
- Benefits & Services
- Provider Reimbursement & Participation
- Cost Containment

Financing

Phase 2: Secondary

- Infrastructure
- Enrollment Processes

Phase 3: Tertiary

- Governance

Universal System Design

- Upcoming Topic: Benefits & Services
- Supporting Materials
  - Grid that allows comparison of existing benefits and services from different coverage sources: Medicaid, Exchange and Essential Health Benefits
  - Are there other resources or tools that could be helpful for this discussion?
- FTAC- TBD assignments from UHCC

FTAC's Focus in 2024

Commission Member Vote:

In 2024, should FTAC's focus continue to be on universal system design (first topic benefits), or on transitional solutions?

Vicki Lowe, Chair

Tab 6

Washington State Health Care Authority

The Washington Health Trust
Eligibility

How SB.5335 achieves universal coverage

Slides submitted 12/5/2023

Presentation on 12/14/2023

For the latest version of these slides go to
wholewashington.org/uhcc-presentations

Designing the Washington Health Trust

- Originally based on the Washington Health Security Trust (WHST) bill
- Inspiration from H.R. 676
- Used Healthy San Francisco as a model (with respect to ERISA) for aligning employer funding
- Met with ESD and DOR to ensure process was feasible and in line with WA State law
- Two financial analyses by Professor Gerald Friedman of UMass Amherst
    - https://wholewashington.org/friedman-financial-analysis-2021

Our goals

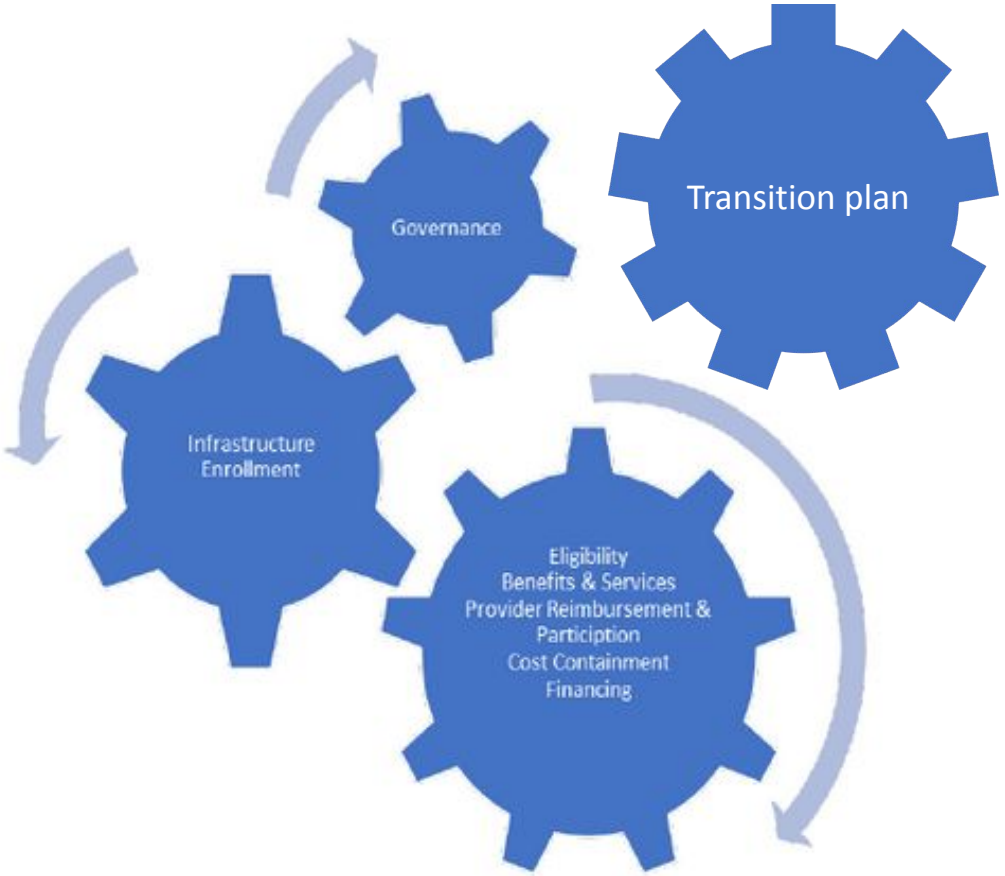
Today

- Define eligibility in the context of a universal healthcare system.
- Roadmap how universal eligibility can be achieved in the context of Washington State including integrating existing programs like Medicaid and Medicare.
- Explain how to create universal employer eligibility while working within the constraints of ERISA.

The future

- Establish an ongoing and collaborative relationship with the Universal Health Care Commission (UHCC)
- A more detailed discussion of the financial considerations with the Finance Technical Advisory Committee (FTAC)
- Co-development of universal healthcare policy for recommendation to the WA legislature

Design components developed by the Commission



Defining Universal Healthcare

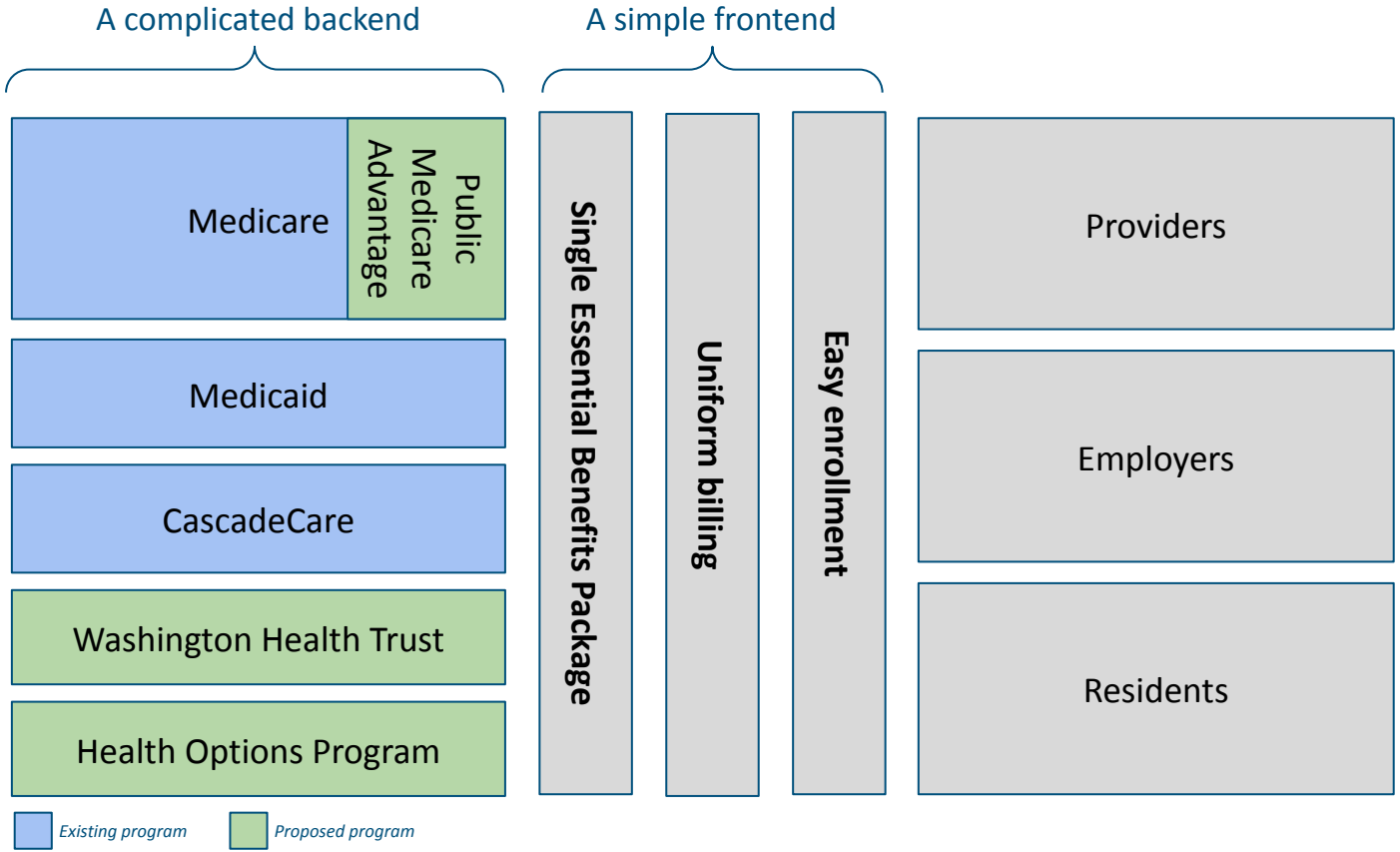
Defining Universal Healthcare: World Health Organization

"Universal health coverage means that **all people have access** to the **full range of quality health services** they need, **when and where they need them**, **without financial hardship**."

Key elements found in successful models:

1. **Everyone is eligible to enroll or automatically enrolled**
2. Universal set of essential health benefits
3. Uniform billing and reimbursement
4. Significantly publicly-funded
5. Non-profit

Simplifying our healthcare system



Enrollment

- The enrollment process is not specified in legislation but is managed by the Washington Health Trust Board & HCA
- Can be done through existing infrastructure like WAHealthPlanFinder, hospitals, the DMV, public libraries, voter registration, etc.

Individuals

Eligibility: Individuals

Who's eligible?

- All Washington residents
- Students Attending College
- Workers Employed in WA
- Spouses and Dependents of Eligible nonresidents

Where do individuals currently get their coverage?

- Employer sponsored health plans
- Medicare
- Medicaid
- The exchanges or other individual plan
- They're uninsured

Individuals: Medicaid (Apple Health)

- No substantial obstacles to enrolling Medicaid recipients.
- Individuals enroll through WAHeathPlanFinder - an excellent model for expanding all enrollment
- We already have an innovation waiver, which gives us flexibility.
- The trust would reimburse providers at the increased negotiated rate for all residents. This guarantees equity for all patients.
- Federal waiver 1115 would allow us to fully integrate Medicaid into the WHT.

Individuals: Medicare

We cannot:

- Apply federal Medicare funds to our state plans without a federal demonstration waiver
- Automatically move people from Medicare to our state plans

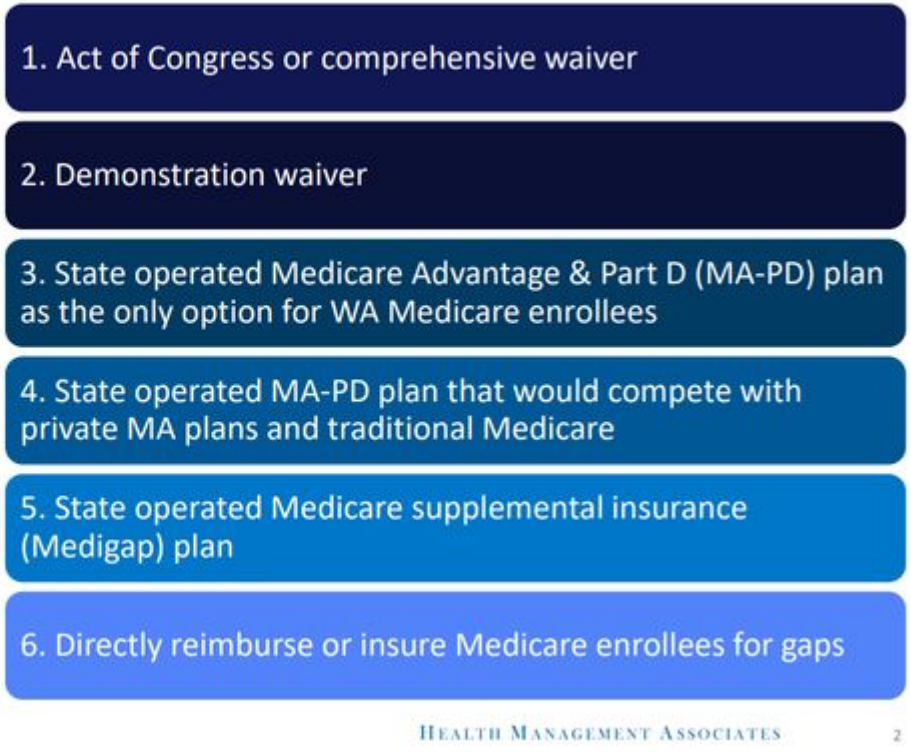
We can:

- **Immediate**: Medicare functions as it does today
- **Interim**: Supplement Medicare with a publicly funded and managed Medicare Advantage plan
- **Long-term**: Fully integrate Medicare after receiving a federal demonstration waiver

Transition: Medicare integration & waivers

- The bill instructs HCA to work on a Demonstration waiver (#2)
- During the transition, the WHT is a Medicare Advantage Plan with Part C and D for those who voluntarily enroll (#4)

We must pass state law & create universal health care infrastructure before a Federal Waiver for integration can be approved.



Transition: The WA Health Benefit Exchange

- Federal funds for cost assistance provided through the exchanges are folded into the WHT
- At 51% enrollment for all state-managed plans (we're currently at 40%), the WHT would be the **only** plan to receive cost assistance
- The exchange could still be used by the HCA to support enrollment and Medicaid eligibility assessment

Transition: **Health Options Program** - covering gaps

Managed by the HCA, the Health Options Program provides support through direct reimbursement for coverage gaps. It ensures coverage and cost equity for those not enrolled in the WHT.

Community Health Access	Medical Reimbursement Accounts
Access to Essential Health Benefits from Community Health Providers	Reimbursements for Out-of-Pocket Costs

The HCA can expand existing structures/programs currently used to support enrollment and provide insurance assistance like the Navigators Program & WAHealthPlanFinder.org.

Employers

Eligibility: Employers

We cannot

- Mandate employers who provide ERISA protected health benefits to participate directly in the WHT.

We can

- Require employers to provide health coverage for all employees.
- Create a 10.5% per-employee **Required Health Expenditure**.
- Define what kinds of spending qualify towards that expenditure.
- Cover all children.

The Washington Health Trust's ERISA workaround was modeled after Healthy San Francisco's city-option which has survived legal challenges.

Employer Health Spending Equity

All employers are required to pay a minimum percentage of each employee's payroll toward that employee's health care.

Required Health Care Expenditure

10.5% of employee compensation

Private Insurance Option + **Direct employee healthcare funding** + **WA Cares (Long Term Care)**

or

Pay 10.5% to ESD directly to have employee covered by WHT

If the employer-sponsored coverage or contributions don't meet or exceed 10.5%, the difference must be paid to the ESD.

Providers

Providers

All licensed providers are eligible to receive reimbursement for services from the WHT, but participation is optional.

All providers and health systems giving care to a WHT enrollee:

- can accept the fee-for-service (FFS) rates set by the WHT Board
- can’t be denied reimbursement by the WHT for any essential health benefits

Rate Estimation: Analysis based on reimbursement rate above Medicare but rates will be negotiated by the Washington Health Trust Board.

Why Would These Solutions Work?

- Legally sound
- Voluntary enrollment
- Community input and public transparency
- Regular assessment with the ability to adapt and improve

Where do we begin?

Transition: Year-by-year

Year 1	Year 2	Year 3	Year 4	Year 5
DOR collects Capital Gains Tax. (Jan) **Employers** begin to sunset revocable health expenditures. (Jan) **UHCC becomes WHT Board** - Designs the Essential Benefits Package & mechanisms needed to negotiate reimbursement rates with providers. (May) **Legislature** makes start up appropriations (July) **WHT** makes policies needed to offer WHT on the Exchange. (Nov) **HCA** Annual Reports begin. (Nov) **WHT** sends Benefits pkg & actuarial analysis to Gov. (Dec)	**ESD** begins to provide assistance to small businesses. (Jan) **Employers** continue to sunset revocable health expenditures. (Jan) **WHT** adopts a budget & reports to Legislative Committees. (May) **WHT is offered to all Washingtonians & eligible non-residents and businesses. (Nov)** **HCA** submits reports on Waiver progress & any statutes needed to Legislative Committees. (Nov)	**WHT** continues to offer coverage to everyone and coverage begins for enrollees. (Jan) **Employers** can not count revocable expenditures toward their required health expenditure. (Jan) **ESD** collects self-employment contribution from self-employed residents. (Jan)	**WHT** continues to offer coverage to everyone and reimburse providers for enrollees. Essential benefits package includes Long Term Care (Jan) **WHT** makes proposals for integrating federal funds and L&I (Jan) All employers must pay the Required Health Care Expenditure towards each employee's health costs. (Jan) **ESD** begins collecting the Employment Contribution from employers, enforcing the Required Health Care Expenditures. (Jan) **HCA** presents plan to further integrate employee health benefits. (Nov)	**WHT** continues to offer coverage to everyone and enrollees. **WHT** begins integrating federal programs, L&I, and employer health benefits plans based-on opportunities available. **Employers** continue to pay the required health care expenditures for each employee **ESD** begins collecting Employer Contributions for enrollment in WHT from out of state employers of WA residents. **ESD** can begin adjusting to the Required Health Care Expenditure rate in coordination with WHT Employment Investment costs for enrollment.

Questions

For the latest version of these slides go to
wholewashington.org/uhcc-presentation

Tab 7

Washington State Health Care Authority

Preliminary Affordability Report

Presentation to Universal Health Care Commission,
Jane Beyer, Senior Health Policy Advisor
December 14, 2023

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Affordability challenges for Washingtonians

Health Care Affordability Growing Problem for All

Consumers: A 2022 survey in Washington found:

- 62% of people had experienced at least one health care affordability burden in the past year, including rationing prescriptions, delaying or going without necessary care and depleting their savings.
- 81% said they worried about affording health care in the future.

Employers: In 2022, OIC found health care costs for the commercial health insurance market in Washington increased by 13%, nearly double the rate of inflation of 7%, between 2016 and 2019.

State Budget: Washington state now spends more than 20% of its general fund budget on health care.

Legislative direction

Legislative direction

- 2023 Legislature directed the Office of the Insurance Commissioner and the Office of the Attorney General to evaluate policy options that could improve overall affordability for consumers, employers and taxpayers.
    - Preliminary Reports – December 1, 2023
    - Final reports – August 1, 2024

Components of Preliminary Reports

Office of the Insurance Commissioner report:

- The structure of Washington's current health care system, including information about vertical and horizontal consolidation of health insurers, hospitals and health care providers.
- Private equity investment trends in Washington.
- An overview of potential policy options to improve health care affordability, some already adopted to some degree in Washington.

Attorney General Office report:

- An overview of current enforcement of federal and state antitrust laws aimed at securing strong market competition.
- A review of how other states monitor and challenge health care consolidation (i.e. mergers and acquisitions).
- A review of non-compete agreements in health care and anti-competitive provisions in insurer/provider contracts.

Structure of Washington's health care system

Vertical and Horizontal Integration Among Hospitals

- 40 of the 101 hospitals in the state are part of the five largest hospital systems: Providence/Swedish, MultiCare, Virginia Mason Franciscan Health, UW Medicine, and PeaceHealth and another 15 are part of smaller multi-hospital systems.

- 79.51% of all licensed beds are part of multi-hospital systems.

- In 2022, 9% of hospital systems owned skilled nursing facilities (SNFs), 82% owned hospital-affiliated clinics, 28% owned freestanding clinics, and 13% own a home health agency.

- Approximately 50% of physicians are employed by hospitals and of these, 65.6% are employed by multi-hospital systems.

Vertical Integration Among Insurers

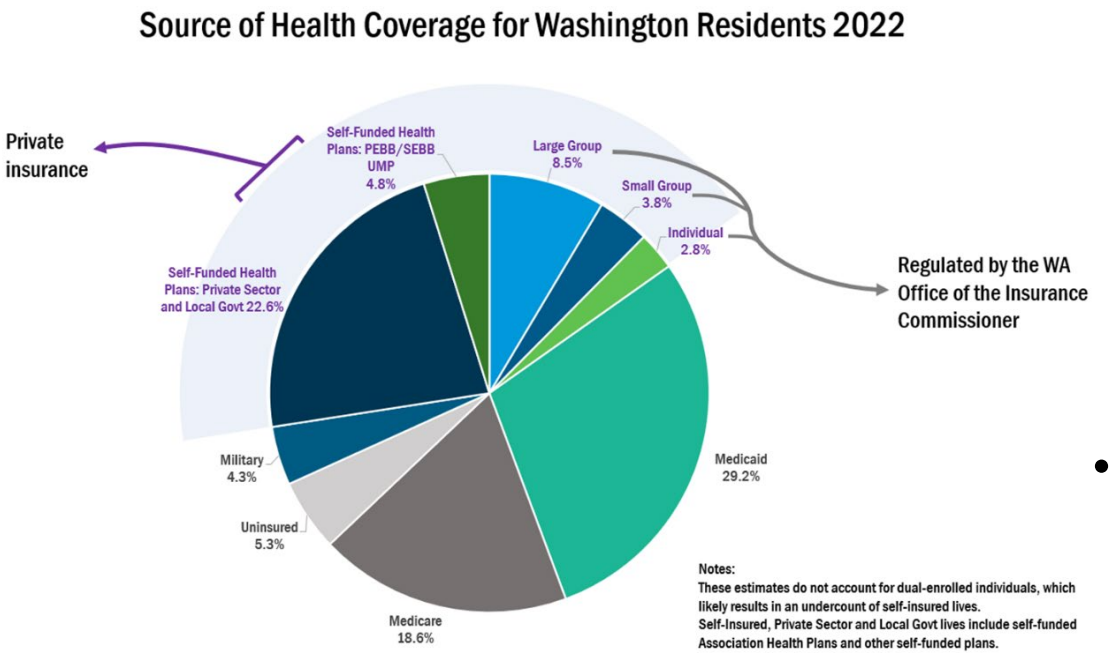
- Insurers actively purchasing physician groups and clinics- United HealthCare is reportedly the largest employer of physicians nationally.
- Insurers or their holding companies have integrated with other sectors including:
  - Pharmacy benefit managers (PBMs)
  - Pharmacy services,
  - Health care benefit managers
  - Third-party administrators
  - Data and analytics
- Beyond acting as health insurers, also involved in various aspects of the care that Washingtonians receive.

Private Equity

- Growing national trend – little public information available and some controversy about the impact on cost and quality of care.
    - Recent review of 55 studies: private equity ownership was most consistently associated with increased cost to patients/payers and mixed to harmful impacts on quality of care.
- Key investment areas: specialists (dermatology, ophthalmology, gastroenterology, primary care, OB/GYN, radiology, orthopedics, oncology, urology, and cardiology) and other health care facilities and services, e.g. hospice and home health care.
- From 2014–2023, 97 health care acquisitions in Washington State
- Private equity & physician staffing companies.
    - TeamHealth – 1 of 6 largest emergency medicine staffing companies nationally.
    - US Anesthesia Partners – Operates in 8 states; largest majority physician-owned + led anesthesia group in the PNW.

Affordability policy options

Several Sources of Coverage Require Different Policies to Address Affordability



- Washingtonians receive health coverage from different sources, each subject to different laws and regulations, with oversight by different state and federal authorities.
- Addressing affordability across these markets may require a combination of policy options.

Health Care Cost Growth Benchmarks

- Cost growth benchmarks establish targets for how much health care spending should grow each year. States set statewide benchmarks; some also apply these benchmarks to providers and payers.

- Established in nine states and have shown mixed results. Massachusetts, the most mature program, recently issued recommendations for improvement, including a need to focus on constraining provider prices.

- Washington's HCCTB, established in 2020, will issue its first report on baseline health care expenditures in Fall 2023.

- HCCTB lacks authority to take action against a provider or payer that exceeds the benchmarks, such as requiring Performance Improvement Plans.

Health Insurance Rate Review

- Process where state Insurance Departments (OIC in Washington), review proposed health plan rates and must approve them prior to their going into effect.

- 43 states have prior rate approval over the individual market, 38 states have prior rate approval over the small group market. Rhode Island imposes a cap on the amount hospitals can increase their prices each year and has a process for large group health plan rate prior approval.

- Under ERISA, states cannot require rate review for self-funded health plans.

- Washington requires prior rate approval only in the individual and small group markets.

Reinsurance

- Reinsurance programs lower premiums for consumers in the individual market by paying a portion of high-cost claims incurred by health insurers.

- 17 states have reinsurance programs that lowered premiums from 5% to 38% in 2022.

- Washington considered reinsurance in 2018 but did not enact it due to the potential cost to the state.

Reference-Based Pricing

- Establishes standard reimbursement rates that are tied to an already defined price standard, such as a percentage of Medicare, for a set of health care services.

- Montana and Oregon established this for their state employee programs (and school employees in Oregon) and realized significant savings as a result.

- Washington has implemented reference-based pricing for its public option plan, Cascade Select. Provider reimbursement is limited to 160% of Medicare in the aggregate. To date, premium increases have been lower than other plans on the Exchange.

All-Payer Model

- An All-Payer Model establishes rates for hospitals that are the same for all payers and sets global budgets for hospital revenue.

- Maryland only state will all-payer model. Has evolved over time 10+ years to a Total Cost of Care Model that expands all-payer rate setting from hospitals to include primary care and specialty providers and provides support and incentives for care redesign.

- Washington had a hospital rate-setting statute in the 1970's and '80s. It was repealed in 1989.

Facility Fee Reform

- Additional oversight and limitation of "facility fees" for care received in outpatient and physician office settings that are part of hospital system.

- Few other states have addressed. Those that have focus on limitations about when and where fees can be charged and additional reporting and transparency; Connecticut has been the most aggressive.

- Washington: Clinics charging facility fees must disclose that the clinic is part of a hospital system and that the patient may be charged a separate fee that could result in additional out-of-pocket expenses.

Medical Loss Ratio Requirements

- The ACA requires insurers in the individual and small group markets to pay 80% and insurers in the large group market pay 85% of the premium collected towards medical care or quality improvement efforts.

- Can be seen as a tool to reduce premiums by limiting administrative expenses and profits. Massachusetts has adopted a higher MLR of 88%.

- Washington uses the minimum MLR requirements established by the ACA.

Public Option Plans

- Public Option plans are designed to be the most affordable plans in the individual and small group markets

- Colorado established a public option plan that is intended to decrease premiums by 15% over three years. Too early to know if goal will be met.

- 2023 enrollment in Washington's public option plans (Cascade Select) at 11% of Washington Healthplanfinder individual market enrollment. Premium increases in public option plans lower than other plans offered on the Exchange. In 2024, Cascade Select will be the lowest cost silver plan in 31 counties.

- Nevada also in the process of implementing a public option.

State Exchange Subsidies

- State funds lower premiums and provide cost sharing assistance for consumers enrolled in Exchange plans.

- Eight states have implemented some form of state-based premium or cost-sharing assistance.

- Washington has a state-funded premium subsidy to Exchange consumers who enroll in Cascade Care silver or gold plans. Dedicated funding for subsidies for certain immigrant groups.

Prescription Drug Pricing Regulation

- Programs to increase transparency, cap out of pocket costs for prescription drugs and oversee Pharmacy Benefit Managers.

- Eight states have implemented programs to oversee and regulate prescription drug prices; insufficient experience to determine their effectiveness.

- Washington's Prescription Drug Affordability Board was established in 2022. Authorized to conduct up to 24 affordability reviews of drugs that have been on the market for 7 years. PDAB had its first meeting in October 2023.

Individual Mandate

- Requires individuals to participate in health insurance coverage to promote universal enrollment and a larger risk pool- penalties could be used to support affordability provisions.

- Five states have enacted individual mandates.

- Washington enacted an individual mandate as part of the 1993 Health Services Act, which was repealed in 1995.

Next Steps

- Discuss policy options with key stakeholders and Legislators to identify which to investigate further. Would welcome input from UHCC.
- Perform in-depth economic and actuarial impact analysis on selected policy options and conduct key informant interviews.
- Findings in final report due August 2024.

Questions?

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WA OIC Preliminary Report on Health Care Affordability

November 29, 2023

Prepared By
Health Management Associates

With an Introduction From
The Office of the Insurance Commissioner

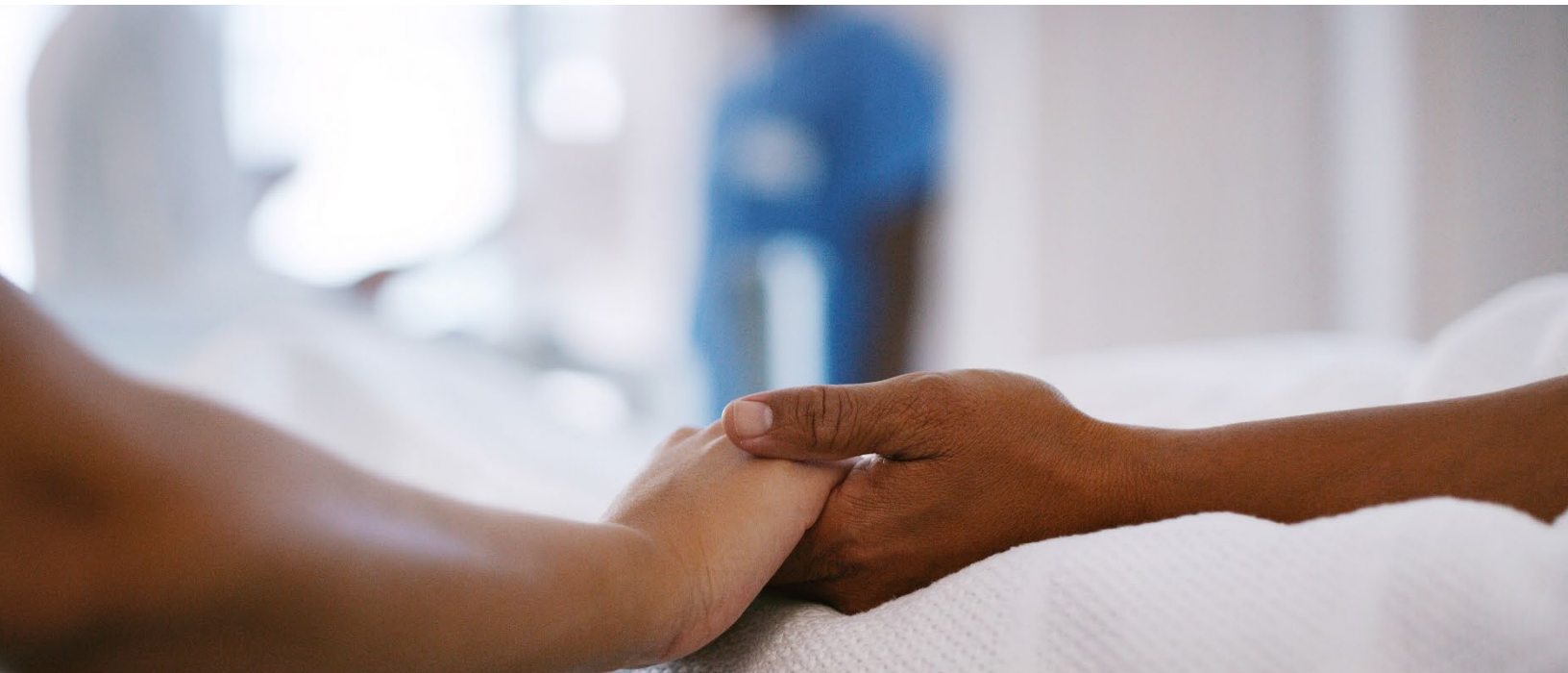
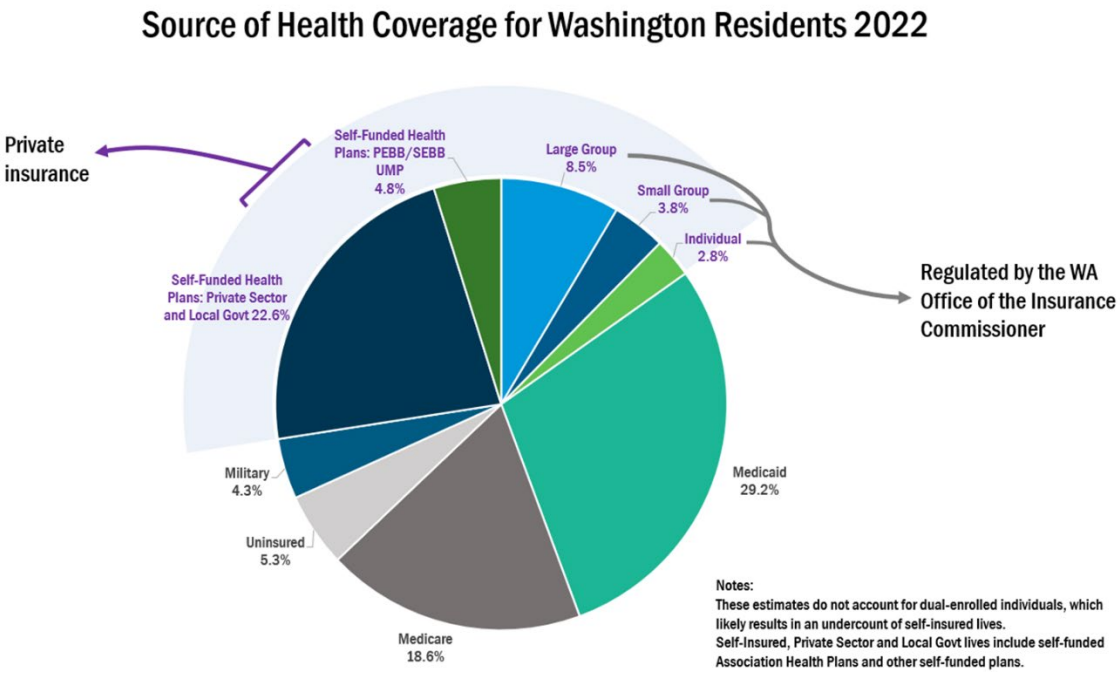


Table of Contents

INTRODUCTION FROM THE OFFICE OF THE INSURANCE COMMISSIONER

Despite having one of the lowest uninsured rates in the country and seeing Washington state's uninsured rate stay under 6%, rising health care costs have created a growing and persistent health care affordability challenge for individuals, families, employers, and taxpayers in Washington state.[1] Health care expenditures now account for over 20% of Washington's general fund budget.[2]



Challenges with health care affordability are not limited to individuals with lower incomes or those without health insurance. A survey of 1,300 Washingtonians in November 2022 found that 62% of respondents had experienced at least one health care affordability burden in the past year – including rationing medication, delaying or going without care, and depleting savings – and that 81% worried about affording health care in the future.[3]

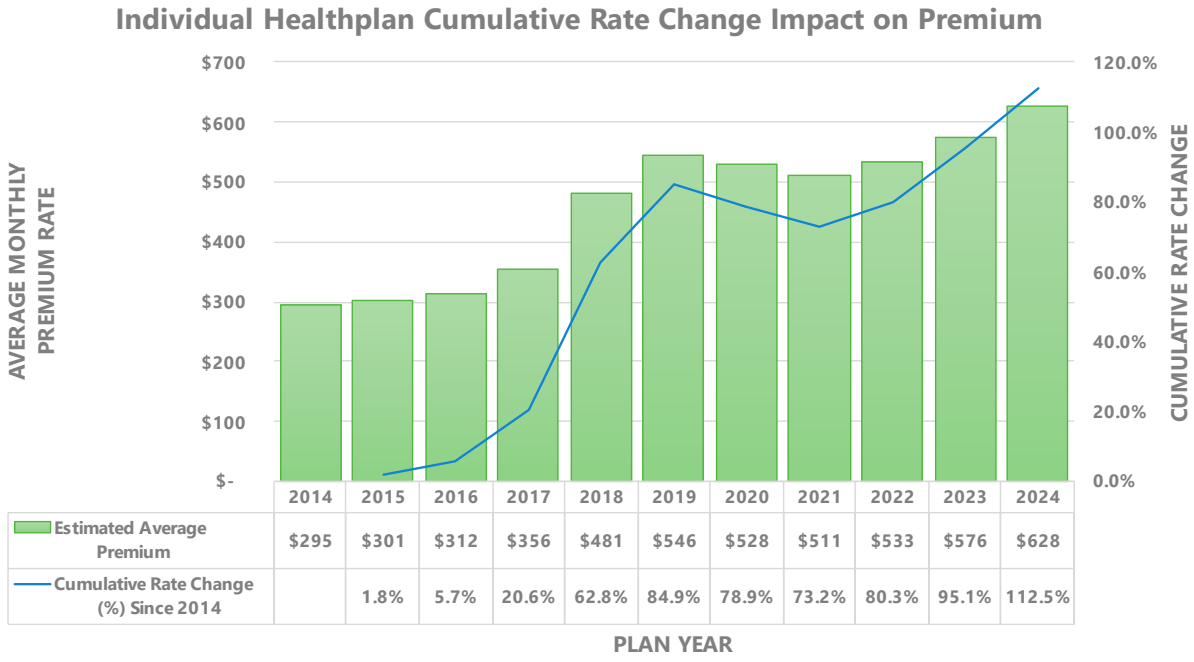
[1] Washington State Office of Financial Management. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief108.pdf

[2] Retrieved from https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/budget-drivers/change-medical-costs

[3] Retrieved from https://www.healthcarevaluehub.org/advocate-resources/consumer-healthcare-experience-state-survey.

This year, the Commonwealth Fund surveyed individuals with all types of health coverage about their ability to afford health care. Across all of the groups surveyed, insured working-age adults said it was "very" or "somewhat difficult" to afford their health care including 43% of those with employer coverage, 57% with individual health plans, 45% with Medicaid, and 51% with Medicare.[4]

In Washington state specifically, workers and businesses have experienced double-digit increases over the last decade, with the total average premium for a single worker rising by 49% and the deductible rising by 78.5% from 2010 through 2020.[5] From 2014 to 2024, premiums for health plans purchased on the Washington state Health Benefits Exchange more than doubled – from $295 per month to $628 per month.



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Estimated Average Premium	$295	$301	$312	$356	$481	$546	$528	$511	$533	$576	$628
Cumulative Rate Change (%) Since 2014		1.8%	5.7%	20.6%	62.8%	84.9%	78.9%	73.2%	80.3%	95.1%	112.5%

[4] "Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer." Retrieved from https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey. November 7, 2023.

[5] "State Trends in Employer Premiums and Deductibles, 2010 - 2020". Retrieved from https://www.commonwealthfund.org/publications/fund-reports/2022/jan/state-trends-employer-premiums-deductibles-2010-2020 November 7, 2023.

An analysis of the commercial health insurance market commissioned by the Office of the Insurance Commissioner (OIC) in 2022 found health care costs for the commercial health insurance market in Washington increased by 13%, nearly double the rate of inflation of 7%, between 2016 and 2019.[6]

Health care costs are driven by two factors – the type and number of health services people use and the price paid for those services. Employers and Washington state have tried to address health care costs through changes in health plan design, such as encouraging use of generic drugs, offering high deductible health plans and encouraging use of higher quality, lower cost health care providers and facilities. Yet, due to changes in the structure of Washington's health care system, moderating the price of health care services has been a substantial challenge. Consolidation in the healthcare industry is a key factor driving up prices.[7] Generally, consolidations do not improve quality of care, but rather, drive up prices and impact access to care for patients and working conditions for providers.[8]

Given the affordability challenges for Washington consumers, employers, and taxpayers, policymakers in Washington state have made several efforts to increase health care cost transparency and oversight, which are described further in this preliminary report. At the same time, it has become clear that this problem is one that pervades all types of health insurance coverage and likely will require an overlapping set of policies to address underlying health care costs while maintaining access to quality care for Washingtonians.

This year, the Legislature recognized the need to better understand policy options designed to improve affordability for consumers, their employers and taxpayers. Sec. 144(13)(a) of the 2023 biennial operating budget [9] directed the OIC and the Attorney General's Office (AGO) to conduct an analysis of a range of policy approaches to improve health care affordability, focusing on other states that have adopted the affordability policy, any impacts of the policy and whether any components of the option have been adopted in Washington state. A final report on affordability policy options will be delivered in August 2024 and will include in-depth actuarial and economic analysis of a subset of the policy options presented in this report and the companion report issued by the AGO. The subset of options to be analyzed will be determined after consultation with interested organizations and legislators.

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[6] Retrieved from https://public.tableau.com/app/profile/onpointhealthdata/viz/WashingtonStateCommercialTrendsinCost2016-2019/TotalTrends?publish=yes

[7] *See e.g.*, Karyn Schwartz et al., *What We Know About Provider Consolidation*, Kaiser Fam. Found. (Sept. 2, 2020) (citing to other relevant articles).

[8] Samuel M. Chang et. al., Examining the Authority of California's Attorney General in Health Care Merger, California Healthcare Found., (Apr. 2020). Elena Prager & Matt Schmitt, Employer Consolidation and Wages: Evidence from Hospitals (Washington Cntr. for Equitable Growth, Working Paper, 2018) (finding evidence of negative wage growth among skilled workers following recent hospital mergers). Carley Thornell, Physicians report that organizational and technology changes are among the biggest burnout factors, athenahealth, (July 2, 2021) (reporting on findings from 799 physician respondents between October and December 2020).

[9] State of Washington. Sec. 144(13)(a) of Engrossed Substitute Senate Bill 5187: Washington State 2023−2025 Biennial Operating Budget. Effective May 16, 2023. Available at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5187-S.SL.pdf?q=20231117085318. Accessed November 25, 2023.)

This preliminary report includes:

- A detailed description of Washington's existing health care insurance and care delivery structure, with a focus on available information regarding vertical and horizonal consolidation among health insurers, hospitals, and providers and an overview of private equity health care investment trends in the state. This information is included to provide a shared baseline understanding of the health care system in Washington state as the legislature considers cost and affordability challenges and the potential impact of health policy interventions designed to address affordability.
- An overview of potential policy options to address underlying health care costs, some of which have already been adopted in Washington.
- A description of the proposed economic model that will be used during the final report—along with actuarial analysis—to evaluate the impacts of a selected set of policy options.

An accompanying report from the AGO provides a detailed analysis of antitrust law and policy options related to health care merger and acquisition oversight and provisions of health insurer/health care provider contracts that impair market competition.

EXECUTIVE SUMMARY

Horizontal Consolidation and Vertical Integration in the Washington Health Care System

Washington State's health care system has changed significantly because of horizontal consolidation and vertical integration across health care providers, facilities, and insurers. For example, in the last three decades, hospital resources and care in Washington have become more concentrated as hospitals have closed or become part of multi-hospital systems. The percentage of hospitals in systems grew to nearly 50% in 2017 from 10% in 1986, according to a study from Washington's Office of Financial Management.[10] The number and percentage have increased since. According to a July 20, 2022, Washington State Health Authority presentation to the Health Care Transparency Board, 40 of the 101 hospitals in Washington are affiliated with the five largest hospital systems: Providence/Swedish, MultiCare, Virginia Mason Franciscan Health, UW Medicine, and PeaceHealth. Another 15 belong to smaller multi-hospital systems.[11] These systems control a substantial portion of available beds and hospital-employed physicians in the state.

- Eight multi-hospital systems[12] have more than 90% of the licensed and more than 65% of the staffed beds at hospitals in the state.
- Eight multi-hospital systems employ more than 65% of the physicians and physician assistants that hospitals employ in the state.
- Most multi-hospital systems own and operate hospital-affiliated clinics, and many own freestanding clinics and other health care facilities.[13]

Similar to the consolidation of hospital systems and their operation of clinical services outside of the hospital, health insurers have purchased, either directly or through their holding companies, physician practices and other parts of the health care delivery system. For example, United HealthGroup, through its Optum subsidiary, is reportedly the largest employer of physicians in the country, with more than 70,000 employed or aligned physicians across more than 2,200 locations in 2023.[14]

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[10] Bolton D. Hospital Mergers in Washington 1986-2017. Washington State Health Services Research Project Research Brief No. 105. Office of Financial Management. March 2022. Available at: https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief105.pdf. Accessed November 25, 2023.

[11] Washington State Health Authority to Report to Health Care Cost Transparency Board. Washington State Hospitals: A Primer on Washington Hospital Costs, Tab 5. July 20, 2022. Available at: https://www.hca.wa.gov/assets/program/hcctb-board-book-20220720.pdf. Accessed November 25, 2023.

[12] A multi-hospital system has more than one hospital. In Washington, these include: Astria, Evergreen, LifePoint, MultiCare, PeaceHealth, Providence, Skagit, University of Washington, Virginia Mason Franciscan, and Confluence. Kaiser Permanente, which is a fully-integrated health care system consisting of a health plan, one hospital, medical clinics, physicians and other health care providers, with facilities throughout the state, is considered a health insurer for purposes of this report.

[13] Washington State Health Authority to Report to Health Care Cost Transparency Board. Tab 5. Washington State Hospitals: A Primer on Washington Hospital Costs. July 20, 2022. Available at: https://www.hca.wa.gov/assets/program/hcctb-board-book-20220720.pdf. Accessed November 25, 2023.

[14] Emerson J. Meet America's Largest Employer of Physicians: UnitedHealth Group. Becker's Payer Issues. Updated February 16, 2023. Available at: https://www.beckerspayer.com/payer/meet-americas-largest-employer-of-physicians-unitedhealth-group.html#:~:text=Meet percent20America's percent20largest percent20employer percent20of percent20physicians percent3A percent20UnitedHealth percent20Group. Accessed November 25, 2023.

With its acquisition of home health provider Signify Health in 2023, CVS Health added 10,000 physicians and other clinicians to the estimated 40,000 physicians and nurses it employs in its MinuteClinics and HealthHUBs.[15]

Health insurers have also integrated with a number of other sectors of the health care industry. The three largest pharmacy benefit managers (PBMs), which collectively account for 89% of the market, are Express Scripts (Cigna), CVS Caremark (Aetna), and Optum Rx (United Health Group).[16]

Washington's experience is consistent with national trends. Through their holding companies and subsidiaries, among the five insurers with the largest market share in Washington:[17]

- Four own companies that provide pharmacy services (retail, specialty and/or pharmacy benefit managers).
- Four own and operate clinical facilities, including medical clinics, home health agencies, lab services, and so on.
- All function as third-party administrators (TPAs) for self-funded employer plans under administrative services only (ASO) contracts.[18]

Table 6, page 27 lists ownership by the five largest health insurers in the state of pharmacy services, health care benefit managers, clinical services, and other health care sectors. This table illustrates the extent to which each of these companies provides health care services to Washingtonians, in addition to their role as health insurers.[19]

An additional recent trend is the investment in health care facilities and services by private equity firms. Private equity firms pool funds from investors to invest in a variety of industries. Private equity investment in various sectors of the health care economy has been growing nationwide over the past two decades. For example, one national study found that private equity purchases of physician practices across a number of specialties grew from to 484 deals in 2021 from 75 deals in 2012.[20]

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[15] American Hospital Association. CVS Health Adds Home Health Services. What's Next? Available at: https://www.aha.org/aha-center-health-innovation-market-scan/2022-09-13-cvs-health-adds-home-health-services-whats-next#:~:text=With percent20the percent20Signify percent20purchase percent2C percent20CVS,soon percent20to percent20be percent201 percent2C500 percent20HealthHUBs. Accessed November 25, 2023.

[1616] National Association of Insurance Commissioners. Pharmacy Benefit Managers. Updated June 1, 2023. Available at: https://content.naic.org/cipr-topics/pharmacy-benefit-managers. Accessed November 25, 2023.

[17] Premera Blue Cross, Cambia, Kaiser, CVS/Aetna and United HealthCare.

[18] *See* Table 6, p. 27

[19] These data are based on information found on insurer websites and financial reports filed by the insurers with the Office of the Insurance Commissioner pursuant to the Insurer Holding Company Act, 48.31B RCW. For details, go to: https://app.leg.wa.gov/rcw/default.aspx?cite=48.31B.

[20] Scheffler R, Alexander L, Fulton B, Arnold D, Abdelhadi O. Monetizing Medicine: Private Equity and Competition in Physician Practice Markets. American Antitrust Institute. July 10, 2023. Available at: https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf. Accessed November 25, 2023.

This report includes data showing that four acquisitions occurred in 2014. By 2023, the total number of acquisitions has grown to 97. Since 2014, private equity firms have made acquisitions in the following categories of clinical services, among others in Washington:

- Physical therapy (12)
- Home care/hospice (10)
- Behavioral health/substance use disorder (SUD)—8
- Ophthalmic/optometric (7)
- Non-specialty medical (4)
- Gastroenterology (3)
- Other (9)[21]

Private equity firms also own physician staffing companies. TeamHealth, one of the six largest emergency medicine staffing companies in the country,[22] employs physicians and other providers of emergency medicine and post-acute care services at hospitals and clinics throughout the state.[23] US Anesthesia Partners, a single-specialty anesthesia practice, provides services at Swedish medical centers and other ambulatory surgery centers (ASCs) in the Seattle area.[24]

Policy Options to Address Health Care Affordability

This report describes policy options that other states have pursued to address health care affordability and, where applicable, compares the Washington experience with that of other states. These policies include:

- Set Health care cost growth benchmarks
- Establish prescription drug pricing regulation
- Enhance health insurance rate review
- Increase health insurer medical loss ratio requirements
- Implement a reinsurance program
- Use reference-based pricing
- Implement facility fee reform (e.g., site-neutral payment requirements)
- Offer public option health plans
- Implement exchange subsidies
- Enact a state individual mandate
- Create an all-payer model, as in Maryland

[21] Data obtained from PitchBook, October 2023.

[22] Monetizing Medicine: Private Equity and Competition in Physician Practice Markets.

[23] TEAMHealth. Locations. Available at: https://www.teamhealth.com/locations/?r=1. Accessed November 25, 2023.

[24] US Anesthesia Partners. USAP--Washington. Available at: https://www.usap.com/locations/usap-washington. Accessed November 25, 2023.

Economic Model

The final report will include actuarial analysis and economic modeling to project the likely impact of adopting policies to address health care affordability. This preliminary report describes the analytic framework of the economic model, which will be used to estimate the impact of the policy options selected for further analysis. The model will examine both direct benefits, such as the effect on health care spending by major purchasers of health insurance and indirect benefits, including increases in wages and reduced spending on means-tested programs. The model also will estimate the multiplier effect, which will reflect the positive ripple effect on Washington's economy as various parties experience savings from lower health care costs, which can be spent on wages, new business investments, etc. The model also will examine the costs that probably would be incurred to develop, implement, and manage the new policies.

The final outputs of the model will be a calculation of the ratio of total benefits to total costs, and the ROI from adopting the policies examined.

PART I: HORIZONTAL CONSOLIDATION AND VERTICAL INTEGRATION IN THE WASHINGTON STATE HEALTH CARE SYSTEM

This part describes the structure of the health care insurance and delivery system in Washington. It first looks at the various settings where physicians are employed in the state, providing data on the percentage of physicians working in hospitals or clinics, single or multi-specialty practice groups, state or federal government, or solo practice.

It then provides data on the percentage of physicians and physician assistants employed by hospitals who work in multi-hospital systems, as well as the percentage of hospital beds in the state that are available within those systems.

Next, it provides data on the extent to which hospitals or health systems own or control other hospitals, clinics and other types of providers.

It then examines the extent to which health insurers in the state, either directly or through their holding companies, own or control entities that provide a variety of health care services in addition to insurance coverage.

Finally, it describes private equity investment in health care companies in the state.

Caveat Related to Data Limitations

The data below were obtained from publicly available sources. Health Management Associates (HMA) is grateful for invaluable assistance from: the Washington State Hospital Association, the Washington State Medical Association, and the staff and subject matter experts at the Health Care Authority, the Department of Health, and the Health Benefit Exchange.

No public, single source was found for several categories of data that the legislature requested in the budget proviso. For example, to determine the medical facilities that hospitals own and operate, HMA had to consult their websites, which contained helpful but incomplete information. In addition, HMA was unable to find public sources to determine the number of providers, other than physicians and physician assistants, employed in each sector of the system.

Under the Insurer Holding Company Act, 48.31B RCW, insurance companies must file financial reports that include Schedule Y, which describes the holding company structure and lists all entities in which the holding company or its subsidiaries have an ownership interest. To the extent that lawmakers are interested in fully understanding the structure of the health care system in Washington and, in particular, the impacts of horizontal consolidation and vertical integration, HMA recommends that the legislature grant additional authority to the appropriate state agencies to collect data on the ownership of health care facilities in the state and the number and types of providers they employ.

For example, the state could require certain categories of health care entities, such as hospitals, physician practice groups of a specified size and private equity firms, to report on who owns them, what other health care entities they own, and the number and types of health care professionals they employ.[25]

Physician Employment in Washington State

It has been widely reported that the number of physicians working in independent practices has been declining. A report by Avalere Health for the Physician's Advocacy Institute found that as of January 1, 2022, almost 50% of physicians nationwide were employed by hospitals or health systems, and 20% were employed by other corporate entities.[26] This trend accelerated during the COVID-19 pandemic.

HMA has not found any single source for current, accurate data on the settings where physicians in Washington work. The Washington Medical Commission surveyed physicians and physician assistants in the state from October 2021−September 2023; 40% of practicing physicians reported being employed by a hospital or clinic.[27],[28]

Tables 1 and 2 (on the following page) show the responses from physicians to the Medical Commission's survey question about their employment settings:[29]

[25] States have required disclosure of ownership of health care entities in connection with review of proposed acquisitions or change of control. These policies are discussed in the companion report that the Office of the Attorney General is submitting. HMA has not found any state law that broadly requires disclosure of ownership outside of this context.

[26] Physician's Advocacy Institute. COVID-19's Impact on Acquisition of Physician Practices and Physician Employment 2019−2022. June 2022. Available at: https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkgjKXB_yZfImFdXlvGg%3d%3d. Accessed November 25, 2023.

[27] Washington Medical Commission. Physician Demographic Census Aggregate Report. October 2023. Available at: https://wmc.wa.gov/sites/default/files/public/MD%20Report%20Oct%202023.pdf.

October 2023. Physicians in Washington must submit the data in this report to attain license renewal. https://wmc.wa.gov/licensing/renewals/demographic-census. Ten percent of the respondents stated that they were retired from clinical practice.

Washington Medical Commission. Physician Assistant Demographic Census Aggregate Report. October 2023. Available at: https://wmc.wa.gov/sites/default/files/public/PA%20Report%20Apr%202022.pdf. Only 2% of physician assistant reported that they have retired from clinical practice.

[29] Respondents were asked: "For patient related activities, indicate your practice arrangement and size of group." T[29] his response includes only physicians who were active; 75% of active physicians responding stated that they were practicing in Washington state. A "single specialty group" is a group of two or more physicians, providing patients with one specific type of care, such as primary care or a specific subspecialty like anesthesiology. A "multi-specialty group" practice is defined as offering various types of medical specialty care within one organization. American College of Physicians, Medical Practice Types, https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/medical-practice-types. Accessed November 25, 2023.

Table 1. Employment Setting Reported by Physicians

Single Specialty Group	5,259	24%
Multi-Specialty Group	4,745	21%
Solo Practitioner	1,622	7%
Employee of a Hospital or Clinic	8,883	40%
State or Federal Employer	2,399	11%
Other	1,827	8%

Table 2. Group Practice Size reported by Physicians

Group size	Single	Single %	Multi	Multi %
501 +	39	1%	1,067	22%
101 - 500	544	10%	1,273	27%
51 - 100	614	12%	486	10%
21 - 50	1,103	21%	505	11%
1 - 20	2,770	53%	830	17%
Unknown	189	4%	584	12%
Total	5,259	100%	4,745	100%

Data from the Washington State Hospital Association and the Washington State Medical Association reflect a higher percentage of physicians working for hospitals in the state—figures that are closer to the national trend. The Office of Financial Management reported that in 2021, a total of 21,332 physicians provided direct patient care in Washington state.[30] HMA estimates that 10,636, approximately 50%, are employed by hospitals. Of these, 65.6% are employed by multi-hospital systems. (See Table 5 on page 25).[31]

[30] Yen W. 2020-21 Physician Supply: Estimates for Washington. Health Care Research Center, Office of Financial Management. October 2021. Available at: https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/workforce/physician_supply_2020-21_washington.pdf. Accessed November 25, 2023.

[31] These figures are estimates and are based on data from different sources reporting on different time periods.

Multi-Hospital Health System

In the past three decades, hospital resources and care in Washington have become more concentrated as hospitals have closed or become part of multi-hospital systems. The percentage of hospitals in systems grew to nearly 50% in 2017 from 10% in 1986, according to a study that the state Office of Financial Management (OFM) conducted.[32] The number and percentage has increased since then. According to a July 2022 presentation to the Health Care Transparency Board, of 101 hospitals in Washington state, 40 are part of the five largest hospital systems: Providence/Swedish, MultiCare, Virginia Mason Franciscan Health, UW Medicine, and PeaceHealth. Another 15 are part of smaller multi-hospital systems.[33]

These changes had a significant impact on the settings in which Washingtonians receive care. In 1986, three multi-hospital systems accounted for 20% of admissions; by 2017, that figure had nearly quadrupled, to 79%. From 1986 to 2017, the number of available hospital beds decreased from 298 per 100,000 population to 170, while the percentage of beds in hospital systems increased to 73% from 19%. As the OFM reported, “a decreasing resource became increasingly concentrated in systems."[34]

Table 3 (page 15) includes data that the Washington State Hospital Association (WSHA) reported to the Washington Department of Health. It lists the number of staff and licensed beds for all hospitals statewide and all multisystem hospitals.

Table 4 (page 17) provides data for each hospital in 10 multi-hospital systems: Astria Health, Confluence, EvergreenHealth, LIfePoint MultiCare, PeaceHealth, Providence, Skagit, University of Washington Medicine, and Virginia Mason Franciscan. The data include:

- Number and list of hospitals in the system
- Number and category of beds in the system
- Percent of all beds in the state, and
- Number of physicians and physician assistants employed by the system.

As noted above, 40%−50% of active physicians in Washington work at hospitals or clinics. Based on data from the Washington State Medical Association (WSMA), HMA estimates that 65.6% of physicians who work at hospitals in the state are employed by multi-hospital systems. With respect to physician assistants who work at hospitals, 68.8% are at multi-hospital systems.[35] (See Table 5, page 25.)

[32] Hospital Mergers in Washington 1986-2017.

[33] Health Care Cost Transparency Board Report, p. 15.

[34] Hospital Mergers in Washington, 1986-2017. The report notes, “some of the change is attributable to the growing number of procedures performed in ambulatory surgical centers. The decrease in numbers, however, raises questions about hospitals’ ability to provide effective care when high demands are placed on resources.”

[35] Data obtained from Washington State Medical Association, October 20, 2023.

In addition to employing a significant percentage of physicians, hospital systems in Washington typically own and operate other types of health care facilities. As WSHA reported in 2022, 9% of hospital systems owned skilled nursing facilities (SNFs), 82% owned hospital-affiliated clinics, 28% owned freestanding clinics, and 13% own a home health agency.[36] Table 4 (page 17) lists non-hospital services owned by or affiliated with multi-hospital systems in the state.

Table 3: Washington State Hospital Beds Landscape[37,38]

Bed Type	ICU	Acute Care	Psychiatric	Skilled Nursing Facilities (SNF)	Alcohol Treatment (AT)	Other	Staffed Beds	Licensed Beds
All Washington Hospitals	1,734	9,164	1,257	218	94	291	12,758	15,427
Multi-Hospital Systems	1,418 (81.78% of all ICU beds)	7,703 (84.06% of all acute care beds)	607 (48.3% of all psychiatric beds)	75 (34.4% of all SNF beds)	78 (83.0% of all AT beds)	276 (94.8% of all other beds)	10,157 (79.61% of all staffed beds)	12,028 (79.51% of all un)

[36] Health Care Cost Transparency Board Meeting, July 20, 2022, p. 11.

[37] Based on data from the Department of Health Hospital Reporting, October 11, 2023. HMA also reviewed this information against data from the Washington Hospital Association received October 27, 2023. When data were unaligned, HMA defaulted to Department of Health information. The data by bed type are from the Washington Department of Health Hospital. They may not yield total beds in system because of classification of swing beds, etc.

[38] Excludes data from Kaiser, a fully-integrated health care system.

Table 4: Multi-Hospital Systems Bed Detail[39]

Based on all WA State hospitals (not solely multi-hospital data), hospitals associated with health systems include acute care, psychiatric, and critical access hospitals. Unless otherwise indicated, the hospital is an acute care facility. Of the state's total hospitals, the Department of Health identifies 39 as critical access hospitals (CAHs), which are small facilities with less than 25 beds in rural areas.[40]

Details about each of the multi-hospital systems is available in Appendix A.

ACRONYMS

AUD: Alcohol Use Disorder
ALF: Assisted living facility
ASC: Ambulatory surgical center
BH: Behavioral health
CAH: Critical access hospital[41]
CH: Community hospital[42]
ICU: Intensive care unit
SNF: Skilled nursing facility
Psych: Psychiatric

[39] The American Hospital Association (AHA) defines a multi-hospital system as two or more hospitals owned, leased, sponsored, or contract managed by a central organization. See Fast Facts on U.S. Hospitals, 2023, at https://www.aha.org/statistics/fast-facts-us-hospitals.

[40] Washington State Department of Health. Critical Access Hospital (CAH) Program Washington State Rural Health Plan. June 2020. Available at: https://doh.wa.gov/sites/default/files/legacy/Documents/2900/609012-CAHlist-RuralHealth.pdf. Accessed November 26, 2023.

[41] Critical Access Hospital is a federal designation under the Rural Hospital Flexibility Program (Flex Program), administered by the federal Office of Rural Health Policy. The purpose of the program is to ensure people enrolled in Medicare have access to healthcare services in rural areas, particularly hospital care. Critical Access Hospitals (CAHs) are small hospitals with fewer than 25 beds in rural areas. There are 39 CAHs in Washington. Most CAHs are operated by public hospital districts. Available at https://doh.wa.gov/public-health-healthcare-providers/rural-health/rural-healthsystems#:~:text=Critical%20Access%20Hospitals%20(CAHs)%20are,operated%20by%20public%20hospital%20districts.

[42] AHA defines a community hospitals as all nonfederal, short-term general, and other special hospitals. These facilities include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals that are inaccessible to the general public, such as prison hospitals or college infirmaries. AHA *Fast Facts*, *Op. cit.*

Table 4: Multi-Hospital Systems Bed Detail

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System[43]	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System[44]	Number of Physicians and Physician Assistants Employed/ Affiliated with System[45]
Astria Health System (not-for-profit)	Astria Sunnyside Hospital, Sunnyside (CAH) (78 licensed, 47 staffed beds) Yakima County Astria Toppenish Hospital, Toppenish (community hospital) (38 licensed, 25 staffed beds) Yakima County	• 14 ICU • 44 acute care • 72 staffed • 116 licensed	• *ICU: 0.81%* • Acute: 0.5% • *Psych: 1.11%* • SNF: 6.88% • *AUD: N/A* • *Other: N/A* • **Staffed: 0.6%** • **Licensed: 0.8%**	• Primary care/rural health clinics (9) • Astria Ambulatory Surgical Center • Astria Sunnyside Hosp. Specialty Surgical Group • Astria Hearing & Speech • Astria Plastic Surgery Ctr • Astria Home Health & Hospital • Astria Health Center Multispecialty & Diagnostics • Telehealth	• Physicians: 58 • Physician assistants: 13

[43] As identified by the Washington Department of Health Hospital Reporting data October 11, 2023.

[44] If number of sites for each non-hospital service was available, it is given in ().

[45] Based on data received from the Washington State Medical Association on October 20, 2023.

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
Confluence (not-for-profit)	Confluence Health Hospital DBA Central Washington Hospital (176 staffed, 176 licensed Beds) Chelan County	• 26 ICU • 150 acute care • 176 staffed • 176 licensed	• ICU: 1.50% • Acute: 1.64% • *Psych: N/A* • *SNF: N/A* • *Alcohol: N/A* • *Other: N/A* • **Staffed: 1.16%** • **Licensed: 1.38%**		• Physicians: 277 • Physician assistants: 78
EvergreenHealth (community-owned/ independent)	EvergreenHealth Kirkland, Kirkland (318 licensed, 317 staffed Beds) King County EvergreenHealth Monroe, Monroe (112 licensed, 66 staffed Beds) Snohomish	• 24 ICU • 281 acute care • 36 AUD • 42 other • 383 staffed • 430 licensed	• ICU: 1.38% • Acute: 3.1% • *Psych: N/A* • *SNF: N/A* • Alcohol: 38.30% • Other: 14% • **Staffed: 3.00%** • **Licensed: 2.84%**	• Primary care (13) • Urgent care (8) Emergency care (3)	• Physicians: 265 • Physician assistants: 22

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
LifePoint (National Presence) Private ***Acquired by private equity firm in 2018***	LifePoint Lourdes Medical Center, Pasco (CAH) (95 licensed, 35 staffed beds) Franklin County LifePoint Trios Health, Kennewick (111 licensed, 111 staffed beds) Benton County LifePoint Lourdes Counseling Center (32 licensed, 20 staffed beds)	• 20 ICU • 116 acute care • 20 psych • 10 other • 166 staffed • 238 licensed	• ICU: 1.15% • Acute: 1.27% • Psych: 1.59% • *SNF: N/A* • *Alcohol: N/A* • Other: 3.44% • **Staffed: 1.10%** • **Licensed: 1.57%**	• Primary care • Specialty care • Acute care rehab units • Outpatient centers (imaging, freestanding emergency departments, cancer centers, ASC, urgent care) • Post acute service providers (SNFs, assisted living facilities, swing bed programs) • Telehealth	• Physicians: 109 • Physician assistants: 15

MultiCare (MC) (not-for-profit	MC Auburn MC, Auburn (195 licensed, 165 staffed Beds) Pierce County MC Capital MC Olympia (107 licensed, 88 staffed beds) Thurston County MC Covington MC (58 licensed/56 staffed beds) King County MC Deaconess Hospital, Spokane (388 licensed, 279 staffed beds) Spokane County MC Good Samaritan Hospital, Puyallup (425 licensed, 394 staffed beds) Pierce County MC Mary Bridge Children's Hospital (Childrens), Tacoma (82 licensed, 82 staffed beds) Pierce County MC Tacoma General/Allenmore Hospital, Tacoma (581 licensed, 451 staffed beds) Pierce County MC Valley Hospital, Spokane Valley (123 licensed, 123 staffed beds) Spokane County MC Yakima Memorial, Spokane Valley (226 licensed, 226 staffed beds) Yakima County MC Navos BH Hospital (Navos West Seattle Campus), Seattle (psych) (70 licensed, 70 staffed beds) King County Wellfound BH Hospital,[46] Tacoma (psych)[47] (120 licensed, 120 staffed Beds) Pierce County	• 341 ICU • 1,342 acute care • 293 psych • 109 other • 2,085 staffed • 2,344 licensed	• ICU: 19.67% • Acute: 14.64% • Psych: 23.31% • *SNF: N/A* • *Alcohol: N/A* • Other: 37.46% • **Staffed: 16.34%** • **Licensed: 15.50%**	• Primary care • Urgent care • Pediatric care • Specialty services including MC BH Network; MC Indigo, Mary Bridge Health Network, Pulse Heart Institute, MC Rockwood Clinic (multi-specialty) • Telehealth	• Physicians: 1,072 • Physician assistants: 161

[47] Navos Behavioral Health Hospital in West Seattle is an independently operated affiliate. Wellfound Behavioral Health Hospital is an independently operated joint venture of MultiCare and CHI Franciscan Health.

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
PeaceHealth (not-for-profit Catholic)	PeaceHealth Peace Island Medical Center, Friday Harbor (CAH) (10 licensed, 10 staffed beds) San Juan, County PeaceHealth Southwest Medical Center, Vancouver (450 licensed, 429 staffed beds) Clark County PeaceHealth St John Medical Center, Longview (346 licensed, 172 staffed beds) Cowlitz County PeaceHealth St. Joseph Medical Center, Bellingham (265 licensed, 265 staffed beds) Whatcom County PeaceHealth United General Medical Center, Sedro-Woolley (CAH) (35 licensed, 35 staffed beds) Skagit County	• 120 ICU • 757 acute care • 34 psych • 911 staffed • 1,106 licensed	• ICU: 6.92% • Acute: 8.26% • Psych: 2.70% • *SNF: N/A* • *Alcohol: N/A* • *Other: N/A* • **Staffed: 7.146%** • **Licensed: 7.31.%**	• Primary care • Cancer care • Heart and vascular • Ob/Gyn • Orthopedics • Pediatric primary and specialty care • Telehealth	• Physicians: 455 • Physician assistants: 80 •

Providence (not-for-profit Catholic)	Providence – Kadlec Regional Medical Center, Richland (337 Licensed, 254 Staffed Beds) Benton County Providence Centralia Hospital, Centralia (128 licensed, 101 staffed beds) Lewis County Providence Holy Family Hospital, Spokane, Spokane (197 licensed, 182 staffed beds) Spokane County Providence Mount Carmel Hospital, Colville (CAH) (55 licensed, 25 staffed beds) Stevens County Providence Regional Medical Center Everett, Everett (595 licensed, 530 staffed beds) Snohomish Providence Sacred Heart Medical Center & Children's Hospital, Spokane (691 licensed, 684 staffed beds) Spokane County Providence St. Joseph's Hospital, Chewelah (CAH) (55 licensed/25 staffed beds[48]) Stevens County Providence St. Mary Medical Center, Walla Walla (142 licensed, 92 staffed beds) Providence St. Peter Hospital, Olympia (372 licensed, 330 staffed beds) Thurston County Providence St. Luke's Rehab Medical Center, Spokane (102 licensed, 72 staffed beds) Spokane County	• 453 ICU • 2,802 Acute • 147 Psych • 40 SNF • 42 alcohol • 57 other • 3,541 staffed • 4,215 licensed	• ICU: 26.12% • Acute: 30.58% • Psych: 11.69% • SNF: 18.35% • Alcohol: 44.68% • Other: 19.59% • **Staffed: 23.41%** • **Licensed: 33.04%**	• Urgent and same day care • Primary care clinics (~15) • Senior care centers • Hospice (Providence Hospice of Seattle) • Home health services and home care, including SNFs • Providence Medical Group – WA offers primary and specialty care	• Physicians: 1,684 • Physician assistants: 210

[48] According to the Department of Health Data, St. Joseph has "25 Licensed and 55 Staffed Beds)

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
Providence (not-for-profit Catholic) **Continued from previous page**	**<u>Affiliates</u>** Providence Swedish Edmonds, Edmonds (217 licensed, 186 staffed beds) Snohomish County Providence Swedish Medical Center, Cherry Hill, Seattle (349 licensed, 227 staffed beds) Swedish First Hill/Ballard (830 licensed, 659 staffed beds) King County Providence Swedish Medical Center – Issaquah (175 licensed, 144 staffed beds) King County				
Skagit Non-Profit	Skagit Regional Health, Mount Vernon (137 licensed, 137 staffed beds) Skagit County Skagit Regional Health Cascade Valley Hospital, Arlington (48 licensed, 48 staffed beds) Snohomish	• 18 ICU • 152 acute care • 15 psych • 185 staffed • 185 licensed 185 staffed	• ICU: 1.04% • Acute: 1.66% • Psych: 1.93% • *SNF: N/A* • *Alcohol: N/A* • *Other: N/A* • **Staffed: 1.072%** • **Licensed:. 915%**	• Urgent care (2) • Clinics (specialty and primary care) (9) • Surgical center (1) • Telehealth	• Physicians: 174 Physician assistants: 32
University of Washington (UW) Medicine Private Non-Profit and Public	UW Medicine/Harborview Medical Center, Seattle (413 Licensed, 412 Staffed Beds) King County US Medicine/Valley Medical Center, Renton (341 Licensed, 330 Staffed Beds) King County UW Medicine/UW Medical Center, Seattle (810 licensed, 476 staffed beds) King County	• 248 ICU • 883 acute care • 84 psych • 3 other • 1,218 staffed • 1,564 licensed	• ICU: 14.30% • Acute: 9.64% • Psych: 6.68% • *SNF: N/A* • *Alcohol: N/A* • Other: 1.03% • **Staffed: 9.55.05%** • **Licensed: 10.3.02%**	• Primary care (25) • Urgent care (5 • Telehealth •	• Physicians: 1,741 • Physician assistants: 120

Multi-Hospital System	Number of Hospitals in System	Number of Beds in System	Percent Beds of WA State All Beds*	Non-Hospital Services Owned or Affiliated with System	Number of Physicians and Physician Assistants Employed/ Affiliated with System
Virginia Mason Franciscan (VMF) (not-for-profit) CHI: Catholic	VMF Health St Anne Medical Center, Burien (133 licensed, 115 staffed beds) King County VMF Health St. Anthony Hospital, Gig Harbor (112 licensed, 112 staffed beds) Pierce County VMF Health St. Clare Hospital, Lakewood (106 licensed, 102 staffed beds) Pierce County VMF Health St. Elizabeth Hospital, Enumclaw (38 licensed, 25 staffed beds) King County VMF Health St. Francis Community Hospital, Federal Way (124 licensed, 124 staffed beds) King County VMF Health St. Joseph Medical Ctr, Seattle (374 licensed, 362 staffed beds) King County VMF Health St. Michael Medical Center, Silverdale (336 licensed, 248 staffed beds) Kitsap County Virginia Mason Franciscan Health/Virginia Mason Franciscan Health Rehabilitation (60 licensed, 60 staffed beds) Pierce County Virginia Mason Medical Center, Seattle (371 licensed, 272 staffed beds) King County	• 154 ICU • 1,176 acute care • 35 SNF • 55 other • 1,420 staffed • 1,654 licensed •	• ICU: 8.88% • Acute: 12.83% • *Psych: N/A* • SNF: 16.06% • *Alcohol: N/A* • Other: 18.90% • **Staffed: 11.13%** • **Licensed: 10.93%**	• Primary care, • Cardio-vascular health • Digestive health, Neuro spine, etc. • Telehealth	• Physicians: 1,142 • Physician assistants: 194

Table 5: Physicians, Physician Assistants, and Nurses (ARNPs) in all Washington State Hospitals and in Multi-Hospital Systems

Provider	Physicians[49]	Physician Assistants[50]	Nurse (ARPN)[51] N = 9,334
All Washington Hospitals	10,636	1,475	3,650 or 39.1%
Multi-Hospital System	6,977 (65.6% of Physicians)	985 (66.8% of Physician Assistants	Unknown

Vertical Integration by Health Insurers in Washington

Similar to the trends in hospital consolidation, US health insurers or their holding companies have been purchasing physician practices and other providers of clinical care. For example, United HealthGroup, through its Optum subsidiary, is reportedly the largest employer of physicians in the nation, with more than 70,000 employed or aligned physicians across more than 2,200 locations in 2023.[52] And, with its acquisition of home health provider Signify Health in 2023, CVS Health added 10,000 physicians and other clinicians to the estimated 40,000 physicians and nurses it employs in its MinuteClinics and HealthHUBs.[53]

In addition, health insurers or their holding companies have integrated with a number of other sectors of the health care industry, including pharmacy benefit managers (PBMs), which administer prescription drug insurance benefits. Their key functions include negotiating prescription drug prices with manufacturers and pharmacies, establishing prescription drug formularies and pharmacy networks, and processing prescription drug claims.

[49] Data obtained from Washington State Medical Association, October 20, 2023.

[50] Ibid.

[51] Washington Center for Nursing. Washington 2021 Nursing Workforce Supply Data Report: Characteristics of LPNs, RNs, and ARNPs. May 2022. Available at: 2022-May_WCN-WA-2021-Nursing-Workforce-Supply-Data-Report-Characteristics-of-LPNs-RNs-and-ARNPs_FINAL.pdf (wcnursing.org). Accessed November 23, 2023.

[52] Jakob Emerson.

[53] American Hospital Association. CVS Health Adds Home Health Services. What's Next? Available at:

https://www.aha.org/aha-center-health-innovation-market-scan/2022-09-13-cvs-health-adds-home-health-services-whats-next#:~:text=With percent20the percent20Signify percent20purchase percent2C percent20CVS,soon percent20to percent20be percent201 percent2C500 percent20HealthHUBs. Accessed November 26, 2023.

The three largest PBMs, which collectively account for 89% of the market, are owned by insurer holding companies: Express Scripts (owned by Cigna), CVS Caremark (owned by CVS/Aetna), and Optum Rx (owned by UnitedHealth Group).[54] The role of PBMs and their impact on the price of pharmaceuticals, and consumer cost sharing is the subject of considerable debate, as is the fact that PBMs often operate their own pharmacies, as do CVS and Optum in Washington State.[55]

Table 6 (page 27) lists ownership among the five health insurers with the largest market share of pharmacy services, health care benefit managers, third-party administrators, clinical services, and other sectors of the Washington health care system. Beyond acting as health insurers for large portions of the state's population, each of these companies is extensively involved in the health care that Washingtonians receive.[56]

[54] National Association of Insurance Commissioners. Pharmacy Benefit Managers. June 1, 2023. Available at: https://content.naic.org/cipr-topics/pharmacy-benefit-managers. Accessed November 26, 2023.

[55] Fiedler M, Adler L, Frank R. A Brief Look at Current Debates about Pharmacy Benefit Managers. Brookings. September 7, 2023. Available at: https://www.brookings.edu/articles/a-brief-look-at-current-debates-about-pharmacy-benefit-managers/#:~:text=Today%2C%20PBMs%20have%20become%20increasingly,is%20a%20relatively%20recent%20development. Accessed November 26, 2023.

[56] As required by the Insurer Holding Company Act, RCW 48.31B, https://app.leg.wa.gov/rcw/default.aspx?cite=48.31B, health insurers file quarterly reports that describe their holding company structure and list other health care companies in which the holding company or its subsidiaries have an ownership interest. These reports are available publicly through the "Consumer Tools" section of the OIC website, https://fortress.wa.gov/oic/consumertoolkit/Search.aspx, by searching for the insurer's name under the "Company Search" tab and then clicking on "View Financial Statements." The holding company data are reported in Schedule Y to the quarterly financial reports. A complete description of all of the ownership interests of each of these holding company systems is beyond the scope of this report.

Table 6: Health Plan Affiliations

Holding Company		Health Plan	Pharmacy Care Services	Health Care Benefits Manager	Data/Analytics/ Clinical Guidelines	Third-Party Administrator	Clinical Services	Other Affiliates
Cambia Health Solutions	*Check if applicable*	✓	✓		✓	✓		✓
	If yes, subsidiary name(s)	Regence BlueShield Asuris Northwest Health BridgeSpan Health Company	Prime therapeutics (collectively owned by several Blues) includes Magellan Rx		Partnering with MultiCare on IT and other innovations	Regence Group Administrators (administers self-funded employer plans) Parent of Health Management Administrators (health plan administrator for self-funded plans)		Cambia Health Foundation (philanthropic arm) Acquired real estate assets of Capital Medical Center
CVS Health Corporation	*Check if applicable*	✓	✓			✓	✓	✓
	If yes, subsidiary name(s)	Aetna	CVS Pharmacies Longs Drugs Navarro Discount Pharmacies Omnicare Aetna Pharmacy CVS Specialty Rx CVS Caremark (PBM)			Aetna	Accordant (disease management) CVS Minute Clinics Signify Health (home health) Coram (home infusion services) HealthHUB	Gold Emblem products Partnership with Microsoft: digital health

Holding Company		Health Plan	Pharmacy Care Services	Health Care Benefits Manager	Data/Analytics/ Clinical Guidelines	Third-Party Administrator	Clinical Services	Other Affiliates
Kaiser Foundation Group	*Check if applicable*	✓	✓			✓	✓	
	If yes, subsidiary name(s)	Kaiser Foundation Health Plan of Washington	Operates its own pharmacy and PBM, with MedImpact & Optum acting as a PBM in some states (varies by product line)			Kaiser Permanente	Permanente Medical Groups (including acquiring Group Health Cooperative of Puget Sound Kaiser Permanente Central Hospital Clinics and offices throughout the state Lab services	
Premera	*Check if applicable*	✓		✓			✓	✓
	If yes, subsidiary name(s)	Premera Blue Cross		Calypso Healthcare Solutions			Kinwell Medical Group	Vivacity (Wellness solutions for employers)
UnitedHealth Group	*Check if applicable*	✓	✓	✓	✓	✓	✓	✓
	If yes, subsidiary name(s)	UnitedHealthcare of Washington United Healthcare Insurance Company	Optum Rx Optum Specialty Diplomat (specialty Rx provider)	United Behavioral Health OptumHealth Care Solutions, LLC OrthoNet LLC Spectera	Optum Change Healthcare InterQual	UMR	Optum Health: Polyclinic Northwest Physicians Networks Everett Clinic* Monarch Health Refresh MH Prospero (home health) Landmark (home health agency) LHC (aging in place services)	VA Mason Franciscan Health partnered with Optum to be the preferred medical center for Polyclinic patients

Private Equity in Washington's Health Care System

Background

In addition to the consolidation among publicly held health plans and companies, Washington's health care system, like that of many other states, has been the focal point of other investment activities, including a growing number of private equity transactions. Unlike the transactions and consolidations that involve publicly traded companies, far less information is publicly available about the status of private equity acquisitions. There are fewer reporting requirements compared with what is required of publicly held companies.

Private equity firms pool money from investors to make investments in a variety of industries. Nationwide, private equity investment in various sectors of the health care economy has been growing over the past two decades. For example, one study showed that private equity purchases of physician practices across a number of specialties grew from 75 transactions in 2012 to 484 transactions in 2021.[57] As the report stated:

> *A common strategy that private firms employ is to acquire a large physician practice—referred to as the "platform" practice—and then acquire smaller practices in the same specialty that have less infrastructure, potentially creating economies of scale and scope, providing managerial expertise, adding ancillary services, and increasing bargaining power with payers.*[58]

Certain specialties have been a particular focus for this type of investment: dermatology, ophthalmology, gastroenterology, primary care, obstetrics/gynecology, radiology, orthopedics, and more recently, oncology, urology, and cardiology.[59] In addition to physician practices, private equity firms also have acquired other health care facilities and services.

The impact of private equity investment in health care is controversial and has been the subject of much debate. Recent studies and reports have raised concerns about the impact of these acquisitions on the price and quality of health care services. Critics argue that by prioritizing profits and overburdening health care companies with debt, private equity investment may jeopardize patient safety. On the other hand, proponents argue that in addition to providing an infusion of capital, private equity ownership may bring valuable management expertise, reduce inefficiency, and leverage economies of scale.

[57] Scheffler et al, p. 4.

[58] *Ibid,* p. 8.

[59] *Ibid,* p. 11.

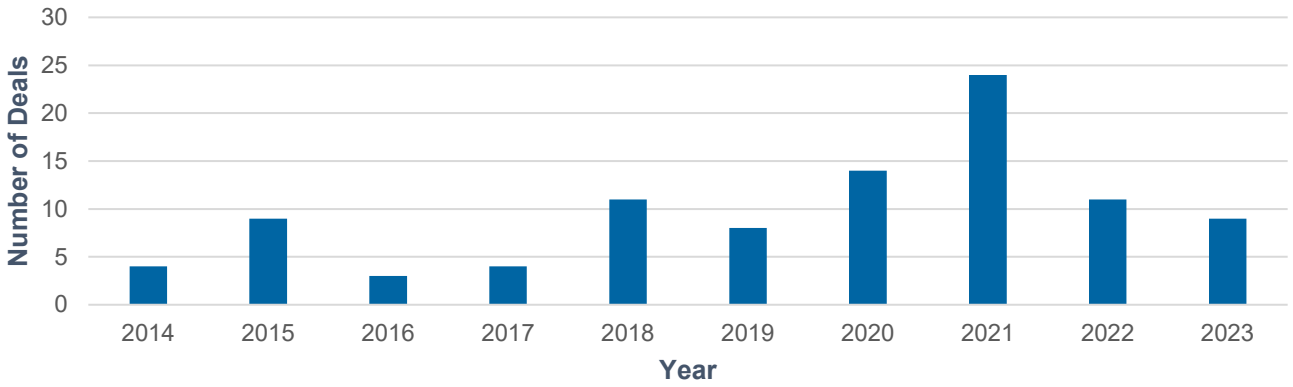
One recent review of 55 studies found that private equity ownership was most consistently associated with increased cost to patients or payers and with mixed to harmful impacts on quality.[60]

The information presented in this report is derived from a comprehensive analysis of health care private equity activity in Washington, sourced from PitchBook, a provider of financial data, research, and analytics.[61]

Summary of Recent Private Equity Activity

Over the span of 10 years, 2014−2023, a total of 97 acquisitions within the health care sector have been documented in Washington State, all of which fall under the private equity deal classification. Figure 1 (below) offers an historical snapshot that reflects year-to-year fluctuations in deals, illustrating the changing nature of the health care private equity market.

Figure 1: Private Equity Deals by Year



Acquisitions by Industry

Figure 2 (on the following page) offers a breakdown of health care transactions by their primary industry group. Most acquisitions have been concentrated in health care services, offering insight into what has drawn the attention of private equity investors. In addition to health care services, health care technology systems, health care devices and supplies, pharmaceuticals and biotechnology, have garnered interest, underscoring the wide variety of potential targets within Washington's health care sector. Many investments are in companies that provide software and other business services to the various sectors of the health care industry.

[60] Borsa A, Bejarano G, Ellen M, Bruch J D. Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review. *BMJ*. 2023;382:e075244. doi:10.1136/bmj-2023-075244.

[61] Pitchbook.com

Figure 2: Primary Industries

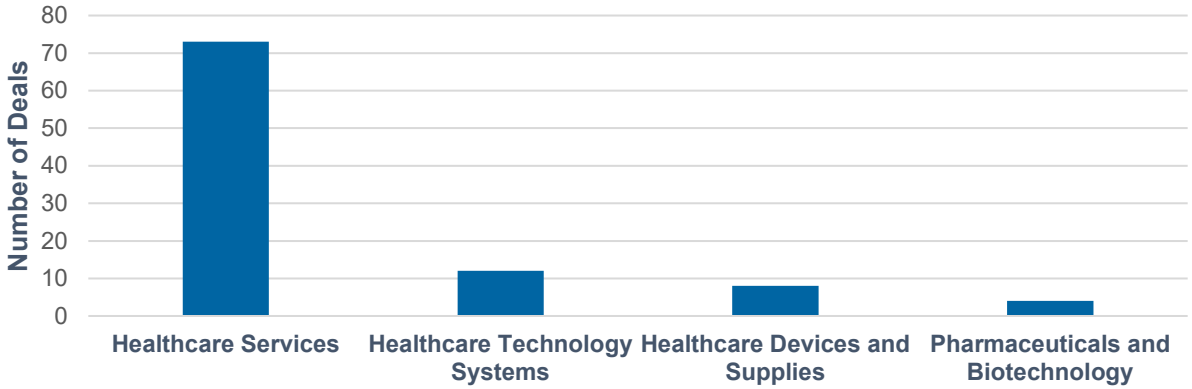


Figure 3 (on the following page) identifies the subcategories of health care clinical services that have been acquired. The greatest number of transactions have occurred in physical therapy, hospice and home health care, behavioral health/substance use disorder (SUD), ophthalmic/optometric, primary care/urgent care, and gastroenterology.[62]

Private equity firms also acquire physician staffing companies. For example, private equity-owned TeamHealth was one of the six largest emergency medicine staffing companies in the United States as of 2022.[63] According to its website, TeamHealth employs physicians who provide emergency medicine and post-acute care in a number of hospitals and clinics in Washington, including St. Elizabeth Hospital, St. Joseph Medical Center−Tacoma, PeaceHealth St. Joseph Medical Center, Island Hospital, St. Anthony Hospital, Providence Centralia Hospital, and Trios Southridge Hospital.[64]

Similarly, US Anesthesia Partners (USAP) is a private equity-owned single-specialty anesthesia practice that operates in eight states, including Washington. According to its website:

USAP Washington is the largest majority physician-owned + led anesthesia group in the Pacific Northwest, consisting of over 120 physicians and 15 CRNAs. We provide high-quality anesthesia services to the renowned Swedish Medical Center at First Hill (FH), Cherry Hill (CH), Issaquah, and Ballard, as well as prominent ambulatory surgery centers in the greater Seattle area.[65]

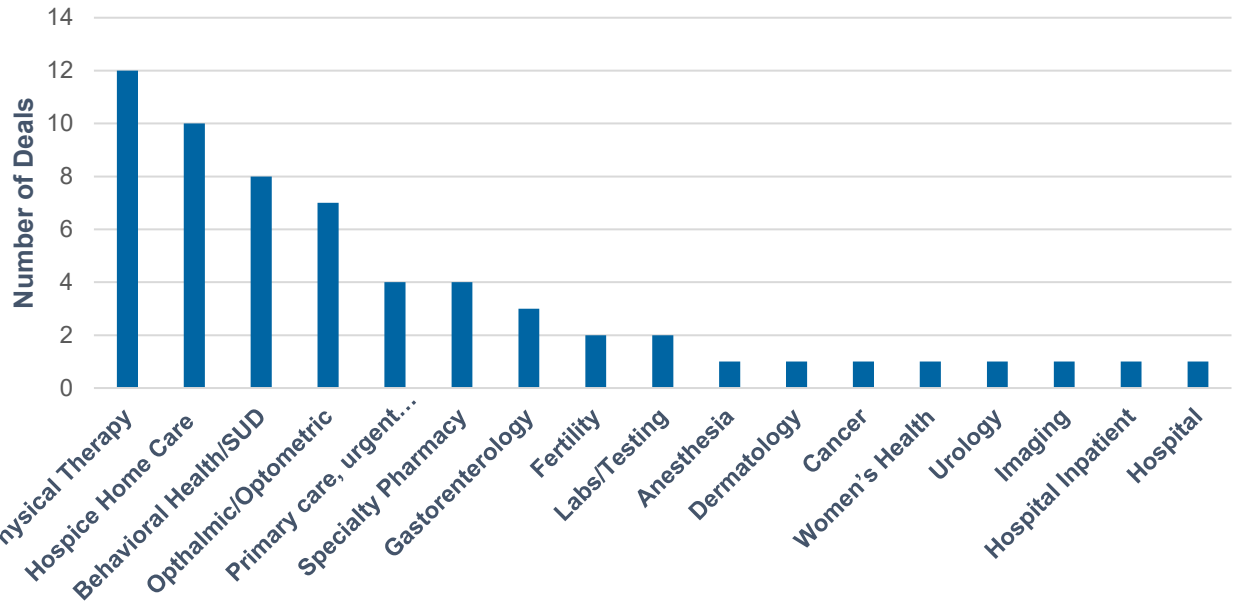
[62] Data obtained from PitchBook, October 2023.

[63] *Ibid,* at p. 8.

[64] TeamHealth.

[65] USAP describes itself as majority physician-owned, it is listed as one Welsh, Carson, Anderson & Stowe's private equity health care companies, a complaint filed in September 2023, the Federal Trade Commission (FTC) alleges that Welsh Carson "created" USAP in 2012 in a scheme to monopolize the market for anesthesia services in Texas.

Figure 3: Subcategories of Clinical Services that Have Been Acquired

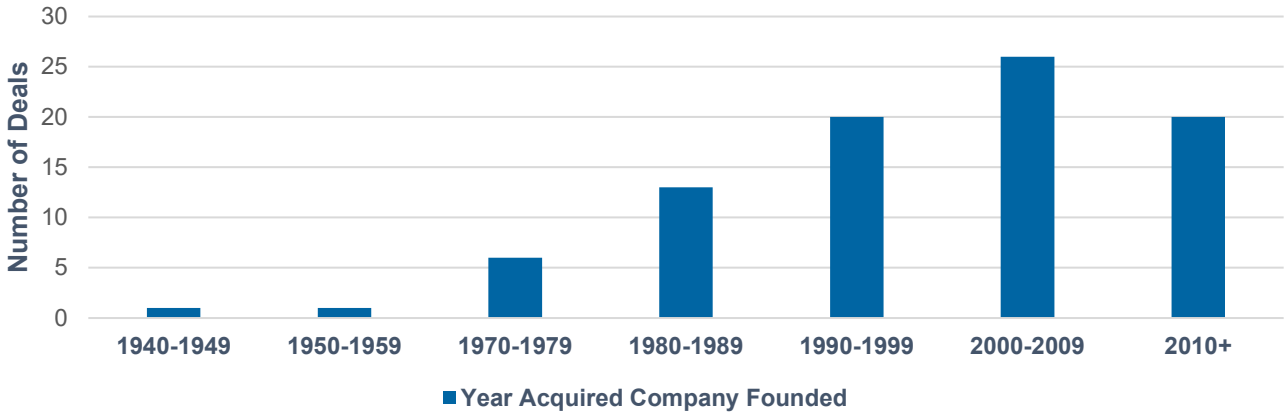


Location and Year Founded

Most of the acquisitions have been in Seattle and Bellevue, which is unsurprising given the high percentage of the state's population residing in those communities.

Figure 4 (on the following page) offers a breakdown of the year when the acquired companies were founded, categorized by the decades in which the companies were initially established. This analysis provides insights into the developmental stages of the companies that have become acquisition targets, offering a glimpse into the evolution of Washington's health care sector. The data illustrate the varying ages of the acquired companies, reflecting both long-established institutions and newer, innovative enterprises.

Figure 4: Years Acquired Companies Were Founded



Duration of Investment and Resale Transactions

One category that HMA did not explore because it is unidentifiable with the available data, is the extent to which resale transactions are occurring in the market. Private equity investments often are part of an investment strategy with predetermined entrance and exit strategies and timelines focused on realizing efficiencies and profits for the acquired entities. An area worth further examination is the impact of the timing of investments and divestures associated with Private Equity on patient affordability.

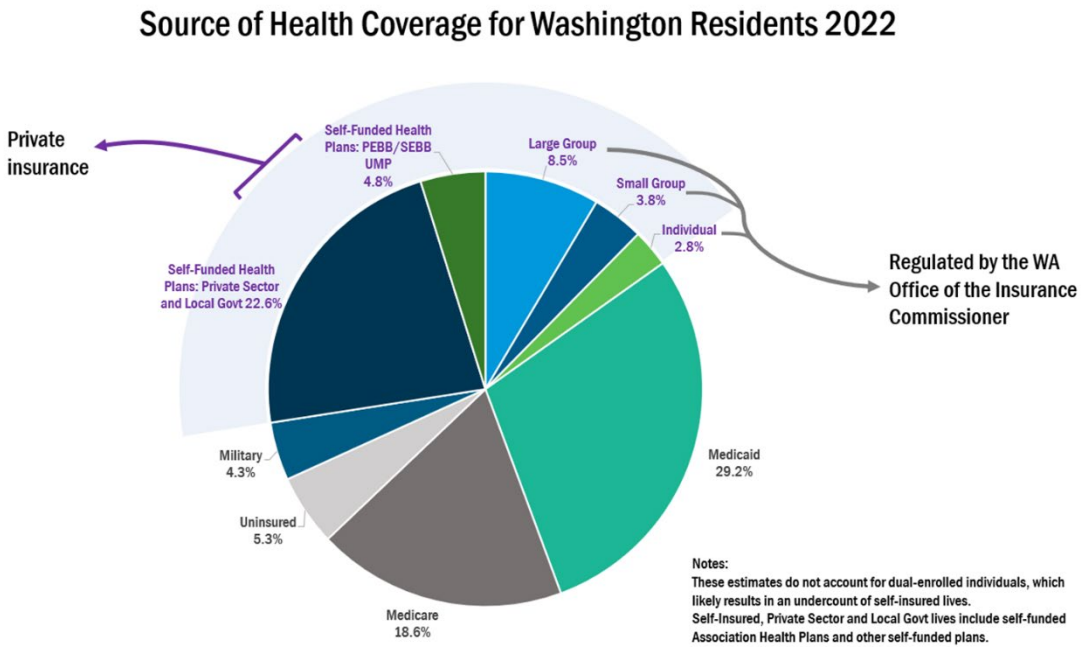
PART II: POLICY OPTIONS TO ADDRESS HEALTH CARE AFFORDABILITY

This part reviews several health policy options that have been proposed or implemented in Washington and other states to address the challenges of health care affordability for consumers, employers, and state government. It describes the purpose and features of each policy and provides information on its adoption and impact on the states where it has been implemented. This part of the report then describes any experience Washington State has had with the policy and compares it with that of other states, noting how Washington's law could be changed based on the results that other states have achieved.

As Figure 5 (below) indicates, Washingtonians receive their health coverage from several different sources in different markets, each subject to different laws and regulations, with oversight from different state and federal authorities.

The policy options described in this report apply differently, or not at all, to these markets. Addressing affordability across these markets may, therefore, require a combination of these policy options.

Figure 5: Source of Health Coverage for Washington Residents



Health Care Cost Growth Benchmarks

Cost growth benchmarks establish targets for how much health care spending should grow each year. States set statewide benchmarks; some also apply these benchmarks to providers and payers.

Have been established in nine states and shown mixed results; the most mature program (Massachusetts) recently issued recommendations for improvement including a need to focus on constraining provider prices.

Washington's HCCTB, established in 2020, will issue its first report on baseline health care expenditures in Fall 2023. It lacks the authority to take any action against a provider or payer that exceeds the benchmarks such as requiring Performance Improvement Plans that are part of some other states' programs.

Set Health Care Cost Growth Benchmarks

A cost growth benchmark program establishes a target for a state's annual growth in health care spending. Nine states, including Washington, have established independent commissions or have increased the authority of an existing regulatory body to set targets for increasing health care costs. States have used a variety of methods to set cost growth targets, using somewhat different economic metrics such as expected state gross domestic product, wage growth, or growth in consumer prices and have given these factors somewhat different weights. Eight of these states—Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Rhode Island, and Washington—have set cost growth targets. California recently created a cost containment commission but has yet to set targets.[66]

Other States' Programs

Appendix B (page 92) is a table from the National Academy for State Health Policy (NASHP) and last updated on January 18, 2023, lists the states that have established cost growth benchmark programs and describes a number of features of each program, including authority, collecting and reporting agency, cost growth benchmark level, total cost of care measurement, quality benchmark measures, and enforcement.

States have set benchmarks using a variety of methods and metrics; however, these targets have fallen within a fairly narrow range (see Appendix B, page 92).[67]

The cost growth benchmark programs in several states include a number of features that distinguish them from Washington State's Health Care Cost Transparency Board (HCCTB). For example, in California, Connecticut, Delaware, Massachusetts, New Jersey, and Oregon, measurement and consideration of health care quality is expressly part of the program. Following is a comparison of key differences in the approach three states—Massachusetts, Oregon, California—and Washington's HCCTB have taken.[68]

[66] During its 2023 legislative session, the Indiana General Assembly passed House Enrolled Act 1004, which the governor signed into law (P.L. 203) in May. The legislation creates a Health Care Cost Oversight Task Force, consisting of members of the state House and Senate, who are tasked with reviewing and making recommendations on a broad list of issues related to health care affordability. Data are to be provided to the task force by the Office of the Secretary of Family and Social Services, Department of Health, and Department of Insurance. The law also requires certain hospital systems to file reports containing extensive, detailed financial information, including revenue from a range of sources.

[67] Milbank Memorial Fund. Health Care Cost Growth Target Values. Available at: https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/health-care-cost-growth-benchmarks-by-state/. Accessed November 26, 2023.

[68] Massachusetts was chosen because it has the longest and deepest experience with a cost growth benchmark program. Oregon was selected because it is a neighboring state, and its health care market has some similarities to Washington's. California was chosen because, as the state to most recently establish a program, it has the benefit of learning from the experience of other states.

Massachusetts

Massachusetts has the longest and deepest experience with setting cost growth benchmarks, having established its Health Policy Commission (HPC) in 2012. The HPC has broader responsibilities and authorities than the HCCTB. In addition to setting the cost growth benchmark and setting and monitoring provider and payer performance relative to the benchmark, other key activities include:

- Creating standards for care delivery systems that are accountable to better meet patients' medical, behavioral, and social needs.
- Analyzing the impact of health care market transactions on cost, quality, and access.
- Investing in community health care delivery and innovations.
- Safeguarding the rights of health insurance consumers and patients regarding coverage and care decisions by health plans and certain provider organizations.[69]

Massachusetts has established a separate state agency, the Center for Health Information and Analysis, which collects data and reports out to the HPC and the public.[70] The HPC has authority to enforce the provisions of its program and is permitted to require that a health care entity[71] file a performance improvement plan (PIP) if it exceeds the cost growth benchmark. The commission also has authority to impose a civil penalty of up to $500,000 as a last resort, if an entity that has been ordered to submit a PIP fails to file an acceptable PIP or fails to implement a PIP in good faith.[72]

In January 2022, the HPC voted to require Mass General Brigham to implement a PIP; this was the first time it had ordered a PIP, and at present it is the only PIP nationwide pertaining to a cost growth benchmark program. The commission approved Mass General Brigham's PIP in September 2022; it proposed an annual savings target of $176.3 million over the PIP's 18-month implementation period.[73] Mass General Brigham's most recent public report states that it is on track to meet its savings target.[74]

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[69] Massachusetts Health Policy Commission. 2023 Annual Health Care Cost Trends Annual Report. September 2023. Available at: https://www.mass.gov/doc/2023-health-care-cost-trends-report/download. Accessed November 26, 2023.

[70] Massachusetts Center for Health Information and Analysis. About the Agency. Available at: https://www.chiamass.gov/about-the-agency/. Accessed November 26, 2023.

[71] A Health care entity is defined as a clinic, hospital, ASC, physician organization, accountable care organization or payer. Physician contracting units with a patient panel of 15,000 or fewer or who collectively receive less than $25,000,000 in annual net patient service revenue are exempted, under Massachusetts General Law, Title I, Chapter 6D, Section 10.

[72] Ibid.

[73] Massachusetts Health Policy Commission Board Meeting. Extract of Presentation. September 27, 2022. Available at: https://www.mass.gov/doc/extract-of-board-presentation-september-27-2022/download. Accessed November 26, 2023.

[74] Mass General Brigham Performance Improvement Plan. March 2023 Update. Available at: https://www.mass.gov/doc/mass-general-brigham-pip-public-6-month-report/download. Accessed November 26, 2023.

Massachusetts Health Policy Commission Board Meeting. Mass General Brigham Performance Improvement Plan March 2023. Extract of Presentation. July 12, 2023. Available at: https://www.mass.gov/doc/mass-general-brigham-pip-public-6-month-report/download. Accessed November 26, 2023.

Oregon

Oregon's Health Authority may require PIPs from any payer or provider organization that unreasonably exceeds the benchmark during any year. Fines may be assessed for late or incomplete submission of data and/or PIPs. Payers or provider organizations that exceed the benchmark in any three out of five years are subject to a financial penalty that varies based on the amount of excessive spending and other factors.[75] Oregon has not yet required any entity to file a PIP. In January 2023, after consideration of macroeconomic factors including inflation and labor market trends, Oregon delayed implementation of the PIP program until 2024.[76]

California

California enacted legislation in 2022 to create an Office of Health Care Affordability (OHCA). In addition to its cost growth benchmark program, OHCA will promote high value system performance by measuring quality, equity, adoption of alternative payment models, investment in primary care and behavioral health and workforce stability. OHCA will also analyze market transactions that are likely to significantly affect market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Based on results of the review, OHCA will coordinate with other state agencies to address consolidation as appropriate. [77]

The Director of the OHCA may take the following progressive enforcement actions commensurate with the health care entity's failure to meet its cost growth target:

- Provide technical assistance to the entity to assist it in coming into compliance.
- Require or compel public testimony from the health care entity regarding its failure to comply with the target.
- Require submission and implementation of a performance improvement plan.
- Assess penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

California is in the process of setting cost growth targets and, therefore, has not yet required any PIPs.

[75] Oregon Legislative Assembly. Enrolled House Bill 2081. Available at: https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2081/Enrolled. Accessed November 26, 2023.

[76] Oregon Health Care Authority. Sustainable Health Care Cost Growth Target Program Update to Accountability Timeline. Revised August 2023. Available at: https://www.oregon.gov/oha/HPA/HP/Cost percent20Growth percent20Target percent20documents/CGT-accountability-update_August-2023.pdf. Accessed November 26, 2023.

[77] California Office of Health Care Affordability. Introduction to OHCA. Available at: https://hcai.ca.gov/ohca/. Accessed November 26, 2023.

State Experiences in Meeting Cost Growth Targets

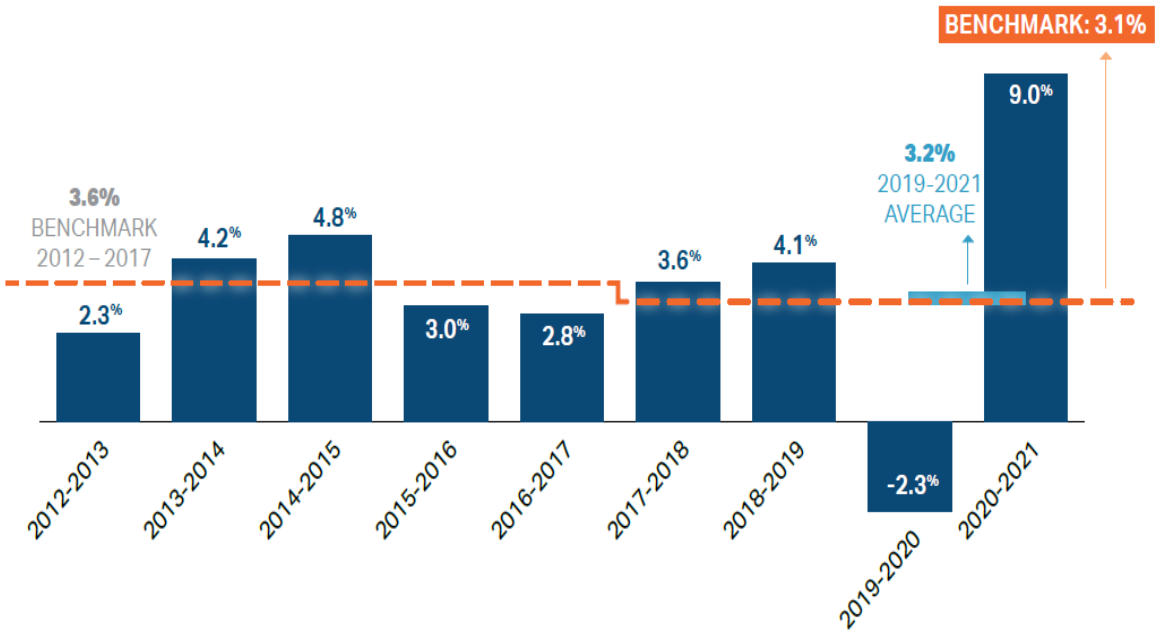
States that have reported on whether cost growth benchmarks have yielded mixed results.

Massachusetts

In Massachusetts, HPC set the benchmark for 2012−2017 at 3.6%; per capita total health care expenditure growth was below the target for three years and exceeded the benchmark for two years. For 2018−2021, the benchmark was set at 3.2%. Costs were below the target one year but exceeded the benchmark three years. For the nine years in which total health care expenditure growth has been evaluated, average annual per capita spending growth has been 3.5%.[78]

The COVID-19 pandemic and the return of higher rates of inflation clearly have had a significant impact on health care cost expenditure growth. Though expenditures declined by 2.3% in 2019−2020, they rose by 9% in 2021−2022, the last year reported.[79]

Figure 6: Annual Growth in Total Health Care Expenditures Per Capita in Massachusetts



Sources: Center for Health Information and Analysis, Annual Reports 2013-2023

[78] Massachusetts Health Policy Commission.

[79] Ibid.

Oregon

Oregon set cost growth targets for 10 years, at 3.4% for 2021−2025 and 3% for 2026−2030, to be adjusted in 2024 if necessary. The target was set using economic data such as historic and projected gross state product, wages, and income. The Medicaid and state employee programs had previously been subject to a 3.4% cost growth target.[80] The state employee program is described in detail in the reference pricing policy part of this report, (page 61).

In its 2023 Sustainable Health Care Cost Growth Target Annual Report, the Oregon Health Authority reported that annual per capita health care spending in 2020−2021 increased by 3.5%, just above the target of 3.4%. A large disparity was evident among markets: total health care expenditures in the commercial market increased 12.1%, compared with 6.5% for Medicare and 2.1% for Medicaid—the only payer that met the target.[81]

Oregon's report included data on which payers and providers met or exceeded the cost growth target. A total of 29 Oregon payers were included in cost growth target reporting for 2020−2021; overall cost growth for payers was 4.7%. Cost growth for commercial payers was 11.5%, compared with 6.0% for Medicare Advantage (MA) and Medicaid plans at 3.0%. Of the 29 payers, 11 met the target for at least one market. Seven commercial payers and eight Medicare Advantage payers exceeded the target with statistical certainty.[82]

A total of 51 provider organizations were included; overall cost growth was 4.9%. Provider organization cost growth in the commercial market was 11.8% versus 6.3% for MA and (3.0%) for Medicaid, and 26 provider organizations met the target for at least one market. In all, 16 commercial provider organizations and 10 Medicare organizations exceeded the target with statistical certainty.[83]

Massachusetts HPC Policy Recommendations

Based on its experience to date, the Massachusetts HPC has made policy recommendations for ways to improve its cost growth benchmark program. Some of these policies were reflected in the legislation that established the OHCA program in California.

[80]Oregon Health Authority. Health Care Cost Growth Trends in Oregon, 2018-2020. May 2, 2023. Available at: https://www.oregon.gov/oha/HPA/HP/Cost percent20Growth percent20Target percent20documents/Oregon-Cost-Growth-Target-Annual-Report-FINAL.pdf. Accessed November 26, 2023.

[81] Oregon Health Authority. Health Care Cost Growth Trends in Oregon, 2020-2021. Available at: https://www.oregon.gov/oha/HPA/HP/Cost percent20Growth percent20Target percent20documents/2023-Oregon-Cost-Growth-Target-Annual-Report.pdf. Accessed November 26, 2023.

[82] Ibid, p. 5.

[83] Ibid.

In its 10th annual report in September 2023, HPC has set forth nine policy recommendations to address what it describes as "alarming trends which, if unaddressed, will result in a health care system that is unaffordable for Massachusetts residents and businesses." Several of those recommendations are relevant to the HCCTB's work and this report, including.[84]

- Strengthen the Health Care Cost Growth Benchmark by using metrics in addition to health status adjusted total medical expense to refer entities for review and a potential PIP so that entities other than payers and providers with primary care networks are subject to review.
- Strengthen the PIP process to allow the HCP to set savings target expectations and identify the types of strategies that should be included in a PIP. This strategy would give the HCP more oversight authority and allow the HCP to apply tougher, escalating financial penalties for above-benchmark spending or noncompliance.
- Establish a new affordability index to be measured annually in a benchmark-like process in recognition of the fact that health insurance premiums and cost-sharing often have increased in excess of the health care cost growth benchmark. The index would track the differential impact of health care premiums and out-of-pocket spending by income, geography, market segment, and other factors.
- Establish new equity benchmark(s) to identify high-priority areas of health inequities, set measurable goals for improvement, and develop a framework for accountability. Require providers to provide annual progress reports.
- Constrain excessive provider prices in recognition that past market initiatives (e.g., tiered and narrow network products, price transparency efforts, risk contracting) have failed to meaningfully restrain provider price growth or reduce unwarranted variation in provider charges. Many states (e.g., Rhode Island, Oregon, Colorado and Maryland) are similarly recognizing that some level of price regulation, rather than market initiatives alone, may be necessary to ensure an equitable and affordable health care system. The HPC recommends:
    - Limiting excessive provider charges in excessive of reasonable benchmark amounts, which HPC defines as more than 200% of what Medicare fee-for-service pays for the relevant service. These price limits could target costs with the greatest impact on spending as well as annual price growth and would be directed at the highest-priced providers and those services for which competitive forces are least likely to contain prices.
    - Require site-neutral payment for certain ambulatory services that are commonly provided in office settings (e.g., office visits, lab tests, basic imaging and diagnostic services, and clinician-administered drugs) to limit hospital "facility fee" charges.)

The recommendations related to constraining excessive provider prices are discussed in the reference-based pricing and facility fees parts of this report.

[84] HCP 2023 Annual Health Care Cost Trends Annual Report, https://www.mass.gov/doc/2023-health-care-cost-trends-report/download at pp. 51-58. Several of the policy recommendations in the report relate to functions of the HPC which are not part of HCCTB's responsibility.

Washington Law and Experience with the Health Care Cost Transparency Board

The Washington State Legislature created the Health Care Cost Transparency Board (HCCTB) in 2020 to identify health care cost trends, set a cost-growth benchmark, and develop recommendations to reduce health care costs.[85] HCCTB also was also charged with increasing price transparency.

In September 2021, the HCCTB approved a cost growth benchmark of 3.2% for 2022–2023, 3% for 2024–2025, and 2.8% by 2026. The benchmark is based on a blend of 70% historical median wage and 30% potential gross state product.[86] The data sources for calculating the benchmark value are set forth in the Board's Technical Manual published in July 2022.[87] In the event of extraordinary circumstances, including drastic changes in the economy or the health care system, the board may consider revising the benchmark or the benchmark methodology.[88] Washington's benchmark generally aligns with other states' cost-growth benchmarks, although the metrics used to arrive at the benchmarks vary.[89]

The HCCTB is collecting data from a variety of sources to evaluate the overall system's performance against the benchmark. To make that measurement, the Board will calculate total health care expenditures (THCE), which include:

- Total Medical Expense (TME): Claim payments made to providers as reimbursement for health care provided, other payments to providers and all cost-sharing paid by consumers, including deductibles, co-payments and co-insurance, and
- Costs to state residents associated with the administration of private health insurance (for example, health plan administrative costs and profit).[90]

The Board has issued data calls to insurers[91] and state agencies and has completed its data validation process. Its first historical baseline benchmark report is expected in fall 2023.

HCCTB also is directed to study and report on the drivers of health care costs. Preliminary findings from this analysis were released and made public at the board's December 14, 2022, meeting.[92]

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[85] Washington State Legislature. Second Substitute House Bill 2457 Chapter 340, Laws of 2020. February 11, 2020. Available at: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/2457-S2.pdf?q=20231126165319. Accessed November 26, 2023.

[86] Washington State Health Care Authority. Health Care Cost Transparency Board Meeting Minutes. September 14, 2021. Available at: https://www.hca.wa.gov/assets/program/board-meeting-summary-20210914.pdf. Accessed November 26, 2023.

[87] Washington State Health Care Authority. Washington's Health Care Cost Growth Benchmark Program Technical Manual. July 7, 2022. Available at: https://www.hca.wa.gov/assets/program/benchmark-data-call-manual-july-2022.pdf. Accessed November 26, 2023.

[88] Ibid.

[89] Melnick G. Health Care Cost Commissions: How Eight States Address Cost Growth. California Health Care Foundation. Available at: https://www.chcf.org/wp-content/uploads/2022/04/HealthCareCostCommissionstatesAddressCostGrowth.pdf. Accessed November 26, 2023.

[90] Washington State Health Care Authority. Health Care Cost Transparency Board Meeting Materials Book. October 18, 2023. Available at: https://www.hca.wa.gov/assets/program/hcctb-meeting-materials-20231018.pdf. Accessed November 26, 2023.

[91] In the context of this report, the term "insurer" has the same meaning as "carrier," as defined in Washington law. RCW 48.43.005

[92] Washington State Health Care Authority. Health Care Cost Transparency Board Meeting Materials Book. December 14, 2022. Available at: https://www.hca.wa.gov/assets/program/hcctb-board-book-20221214.pdf. Accessed November 26, 2023.

These results are discussed in HCCTB's 2023 report to the legislature.[93] Beginning in 2024, HCCTB will be responsible for identifying providers and payers with cost growth that exceeds the benchmark, focusing on the state's largest health care systems and provider groups.[94]

In 2022, Washington enacted legislation directing the HCCTB to also measure and report on primary care expenditures in Washington and on progress toward increasing it to 12% of total health care expenditures.[95] The HCCTB formed a primary care advisory committee to develop primary care expenditure measures.

The structure of the HCCTB, its methodology for determining cost growth benchmarks, the sources of the data it collects, and its plans for monitoring whether the benchmarks have been met are similar to what other states with similar programs have done and will do in the future. There are, however, some important differences. Perhaps the most significant is that though the HCCTB has no authority to take any enforcement action against a provider or payer that exceeds the benchmark, three states—Massachusetts, Oregon, and California—do have such authority.[96] Furthermore, in some states the entity that administers the cost growth benchmark program is responsible for a broader scope of issues related to the health care system, such as mandating an increase in primary care spending or promoting efforts to improve health care quality.

Summary of State Cost Control Benchmark Experience

The HCCTB's experience, along with the experience of other states, demonstrates that cost growth benchmark programs are valuable in focusing attention on growth in health care costs, providing data and making public the drivers of the cost of health care, and beginning to hold accountable those entities that are causing excessive cost growth. Some modifications could be made to Washington's program to align with other states' programs, notably by providing it with the authority to require PIPs and financial penalties, when appropriate, of entities that surpass the benchmark. Washington State also could adopt other policies to address affordability, as discussed elsewhere in this report.

[93] Washington State Health Care Authority. Health Care Cost Transparency Board Annual Report. August 1, 2023. Available at: https://www.hca.wa.gov/assets/program/leg-report-hcctb-20230905.pdf. Accessed November 26, 2023.

[94] Ibid.

[95] Washington State Legislature. Substitute Senate Bill 5589. Available at: https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session percent20Laws/Senate/5589-S.SL.pdf#page=1. Similarly, In Connecticut, the Office of Health Strategy is directed to set targets by 2025 for increased primary care spending as a percentage of total health care expenditures. Available at: https://portal.ct.gov/OHS/Content/Cost-Growth-Benchmark. Accessed November 26, 2023.

[96] During the 2023 Washington State legislative session, lawmakers considered a bill that would have authorized the HCCTB to require a PIP from payers and providers that have "substantially exceeded the health care cost growth benchmark without reasonable justification or meaningful improvement for two of the previous three calendar years." The House passed the bill, but it did not come to a vote in the Senate. For details, go to: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/House percent20Bills/1508-S.E.pdf?q=20231103110712

Prescription Drug Pricing Regulation

Programs to increase transparency, cap out of pocket costs for prescription drugs and oversee Pharmacy Benefit Managers.

Eight states have implemented programs to oversee and regulate prescription drug prices; there is not enough information available yet to determine the effectiveness.

Washington's Prescription Drug Affordability Board was established in 2022 and has the authority to conduct up to 24 affordability reviews of drugs that have been on the market for 7 years. The PDAB had its first meeting in October 2023.

Establish Prescription Drug Pricing Regulation

High prescription drug costs caused 9 million American adults younger than age 65 (8.2% of people taking prescription drugs) to stop taking their medications as prescribed in 2021, according to a report from the CDC. Out-of-pocket costs for retail prescription drugs totaled $63 billion that year.[97] Some estimates of the impact of these high costs are even more disconcerting. The Kaiser Family Foundation reported that in 2021, 29% of all adults reported not taking their medication as prescribed, and 24% of people taking prescription drugs and 23% of older adults say it is difficult for them to afford their medications.[98]

States have pursued a variety of policies to address the high cost of prescription drugs. The most common approaches include:

- Increasing price transparency
- Capping out-of-pocket costs for certain medications, in particular insulin
- Limiting certain PBM practices

Some states have recently passed legislation establishing programs to regulate prescription drug prices. Eight states have enacted legislation creating Prescription Drug Affordability Boards (PDABs) since 2019: Colorado, Maine, Maryland, Minnesota, New Hampshire, Ohio, Oregon, and Washington.[99]

Under state PDAB laws, the boards conduct affordability reviews on selected prescription drugs based on criteria established by statute or regulation. They are tasked with making recommendations to state officials regarding ways to make these drugs more affordable for residents. These recommendations typically apply to commercial health plans (self-funded employer plans are excluded but may participate voluntarily), state employee health plans and Medicaid plans, although some states limit their scope to publicly funded health plans. Laws Colorado, Maryland, Minnesota, Oregon and Washington, give their PDABs authority to establish upper price limitations (UPLs) after conducting affordability reviews. Colorado is furthest along in this process, having recently chosen five prescription drugs for review.[100]

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[97] Mykyta L, Cohen RA. Characteristics of Adults Aged 18−64 Who Did Not Take Medication as Prescribed to Reduce Costs. National Center for Health Statistics. June 2, 2023. Available at: https://stacks.cdc.gov/view/cdc/127680. Accessed November 26, 2023.

[98] Kaiser Family Foundation. Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including Larger Shares Among Those with Health Issues, with Low Incomes and Nearing Medicare Age.

Available at: https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/. Accessed November 26, 2023.

[99] National Academy for State Health Policy (NASHP). State Laws to Lower Prescription Drug Costs: 2017-2023. Updated October 13, 2023. Available at: https://nashp.org/state-drug-pricing-laws-2017-2023/. The NASHP web page contains a comprehensive list of state laws addressing prescription drug prices.

[100] Colorado Department of Regulatory Agencies. Colorado Prescription Drug Affordability Review Board and Advisory Council. August 4, 2023. Available at: https://doi.colorado.gov/insurance-products/health-insurance/prescription-drug-affordability-review-board. Accessed November 26, 2023.

Washington Law and Experience with Prescription Drug Transparency and Price Regulation

Washington has sought to address affordability by establishing policies focused on addressing rising prescription drug costs. The approach has been applied in two phases: 1) increased transparency and 2) greater oversight and enforcement.

In 2019, the Washington State Legislature established the Prescription Drug Price Transparency Program (PDPTP) to understand of the drivers and impacts of drug costs.[101] Under this program, HCA gathers prescription drug cost information from insurers, PBMs, manufacturers, and other entities to create an annual report on how prescription drugs affect health care costs.

In the first annual report, based on data from 2020 and reported in 2021, HCA identified that drug price increases may affect health care premiums. The extent of the impact, however, could not be identified, in some part because of limitations in HCA's ability to analyze this relationship without a comprehensive set of claims data for all health plans in Washington.[102]

The report suggested several statutory changes, including requiring health insurers, PBMs, manufacturers, and other entities to provide additional data to HCA. HCA noted that these changes would improve the program's ability to understand the impact of prescription drugs on rising health care premiums. Many of these recommendations, including these additional reporting requirements, were included in the legislation that passed in 2022. This legislation also created the Prescription Drug Affordability Board (PDAB), which has additional oversight and enforcement authority over the cost of prescription drugs.[103]

Beginning in 2023, the PDAB is empowered to conduct up to 24 affordability reviews of drugs that have been on the market for at least seven years, including drugs dispensed at a retail, specialty, or mail-order pharmacies, exclusive of that FDA has designated solely for the treatment of a rare disease or condition. These drugs also meet the following benchmarks to be considered for an affordability review:

- Brand name prescription drugs that have a:
    - Wholesale acquisition cost of $60,000 or more per year or for course of treatment lasting less than one year
    - Price increase of 15% or more in any 12-month period or for a course of treatment lasting less than 12 months
    - 50% cumulative increase over three years

- Biosimilar products with an initial wholesale acquisition cost that is not at least 15% lower than the referenced biological product

[101] Engrossed Second Substitute House Bill 1224 Chapter 334, Laws of 2019.

[102] Washington State Health Care Authority. Drug Price Transparency (DPT) program Annual Report 2022. January 2022. Available at: https://www.hca.wa.gov/assets/program/hca-dpt-annual-report-2022.pdf. Accessed November 26, 2023.

[103] Second Substitute Senate Bill 5532 Chapter 153, Laws of 2022.

- Generic drugs with a wholesale acquisition cost of $100 or more for a 30-day supply or less that has increased in price by 200% or more in the previous 12 months

The legislation included additional parameters for affordability reviews including establishment of advisory panels. The advisory panels include stakeholders such as patients, patient advocates, and a representative from the pharmaceutical industry. Affordability reviews will be focused on determining if the drug led to or will lead to excess costs or are not sustainable to the health care system over a ten-year period. PDAB will have the authority to set an upper payment limit for up to 12 prescription drugs annually beginning in January 2027.[104]

The HCA proposed legislation in 2023 to strengthen the PDAB. It would have:

- Made all prescription drugs subject to eligibility reviews, rather than limiting it to 24
- Lowered the threshold criteria from $60,000 to $25,000 per year or course of treatment or price increases of 10% or more in any 12-month period or 25% over three years
- Begun the affordability reviews in 2026 rather than 2027
- Eliminated the upper payment limits[105]

This legislation did not pass; hence, the parameters included in the original legislation creating the PDAB remain in place. The PDAB held its first meeting in October 2023.[106]

[104] Ibid.

[105] State of Washington House Bill 1269. 2022−2023 legislative session. First read January 12, 2023. Available at: https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/House%20Bills/1269.pdf?q=20231107061920. Accessed November 26, 2023.

[106] Washington State Health Care Authority. Prescription Drug Affordability Board. October 20, 2023. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/clinical-collaboration-and-initiatives/prescription-drug-affordability-board. Accessed November 26, 2023.

Health Insurance Rate Review

Rate review is a process where state Insurance Departments (OIC in Washington), review proposed health plan rate increases and must approve them prior to their going into effect.

43 states have prior rate approval over the individual market, 38 states have prior rate approval over the small group market. States are pre-empted by ERISA from requiring rate review for self-funded health plans. Rhode Island has leveraged its authority to impose a cap on the amount hospitals can increase their prices each year and has a process for large group health plan rate prior approval.

Washington requires prior rate approval only in the individual and small group markets.

Enhance Health Insurance Rate Review

Through a process known as prior rate approval, Departments of Insurance (DOI) independently review and assess a health plan's proposed changes and associated documentation. These reviews may include assumptions about medical trend and utilization, changes in enrollment volume and health status of enrollees, and compliance with state and federal changes to policies, regulations, or law. DOIs require insurers to submit their rate requests and provide documentation justifying the proposed increase or, in limited cases, decrease to demonstrate they are adequate, reasonable, and non-discriminatory. A total of 43 states have prior rate approval authority over their individual market rates, and 38 states have prior rate approval in the small group market.[107] All but two states administer their own rate review programs in the individual and small group markets, including states that do not conduct prior rate approval.[108]

The rate review process may include public hearings during which interested parties may comment on the proposed rates. At the conclusion of this process, the DOI makes a final determination as to how much of the proposed rate change is justified and directs the insurer to finalize its rates based on this determination. Typically, final rates wind up being lower than proposed, although in some instances a DOI has determined rates to be inadequately priced and at risk of not covering all the plan's potential health care and administrative costs. In these cases, the DOI has directed insurers to increase their rates. Most states use the rate review process, typically for the fully insured individual and small group markets, although some states have extended this approach to the large group market as well. In addition, the Employee Retirement Income Security Act of 1974 (ERISA) preempts some states from requiring rate review of self-funded health plans.

States have leveraged their rate review authority and capabilities to address affordability through a variety of specific policies applying to different coverage markets, including limitations on hospital price increases and large group health plan rate prior approval as described below.

Rhode Island Hospital Price Caps

Rhode Island's Office of the Health Insurance Commissioner (OHIC) has leveraged its authority to limit the amount that hospitals can increase their prices for inpatient and outpatient services. This cap is part of a broader set of affordability standards[109] that OHIC enforces through its rate review process, which requires prior approval of fully-insured commercial rates.

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[107] Corlette S, Raimugia V. Looking Under the Hood: "Enhanced" Health Insurance Rate Review to Improve Affordability. Georgetown University Center on Health Insurance Reforms. Available at: https://georgetown.app.box.com/v/looking-under-the-hood. Accessed November 26, 2023.

[108] Centers for Medicare & Medicaid Services. State Effective Rate Review Programs. Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet. Accessed November 26, 2023.

[109] State of Rhode Island Office of The Health Insurance Commissioner. Affordability Standards. Available at: https://ohic.ri.gov/policy-reform/affordability-standards. Accessed November 26, 2023.

Though not applicable to the self-funded group health plans, the impact of these standards would extend to contract negotiations if an insurer uses a common contractual fee schedule across its fully insured and self-funded health plan markets.[110] Rhode Island's affordability standards also require an annual 1% increase in spending on primary care in 2010−2014 without any corresponding increase in premiums.

OHIC's regulatory authority[111] gives the Health Insurance Commissioner considerable authority over commercial insurance pricing, including the ability to "consider whether the health insurer's products are affordable, and whether the carrier has implemented effective strategies to enhance the affordability of its products." It is from this broad authority that the affordability standards, including the hospital price cap, are established. The cap was designed to align health care cost increases with measures of price changes.

OHIC selected the Consumer Price Index for All Urban Consumers Less Food and Energy (CPI-U) as the benchmark and set the allowable price increase at no more than 1% above it, which means that the price for inpatient and outpatient services can increase only up to 1% above CPI-U. Though not implemented initially, in recognition of price disparities that existed across the hospital industry before the provider rate cap, OHIC revised the regulations to allow outlier, lower-cost hospitals to increase their rates above CPI-U +1% to bring their pricing in line with the rest of the industry. Once these pricing disparities were addressed, the provider rate cap was applied to these facilities as well.

OHIC assesses insurers' compliance with the hospital rate cap through the rate review process for the individual, small group, and large group markets. As part of the review, OHIC assesses the annual trend assumptions for inpatient and outpatient costs against the rate increase the insurer has requested to determine whether the combined average increase exceeds CPI-U +1%. If so, OHIC requests more information to determine the source of the non-compliant increase. If the discrepancy is the result of a filing issue, the insurer is directed to update its filing. If the discrepancy is because the average cost increase exceeds the provider price cap, the insurer is directed to re-engage with hospitals to secure lower reimbursement levels to bring the average increase into compliance with the cap. Unit of services payment methodologies, such as diagnosis-related groups (DRGs), must be used to calculate pricing adjustments. Requests for increases of more than CPI-U +1% must go to OHIC for review, and exception requests must be justified. OHIC has the authority to approve or disapprove exception requests.

The impact of this price control was significant, resulting in an immediate reduction in cost growth shortly after the provider rate cap was implemented in 2010. A *Health Affairs* study and report[112] on the effectiveness of the affordability standards, including the hospital rate cap, declared, "State regulators in Rhode Island achieved among the largest total health care spending changes observed from payment reforms to date."

[110] This would be commercial insurers who also perform third party administrator services for self-insured employers, negotiating with hospitals on their behalf and leveraging their established fully-insured contractual fee schedule.

[111] State of Rhode Island Legislature. Powers and Duties of the Office of the Health Insurance Commissioner. Available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/230-RICR-20-30-4%20Effective%20August%2020%202023.pdf. Accessed November 26, 2023.

[112] Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Affairs*. 2019;38(2):237−245. doi: 10.1377/hlthaff.2018.05164.

When comparing the impact of the rate cap to spending in a control group from before and after the policy went into effect, the authors determined that, "quarterly FFS spending among the Rhode Island group decreased by $76 per enrollee after implementation of the policy, or a decline of 8.1% from 2009 spending."

Rhode Island Large Group Rate Review

Because large group premiums are experience-rated, OHIC determined that a review and approval process like individual and small group prior rate approval was infeasible. To apply the regulatory requirements described above to all fully insured health plans, including large group plans, OHIC developed a unique approach to reviewing large group health plan rates.

Because each large employer's group membership has a different experience, replication of the review process for individual and small group would require an employer-by-employer review, something no state regulatory agency, including OHIC, has the capacity to accomplish. Given this reality, OHIC designed a large group rate review process aimed at protecting employers and their employees from unreasonable and unfair rate increases, without needing to go line by line through each employer's membership. Instead, OHIC's large group rate approval approach involves reviewing fully insured large group filings at the aggregate level for each participating insurer.

Insurers that request increases are required to submit the following information for OHIC's consideration: anticipated medical expenses, administrative costs, and profits/contributions to reserves to inform their weighted average increase across their entire large group book of business. OHIC reviews these requests and, as with individual and small group rate review, will direct insurers to remove unjustified factors and assumptions from the proposed rate change. This process concludes with a final determination and approval of a an overall, weighted average increase (or decrease) within which the insurer is required to keep overall spending. This methodology effectively results in an overall, insurer-specific, large group spending cap.

Throughout the year, OHIC monitors each insurers' progress against this annual target through quarterly reviews and an end of year audit to ensure total spending stays within the approved increase. OHIC's enforcement authority for insurers that exceed the annual approved increase ranges from penalties to member refunds and decertification from participation in the large group market. Requests for exceptions or good cause waivers must be justified, are subject to OHIC's approval and are rare.

Final approval of large group rates is not reported on a market-wide basis and is instead published individually by insurer. Proposed and final rates for plan years 2021 through 2024 are listed below. Additional information and historical data can be found on the OHIC website.[113]

[113] State of Rhode Island Office of the Insurance Commissioner. All Previous Years Health Plan Review Documents. Available at: https://ohic.ri.gov/ohic-formandratereview-olddocs.php. Accessed November 26, 2023.

Table 7: Rhode Island Large Group Rates

Year	Requested Rate Changes	Approved Rate Changes
PY2021	−0.3% to 10.7%	−0.3% to 9.6%
PY2022	7.4% to 14.1%	4.6% to 7.7%
PY2023	7.0% to 13.4%	5.4% to 8.9%
PY2024	5.9% to 12.4%	0.3% to 10.4%

Washington State Law and Experience with Rate Review

Current state law in Washington requires prior rate approval by the OIC in the individual and small group markets.[114] Large group health plan rates are negotiated between the insurer and the employer or association without prior approval by OIC. For the prior rate approval process, insurers must demonstrate that their rates are actuarially sound, that they are reasonable in relation to the covered benefits, and that they meet all state and federal regulatory requirements, including the ACA's rating rules. Insurers must comply with the single risk pool requirements of each market, meaning they must rate for and treat the consumers of the individual and small group markets uniformly, and should account for the experience of the entire market (i.e., the pool), when setting rates. The only allowable individual adjustments to rates are age, family size, tobacco use, and geographic area.

To inform their annual rate proposals and projections, insurers must submit to the OIC their prediction of future premium components, including medical trend, administrative costs, and profit/contribution to surplus. Surplus funding is considered as part of the overall review process, but OIC is unauthorized to direct a company with excessive surplus levels to use it to lower rates. For 2024, OIC approved an 8.94% average rate increase over 2023 in the individual market, a decrease from the proposed average of 9.11%.[115] In the small group market, rates increased on average by 8%.[116]

[114] Washington Office of the Insurance Commissioner. Title 284. RCW 48.18.110(2), RCW 48.44.020(3), RCW 48.46.060(4), 48.19.010(2), RCW 48.44.040, RCW 48.46.060(6). Accessed November 26, 2023.

[115] Washington State Office of the Insurance Commissioner. Average Rate Increase of 8.9% Approved for 2024 Individual Health Insurance Market. Available at: https://www.insurance.wa.gov/news/average-rate-increase-89-approved-2024-individual-health-insurance-market. Accessed November 26, 2023.

[116] Washington State Office of the Insurance Commissioner. 13 Insurers Approved to Sell Health Insurance to Small Businesses in 2024. Available at: https://www.insurance.wa.gov/news/13-insurers-approved-sell-health-insurance-small-businesses-2024. Accessed November 27, 2023.

Medical Loss Ratio Requirements

The ACA requires insurers in the individual and small group markets to pay 80% and insurers in the large group market pay 85% of the premium collected towards medical care or quality improvement efforts.

This can be seen as a tool to reduce premiums by limiting administrative expenses and profits. Massachusetts has adopted a higher MLR of 88%.

Washington uses the minimum MLR requirements established by the ACA.

Increase Health Insurer Medical Loss Ratio Requirements

The Affordable Care Act (ACA) requires fully-insured commercial market insurers to pay a minimum amount of the premium collected towards medical care or quality improvement initiatives. In the individual and small group markets, this threshold is 80% or higher; in the large group market it is 85%. Consequently, individual and small group insurers cannot allocate more than 20% of premium collected to profit or administrative expenses, such as staff costs and marketing. Large group insurers cannot allocate more than 15% of premium to profit and administrative costs. If expenses and profit exceed these thresholds, the difference must be returned to customers as refunds or rebates.

When the ACA was enacted, the medical loss ratio (MLR) was seen as a consumer protection lever to improve the value of individual and employer-based health insurance, ensuring consumers got the most out of their premium contributions while also incentivizing efficient insurer operations and limiting profit potential. Starting with plan year 2011, insurers nationwide were required to meet the MLR standards or pay consumer rebates, with a few exceptions granted by CMS on a case-by-case basis. Except for Massachusetts, which set its MLR at 88% for their merged individual and small group market, no states have adopted MLRs higher than the federal requirements.

In 2012, more than $500 million in rebates were issued nationwide across all three markets, only 0.2% of which were issued in Washington. The highest aggregate rebates ever issued were for plan year 2019,[117] the year after insurance departments responded to the federal government eliminating cost-sharing reduction payments to health insurers. States allowed health insurers to account for the lost federal revenue by increasing prices on Silver Plans offered through the Exchange marketplaces only, often referred to as “silver-loading.” This mechanism was a major driver of MLRs that dipped below 80% in the individual market, resulting in nearly $2.5 billion in rebates to consumers, and $45.5 million, or just under 2% in Washington. Washington’s highest rebate year was in 2020, when rebates totaled nearly $49 million—2.4% of total rebates nationally.[118]

The primary goal of this policy was to increase the value of the health plans that consumers and employers enroll in, but MLR also was viewed as an affordability tool that could serve to reduce premium rates through limits on administrative expenses and profits. Though the policy has served to increase the amount of spending on medical care and has resulted in billions of dollars in refunds to consumers, it is less clear how well it has served to reduce costs and premiums. Some policy even suggest that MLR incentivizes insurers and providers to work together to navigate compliance with the requirement by increasing claims costs.[119]

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[117] Ortaliza J, Krutika A, Cox C. 2023 Medical Loss Ratio Rebates. Kaiser Family Foundation. May 17, 2023. Available at: https://www.kff.org/private-insurance/issue-brief/medical-loss-ratio-rebates/. Accessed November 27, 2023.

[118] Kaiser Family Foundation. Total Medical Loss Ratio (MLR) Rebates in All Markets for Consumers and Families. Available at: https://www.kff.org/health-reform/state-indicator/mlr-rebates-total/?activeTab=graph&currentTimeframe=0&startTimeframe=9&selectedDistributions=total-rebates&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed November 6, 2023.

[119] Livingston S. The Medical Loss Ratio's Mixed Record. *Modern Healthcare*. March 14, 2020. Available at: https://www.modernhealthcare.com/insurance/medical-loss-ratios-mixed-record. Accessed November 27, 2023.

It is possible that MLR requirements in combination with policies targeting health care service pricing could lessen this incentive.

Washington State Law and Experience with MLR minimums

Washington State has not enacted legislation requiring higher MLR minimums. The state uses the ACA MLR requirements described above.

Reinsurance

Reinsurance programs lower premiums for consumers in the individual market by paying a portion of high-cost claims incurred by health insurers.

17 states have reinsurance programs that lowered premiums from 5% to 38% in 2022.

Washington considered reinsurance in 2018, but did not enact it due to the potential cost to the state.

Implement a Reinsurance Program

Reinsurance is a risk stabilization program used in many states to limit premium increases and to promote financial stability and predictability in health insurance markets impacted by high-cost and volatile claims activity. These programs are federal-state partnerships enabled and partially funded by the federal government through 1332 state innovation waivers.[120] The ACA provides that states may apply for state innovation waivers under section 1332 of the act. The waivers permit a state to find alternatives to certain ACA provisions to implement innovative, state-specific approaches. CMS must approve these waivers, and the states must satisfy certain guardrails intended to protect consumers and federal expenditures on the program.[121] States must contribute to the cost of these programs and through premium assessments, individual mandate revenues,[122] other fees, and general appropriations. All states that have implemented these programs have done so in the individual market only, except Maine, which has extended the program to small employers through a pooled individual and small group market.[123]

Reinsurance programs help mitigate uncertainty by providing a financial backstop to health insurers by paying for some or all high-cost claims, based upon either specific costly conditions or aggregate claim costs. The conditions-based model pays for specific conditions, either in total or partially. The claims-based model generally pays a portion of the eligible claims, known as the coinsurance rate, between the threshold, called the attachment point and the ceiling, known as the cap, above which the insurer resumes paying the full cost. At present, 17 states[124] have 1332 waivers for reinsurance, and of those, only Alaska and Idaho use the claims-based model.

In the individual market, reinsurance has the greatest impact on customers who are ineligible for ACA premium tax credits and are therefore responsible for paying the full monthly price of their plan. These unsubsidized customers bear the full brunt of yearly premium increases, unlike subsidized customers who are shielded, in part or entirely, from paying premium increases because of the corresponding increase in the ACA advanced premium tax credit value.

[120] Centers for Medicare & Medicaid Services. Section 1332: State Innovation Waivers. Available at: https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers. Accessed November 27, 2023.

[121] Ibid.

[122] Rhode Island has a state-based individual mandate requiring residents to have health insurance or pay a penalty on their state taxes. Individual mandate penalties fund the state's share of their 1332 state innovation waiver for reinsurance in the individual market.

[123] https://www.maine.gov/governor/mills/news/federal-government-approves-maines-plan-improve-health-insurance-small-businesses-2022-07-15

[124] State of Maine Office of the Governor. Federal Government Approves Maine's Plan to Improve Health Insurance for Small Businesses. July 15, 2022. Available at: https://www.ncsl.org/health/state-roles-using-1332-health-waivers. Accessed November 27, 2023.

In 2022, the impact of reinsurance programs across the country ranged from a 5% premium reduction to 38%. The average premium reduction impact across all reinsurance programs was 14.5%.[125] In 2023, the first year Maine's reinsurance was extended to small employers, the projected premium reduction impact was 8% for individuals and 6% for small employers.[126]

Washington State Law and Experience with Reinsurance

Washington state considered reinsurance legislation in 2018, but it was not enacted because of concerns related to funding the state share of program costs. Generally, federal and state contributions to reinsurance are split similarly to the percentage of individual market consumers receiving premium tax credits and those who are not. The federal funding is generated by how much the program will reduce premium tax credits, so the generosity is dependent on the number of consumers receiving tax credits.

In 2018, approximately 50% of consumers covered through the Washington Health Benefit Exchange were receiving ACA advance premium tax credits. As a result of enhancements to the premium tax credits that Congress created, the share of unsubsidized customers has decreased in recent years, to approximately 30%, which would likely reduce the state's share of the cost of a 1332 reinsurance program. The impact of a reinsurance program is likely to have dropped as well, as fewer unsubsidized customers are able to reap the program benefits. Alternatively, the amount of available passthrough funding could increase because a greater portion of individual market enrollees are receiving subsidies through the American Rescue Plan[127] and the Inflation Reduction Act.[128]

[125] Centers for Medicare & Medicaid Services. Data Brief on State Innovation Waivers: State-Based Reinsurance Programs. December 2022. Available at: https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/1332-data-brief-dec2022.pdf. Accessed November 27, 2023.

[126] State of Maine Bureau of Insurance. State of Maine – Section 1332 State Innovation Waiver. February 10, 2022. Available at: https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/maine-section-1332%20waiver-complete-application-02-10-2022.pdf. Accessed November 27, 2023.

[127] US Congress. American Rescue Plan Act of 2021. Government Printing Office. Available at: https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf. Accessed November 27, 2023.

[128] US Congress. H.R.5376 - Inflation Reduction Act of 2022. Congress.gov. August 16, 2022. Available at: https://www.congress.gov/bill/117th-congress/house-bill/5376. Accessed November 27, 2023.

Reference-Based Pricing

Establishes standard reimbursement rates that are tied to an already defined pricing level, such as a percentage above what Medicare pays, for a set of health care services.

Montana and Oregon have established this for their state employee programs (and school employees in Oregon) and have realized significant savings as a result.

Washington has implemented reference-based pricing for its public option plan, Cascade Select. Provider reimbursement is limited to 160% of Medicare in the aggregate. To date, premium increases have been lower than other plans on the Exchange

Use Reference-Based Pricing

Reference-based pricing requires health care purchasers or health plans to establish standard reimbursement levels that they will pay for a set of health care services, such as hospital care. The reference point, or price, is tied to already defined and established pricing levels, such as Medicare reimbursement rates, and is usually set as a percentage of the reference rate. Prices cannot exceed the reference-based price. Medicare-based reference pricing ties reimbursement levels and growth to an established and transparent payment methodology that includes adjustments for cost growth over time. Reference pricing is a policy lever states are looking to more often as a mechanism for managing costs and predicting cost growth over time.

Montana's State Employee Plan

In the early 2010s, Montana turned to reference-based pricing to address uncontrolled and unsustainable state employee health plan cost increases and program reserves that were projected to be fully depleted by the end of 2017. The state employee health plan is self-insured and the state contracts with a third-party administrator to support the benefit plan serving approximately 29,000 members. Through contract negotiations with the hospital industry, the Montana Health Care and Benefits Division modified and standardized reimbursement levels for hospital inpatient and outpatient services to achieve pricing predictability and contain costs.

Prior to reference-based pricing, the Montana Health Care and Benefits Division (HCBD) paid each hospital negotiated discounts off their respective chargemaster,[129] which resulted in reimbursement ranging from 191% to 322% of Medicare for inpatient and 239% to 611% for outpatient services to the state's 11 acute care hospitals.

[129] A hospital chargemaster is the collection of standard list prices for hospital services. Chargemaster rates are essentially the health care market equivalent of a manufacturer's suggested retail price (MSRP) in the car buying market. What is a Chargemaster? https://nashp.org/can-we-please-stop-fixating-on-hospital-chargemasters/#:~:text=What%20Is%20a%20Chargemaster%3F,in%20the%20car%20buying%20market.

NASHP commissioned a study to analyze the impact of the program estimated that from state fiscal year (SFY) 2017−2019, the program saved nearly $48 million.[130] The state saved more than $30 million on inpatient services, which resulted in approximately $60 per employee per month (PEPM) in savings. Outpatient services were $17.5 million lower, which resulted in $32 PEPM in savings over three years. The study also found "no evidence of hospital closure or induced utilization to offset lower rates."

In addition, according to a HCBD presentation given to the Maine legislature in November 2019, state health plan reserves were approximately $60 million prior to December 2014 and were projected to be fully depleted and in the negative by the end of 2017. After the implementation of reference pricing, reserves instead grew and by the end of 2017 were at more than $112 million.[131]

Despite the program's success, Montana has indicated a willingness to move away from reference pricing. HCBD recently reprocured the state employee plan administrative services and is allowing flexibility to the awarded vendor (BCBS of Montana) in the resulting contract, setting financial targets but giving the health plan flexibility to achieve those targets through contracting mechanisms other than referencing pricing. "The contract calls for using Medicare's rates as a baseline to set overall targets for the amounts the plan will reimburse hospitals. It gives Blue Cross the ability to meet those goals with reference-based pricing — but also by negotiating deals with individual health care providers using a mix of reimbursement models."[132]

[130]Starting in July 2016 with reference-based pricing, payments for hospital services were capped at a multiplier of Medicare. Reimbursement for applicable hospital services had to stay within could not exceed those amounts. The price levels were set at 220−225% of Medicare for inpatient services and 230−250% for outpatient services. All 11 acute care hospitals were subject to these payment requirements. CAHs were exempted. Lower cost hospitals were able to implement the change most efficiently without disruption or material change to revenues, whereas higher costs hospitals were given a three-year grace period to come into compliance with the reference-based pricing requirements. For more information, go to: Starting in July of 2016 with reference-based pricing, payments for hospital services were capped at a multiplier of Medicare. Reimbursement for applicable hospital services could not exceed those amounts. The price levels were set at 220-225% of Medicare for inpatient services and 230-250% for outpatient services. All eleven acute care hospitals were subject to these payment requirements. Critical access hospitals were exempted. Lower cost hospitals were able to implement the change most efficiently without disruption or material change to revenues while higher costs hospitals were given a three-year grace period to come into compliance with the reference-based pricing requirements. For details, go to:

https://leg.mt.gov/content/publications/fiscal/2023-Interim/March-2022/MARA-NASHP.pdf

[131] Bartlett M. Benchmarking Hospital Pricing. November 2019. Available at: https://legislature.maine.gov/doc/3522. Accessed November 27, 2023.

[132] Houghton K. Montana's Tax-Exempt Hospitals Oppose Increased Oversight by State Officials. Kaiser Family Foundation. February 13, 2023. https://kffhealthnews.org/news/article/montanas-tax-exempt-hospitals-oppose-increased-oversight-by-state-officials/. Accessed November 27, 2023.

Oregon State Employee Health Plan

In response to out-of-control spending for Oregon's state and public employee health plans, the legislature established reference pricing, requiring payments for applicable hospital services to not exceed 200% of Medicare prices for in-network services and 185% for out-of-network services.[133] The law requires in-network and out-of-network (OON) payments for inpatient and outpatient hospital services to be at or below a multiplier of Medicare pricing, establishing a standard ceiling or reference point that hospital services cannot exceed. The intent behind the lower reference-based price for OON services was to provide an incentive to hospitals to stay at the bargaining table with health plans. The legislature also established a budget growth cap, limiting the amount per-member expenditures in self-insured plans and premium growth in fully insured plans at no more than 3.4% annually.

If the insurer or third-party administrator (TPA) contract has a payment methodology that is an alternative to FFS and uses value-based payments, capitation, bundled payments, or some other payment methodology, the reference-based pricing limits must be incorporated into the insurer's or TPA's payment methodology. It must be documented annually through plan design submissions. Reference-based pricing requirements do not apply to certain small hospitals,[134] rural CAHs, hospitals in counties with fewer than 70,000 people, sole community hospitals or hospitals with Medicare payments totaling 40% or more of their payments.

Lastly, to prevent providers from increasing prices up to the payment limit for services below the newly established reference-based price, clarifying regulations[135] were issued to ensure that applicable reimbursement was the lesser of billed charges, the contracted rate, or the reference-based price.

This reference-based pricing requirement applies to employee health plans administered by the Oregon Educators Benefit Board (OEBB) and the Public Employees Benefit Board (PEBB), which were recently merged and are jointly administered. According to an Oregon Health Authority presentation to a legislative committee in March 2023, OEBB and PEBB together serve nearly 300,000 Oregonians, 147,000 through OEBB and approximately 141,000 through PEBB.[136] OEBB is self-insured and PEBB offers fully insured and self-insured plans, with over 80% of members enrolled in self-insured plans as of July 2023.[137]

[133] Oregon Legislature. Enrolled Senate Bill 1067. Available at: https://olis.oregonlegislature.gov/liz/2017R1/Downloads/MeasureDocument/SB1067/Enrolled. Accessed November 27, 2023.

[134] Type A hospitals are small hospitals (with 50 or fewer beds) that are located more than 30 miles from another hospital; Type B hospitals are small hospitals that are located within 30 miles of another hospital. https://www.oregon.gov/oha/HPA/ANALYTICS/HospitalReporting/Hospital%20Type%20Document.pdf. Accessed November2023

[135] https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=pL7k9ex2qwwQs0-O7TqeZV0_9uZCmTeX8QLLDO0ETKCC8tGP2ryY!739320507?ruleVrsnRsn=275541

[136] https://olis.oregonlegislature.gov/liz/2023R1/Downloads/CommitteeMeetingDocument/265527

[137] https://www.oregon.gov/oha/PEBB/MeetingDocuments/PEBB-Board-Agenda-Attachments-20230718.pdf

A Willis Towers Audit presented to the OEBB/PEBB Board of Directors in October 2022 estimated the savings created by reference pricing to be $59m in 2020 and almost $113m in 2021.[138] A NASHP article analyzing the results of the program highlighted that the average Medicare reimbursement level declined went from 215% of Medicare pre-limit to 163% of Medicare in 2021.[139]

Nevada Public Option Plan

Nevada enacted legislation[140] in 2021 to create a public option plan on its state-based exchange by 2026 to improve affordability and access to quality health plans for individuals and families purchasing health insurance in the individual market. The legislation mandated that premiums be reduced by 15% over four years from a 2024 reference-based price.[141] It allowed the state to require Medicaid managed care organizations to propose a good faith offer of a public option plan achieving these premium reductions on the exchange.[142] The legislation authorized the state to submit a 1332 state innovation waiver to implement the program and to use passthrough funds generated by the public option premium reductions to further reduce consumer affordability barriers. Actuarial analysis studying the impact of the public option as well as the potential passthrough funding created by it found "these reforms could bring in up to $344 million to the state and decrease the uninsured rate among people currently eligible for but not enrolled in subsidized marketplace coverage by up to 12% over five years."[143]

The initial waiver application is due January 1, 2024. The governor and his administration recently announced[144] a change in strategy and approach. They intend to leverage the public option created passthrough savings to fund a market stabilization program to bring "…greater stability to Nevada's individual market for health insurance by reinvesting 1332 waiver funds back into the marketplace and provider system."[145] As proposed, the marketplace stabilization program will create and fund:

- A reinsurance program in the individual market
- A quality incentive program to reward insurers offering the public option who meet quality and access measures and to prevent cost-shifting the financial burden of the premium reduction requirements to providers; and
- A provider workforce loan repayment and scholarship program to grow the health care workforce in Nevada

[138] https://www.oregon.gov/oha/PEBB/MeetingDocuments/PEBB-Board-Agenda-Attachments-20221018.pdf

[139] https://nashp.org/oregon-saves-millions-using-reference-based-pricing/

[140] https://www.leg.state.nv.us/App/NELIS/REL/81st2021/Bill/8151/Text

[141] Defined as "…the average second-lowest cost silver level plan available through the Exchange during the 2024 plan year by county trended forward for inflation according to the Consumer Price Index for Medical Care and any adjustments to reflect local changes in utilization and morbidity."

[142] https://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Resources/PublicOption/NV%20Public%20Option%20Fact%20Sheet%2010-14-2022.pdf

[143] https://chirblog.org/nevada-actuarial-study-projects-significant-savings-public-option-plans/

[144] https://thenevadaindependent.com/article/lombardo-to-move-forward-with-public-option-with-a-new-twist-reinsurance

[145] Nevada Department of Health and Human Services. Transforming the Nevada Public Option into a Market Stabilization Program. October 11, 2023. Available at: https://gov.nv.gov/Newsroom/PRs/2023/2023-10-11_nv-public-option/ Accessed November 27, 2023.

Actuarial analysis studying this change in 1332 waiver approach has not been released.

Washington State Law and Experience with Public Option Plan Cap on Provider Reimbursement

Washington's public option, Cascade Select[146], leverages reference pricing to mandate aggregate provider reimbursement levels. It requires public option plan reimbursement to not exceed 160% of Medicare in the aggregate. To achieve this aggregate cap, insurers can negotiate different reimbursement levels across broad categories of services, such as inpatient and outpatient services, as long as reimbursement levels for primary care providers is not lower than 135% of Medicare and critical access hospital reimbursement is not lower than 101% of their costs. Cascade Select plans are only available through Washington Healthplanfinder and are actively selected and administered by the Health Care Authority.[147]

The public option was created to improve affordability and access to quality health plans for individuals and families purchasing health insurance in the individual market. Through the provider reimbursement cap, standard plan design requirements covering more services before the deductible, and state premium assistance to lower income consumers,[148] consumers have access to higher value plans at a lower cost than the non-public option plans offered on the Exchange.

Cascade Select plan enrollment tripled in 2023, and now makes up more than 11% of Washington Healthplanfinder individual market enrollment.[149] Premium increases in public option plans have been lower than for other plans offered on the Exchange. In 2024, Cascade Select will be the lowest cost Silver in 31 of 39 counties, up from 13 counties in 2023.[150]

The legislature has tasked the Washington Health Benefits Exchange (WAHBE) with submitting an actuarial study by December 1, 2023, that analyzes strategies to change the public option plan in ways that could generate federal pass-through funding through a revision to the state's existing 1332 state innovation waiver. Additional pass-through funds would be invested in affordability programs designed to reduce consumer out-of-pocket spending on premiums and cost-sharing.

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[146] Washington State Health Care Authority. Cascade Select (Public Option). Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/cascade-select-public-option. Accessed November 27, 2023.

[147] Washington State Legislature. Engrossed Substitute Senate Bill 5526. Available at: https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session percent20Laws/Senate/5526-S.SL.pdf?q=20220203164635. Accessed November 27, 2023.

[148] Washington Health Plan Finder. Cascade Care Savings. Available at: https://www.wahealthplanfinder.org/us/en/my-account/savings-options/cascade-care-savings.html. Accessed November 27, 2023.

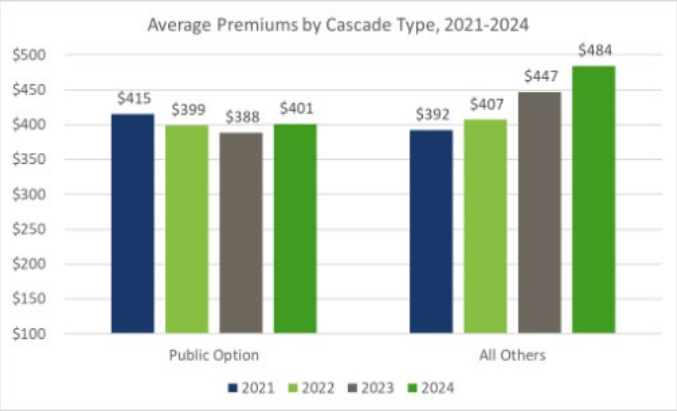
[149] Washington State Health Care Authority. Enrollment Triples in Washington's Cascade Select Public Option. Available at: https://content.govdelivery.com/accounts/WAHCA/bulletins/3482512. Accessed November 27, 2023.

[150] Washington State Health Care Authority. In 2024, Cascade Select Plans Will Be Available in 37 Out of 39 Washington State Counties. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/cascade-select-public-option. Accessed November 27, 2023.

Figure 7: Status of Washington's Public Option 2023

Public Option Shows Promise, But Needs Strengthening

Public option plans supporting customer affordability compared to other Exchange plans, but premiums still not meaningfully lower.



Rates for 40-year-old nonsmoker, inclusive of all counties, and are not weighted for enrollment. Rates are before any available state or federal subsidy.

Source: 2021 -2024 OIC Carrier Rate Filings

Plan Type	Last Year	This Year	2022-2024
Cascade Public Option	-3%	3%	0.5%
All Others	10%	8%	19%

CASCADE CARE

Facility Fee Reform

Additional oversight and limitation of "facility fees" for care received in outpatient and physician office settings that are part of hospital system.

State efforts have been few and focus on limitations about when and where fees can be charged and additional reporting and transparency; Connecticut has been the most aggressive.

Washington requires that provider-base clinics charging these fees disclose that the clinic is part of a hospital system and that the patient may be charged a separate fee that could result in additional out-of-pocket expenses.

Implement Facility Fee Reform

Hospitals charge facility fees for care provided in outpatient and physician office settings that are hospital-owned or controlled. These charges ostensibly reflect hospital overhead expenses. However, the facility fees are not necessarily intended to cover costs specific to the setting where care is being provided or the patient being charged the fee. Federal and state governments, health plans and consumer, have been raising concerns about the use and cost of hospital facility fees for services provided in outpatient settings and physician practices**.**

The expanded use and increasing price tag of facility fees have created affordability and cost control issues for both Medicare and commercial insurers. Some hospital administrators argue that primary care and other outpatient services generally cost more in hospital-based settings, including off-campus facilities, because of the overhead costs associated with running the facility and providing around-the-clock care. The fees merely reflect these additional costs. Conversely, critics of this practice argue that facility fees are a mechanism for increasing hospital revenues and profits and that the expense contributes neither to the care being delivered in off-campus settings nor the upkeep or maintenance of those facilities.[151]

Hospital purchases of independent outpatient and physician practices resulting in new hospital facility fees that increase costs and in many cases cause higher consumer cost-sharing, are driving widespread concerns about facility fees. According to a Georgetown University Center on Health Insurance Reforms (CHIR) report,[152] health insurers "face higher prices for outpatient services as a result of vertical integration, with estimates ranging from a 14.1% increase for all services provided by acquired physician practices, to a 5% increase in outpatient primary care prices." Facility fees for health insurance are generally unregulated and are set through contract negotiations, giving large hospital systems with dominant market position considerable leverage over pricing. This dynamic has resulted in growing fees and considerable variation in pricing across hospitals and markets.

Regulating or limiting facility fees for hospital-owned outpatient and physician practices is seen as a tool for combating vertical integration, as the facility fee financial incentive associated with owning these outpatient settings could be reduced. The Medicare Payment Advisory Commission has studied this issue extensively and has made recommendations[153] on moving toward a site-neutral approach to Medicare payments for outpatient and physician-based services. These recommendations are currently being considered by Congress.

[151] For a comprehensive discussion of facility fees and the ongoing debate over whether and how to regulate them, see go to https://www.healthaffairs.org/content/forefront/facility-fees-101-all-fuss.

[152] Monahan CH, Davenport K, Swindle R. Protecting Patients from Unexpected Outpatient Facility Fees: States on the Precipice of Broader Reform. July 2023. Available at: https://georgetown.app.box.com/v/statefacilityfeereport. Accessed November 27, 2023.

[153] Goldman M. MedPAC Wades Back into Outpatient Site-Neutral Payments. *Modern Healthcare*. November 9, 2021. Available at: https://www.modernhealthcare.com/payment/medpac-wades-back-outpatient-site-neutral-payments. Accessed November 27, 2023.

NASHP has also studied the issue, providing research and technical assistance to states, and has developed model legislation designed to give states authority and tools necessary to regulate and limit facility fees.[154]

Facility Fee Regulation State Initiatives

In recent years, states have increased efforts to regulate facility fees and foster transparency around the issue in the interest of limiting facility fee charges, curbing price growth, and educating consumers. These steps include:

- Regulating or outlawing facility fees at off-campus hospital owned outpatient settings and physician offices
- Limiting facility fees for some on-campus services
- Limiting or prohibiting consumer cost-sharing for facility fees
- Requiring hospital owned facilities to disclose to patients their affiliations and potential for a facility fee charge on their bill
- Requiring hospitals to report facility fee activity to a state agency

To date, state efforts to limit and regulate facility fees have been limited. Connecticut has been the most aggressive state. Current law prohibits facility fees for certain off-site outpatient services as well as telehealth services. Starting July 1, 2024, hospitals will be prohibited from charging facility fees for on-campus services, with limited exceptions. Civil penalties of up to $1,000 will be issued for violations of this law.[155] This law was and is still opposed by the hospital industry, which argued that facility fees are critical to covering the costs of providing adequate and quality care in outpatient settings, which in turn saves everyone money by preventing more costly inpatient and emergency care.[156] Indiana recently enacted a limitation on facility fees charges for outpatient services in off-campus office settings by certain non-profit hospitals[157] on. Facility fees for for-profit hospital systems as well as for on-campus non-profit outpatient services will still be allowed.[158] Indiana's law goes into effect on January 1, 2025.

The State of Maine recently enacted legislation creating a task force charged with studying and reporting on the impact of facility fees on consumers and costs and to make recommendations to the legislature on solutions for addressing or limiting their impact on affordability.[159] A table summarizing other state efforts to evaluate, limit and address facility fees from the above referenced CHIR report can be found in Table 8.

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[154] National Academy for State Health Policy. NASHP Model State Legislation to Prohibit Unwarranted Facility Fees. August 24, 2020. Available at: https://nashp.org/nashp-model-state-legislation-to-prohibit-unwarranted-facility-fees/. Accessed November 27, 2023.

[155] https://www.cga.ct.gov/2023/rpt/pdf/2023-R-0152.pdf

[156] https://ctmirror.org/2023/10/26/hospital-outpatient-facility-fee-charge-care/

[157] Defined as non-profit hospitals with patient revenue of at least $2 billion on the hospital system's audited 2021 financial statements.

[158] Indiana General Assembly. House Enrolled Act No. 1004. Available at: https://iga.in.gov/pdf-documents/123/2023/house/bills/HB1004/HB1004.07.ENRS.pdf. Accessed November 27, 2023.

[159] State of Maine. An Act to Create Greater Transparency for Facility Fees Charged by Health Care Providers and to Establish the Task Force to Evaluate the Impact of Facility Fees on Patients. P.L. 410. Approved by the Governor July 10, 2023. Available at: https://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0720&item=3&snum=131. Accessed November 27, 2023.

Table 8: State Facility Fee Requirements

Table 1. Outpatient Facility Fee Requirements in 11 Study States

	Regulatory Reform				
STUDY STATE	**1. Prohibition on Facility Fees** State prohibits providers from charging facility fees for specified procedures and/or care settings	**2. Out-of-Pocket Cost Protections** State limits consumers' financial exposure to outpatient facility fees in specified circumstances	**3. Consumer Disclosure Requirements** State requires specified providers and/or insurers to disclose that outpatient facility fees may be charged and/or the expected amount of outpatient facility fee charges or cost-sharing obligations, as applicable	**4. Hospital Reporting Requirements** State requires that hospitals make annual or one-time disclosures to the state on outpatient facility fee-related data	**5. Provider Transparency Requirements** State requires that health care providers register with national or state databases to better monitor where care is provided and/or who is providing care
COLORADO		No balance billing for facility fees for preventive services*	Hospitals and hospital-owned facilities,* freestanding emergency departments (EDs)	One-time study	Unique national provider identifier for off-campus locations
CONNECTICUT	Evaluation and management services on-* and off-campus, telehealth	No separate copayment on off-campus outpatient facility fees	Hospitals and hospital-owned facilities, insurers	Annual reporting	
FLORIDA			Hospitals and hospital-owned facilities, freestanding EDs		
INDIANA	Off-campus office settings owned by non-profit hospitals*			Annual reporting	
MAINE**	On- and off-campus office settings				
MARYLAND	Telehealth, COVID-19 testing and monoclonal antibodies		Hospitals and hospital-owned facilities	Annual reporting	
MASSACHUSETTS			Hospitals and hospital-owned facilities, insurers		Provider registry on ownership and affiliation
NEW YORK	Preventive services		Hospitals and hospital-owned facilities		
OHIO	Telehealth				
TEXAS	Drive-thru services at freestanding EDs		Freestanding EDs, insurers		
WASHINGTON	Telehealth (audio-only)		Hospitals and hospital-owned facilities	Annual reporting	

* Legislation has been enacted but requirement has not yet gone into effect. ** Maine recently enacted a bill to establish a task force to study facility fee billing and make a report to the legislature with recommendations. It also requires the state's all payer claims database to annually report on facility fee payments based on otherwise available data beginning in January 2024.

Washington State Law and Experience Related to Facility Fees

Washington State law requires provider-based clinics that charge a facility fee to post and disclose to patients that the clinic is licensed as part of a hospital and that the patient may be charged a separate facility fee that could result in additional out-of-pocket expenses.[160] Washington also requires hospitals with provider-based clinics to include in their year-end financial reports to the Department of Health (DOH) information about facility fees. These reports are available on the DOH website,[161] and information for 2022 is summarized in Table 9, page 69.

[160] Washington State Legislature. RCW 70.01.040: Provider-Based Clinics that Charge a Facility Fee—Posting of Required Notice—Reporting Requirements. Available at: https://app.leg.wa.gov/RCW/default.aspx?cite=70.01.040&pdf=true. Accessed November 27, 2023.

[161] Washington State Department of Health. 2022 Facility Fees. Available at:

Table 9: 2022 Hospital Facility Fees

Name	Number of Clinics	Annual Patient Visits	Annual Facility Fee Revenue	Lowest Facility Fee	Highest Facility Fee
EvergreenHealth	2	19,925	$ 4,115,576	$ 100	$ 233
Inland Hosptial	1	2,462	$ 209,490	$ -	$ 255
Kadlec Regional Medical Center	15	197,376	$ 16,305,430	$ 1	$ 704
Olympic Medical Center	18	173,474	$ 43,904,378	N/A	N/A
Overlake Hospital Medical Center	3	19,472	$ 2,244,469	$ -	$ 349
Providence Centralia Hospital	4	6,102	$ 832,634	$ 45	$ 658
Providence Regional Medical Center Everett	1	19,492	$ 2,560,631	$ 28	$ 830
Providence Sacred Heart Medical Center	1	5,341	$ 525,758	$ 33	$ 678
Seattle Cancer Care Alliance	7	127,254	$ 18,089,720	$ 67	$ 502
Seattle Children's Hospital	8	92,739	$ 6,011,663	$ 25	$ 180
Skagit Valley Hosptial	4	104,315	$ 4,377,149	$ -	$ 2,900
Swedish Medical Center - First Hill	4	34,494	$ 4,234,684	$ 5	$ 608
University of Washington Medical Center	20	126,122	$ 10,344,460	$ -	$ 253
UW Medicine/Harborview Medical Center	6	7,548	$ 506,742	$ -	$ 253
UW Medicine/Valley Medical Center	5	281,954	$ 13,243,390	$ 0.4	$ 3,860
Yakima Valley Memorial	13	88,958	$ 4,723,220	$ -	$ 618

https://doh.wa.gov/data-statistical-reports/healthcare-washington/hospital-and-patient-data/hospital-financial-data/hospital-facility-fees/2022-facility-fees. Accessed November 27, 2023.

Public Option Plans

Public Option plans are designed to be the most affordable plans in the individual and small group markets.

Colorado has established a public option plan that is intended to decrease premiums by 15% over three years. It is not clear that this goal will be met.

Enrollment in Washington's public option (Cascade Select) now makes up more than 11% of Washington Healthplanfinder individual market enrollment. Premium increases in public option plans have been lower than for other plans offered on the Exchange; in 2024, Cascade Select will be the lowest cost silver in 31 of 39 counties.

Offer Public Option Health Plans

Colorado's Public Option Premium Reduction Enforcement

The Colorado Option,[162] is intended to improve access to care, affordability, and to reduce racial health care disparities for consumers in the individual and small group markets through standard plan designs and premium reduction requirements. Starting in 2023, insurers are required to offer public option plans in any county in which insurers offer individual or small group plans. They also must decrease premiums for their public option plans by 15% over three years (5% annually) from a 2021 baseline. In addition, public option plans must adhere to standard plan designs that limit out-of-pocket spending and barriers to care.

The plans also have provider network requirements prohibiting networks narrower than non-public option plans and mandate contracting with 50% or more of Essential Community Providers[163] in the plan's service area, up from the federal standard of 35%. The Colorado Division of Insurance has estimated that the Colorado Option will save Coloradans $14.7 million in 2023.[164] Not all insurers were able to meet the premium reduction requirement of 5% in 2023.[165]

Starting in plan year 2024, insurers that cannot meet the annual premium decrease or network participation requirements for their Colorado Option plans will be subject to a public hearing process with the Colorado Division of Insurance to determine the cause of the failure to meet the requirements and to identify corrective actions. The hearing process is intended to create transparency. Once the hearing process begins, insurers and providers have the opportunity to negotiate and reach agreement. If the parties have reached an impasse, the hearing process is designed to find the root cause of the non-compliance. Through a final agency order, the commissioner can set lower provider reimbursement rates if they are the cause of the insurer's inability to meet the premium target and to direct the insurer to use those rates in their plan filings. Hearings were initially scheduled for plans filed in 2023 for the 2024 plan year, but none were held.[166]

Nevada's and Washington state's public option plans are reviewed on pages 62 and 63.

[162] Colorado Division of Insurance. Colorado Option 2023 Standard Plans Quality and Affordable Health Insurance Coverage. Available at: https://drive.google.com/file/d/1HcCxoBi76XCHEwVN3O3qKbPUa6vdkFAk/view. Accessed November 27, 2023.

[163] CMS defines "Essential Community Providers" (ECPs) as providers that predominantly serve low-income, medically underserved individuals. Details available at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/ecp-faq-20130513.pdf. CMS regulations set forth the requirements for plans to contract with ECPs. See 45 CFR 156.235, https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-C/section-156.235#p-156.235(a)(2)(ii)(B).

[164] Ingold J. Colorado Health Insurance Rates Are Set to Rise Next Year—But Some People Could Still Pay Less

https://coloradosun.com/2022/10/26/colorado-option-health-insurance-prices-2023/. *Colorado Sun*. Available at: https://coloradosun.com/2022/10/26/colorado-option-health-insurance-prices-2023/. Accessed November 27, 2023.

[165] Hawryluk M. Colorado Option's Big Test: Open Enrollment. *KFF Health News*. December 7, 2022. Available at:

https://kffhealthnews.org/news/article/colorado-public-option-test-open-enrollment/. Accessed November 27, 2023.

[166] Ingold J. Why Every Public Rate Hearing for the Colorado Option Health Insurance Plans Got Canceled. *Colorado Sun*. Available at: https://coloradosun.com/2023/07/05/colorado-option-health-insurance-hearings-canceled/. Accessed November 27, 2023.

State Exchange Subsidies

State funds are used to lower premiums and provide cost sharing assistance for consumers enrolled in Exchange plans.

Eight states have implemented some form of state-based premium or cost-sharing assistance.

Washington has a state-funded premium subsidy to Exchange consumers who enroll in Cascade Care silver or gold plans.

Implement Exchange Subsidies

The ACA originally provided financial assistance through state Exchanges in the form of premium tax credits and cost-sharing reductions (CSRs), available to consumers without access to affordable, qualified coverage through some other means and who met the income eligibility requirements. Qualified consumers with incomes of 100%−400% of the federal poverty level (FPL) could receive premium tax credits to reduce monthly premiums, which were most generous at the lowest income levels, declining in value as income increased. Qualified consumers at 100%−250% of FPL were also eligible to receive cost-sharing reductions, if they enrolled in Silver plans. CSRs decline in generosity as income increases. Select populations, such as lawfully present immigrants under 100% of FPL not qualified for Medicaid[167] and Native American and Alaska Native[168] populations qualify for additional financial assistance opportunities.

The ARPA[169] changed the ACA premium tax credits, enhancing their value and expanding their availability to populations earning more than 400% of FPL. These enhanced premium tax credits are authorized through 2025. Though these changes have improved affordability for millions of people enrolling in exchanges across the country, cost of coverage and care affordability gaps remain.

State Initiatives

To address affordability gaps, states have created targeted premium and cost sharing assistance programs in the form of income-based subsidy and cost-sharing wraps as well as population specific programs. California,[170] Colorado,[171] Connecticut,[172] New Mexico,[173] and Vermont[174] all provide qualified exchange customers with additional premium and cost-sharing subsidies. Maryland[175] provides additional premium subsidies to qualified adults ages 18−37 and with income up to 400%, Massachusetts provides premium

[167] HealthCare.gov. Coverage for Lawfully Present Immigrants. Available at: https://www.healthcare.gov/immigrants/lawfully-present-immigrants/. Accessed November 27, 2023.

[168] Centers for Medicare & Medicaid Services. Information for American Indians and Alaska Natives Applying for Coverage. Available at: https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/downloads/information-for-aians-applying-for-coverage2017.pdf. Accessed November 27, 2023.

[169] US Congress. American Rescue Plan Act of 2021. P.L.117–2. March 11, 2021. Available at: https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf. Accessed November 27, 2023.

[170] Covered California. Covered California to Launch State-Enhanced Cost-Sharing Reduction Program in 2024 to Improve Health Care Affordability for Enrollees. Available at: https://www.coveredca.com/newsroom/news-releases/2023/07/20/covered-california-to-launch-state-enhanced-cost-sharing-reduction-program/. Accessed November 27, 2023.

[171] Connect for Health Discounts. Healthcare Discounts. Available at: https://connectforhealthco.com/financial-help/healthcare-discounts/. Accessed November 27, 2023.

[172] Access Health CT. Financial Help. Available at: https://www.accesshealthct.com/financial-help/. Accessed November 27, 2023.

[173] New Mexico Office of Superintendent of Insurance. 2024 Plan Year Health Insurance Marketplace Affordability Program Policy and Procedures Manual. April 13, 2023. Available at: https://a.storyblok.com/f/132761/x/9707cfc6bb/final_2024-health-insurance-marketplace-affordability-program-policy-and-procedures-manual_230412.pdf. Accessed November 27, 2023.

[174] Department of Vermont Health Access. Vermont Health Connect. Available at: https://info.healthconnect.vermont.gov/financial-help. Accessed November 27, 2023.

[175] Maryland Health Connection. Young Adult Subsidy Program Expands Age Range. Available at: https://www.marylandhealthconnection.gov/young-adult-subsidy-program-expands-age-range/. Accessed November 27, 2023.

subsidies to qualified individuals up to 500%,[176] and New Jersey provides premium subsidies to qualified customers up to 600% of FPL.[177]

Washington State Law and Experience Related to Additional Individual Market Premium Subsidies

Washington provides state-funded premium subsidies to Washington Healthplanfinder customers with incomes up to 250% FPL who enroll in Cascade Care Silver or Gold plans. Starting in 2024, all Washingtonians regardless of immigration status who are ineligible for the ACA premium tax credits may also receive these premium subsidies.

[176] https://www.mahealthconnector.org/learn/plan-information/connectorcare-plans

[177] https://nj.gov/getcoverednj/financialhelp/gethelp/

Individual Mandate

Requires individuals to participate in health insurance coverage to promote universal enrollment and a larger risk pool- penalties could be used to support affordability provisions.

Five states have enacted individual mandates.

Washington enacted an individual mandate as part of the 1993 Health Services Act which was repealed in 1995.

Enact a State Individual Mandate

The individual mandate, also known as the individual shared responsibility provision,[178] was included in the ACA based on the assumption that the pathway to universal coverage would be achieved through a combination of financial incentives, consumer protections, and penalties for not participating. The incentive came in the form of federal funding for the expansion of Medicaid to childless adults as well as the premium tax credits and corporate social responsibilities (CSRs) described earlier. Consumer protections included the elimination of preexisting condition denials, removal of annual and lifetime benefit caps, essential health benefit requirements, among many others. The penalties for failing to offer or enroll in coverage were fines assessed through the federal tax filing process on employers that didn't offer comprehensive and affordable health insurance and on individuals who choose to be uninsured. The latter is known as the individual mandate penalty. The individual mandate penalty was set as either a specific dollar amount or a percentage of family income, whichever was greater. The penalty was phased in beginning in 2014 and reached a maximum of the greater of $2,085 per family or 2.5% of household income above the income tax filing threshold. The penalty was reduced to $0 by Congress, effective in 2019.[179] In tax year 2017, 4.6 million returns reported penalties totaling approximately $3.6 billion.[180]

Other States

Massachusetts implemented an individual mandate[181] and other access and affordability reforms in 2006, which was superseded by the ACA's individual mandate and then reinstated after its elimination. California,[182] the District of Columbia,[183] New Jersey,[184] and Rhode Island[185] all enacted their own state-based individual mandates which largely mirrored the ACA individual mandate and were effective in 2019 or 2020. The advocacy for enacting state-based individual mandates was generally similar across these states and DC, arguing that achieving universal coverage is dependent on incentives, penalties, and full participation in the health care system. A related argument used during legislative advocacy for the individual mandate was that associated penalty revenues could be invested into affordability programs, such as state subsidies or reinsurance, utilizing these fines to improve access and affordability.

[178] https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision

[179] https://www.kff.org/interactive/penalty-calculator/

[180] https://sgp.fas.org/crs/misc/R44438.pdf

[181] https://www.mass.gov/regulations/830-CMR-111m21-health-insurance-individual-mandate-personal-income-tax-return-requirements

[182] https://www.coveredca.com/marketing-blog/why-are-californians-required-by-law-to-have-health-insurance/

[183] https://code.dccouncil.gov/us/dc/council/code/titles/47/chapters/51

[184] https://nj.gov/treasury/njhealthinsurancemandate/

[185] https://tax.ri.gov/guidance/health-insurance-mandate

Washington State Law and Experience with the Individual Mandate

In 1993, the Washington state Legislature enacted the Health Services Act, a comprehensive health care reform measure. The law included a requirement for individuals to enroll in coverage that would have been effective as of January 1, 1999.[186] The individual mandate was repealed in 1995.

[186] Formerly RCW 43.72.210 (Sec. 463 of Chap. 492, Laws of 1993)

All-Payer Model

An All-Payer Model establishes rates for hospitals which are the same for all payers and sets budgets for hospital revenue.

Maryland's model has changed over time to a Total Cost of Care Model that expands all-payer rate setting to primary care and specialty providers and provides support and incentives to reduce.

Washington had a hospital rate-setting statute like Maryland's in the 1970's and '80s. It was repealed in 1989.

Create an All-Payer Model Like Maryland's

Original Hospital Rate-Setting

Starting in the 1970s, Maryland established a hospital rate-setting system that was authorized through an agreement with CMS which exempted the state from Medicare's Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS). The agreement was based on the understanding that Maryland would keep Medicare inpatient payments per admission below the national growth rate. To accomplish this, all Maryland payers were required to pay the same rate for the same service at the same hospital.

In 2010, Maryland implemented a global budget program for rural acute care hospitals. Under the model, the state provided eight participating rural hospitals with an annual budget for all inpatient, emergency department, and outpatient services from all payers (Medicare, Medicaid, commercial, and self-pay). The state extended the global budget program to include urban and suburban hospitals with the Maryland APM in 2014. Maryland made this transition away from the rate-setting system because cost per admission had been increasing faster than the national average and state officials worried they would lose their CMS exemption. In addition, "…the focus on cost per admission was poorly aligned with other health care delivery system reforms under way in Maryland and nationally that focused on comprehensive, coordinated care across delivery settings."[187]

All-Payer Model

In 2014, the Maryland Health Services Cost Review Commission (HSCRC) fully implemented the all-payer, global hospital budget cost containment initiative created by a CMS waiver. This All-Payer Model (APM) allowed the state to set nearly all inpatient and outpatient hospital rates, included a hospital revenue growth target and incentivized efforts to deliver high-quality services and improve population health. The APM was built upon the hospital rate-setting model and included commitments to limit hospital revenue growth over the 5-year waiver period to less than 3.58% and to create more than $330m in Medicare savings.[188]

The APM established an annual global budget for each hospital which was baselined in 2013 and adjusted annually based on several factors including inflation, population changes, and utilization. All regulated acute care hospitals participated in the program. HRSRC set the hospital's rates for all payers based on their global budget and allowed Medicaid and Medicare payers a 6% discount. The global budget included a hospital specific revenue ceiling and hospitals were penalized for overages as well as underspending exceeding 0.5% of revenue. Due to fluctuations in expected utilization, hospitals were allowed to adjust their rates mid-year in the interest of hitting their global budgets and could independently increase or decrease their rates by up to 5%, above which they would need approval from HSCRC. Adjustments above 10% were not allowed except under exceptional circumstances.[189]

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[187] https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf

[188] Maryland HSCRC, *Maryland's Total Cost of Care Model: Background and Summary, https://hscrc.maryland.gov/Documents/Modernization/TCOC%20Background%20and%20Summary%20_5_23_18%20.pdf*

[189] Ibid.

For the five-year waiver period HSCRC reported that they met or exceeded all the originally set performance targets.[190] Annual hospital revenue growth per capita from 2014-2018 was 1.92%, well below the target of less than or equal to 3.58%. Medicare savings were $1.4 billion over the waiver period, exceeding the original target of $330 million or more. A CMS final evaluation report highlighted that total Medicare expenditures in Maryland "…declined by 2.8% and hospital expenditures declined by 4.1% without shifting costs to other parts of the health care system. A 17.2% reduction in outpatient department service expenditures drove Medicare hospital savings."[191] Table 10 is a table from HSCRSC that includes additional results and outcomes from the 5-year APM performance period.

Table 10: Outcomes from Maryland's All-Payer Model

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ $330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

* $273 million in Medicare TCOC savings in 2018 alone – aka Medicare savings run rate vs. 2013 base

[190] https://hscrc.maryland.gov/Documents/Maternal percent20Task percent20Force/HSCRC percent20All percent20Payer percent20Model percent20PY5 percent20Results.pdf

[191] https://www.cms.gov/priorities/innovation/files/reports/md-allpayer-finalevalrpt-fg.pdf

Total Cost of Care Model

In January 2019, Maryland implemented the total cost of care model (TCOC), which builds on global budgets tested in the alternative payment model (APM), and moves beyond hospitals to accept responsibility for limiting the growth in total cost of care for Maryland Medicare beneficiaries.[192] The model creates incentives and supports for hospitals, primary care practices, and other providers that seek to reduce spending, enhance quality, improve population health and health equity, and achieve care transformation targets. The TCOC model also establishes multi-payer pricing for medical services that hospitals, primary care providers, and specialists deliver; sets each hospital's annual revenue from all payers; and supports improved care coordination and the provision of patient-centered care.

The TCOC model covers hospital payments, care redesign, and the state's primary care patient management services to reduce overall spending.

- The Hospital Payment Program is mandatory and allows participating hospitals to receive population-based compensation for all services they provide throughout the year.
- The Care Redesign Program is voluntary and allows participating hospitals to offer incentive payments to nonhospital health care providers who collaborate with the hospital to conduct care redesign activities. Participating hospitals can earn incentive payments only if they achieve savings under their global budget.
- The Maryland Primary Care Program (MDPCP) is voluntary and open to all Maryland qualifying primary care providers, including federally qualified health centers (FQHCs). Under this arrangement, CMS pays participating providers risk- and deprivation-adjusted care management fees, as well as performance-based incentive payments for providing comprehensive primary care. The program focuses on five comprehensive primary care functions: access to care, care management, comprehensiveness and coordination, patient and caregiver experience, and planned care and population health.

Under TCOC, Maryland accepts accountability for growth in Medicare spending per enrollee, and each hospital is subject to a Medicare performance adjustment (MPA) based on total per capita spending increases in its service area relative to a target growth level. Through TCOC, Maryland aims to save on Medicare per capita total cost of care during each model year (2019−2023). The state's goal is to achieve more than $1 billion in Medicare total cost of care savings by the fifth model year, 2023.[193]

[192] Maryland HSCRC, *Maryland's Total Cost of Care Model: Background and Summary, https://hscrc.maryland.gov/Documents/Modernization/TCOC%20Background%20and%20Summary%20_5_23_18%20.pdf*

[192] Ibid.

[193] https://hscrc.maryland.gov/Documents/Modernization/7-30-18 percent20Announced percent20Terms_FINAL.pdf

Washington State Law and Experience with Hospital Rate-setting

In the 1970s and 1980s, Washington had hospital rate-setting authority similar to Maryland's. One study assessing the impact of hospital rate setting during this time period noted it was "successful at controlling the rate of increase in hospital costs in most of the states that implemented this type of regulation."[194] The same study noted that Washington was one of two states in which it proved to be less successful, with hospital costs increasing faster than the nationwide average. Another study[195] found that Washington's rate setting commission's approach to regulating hospitals varied from that employed by Maryland and other states, which set growth targets and established compliance incentives but deferred the work of achieving these goals to the hospital administrators.

Washington's approach was more hands-on and received an unenthusiastic welcome from the hospital industry. "Despite the very large annual hospital allowances afforded by the Washington commission and despite an enabling statute that was nearly identical to Maryland's, Washington's system proved unpopular with hospitals and was terminated in 1989."[196]

[194] https://www.issuelab.org/resources/11206/11206.pdf

[195] https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf

[196] Ibid.

PART III: ECONOMIC MODEL TO REVIEW THE IMPACT OF SELECTED POLICY OPTIONS

Background

This part describes several policies Washington policymakers might consider adopting or amending to reduce the growth in the total cost of health care. Part III describes how HMA will determine the potential impact of the selected policies on Washington's health care system. The results of this analysis will be included in the final report, which will be available in July 2024.

This analysis will include several inputs including the costs to the state of developing and managing the new policy initiatives and the direct and indirect benefits of adopting new policies or amending existing policies to reduce health care spending and improve health care affordability in Washington. The cost- benefit analysis will estimate the direct and indirect benefits to the state, to employers and Washington residents, and compare total benefits to total costs, resulting in a benefit-to-cost ratio and an ROI on the state's investment.

The analysis also will show to what extent the policy initiatives selected are likely to meet or exceed the benchmarks established by the Washington HCCTB (described in Part II on page 41). Finally, the analysis will include what is likely to happen if none of the policy reforms selected for modeling are adopted and implemented.

Key Assumptions

The National Bureau of Economic Research published an important report on key factors driving the growth in health care spending in December 2022.[197] This study identifies five factors driving increased health care spending:

1. Technological change
2. Income growth and macroeconomic change
3. Population demographics
4. Health insurance generosity
5. Unit prices of medical care goods and services

This report concluded that the growth in income—and its interaction with technology—is the dominant driver of medical spending growth. CMS recently released the federal government's forecast for national health expenditures. CMS projects that in 2022−2031, average annual growth in national health expenditures will be 5.4%. It is expected to outpace the average annual growth in gross domestic product (GDP), which is projected to be 4.6%.[198]

[197] Smith SD, Newhouse JP, Cuckler GA. Health Care Spending Growth Has Slowed: Will the Bend in the Curve Continue? National Bureau of Economic Research. Wording Paper 30782. Cambridge, MA. December 2022. http://www.nber.org/papers/ww30782.

[198] CMS Office of the Actuary Releases 2022-2031 National Health Expenditure Projections. June 14, 2023. CMS Office of the Actuary Releases 2022-2031 National Health Expenditure Projections | CMS

The following table, based on the CMS data, shows the long-term average annual growth of health expenditures over 40 years in Washington and it with the projected spending increases in United States. This table shows where the spending growth is coming from as broken down in terms of the various sectors of the health care system.

Table 11: Average Annual Percent Growth 1980 - 2020[199]

Category	Washington	United States	Variance
Home Health Care	10.4%	9.4%	1.00%
Other Professional Services	9.2%	9.6%	-0.40%
Prescription Drugs	8.8%	7.8%	1.00%
Other Health, Residential, and Personal Care	8.4%	9.8%	-1.40%
Physician & Clinical Services	7.3%	7.8%	-0.50%
Personal Health Care	7.1%	7.6%	-0.50%
Durable Medical Products	6.7%	7%	-0.30%
Nursing Home Care	6.6%	6%	0.60%
Hospital Care	6.5%	7.7%	-1.20%
Other Non-durable Medical Products	6.4%	6.4%	0.00%
Dental Services	6.1%	6.3%	-0.20%
Total Health Expenditures	7.6%	7.1%	0.50%

As noted, the underlying assumption of this analysis is the extent to which the selected policy interventions are aimed at the major drivers of increases in Washington health care costs. HMA will use a combination of existing research complimented by quantitative data and qualitative experience from other states that have implemented comparable policy reforms.

[199] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/state-provider

This information will help determine the expected magnitude of the reduction in total health spending in Washington. If no other states have tested one or more policy option(s), HMA will use gather information from the existing research and key expert interviews.

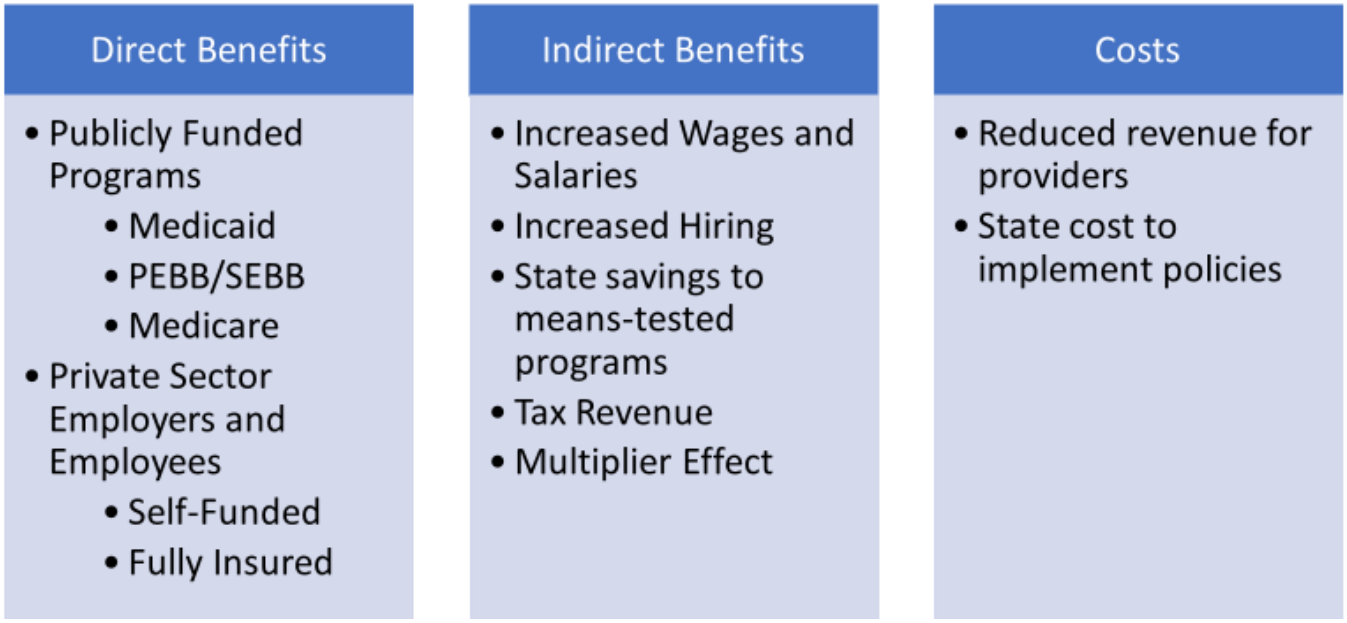
The baseline is determined based on two factors: the expected growth in total health spending if the status quo is maintained and the overall performance of the economy. For example, if the United States experiences a significant and prolonged recession in 2024, perhaps extending into 2025, the baseline growth in total health care spending would decline. The opposite is also true. An unexpectedly strong economic performance will increase the baseline growth of total health spending.

The estimated gap between the expected growth in total health care spending in Washington in the absence of policy reforms and the expected growth in total health care spending if all the policies modeled are successfully implemented, will illustrate the extent to which the state benchmarks will be met and any remaining gaps.

Benefits and Costs

Following this determination, the analysis will then evaluate the benefits and costs of potential reductions in the growth of total health spending to the overall economy in Washington (see Figure 8 below).

Figure 8: Summary of Benefits and Costs of the Analysis



Direct Benefits

Reducing the growth of health care spending could have direct benefits for health care purchasers and individual Washingtonians. These anticipated enhancements are described below.

Publicly-Funded Programs

Washington purchases health care for a significant portion of the population, including people who are enrolled in Medicaid and public and school employees. In addition, the state offers state-funded subsidies for some Washingtonians who purchase coverage through the Exchange.

- **Medicaid:** More than 2 million Washingtonians are enrolled in the state's Apple Health (Medicaid) Program.[200] HMA will estimate the reduction in expenditures to the Medicaid program and any reductions to health care spending for Medicaid will be split with the federal government using the 50% matching rate.
- **Public and school employees through the PEBB and SEBB programs:** As of October 2023, the Washington Health Care Authority reported that 609,896 individuals are enrolled in the state's School or Public Employee Benefits programs.[201] Reductions in the growth of health care spending will manifest in reduced premiums that the state pays to the health plans serving state and school employees and reduced cost sharing for the employees and their families. Impacts on covered individual's premiums can vary based on the exact plan in which the person is enrolled and how the plan's costs compares with the significant state contribution, which covers the most premium costs.
- **Medicare:** A total of 18 percent of Washingtonians are enrolled in Medicare, about 45% of whom are in MA plans.[202] It is expected that policies will result in reduced growth in Medicare spending. However, because Medicare is 100% federally funded, unless the state chooses to negotiate with CMS to obtain expected savings, which is unlikely, no estimates will be made.

Private Sector Employers and Employees

- **Self-Insured Employers:** Slower growth in health care spending will result in lower-cost large, self-insured employer health benefits, including employers like Amazon, Starbucks, Deloitte Digital, Costco, and Microsoft. Self-insured firms are exempt from most state health insurance regulations under ERISA. Employees of such businesses also could receive savings in the form of lower premium sharing and lower out-of-pocket costs. Employers could choose to funnel savings from lower health care costs into other forms of compensation such as salary.
- **Fully-Insured**: The slowdown in the growth of total health spending should also lead to lower premiums for the entire fully insured market. HMA will estimate the savings to these purchasers including:
    - Large group market
    - Small-group market
    - Individual markets and health plans participating in the ACA Marketplace in Washington.

[200]Figure as of July 2023. Lousie Norris, Healthinsurance.org, https://www.healthinsurance.org/medicaid/washington/

[201] https://www.hca.wa.gov/assets/pebb/pebb-enrollment-202310.pdf0.

[202] Louise Norris. Healthinsurance.org. July 5, 2023, https://www.healthinsurance.org/medicare/washington/

HMA will consider and include a brief discussion about any potential impact of the reduction or slowing of total health care spending on access to care and quality of care based on existing research.

Indirect Benefits

The reduction in the growth of total health care spending could produce a variety of indirect benefits, which will be included in the analysis. Examples include:

Increased Wages and Salaries

Some portion of the lower employer costs could lead to increases in wages and salaries for employees or a reduction in the share of employee health care premium contributions, deductibles and copayments. Because virtually all the literature related to this topic focuses on the reverse—how much will wages fall if employer health care costs keep spiking—it is difficult to foresee the outcome because we cannot just assume that the opposite effect would be commensurate in size.

Increased Hiring

It is also possible that as a result of savings to employers some degree of increased hiring may occur. This effect is likely to be relatively small but will be taken into account. The increase in jobs may lead to at least a small decrease in Medicaid enrollment, adding a bit to the State's savings.

State Savings from Reduced Spending on Means-Tested Programs

Washington should also experience some savings from reductions in the state's contributions to means-tested government programs.

- HMA will estimate the reduction in ***Temporary Assistance for Needy Families (TANF)*** spending that could accompany the projected health spending reductions as the favorable impact on the Washington economy draws some TANF recipients into employment, or improved earnings, which will reduce their TANF benefits or move them out of TANF. This move is a potential indirect benefit.

- ***Washington State Social and Economic Services*** operates a State Food Assistance Program (FAP) for legal immigrants who are ineligible for SNAP and the Pregnant Women Assistance Program for low-income pregnant women who are ineligible for TANF.[203] HMA will consider the likelihood that spending under these programs could edge down as employment increases as a result of the reforms that slow the growth of total health spending.

[203] Washington Department of Social and Health Services, Economic Services Administration. State Food Assistance Program (FAP) | DSHS (wa.gov)

Tax Revenue

HMA will estimate the increase in tax revenue Washington could realize from the reduction in the growth of total health care spending. Washington has a state sales tax rate of 6.50%. The maximum local sales tax rate is 4.10% and the average combined state and local sales tax rate is 8.86%.[204] Washington does not have a personal or business income tax but does have a business and occupation tax (B&O) and/or a public utility tax. The increased tax revenue would emerge from the higher wages and salaries and the possibility of some new hiring.

The Multiplier Effect

In addition to all the benefits explained above, favorable ripple effects are likely to emerge as people who benefit begin to spend a large portion of their new income (i.e., the multiplier effect). The multiplier effect is the change in final income emerging from a new injection of spending into the economy.

Costs

Implementation and Operating Costs

New policies will require staffing and administrative overhead costs. HMA will work with OIC and other state agencies to obtain estimates for these costs. This would involve both initial implementation and ongoing, "steady state" costs. There may also be costs associated with bringing a contractor on board to help develop and manage the policy initiatives. In addition, there could be contracting costs for particular types of expertise (e.g., actuarial analysis and data analysis).

Benefit-to-Cost Ratio and ROI

Each of these benefits and costs will be used to calculate the ratio of total benefits to total costs and the ROI—the net gain from the original investment divided by the cost of the original investment. The original cost of the investment will be the cost to the state of implementing and managing the set of policies chosen to reduce the growth in total health care spending. The net gain will be the total benefits (direct and indirect, including the multiplier effect less the costs imposed on certain groups in the private sector) minus the cost as just described. Next, the net gain is divided by the total cost to arrive at the ROI. That amount will first be described as a ratio and next as a percentage gain.

The benefit-cost and ROI analysis will be conveyed in the following modalities:

- An in-depth report that fully explains the economic model, with an Executive Summary
- A concise (2-3 page) Summary paper
- A PowerPoint presentation.

[204] Tax Foundation. Taxes in Washington. Washington Tax Rates & Rankings | State Tax Data Explorer (taxfoundation.org)

APPENDIX A: NOTES FOR MULTI-HOSPITAL SYSTEMS BED DETAIL (TABLE 4)[205]

- **Astria Health**: Non-profit health care system based in Eastern Washington. Astria Health is parent of two community-focused hospitals - Astria Sunnyside Hospital and Astria Toppenish Hospital.
    - Includes inpatient hospital care, emergency services, and outpatient services in Yakima Valley
    - *Information sourced from at astria.health*
    - *Community Health Needs Assessment at https://www.astria.health/site/files/file_manager/page/shared/2021-Astria-Community-Health-Needs-Assessment.pdf*

- **Evergreen Health**: Community-owned independent Hospital system.
    - Includes 13 Primary Care sites and eight Urgent Care centers, two emergency care units
    - Evergreen Health Medical Group (EHMG) is a physician led group of 350+ PCPs and specialists who are employed by EvergreenHealth; EHMg includes 12 or 13 primary care practices, 48 specialty practices and teams of hospitalists and intensivists.
    - *Information sourced from evergreenhealth.com*

- **LifePoint Health**: Headquartered in Tennessee with locations nationwide, including acute care hospitals, rehab facilities, and BH facilities (in 2018, 89 hospital campuses in 31 states)
    - Physician practices (primary and specialty care), acute care rehab units, outpatient centers (imaging, free standing emergency departments (EDs), cancer centers, ambulatory care centers (ASCs), urgent care, post-acute service providers (SNFs, ALF, Swing bed programs)
    - 2018: Acquired by private equity firm Apollo Global Management and merged with RCCH Healthcare Partners; 2021 – acquired Kindred Health (renamed Scion Health)
    - *Information sourced from https://lifepointhealth.net*

- **MultiCare**: Not-for-profit, community-based, locally-owned health system in Washington State.
    - Includes acute care and BH hospitals and one acute-care pediatric hospital in Tacoma, as well as urgent care, pediatric care, and specialty service, and 256+ primary, urgent, specialty clinics in Pierce, King, Kitsap, Thurston, Snohomish, Spokane and Yakima counties; 1,800 staff providers, 22,000 employees
    - Joint venture with Virginia Mason Franciscan Health, Wellfound BH Hospital
    - Navos BH Hospital in West Seattle is an independently operated affiliate; Wellfound BH is an independently operated joint venture with Multi-Care and CHI Franciscan
    - Nationwide imprint: 11 hospitals, 260+ primary, urgent, and specialty care clinics; 2,099 beds, 19,767 employees, 1,560 employed providers
    - *Information sourced from https://www.multicare.org/; annual report:* Annual Report 2022 - MultiCare

[205] The AHA defines a multi-hospital system as two or more hospitals owned, leased, sponsored, or contract managed by a central organization.

- **PeaceHealth**. Not-for-profit health care system.
    - Includes medical centers, CAHs, and medical clinics in WA, OR, AK
    - Nine clinics/sites all offering primary care, cancer care, heart and vascular, Ob/Gyn, orthopedics, pediatric primary and specialty care
    - *Information sourced from https://www.peacehealth.org/*

- **Providence**: Largest health care provider in Washington State.
    - Providence serves five areas: North (WA Puget Sound, AK), Central (Eastern WA, Western MT, OR, West TX/Eastern NM), and South (So. Cal and No Cal)
    - Hospitals, urgent and same day care and primary care clinics (~15 clinics), senior care centers, hospice (Providence Hospice of Seattle), and home health services and home care, including SNFs
    - Affiliated with Swedish Health Services and Pacific Medical Centers in Western WA, and Kadlec in Eastern WA
    - Providence Medical Group operates 250 clinics in AK, CA, MT, OR, WA with over 34,000 physicians, 36,000 nurses, 1000 clinics, 1 health plan
    - Providence WA: Puget sound area, according to financial statement, eight hospitals in King, Snohomish, Lewis, and Thurston Counties, and a network of over 200 primary and specialty care clinics in Puget Sound area. For Central division, nine hospitals in Eastern WA and Western MT
    - *Information sourced from https://www.providence.org/about/washington*
    - *Annual Report at https://www.providence.org/about/annual-report/reports/providence*

- **Skagit Regional Health:**
    - Includes 2 hospitals, 12 clinics, a wound care center, hospice, primary and specialty care practices, cardiology, family medicine, etc. as well as two urgent care clinics; a surgical center is set to open in December 2024. According to press release, clinics located at Anacortes, Arlington, Camano Island, Darrington, Granite Falls, Mount Vernon, Oak Harbor, Smokey Point and Stanwood
    - *Information sourced from https://www.skagitregionalhealth.org/home/location-landing/skagit-valley-hospital*

- **UW Medicine.** University of Washington Medical Center, teaching hospital, multiple service lines. Family of organizations – some private nonprofit organizations and some public).
    - UW Medicine is a family of public and private nonprofit organizations operated or managed care, part of an integrated health system including:
        - Harborview MC (Acute Care partnership with King County, which owns the hospital, and UW, through which UW Medicine manages the hospital), Valley MC (acute care community hospital in South King County; operates more than 48 primary, urgent, and specialty care clinics), UW MC (acute care with two Seattle Campuses – Montlake and Northwest; owned by UW), UW Medicine Primary Care (network of community-based primary and urgent care clinics throughout Puget Sound regions), UW Physicians (2,600 providers and health care professionals associated with UW medicine) , UW School of Medicine , Airlift Northwest (air medical transport); Fred Hutchinson Cancer Center (Independent non-profit which is UW Medicine's cancer program).
        - Key Affiliates: Bloodworks Northwest, Hall Health Center, MultiCare Health System, Northwest Kidney Centers, PeaceHealth, Seattle Children's, Skagit Regional Health, VA Puget Sound/Boise/American Lake.
        - Integrated Networks:
        - Wholly Owned: UW Medicine Choice Care LLC.
        - Partially Owned: Embright – Pacific NW Clinically Integrated Network (with Multi-Care and LifePoint).
        - Contractual: UW Medicine Accountable Care Network, UW Medicine Post-Acute Care Network.
    - UW Medicine Accountable Care Network includes access to: 1000+ PCPs, 5000+ specialists, 1000+ clinics, 18 hospitals, 70+ urgent care clinics, 19 Eds.
    - Partially Owned Networks: Children's University Medical Group (with Seattle Children's), LifePoint - UW Medicine LLC, Trios Health, a UW Medicine Community Health Partner.
    - *Information sourced from https://www.uwmedicine.org/practitioner-resources;* Fact Book Aug2023 v4.pdf (uwmedicine.org)

- **Virginia Mason Franciscan.** Health system formed by integration of CHI Franciscan and Virginia Mason.
    - Hospital, clinic, care locations - 10 hospitals and 300 care sites in Puget Sound.
    - Owned by Common Spirit (Chicago-based parent company – acquired in 2020). CommonSpirit represents a $29 billion merger of Dignity Health and Catholic Health Initiatives (2019). Combined organization operates 12 hospitals and more than 250 sites. CHI Franciscan and Virginia Mason employ more than 21,000 people, including nearly 5,000 employed and affiliated Providers.[206]
    - *Information sourced from https://www.vmfh.org/*

[206] https://www.fiercehealthcare.com/hospitals/virginia-mason-acquisition-talks-commonspirit-s-chi-franciscan

APPENDIX B: COMPARISON OF STATE BENCHMARK PROGRAMS

State	Authority	Collecting and Reporting Agency	Cost-Growth Benchmark Level	Total Cost of Care Measurement	Quality Benchmarks/ Measures	Enforcement
California	AB 1130 (2021–2022)	AB 1130 establishes the Department of Health Care Access and Information (HCAI) Office of Health Care Affordability (OHCA) to, among other responsibilities, set and enforce cost targets under the Health Care Affordability Board.	The Board will set the first statewide target, for 2025, by June 1, 2024. The Board also may develop targets that apply to specific sectors, such as geographic regions, as well as targets specific to fully integrated delivery systems, types of health care entities and individual health care entities. The Board will define sectors by October 1, 2027, and set sector-specific targets by June 1, 2028.	Total health care expenditures" is defined as all health care spending in the state by public and private sources, including all of the following: (1) All claims-based payments and encounters for covered health care benefits. (2) All non-claims based payments for covered health care benefits such as capitation, salary, global budget, or other alternative payment methods. (3) All cost-sharing for health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles. (4) The net cost of health coverage. (5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision.	While quality benchmarks were not established in statute, the office will adopt a single set of standard measures for assessing health care quality and equity across health care service plans, health insurers, hospitals, and physician organizations. Health care entity performance will be included in the annual public report. The measures will use recognized clinical quality, patient experience, patient safety, and utilization measures for health care service plans, health insurers, hospitals, and physician organizations. They also consider available means for reliable measurement of disparities in health care, including race, ethnicity, sex, age, language, sexual orientation, gender identity, and disability status.	Commensurate with the health care entity's offense or violation, the director may take the following progressive enforcement actions: (1) Provide technical assistance to the entity to assist it to come into compliance. (2) Require or compel public testimony by the health care entity regarding its failure to comply with the target. (3) Require submission and implementation of performance improvement plans, including review and input from the board prior to approval. (4) Assess penalties in amounts initially commensurate with the failure to meet the targets, and in escalating amounts for repeated or continuing failure to meet the targets.

Connecticut	Executive Order No. 5 (2020)	Office of Health Strategy	The Office of Health Strategy (OHS) recommended benchmarks of: • 3.4% for Calendar Year 2021 • 3.2% for CY 2022 • 2.9% for CYs 2023, 2024, and 2025 All payers and populations are to reach a primary care spending target of 10% by 2025, with OHS having set a conservative target of 5.0% for 2021 and convening a work group to make recommendations for 2022−2024.	To be determined by the technical team and advisory board along with the Office of Health Strategy.	Office of Health Strategy's Quality Council will develop quality benchmarks across all public and private payers, including: • Clinical quality measures; • Under-utilization measures; • Patient safety measures. Measures under consideration include: • Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient-Centered Medical Home (PCMH) Survey • Plan all-cause readmission • Breast Cancer Screening	Enforcement not discussed.
Delaware	Executive Order 25 (2018)	The Delaware Economic and Financial Advisory Committee sets the health care spending benchmark. The Delaware Health Care Commission is responsible for collecting information and analyzing performance against the benchmark.	Benchmark set in Executive Order at: • Calendar Year (CY) 2019: 3.8% per capita spending growth • CY 2020: 3.5% + 0.5% (transitional market adjustment) • CY 2021: 3.25% + 0.25% (transitional market adjustment) • CY 2022: 3% + 0% (transitional market adjustment) • CY 2023: 3% + 0% (transitional market adjustment)	Total health care expenditures (THCE) in aggregate = commercial total medical expenses (TME) + Medicare Advantage TME + Medicare fee-for-service (FFS) TME + Medicaid Children's Health Insurance Program (CHIP) Managed Care Organization (MCO) TME + Medicaid Fee-for-Service TME + Veterans Affairs (VA) TME + insurer net cost private health insurance (NCPHI) THCE (per capita) = THCE in aggregate/population This measurement excludes payment on behalf of out-of-state residents and generally excludes payment on vision and dental. Reported amounts represent the total allowed amount (payer paid + copay and deductible associated, but premiums are not included).	• Emergency department utilization rates • Opioid- related overdose deaths • Residents per 1,000 with overlapping opioid and benzodiazepine prescriptions • Adult obesity • Adult tobacco use • High school students who were physically active • Statin therapy for patients with cardiovascular disease, with adherence of 80% • Persistence of beta-blocker treatment after a heart attack	Silent on enforcement. Public information is not yet available on recourse if/when benchmark is exceeded. Performance against the benchmark will be reported publicly, as per member per year costs, and made at the statewide level with drill-down analyses.

Massachusetts	MA Chapter 224 of the Acts of 2012	Center for Health Information and Analysis and Health Policy Commission	Benchmark codified in MA Chapter 224 of the Acts of 2012: • 2013-2017: 3.6% Equal to growth rate of potential gross state product (PGSP). • 2018-2022: PGSP minus 0.5% (3.1% in 2018), but the Health Policy Commission has the authority to vote it back up to the PGSP or 3.6%,and voted to maintain the benchmark at 3.1%. •2023 and beyond: The PGSP growth rate	The Center for Health Information and Analysis - the state's all-payer claims database - measures the total health care expenditures and compares them against growth of the state's economy. The Health Policy Commission is charged with monitoring health care costs trends, price variation, cost growth at individual health care entities, and scrutinizing health care market power.	• Patient-reported experience during acute hospital admission • Primary care patient-reported experiences for adults • Primary care patient-reported experiences for pediatrics • Trends in statewide, all-payer adult acute hospital readmission rate, discharges, and readmissions • All-payer readmissions among frequently hospitalized patients • Rates of maternity-related procedures relative to performance targets • Number of hospitals meeting Leapfrog standards for implementing interventions to improve medication safety • Incidence of health care-associated infections	If the Health Policy Commission (HPC) determines that an entity has an unwarranted pattern of contributing to excessive health care spending in the Commonwealth, it can vote to require the entity to submit a Performance Improvement Plan (PIP) to achieve meaningful, specified cost-savings. The PIP must be submitted within 45 days of the entity receiving the PIP notice. If the entity's PIP is approved by the HPC, it is implemented over 18 months. The HPC will monitor the implementation and ultimately determine if the outcome is sufficient to address the underlying causes of the entity's spending growth, or if additional action is needed. A fine of $500,000 can be assessed for non-compliance.
Nevada	Executive Order 2021−2029	The Nevada Department of Health and Human Services Patient Protection Commission (PPC) was designated the sole state agency responsible under AB 348 (2021), enacted prior to the governor's December 2021 executive order.	CY 2022: 3.19% CY 2023: 2.98% CY 2024: 2.78% CY 2025: 2.58% CY 2026: 2.37% By October 1, 2026, the PPC shall recommend to the Governor appropriate benchmarks for 2027 and beyond	THCE has three components: • All medical expenses paid to providers by private and public payers, including Medicare and Medicaid • All patient cost-sharing amounts (e.g., deductibles and co- payments) • The net cost of private health insurance (e.g., administrative expenses and operating margins for commercial payers)	Quality measures are not discussed in Executive Order 2021-29 or AB 348.	The PPC advanced a bill draft request to codify Executive Order 2021-29. The proposed legislation, AB 6 (2023), includes public reporting and an annual informational public hearing on health care cost trends and the factors contributing to such costs and expenditures. The PPC is considering additional enforcement mechanisms such as performance improvement plans and financial penalties.

New Jersey	Executive Order 217 (2021)	The Governor's Office of Health Care Affordability and Transparency is leading an Interagency Working Group.	The target growth rate is 3.2%, based on a 25% potential gross state product and 75% median household income blend Calendar Year 2022: Initiate data collection and reporting CY 2023: 3.5% CY 2024: 3.2% CY 2025: 3.0% CY 2026: 2.8% CY 2027: 2.8%	Total health care expenditures includes: • All payments on providers claims for reimbursement of the cost of health care provided • All other payments not included on providers' claims • All cost-sharing paid by members including but not limited to copayments, deductibles, and coinsurance • Net cost of private health insurance Expenditures include claims for: hospital inpatient and outpatient spending; primary care; specialty care and other professional spending; long-term care; pharmacy; and all other claims-based spending. Also included are non-claims payments (like incentive and value- based payments to providers), patient cost-sharing, and the cost of administering health insurance.	Quality will be a component of New Jersey's Cost Driver Analysis as part of the benchmark effort. Other key components include equity, access, and affordability. Reports will be released annually with further details to help point to the "whys" behind cost increases and specific areas driving spending growth.	Enforcement not discussed.
Oregon	SB 889/Chapter 560 (2019)	Collection responsibilities are to be determined by the Health Care Cost Growth Benchmark Implementation Committee. The following entities are responsible for the cost growth target program: • Oregon Health Authority • Department of Consumer and Business Services • Oregon Health Policy Board	The Implementation Committee recommended a benchmark of 3.4% for 2021−2025 and then 3.0% for 2026−2030 (to be adjusted in 2024 if needed). State programs (Medicaid/State Employee Health Plan) are already subject to a 3.4% growth target.	Total Health Care Expenditures should be defined as the "allowed amount" of claims-based spending from an insurer to a provider, all non-claims-based spending from an insurer to a provider, pharmacy rebates, and the net cost of private health insurance.	The Implementation Committee recommended that The Health Plan Quality Metrics Committee should identify a subset of its existing menu of quality measures for reporting as part of the Sustainable Health Care Cost Growth Program, while aligning with the Coordinate Care Organizations, Public Employees' Benefit Board, and Oregon Educators Benefit Board contractual measure sets as much as possible.	Oregon HB 2081 (2021) requires performance improvement plans from any payer or provider organization that unreasonably exceeds the benchmark during any year. Fines are assessed for late or incomplete submission of data and/or performance improvement plans. Additionally, payer or provider organizations that exceed the benchmark in any three out of five years are subject to a financial penalty that varies based on the amount of excessive spending.

Rhode Island	Executive Order 19-03 (2019)	Office of Health Insurance Commissioner and Executive Office of Health and Human Services	Benchmark set in executive order at 3.2% for 2019−2022, which is equal to Rhode Island's per capita gross state product. • During 2022, target will be reassessed and maintained or replaced for 2023. Health care cost-growth target is expressed as the percentage growth from the prior year's per capita spending.	Office of Health Insurance Commissioner will lead efforts to perform a series of data collection activities and calculations. Total health care expenditures (THCE) in aggregate = Commercial total medical expenses (TME) + Medicare Advantage TME + Medicare fee-for-service (FSS) TME + Medicaid managed care organization TME + RI Executive Office of Health and Human Services FFS TME + Insurer net cost of private health insurance THCE (per capita) = THCE in aggregate/RI Population This measurement includes all the same qualifiers as Delaware. In addition, provider resources applied in the delivery of care for uninsured individuals are not included as they are not technically spending.	Quality measures are not discussed.	Silent on enforcement. Office of Health Insurance Commissioner will publicly report on performance against the target at a statewide level, with several drill-down analyses. Silent as to what action should be taken if benchmark is exceeded.
Washington	HB 2457/Chapter 340 (2020)	The Health Care Authority established the Health Care Cost Transparency Board	Calendar Year 2022: 3.2% CY 2023: 3.2% CY 2024: 3.0% CY 2025: 3.0% CY 2026: 2.8%	"Total health care expenditures" means all health care expenditures in the state by public and private sources, including: All payments on health care providers' claims for reimbursement for the cost of health care provided • All payments to health care providers other than the aforementioned payments • All cost sharing paid by residents of this state, including copayments, deductibles, and coinsurance The net cost of private health care coverage	Quality measures are not discussed in the establishing legislation for Washington's benchmark program.	Enforcement not discussed.

Tab 8

Washington State Health Care Authority

Preliminary Report: Healthcare Affordability

This document is the report to the Washington State Legislature as directed by the 2023 Legislative Operating Budget codified in Engrossed Substitute Senate Bill 5187 Section 126 (33).

Executive Summary

Consolidation is prevalent in the healthcare industry, contributing to a significant increase in healthcare concentration.[1] Many healthcare providers[2] in Washington consolidated in recent years, as shown in Figure 1.[3] This environment is linked to:

- Increased patient prices[4] without improvements in the quality of care;[5]
- Impacts on healthcare labor markets, such as suppressed wage growth for hospital workers[6] and degraded working conditions.[7]

Given the impacts of healthcare consolidations on cost, quality, access to healthcare, working conditions and wages, states are amplifying their efforts to scrutinize local healthcare markets. This preliminary report provides:

- Information about current law in Washington and other states regarding healthcare transaction notifications and reviews, restrictions on anticompetitive contract clauses and non-compete agreements; and
- A primer on enforcement of federal and state antitrust laws.

Transaction Notification and Review

In recent years, states enacted laws to require the parties to a healthcare transaction to report the transaction prior to closing. This notice provides a new avenue for antitrust enforcers—responsible for reviewing mergers and acquisitions for potential harm to competition—to learn about transactions before they close. In some states, the department of health and agencies specifically designed to control healthcare costs and develop affordability solutions assess the impact of proposed transactions on broader criteria, including affordability, access to services, and quality of care.[8]

Anticompetitive Contracts

States are also restricting or banning anticompetitive contract clauses between insurers and healthcare providers that can drive up prices for patients and their employers.[9] This proactive

Key Findings

Washington's transaction notification program enables more scrutiny of healthcare consolidations.

Washington lacks authority to review transactions for anything other than competition concerns, such as affordability.

Washington is unable to challenge or restrict transactions through an administrative process, but must go to court.

Most anticompetitive contract clauses are not restricted in Washington.

These contract clauses can result in increased costs for patients. Banning or restricting these clauses can be more efficient and effective than litigation, which is reactive and resource-intensive.

Non-competes agreements can impact provider-patient relationships.

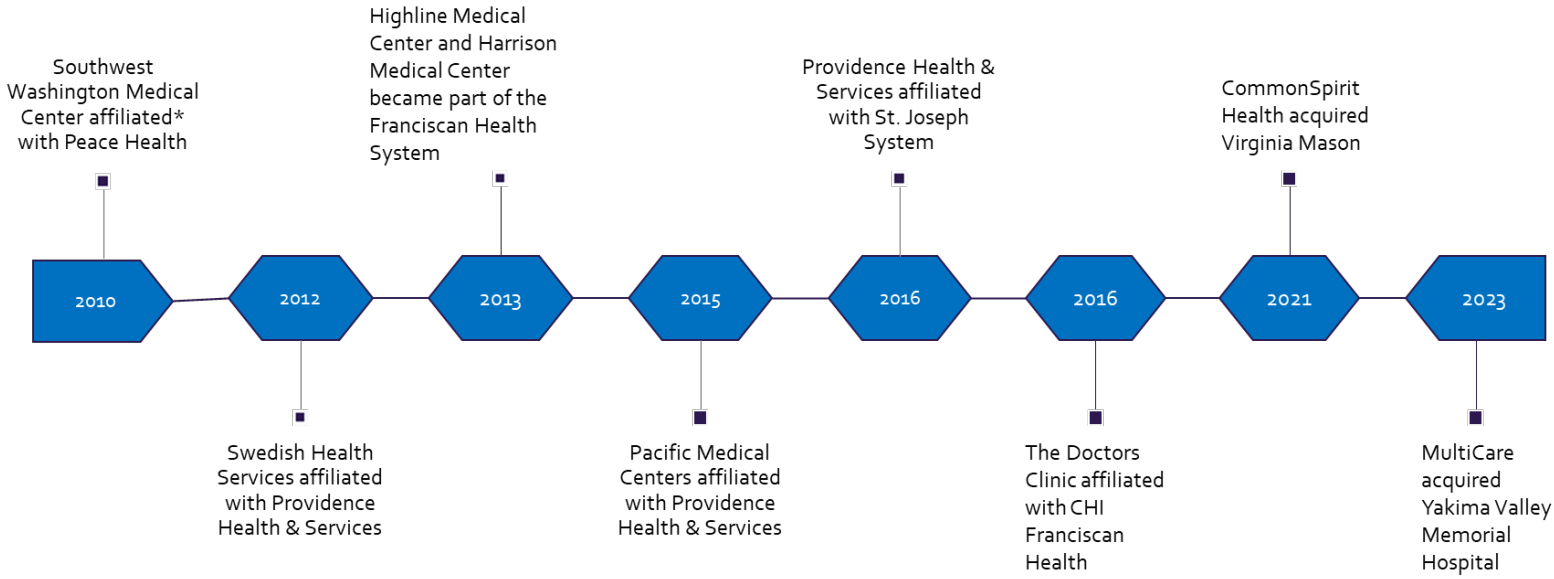
These agreements are unenforceable in Washington for those making below a certain amount, but this earnings threshold does not cover many healthcare workers.

approach can be more efficient and effective than litigation, which addresses the harms caused by these clauses after they have occurred and may not restrict the practice across-the-board.

Non-Compete Agreements

Finally, states are leading efforts on limiting the use of non-compete agreements, which restrict workers from seeking employment with a competitor, leading to decreased job mobility, lower wages, and increased prices. In healthcare settings, these agreements can limit providers' ability to continue patient relationships.

Figure 1: Examples of Recent Consolidation in Washington



*Affiliations describe a range of business arrangements that fall short of mergers or acquisitions. Healthcare providers that affiliate may share health records systems or jointly provide operational services.

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Glossary

- **All-or-Nothing Contract** - requires an insurer that wants to contract with a particular healthcare provider or affiliate in a healthcare system to contract with all the other providers in that system. Simply put, if the insurer wants its enrollees to have access to a hospital in an area, it needs to agree to provide access to all the other facilities, even if those facilities provide higher cost, lower quality services. Healthcare entities typically use all-or-nothing provisions to leverage the status of their *must-have healthcare providers* in a highly concentrated market to demand higher payment rates for the entire organization, including for providers in more competitive areas and specialties.[10]
    - **Must-Have Healthcare Provider** - a hospital or provider group which has monopoly-status in a particular area or a hospital or provider group that is required to meet state adequacy laws (i.e., an insurer cannot construct an adequate network without them).

- **Anti-Incentive Provisions** - require that an insurer place all physicians, hospitals, and other facilities associated with the dominant healthcare provider in the most favorable tier of providers (*anti-tiering*) or at the lowest cost-sharing rate to avoid steering patients away from that network (*anti-steering*), even if providers in that network are more expensive or are of lower quality than other providers in that area.[11] These clauses are often used by dominant health systems asking insurers to place these systems in the lowest cost tier for consumer cost sharing, regardless of their quality or cost performance.[12] These clauses can cripple insurers' abilities to direct patients to higher-value providers or require patients to pay a higher co-pay for higher-cost providers.
    - **Tiering** - occurs when an enrollee (patient) pays less out of their own pocket for care received from a provider in a more favorable group ("tier") and pays more if they see a provider in a less favorable tier. Insurers use tiering to incentivize enrollees to seek care at lower cost or higher quality providers.
    - **Steering** - a common cost containment practice used by insurers to steer patients from higher priced in-network providers to less expensive providers. Steering can take many forms. For example, "hard" steerage—authorizing a service or procedure *only* if it is performed in a particular setting, and "soft" steerage—providing a patient with economic incentives, such as reduced out-of-pocket expenses, for obtaining care from a particular provider. Accordingly, healthcare providers have been using their leverage to negotiate contractual provisions that limit (or even prohibit) an insurer, during the performance of a contract, from steering patients to alternative sites of care, typically a rival competing for similar services.

- **Cost Growth Benchmark** - limits how much a state's healthcare spending can grow each year. A benchmark does not cap price or spending growth. It is designed as a measurable goal to track the state's progress in moderating spending growth over time.

- **Cross-market Merger** - involves combinations among in-state healthcare providers that are in neighboring markets as well as providers that are far apart geographically. In geographical cross-market mergers, providers do not directly compete in the same local geographic market, but could sell the same, related, or complementary products or services to a common customer or set of customers.[13] By contrast, product cross-market mergers include mergers between entities that offer different products and services, regardless of whether these entities are in the same or different geographic markets, such as the mergers of different specialties in a single physician market. These mergers can trigger price increases and result in the elimination of certain service lines, limiting access to care.[14]

- **Gag Clause** - provision in a contract that prevents insurers, employers who purchase insurance, and *self-funded health plans* from providing plan members with access to pricing, quality, and cost information, which can help patients make better care decisions.[15] Gag clause provisions may hide any overall price difference from patients.

    - **Self-funded Health Plan** - one in which the employer assumes the financial risk for providing health benefits to its employees.

- **Horizontal Merger** - occurs between similarly situated market participants operating in the same product and geographical market. These mergers, such as mergers of two hospitals or two physician groups, eliminate close competitors performing similar levels of service, causing direct harm to competition. For example, consolidation among health systems is associated with higher premiums for plans sold on Affordable Care Act marketplaces,[16] and reduced wage growth,[17] without improvement in the quality of care.[18] Antitrust enforcers and economists group mergers into horizontal and non-horizontal mergers (i.e., vertical and cross-market), but many recent healthcare mergers include both horizontal and non-horizontal elements.[19]

- **Most-Favored-Nations or Pricing-Parity Clause** - guarantees that a buyer of goods or services (an insurer in the healthcare markets) receives terms from the seller (i.e., a hospital or physician) that are at least as favorable as those provided to any other buyer. Health systems with a strong presence in an area can offer an MFN to an insurer in exchange for higher rates guarantying to the insurer the most favorable pricing (i.e., no other insurer will negotiate lower rates).[20] To keep their strong market position, dominant insurers often do not need to negotiate a "low" reimbursement rate from healthcare providers; they need to negotiate the lowest rate among their competitors. This protects the position of the most dominant insurer in the market.

- **Stealth Consolidation** - refers to anticompetitive mergers and acquisitions that escape antitrust scrutiny, usually because the transacting entities may be relatively small in size. However, the cumulative effect of these transactions on competition is large. Private equity

roll-ups and *buy-and-build* strategies are part of these serial acquisitions, where an individual transaction, such as an acquisition of an individual or small physician group practice, is too small to trigger scrutiny in isolation.[21]

  - **Roll-up** - a serial acquisition strategy involving a series of often smaller transactions, appearing insignificant in isolation, but whose cumulative impact significantly harms competition.
  - **Buy-and-build** - the bolting together of smaller entities into business empires.

- **Vertical Merger** - occurs between entities operating at different levels in the distribution chain, such as acquisitions of physicians' practices, laboratories or outpatient clinics by a hospital, or a health system, or acquisitions of healthcare providers by insurers. Since these groups do not directly compete, they may not initially appear to be anticompetitive. As noted in some studies, the combinations result in price increases in both the hospital and the acquired physician group, with reduced to no improvement in quality.[22]

State Healthcare Notification & Review Laws Enable States to Assess the Impact of Transactions Before They Occur

States' efforts to curb anticompetitive healthcare consolidations, control costs and enhance access to affordable healthcare notification laws led to the enactment of state healthcare notification laws, which require healthcare providers to notify state entities before completing a merger, acquisition or other affiliation. These laws provide more visibility into healthcare consolidations and enable states to review—and in some cases, approve or restrict—transactions before closing. This authority may be housed within the State Attorney General's Office, another state agency, or a newly created entity.

Current Law in Washington

Since 2020, Washington has mandated at least 60 days' advance written notice to the Attorney General's Office (AGO) for certain healthcare providers before undergoing a "material change."[23] Transactions covered by the statute include mergers, acquisitions or contracting affiliations between two or more healthcare entities that did not have previous common ownership. There are no fees imposed on healthcare entities for the transaction review program. The Antitrust Division within the AGO receives no general fund support, funding its own actions through recoveries made in other cases.

- **Healthcare entities must notify states before completing a merger, acquisition, or other affiliation.**
- **Washington receives notice of a wide range of transactions and reviews for harms to competition.**
- **Some states also review transactions for impacts to affordability, access to services, and quality of care.**
- **Some states have statutory authority to approve, reject or impose conditions on transactions without going to court. Washington lacks this authority.**

Washington's law:

- ✓ Requires notice of transactions involving healthcare providers besides non-profit hospitals.
- ✓ Covers in-state transactions regardless of size and dollar thresholds (out-of-state entities are subject to the requirement if they generate at least $10 million or more in healthcare service revenue from Washington patients).
- ✓ Mandates reporting of contract affiliations between hospitals and groups of seven or more affiliated providers.
- ✓ Focuses on capturing anticompetitive transactions.
- ✓ Provides discretion, enabling the AGO to focus on transactions that may cause the most harm, rather than requiring the agency to conduct a review or prepare a report for every transaction notice.
- ✓ Protects the confidentiality of information submitted to the AGO.
- ☒ Does not cover physician groups with fewer than seven providers.
- ☒ Does not direct the AGO to consider the impact of transactions on affordability, access to services, or quality of care.
- ☒ Does not authorize the AGO to administratively approve, reject or impose conditions on transactions without going to court.
- ☒ Does not provide for a public involvement process.

Comparing Washington to Other States

Washington's law provides visibility on a wide range of potentially harmful transactions. It is one of a small number of states that requires notification of transactions involving physician groups with at least seven providers and all hospitals.[24] In addition, Washington does not limit notice of most transactions to a particular revenue threshold.

In contrast, some states have broader authority than Washington, enabling reviews beyond antitrust concerns to capture the impact of transactions on affordability, access to services, and quality of care. These programs are often embedded in offices doing other health policy work, and in some cases, spearheading multiple programs to address healthcare affordability. The Washington State Legislature is considering bills, such as the Keep Our Care Act, that would expand the scope of the Attorney General's review to assess whether transactions will negatively impact accessible, affordable healthcare in the state.[25] This change, if enacted, would make Washington more similar to the three programs described in Table 1, though the state would be unique in housing an expanded review program within the Attorney General's Office. Recently

signed legislation in Minnesota requiring pre-closing notification for certain healthcare transactions authorizes the Attorney General to challenge transactions that impact the public interest.[26] Factors informing whether a transaction is contrary to the public interest include whether the transaction will reduce the community's continued access to affordable and quality care, increase healthcare costs for patients, and impact total healthcare spending, among other factors. Appendix I provides additional information about states' healthcare notification laws.

Table 1: Healthcare Transaction Review Programs in Select States

	California	**Massachusetts**	**Oregon**
Agency	Office of Health Care Affordability	Health Policy Commission, an independent state government agency	Oregon Health Authority
Year of First Review	2024	2013	2022
Type of Review	Discretionary	Initial Review: Mandatory; Full Review: Discretionary	Mandatory
Factors for Review	Issues under consideration (pending): competition; costs to payers, purchasers, or consumers; affordability; availability or accessibility of healthcare services; quality of care	Impact to healthcare cost benchmark or competitive market[27]	Competition; costs to consumers; access to services; health equity and healthcare quality[28]
Approximate Program Staffing	26 now, expanding to 100	5	4*
Fees	No— funded through general fund appropriations	Hospitals pay agency's entire budget; no additional fees	Yes**
Consultant Costs	Covered by healthcare entities involved in transaction; no cap; appeals process for "unreasonable" costs	Hospitals pay agency's entire budget	For comprehensive reviews only: covered by healthcare entities involved in transaction; no cap

*The program was established with 4 positions, but according to program officials, additional staffing is necessary to conduct required reviews.

**The fees for preliminary reviews are $2,000; fees for comprehensive reviews range from $25,000 to $100,000 depending on the revenues of the entities involved.

Table 2 provides information about the transparency of the transaction review programs in Massachusetts and Oregon. Certain information can be redacted for public posting. While the program in California's Office of Health Care Affordability is new, the existing program in the Attorney General's Office, requiring notice of nonprofit healthcare transactions, also provides for a public meeting and posts submissions on the website with redactions for confidential information.[29] Attempting to strike a balance, the New York Attorney General must post a summary of proposed transactions online for public comment, but the materials submitted to New York Department of Health and then transmitted to the Attorney General are not posted in full.[30]

Table 2: Transparency Mechanisms: Transaction Review Information Posted Online

	Massachusetts	**Oregon**
Transaction notice	✓	✓
One-page summary of proposed transaction		✓
Preliminary review report	✓	✓
Supplemental information from entities involved in transaction	✓	✓
Public comments	✓	✓
Comprehensive review report	✓	✓

After Massachusetts and Oregon complete their public processes, the states have different authorities. The Massachusetts Health Policy Commission has no authority to challenge or restrict proposed transactions. Rather, it refers certain cost and market impact review[31] final reports to the Attorney General, which can use that analysis to determine whether to challenge a proposed transaction on anticompetitive grounds. Notably, the agency conducted nine cost and market impact reviews out of 162 transactions reviewed since 2013.[32] According to an agency official, HPC uses the cost and market impact review process judiciously because it is intensive. Similarly, in Connecticut, the Office Health Strategy refers final cost and market impact review reports to the Attorney General if a healthcare entity has a dominant market share or charges prices that are materially higher than median prices. In Oregon, the Health Care Market Oversight Program is responsible for approving, approving with conditions, or disapproving proposed transactions. The agency approved with conditions about half of the transactions reviewed as of October 2023.[33] In some cases, healthcare entities approved with conditions are required to submit compliance reports for five or more years. Conditions placed on individual transactions include maintaining access to specific services for ten years, prohibiting facility fees, and banning restrictions on employment opportunities for former employees.

Legislation Banning Anticompetitive Contract Clauses May Be More Efficient Than Litigation in Protecting Patients

In the current concentrated healthcare landscape, states are pursuing alternatives to litigation to proactively address anticompetitive practices. Four contract clauses that raise the most concerns among antitrust enforcers and lawmakers are all-or-nothing contracts clauses, anti-incentive provisions (anti-tiering and anti-steering), nondisclosure requirements (gag clauses), and most-favored-nation (MFN) clauses. Legislation restricting or banning anticompetitive contract clauses can be more efficient and effective than litigation.[34] These contract clauses can harm patients, since insurers often pass increased costs onto patients and their employers through increased premiums.[35] Through litigation, states address the harms caused by contractual provisions that can stifle competition *after* they have occurred. Moreover, time- and resource-intensive litigation may not result in the elimination of these practices across the state.

- **Certain anticompetitive contract clauses can result in increased costs for patients.**
- **Some states are restricting or banning these clauses.**
- **Washington has not banned most anticompetitive contract clauses.**
- **Legislation can be more efficient and effective than litigation, which is reactive and resource-intensive.**

Current Law in Washington

Washington prohibits most-favored-nations clauses in some healthcare provider contracts.[36] Washington does not prohibit other contractual provisions that limit patients' ability to obtain price information and prevent providers from incentivizing patients to seek care at a lower cost or from higher quality providers. The Washington State Legislature has considered bills, such as Senate Bill 5393 (2023) and House Bill 1160 (2021), that would restrict certain anticompetitive contractual provisions.[37] The former bill will remain active in the 2024 Legislative Session.

Comparing Washington to Other States

Massachusetts[38] (2010), Nevada[39] (2021), Connecticut[40] (effective July 1, 2024), and Texas[41] (2023) enacted legislation banning anti-tiering and anti-steering clauses in some contracts. In addition, in 2023, legislatures in California,[42] Maine,[43] New Jersey,[44] and New York[45] considered restrictions on anti-tiering or anti-steering contract provisions. Among the legislation that passed, Connecticut's law also bans gag-clauses, and all-or-nothing clauses.[46] In Texas, the statute prohibits MFNs, gag clauses, anti-steering and anti-tiering clauses in provider network contracts.[47] Massachusetts also bans all-or-nothing provisions, but these only apply to specific plans, not across all plans.

States that passed legislation in recent years aimed it at providers[48] or multiple entities. For example, Connecticut's law is the most comprehensive, subjecting providers, health insurance carriers, and health plan administrators to the restrictions. In contrast, when the restriction is aimed only at insurance carriers, such as in Massachusetts,[49] state enforcement may be limited. For example, state insurance regulators do not have authority over self-funded insurance plans. These are plans offered by larger companies where the employer collects premiums from enrollees and takes on the responsibility of paying employees' and families' medical claims. In Washington, more people are covered by self-funded insurance plans than those regulated by the Office of the Insurance Commissioner.

While prohibitions and restrictions on anticompetitive contractual provisions are promising,[50] legislation may not alleviate all risks. For example, legislation aimed at prohibiting certain terms in written contracts may not capture *de facto* leverage exercised by dominant firms at the negotiation stage, particularly through oral and other agreements.[51] Additionally, these legislative prohibitions may fail to capture the potential cumulative effect of multiple contract terms used in combination.[52] To address these shortcomings, some scholars propose creating an oversight entity or expanding existing state regulatory oversight.[53]

Non-Compete Agreements in Healthcare Can Harm Both Workers and Patients

Non-compete agreements across all professions in the healthcare industry can restrict workers from seeking employment with a competitor or from starting a competing business. These agreements can lead to less job mobility, lower wages for workers, and increased healthcare prices.[54]

Besides their implication for workers' mobility, non-competes further strain the provider-patient relationship,[55] which is critical to providing equitable care.[56] These clauses may prevent physicians from continuing to care for their patients should they leave a particular practice. Limiting the healthcare provider market can lead to inadequate provider networks and decreased access to care. For providers concerned about potential retaliation, non-competes can also pose a threat to advocacy efforts for better clinical standards and patient safety.[57]

Earlier this year, the FTC proposed banning all non-compete agreements.[58] There is no timetable for finalizing the rule and it is unclear whether a final rule would apply to non-profit hospitals.[59]

- **Non-compete agreements restrict workers' job mobility. In healthcare, they impact provider-patient relationships.**
- **Washington restricts non-compete agreements for employees and independent contractors making below a certain amount – physicians and other healthcare workers often earn more.**
- **Other states restrict non-compete agreements outright or have specific restrictions on non-competes involving physicians and other healthcare providers.**

Current Law in Washington

States are leading efforts to restrict the use of non-competes. Since 2020, non-competes agreements are unenforceable in Washington for employees and independent contractors if they make below a certain earnings threshold or if the terms of the non-compete violates certain statutory constraints.[60] The earnings thresholds are adjusted each year and are posted on the Department of Labor and Industries' website.[61] The 2023 threshold for W-2 employees is $116,593.18. The 2023 threshold for independent contractors is $291,482.95. Although higher paid healthcare workers and physicians likely earn more than the statutory threshold, they may still argue that a non-compete is unenforceable for other reasons.

Comparing Washington to Other States

Many states have some level of restrictions on non-competes.[62] Like Washington, at least seven states have enacted legislation to block enforcement of non-competes against low-wage or low-skilled workers since 2019.[63]

Other states, including Minnesota, North Dakota, Oklahoma,[64] and California,[65] prohibit non-compete agreements outright. Expanding worker's protection and enforcement options, California's governor recently signed two bills banning any restraint of trade through contracting clauses like non-compete agreements, and making clear that a violation of California's non-compete ban constitutes unfair competition.[66] Notably, the bill reaches all employment contracts regardless of where the contract was signed or where the employment is maintained, even if outside of the state of California.

States Laws Pertaining to Non-Compete Agreements in Healthcare

Some states have specific restrictions on non-competes involving physicians and other healthcare professionals. For example, Rhode Island, Delaware, Massachusetts and New Hampshire ban physician non-compete agreements.[67]

Other states prohibit only certain physician non-competes. For example:

- West Virginia declares physician non-competes void if they last longer than a year, extend more than 30 miles, or are applied against a fired employee.[68]
- Similarly, Connecticut and Tennessee place statutory limits on the length of time and geographic restrictions in physician non-compete agreements.[69]
- Colorado prohibits employers from collecting damages for breach of a non-compete if physicians are providing treatment of a rare disorder for a previously established patient.[70]
- Florida prohibits non-competes between physicians and entities such as rural hospitals that have no real competition in their geographic area.[71] Such non-compete agreements remain "void and unenforceable" for three years after a competitive entity enters the same county.
- Indiana prohibits a primary care physician and an employer from entering into a non-compete agreement.[72] Under this law, non-compete agreements for other physicians are not enforceable under certain circumstances.[73]
- Texas allows physician non-competes, but their law includes certain provisions to protect patients and ensure continuity of care. Accordingly, the agreements must (1) not deny the physician access to a list of patients they saw or treated in the year prior to the termination of the employment contract; (2) provide access to patient records upon authorization by the patient; (3) allow the physician to continue to provide care to

patients during the course of an acute illness; and (4) include a provision allowing the physician to buy out the agreement for a reasonable price.[74]

Some states broadened their non-compete bans to include other healthcare professionals besides physicians. For example, New Mexico[75] banned contractual provisions that restrict any healthcare practitioner's right to provide clinical healthcare services after employment. South Dakota's near-total prohibition against non-compete provisions includes nurses and many other healthcare providers.[76] One of two pending bills in Iowa is also aimed at nurses, setting an income threshold, while the other seeks to ban all non-competes for everyone earning less than 150 percent of state or federal minimum wage. Alabama's ban on non-competes includes physical therapists.[77] A bill in Massachusetts would ban non-competes for physician assistants.[78] A more expansive bill in New York, if enacted, would cover "de facto" agreements that have the effect of prohibiting individuals from seeking or accepting employment.[79]

Overview of Antitrust Oversight in Healthcare

The Role of Antitrust Agencies as Market Regulators and Enforcers of Antitrust Laws

Antitrust enforcers review mergers and acquisitions for potential harm to competition, challenging proposed transactions that may substantially lessen competition, imposing conditions on allowed transactions that offer benefits but pose some risks to competition, and enforcing laws prohibiting anticompetitive conduct. Two federal antitrust enforcers share responsibilities for antitrust enforcement in healthcare. The Federal Trade Commission (FTC) and the Antitrust Division of the U.S. Department of Justice (DOJ) jointly enforce the federal antitrust laws—the Sherman Act[80] and the Clayton Act;[81] the FTC also enforces the FTC Act.[82] The FTC Act [83] prohibits unfair methods of competition and unfair or deceptive acts or practices, anticompetitive transactions covered by the Sherman Act and the Clayton Act, and other anticompetitive practices. Unlike the Sherman Act and the Clayton Act, the FTC Act generally cannot be applied to nonprofit entities, but it can be applied to nonprofit and for-profit health insurance companies, as authorized by the Competitive Health Insurance Reform Act of 2020.[84] While their authority is joint, the agencies typically divide their reviews along business lines: the FTC oversees healthcare entity transactions, while the DOJ overseas health insurance transactions. Their transactional review and enforcement is subject to the notice and reporting limitations under the Hart-Scott-Rodino Act ("HSR Act"),[85] which mandates that merging entities report their plans before closing the deal if the transaction exceeds a specified value ($111.4 million in 2023), giving the federal enforcers notice and time to investigate and intervene if needed.[86]

The DOJ and FTC issue and revise merger guidelines (i.e., Horizontal Merger Guidelines and Vertical Merger Guidelines) setting forth how the agencies conduct an antitrust analysis for certain identified conduct. Since 1968, the DOJ and FTC have issued and revised merger guidelines several times, including in 1982, 1984, 1992, 1997, 2010 and 2020. While not binding on the courts, the guidelines help shape the evolution of both state and federal antitrust law, and serve as important enforcement tools. In July 2023, the agencies proposed new merger guidelines outlining greater scrutiny for transactions involving private equity sponsors and institutional investors and serial acquisitions, as well as more scrutiny for labor markets.[87] A group of Attorneys General, including Washington, submitted public comments with recommended revisions to nearly all of the Draft Guidelines, and several Attorneys General issued specific comments addressing labor market issues, which the guidelines did not previously address.[88]

In addition to enforcing state antitrust laws, state attorneys general share authority with DOJ and FTC in enforcing federal antitrust laws. State attorneys general may bring federal actions for

damages and injunctive relief under Sections 4 and 16 of the Clayton Act, respectively, as either direct purchasers and as *parens patriae* on behalf of their state's residents.[89] Most states have their own antitrust statutes that are typically read in harmony with federal antitrust laws, but some states have more expansive antitrust laws.[90] State antitrust enforcers bolster and supplement the efforts of their federal counterparts, and can also act independently of federal enforcers. States often collaborate with their federal counterparts, too, and the enforcers' concerns can coincide.

Case Spotlight – Federal and State Collaboration

2018 - Massachusetts and the FTC

State and federal enforcers investigated the proposed hospital merger between Beth Israel Deaconess Medical Center and the Lahey Health System. The Attorney General entered into a negotiated consent decree, filed with the court, which imposed a set of conditions—including conditions to address potential access barriers—before the merger could proceed. Another condition included setting an "unprecedented" price cap by prohibiting post-merger price increases from exceeding 0.1% below the state's Cost Growth Benchmark for seven years. As a result of the state settlement, the FTC voted to close its investigation. Because Massachusetts received pre-merger notice of this transaction, pursuant to their state statute, they were able to challenge it before closing.

Highly Concentrated Healthcare Market Conditions Require More Oversight, Particularly Vertical Mergers

Acting with limited resources, antitrust enforcers have prioritized challenging horizontal hospital mergers. These enforcement challenges ceased after a period of losses in the 1990s, which led to further hospital consolidations. Thereafter, the FTC conducted a series of retrospective analyses of mergers, which resulted in new legal analytical tools to evaluate the competitive effects of horizontal consolidation, and triggering a resurgence of enforcement actions. Following those retrospective studies of consummated hospital mergers, the FTC was able to obtain thirteen federal injunctions in hospital cases from 2008 to 2018, after getting only two from 1997 to 2007.[91] The litigation reshaped the focus of the horizontal hospital merger analysis by employing new tests based on the economic understanding of hospital markets. Successful enforcement cases followed, with courts unanimously employing a multi-stage model of hospital competition, and concluding that price effects of the mergers depended on the response of insurers, not patients, who are generally insensitive to retail hospital prices.[92] This economic framework for analyzing competition in healthcare markets, and the years of successful legal

precedent it has produced, has become a bedrock for enforcement actions to challenge horizontal or within-market transactions. However, this strategy is not replicable for vertical mergers.[93]

For reasons beyond the scope of this report, lawsuits blocking vertical mergers can be very challenging.[94] After an outpouring of concern that vertical mergers can harm competition, the FTC held hearings on vertical integration in 2018, and jointly issued with the DOJ the long-awaited Vertical Merger Guidelines in 2020. But even these guidelines reflect the view that efficiencies created by vertical integration may justify consolidation. Due to criticism that these guidelines were not equipped to transform vertical merger enforcement, the FTC withdrew them in 2021. Some authors urged federal agencies to update the guidelines to set "workable," "economically sound standards" to assist the courts, enforcers and market participants in evaluating vertical deals.[95] In 2020, the FTC also announced a new retrospective review to include an assessment of the competitive impact of vertical combinations, particularly hospital acquisitions of physician practice groups,[96] which will allow the FTC to study the effects of consummated physician group and healthcare facility mergers that occurred from 2015 through 2020.[97] The FTC anticipates that it will collect data over several years and there is no definitive date for completion of the project.

Without supportive economic data, legal precedent and updated standards in the merger guidelines, antitrust enforcers left vertical mergers unchallenged.[98] The lack of enforcement triggered more healthcare consolidations, inviting entities to test the boundaries of antitrust enforcement. In recent years, however, antitrust enforcers have signaled more willingness to litigate vertical merger cases, as opposed to settling, despite losing the last two merger challenges that raised vertical concerns. Last year, the DOJ and a few states lost their challenge to the UnitedHealth-Change Healthcare merger, which raised both horizontal and vertical concerns.[99] That case brings forward even more issues in antitrust enforcement—evaluation of a private equity firm as a divestiture buyer.

Conduct Remedies Provide an Avenue to Address Harms Associated with Consolidation, Especially Vertical Transactions

Federal and state antitrust laws typically confer trial courts with broad equitable authority to fashion remedies that address a transaction's competitive harm. When reviewing the transactions, antitrust enforcers have the ability to use structural remedies—such as blocking or undoing a recent merger, or requiring a divestiture of assets to restore or maintain competition—or conduct remedies—promises by the merged entity as to future business conduct, to be monitored for compliance after closing. Horizontal mergers have traditionally been blocked or unwound. However, these structural remedies are harder to impose after a merger is executed. Specifically, for healthcare mergers, the merged entities claim that unwinding a consummated merger would negatively impact patient care, as the merged entities have become too financially

and clinically integrated. In contrast, conduct remedies allow the healthcare transaction to proceed with some set of conditions in place, monitored for a set time by antitrust enforcers. Antitrust enforcers historically disfavored conduct remedies, in part because they require resource-intensive monitoring to ensure that the merged entity is complying with conditions. When used effectively, however, conduct remedies can mitigate anticompetitive concerns and may provide an avenue to address vertical transactions.

Case Spotlight – Conduct Remedies

Washington (2018)

The Washington State Attorney General filed a lawsuit against Franciscan Health System seeking a structural remedy by asking the District Court to undo Franciscan's acquisition of a physician group, WestSound Orthopedics in Silverdale, and affiliation with The Doctors Clinic, a multispecialty physician practice, because of violations of Section 1 of the Sherman Act, Section 7 of the Clayton Act,[100] and corresponding state law.[101] The District Court dismissed the claim involving the acquisition of the physician group, but ruled that the State's claim regarding the affiliation with The Doctors Clinic would go to trial.[102] The state concluded its litigation with a consent decree imposing a set of conduct remedies[103] and monetary relief. For example, Franciscan is required to notify Attorney General's Office of future deals that could decrease competition.

California (2021)

The California Department of Managed Health Care (DHMC) conducted a comprehensive review of Centene Corporation's acquisition of Magellan Health Inc., to address both horizontal and vertical concerns raised by that transaction.[104] On December 30, 2021, DHMC announced that it had approved the merger with conditions to ensure that it does not adversely impact enrollees or the stability of California's healthcare delivery system.[105] This was the first merger reviewed under the 2018 law that gave DHMC more authority to review health plan mergers, including a public involvement process to receive comments about the transaction, and an independent health system impact analysis.

Limited Enforcement Activity on Cross-Market Transactions Until Recently

There has been a widespread increase in the number of cross-market mergers, which account for more than half of all the hospital mergers in the last decade.[106] This triggered further research to assess the potential for these enlarged entities to charge higher prices.[107] Until recently, only a handful of economic analyses focused on cross-market mergers, limiting enforcers' ability to rely on empirical data to show the potential consequences of these transactions.[108] Some economists concluded that certain cross-market healthcare mergers result in significant post-merger price increases.[109] However, legal scholars, economists and antitrust enforcers need to do more analysis to determine the circumstances when these deals harm healthcare competition.[110]

There have been relatively few lawsuits challenging cross-market transactions due to the limited availability of empirical data proving that these deals harm competition.[111] One example of a cross-market deal between two large health systems was Colorado-based Catholic Health Initiatives' merger with San Francisco's Dignity Health in 2019, resulting in one of the largest health systems in the U.S. with 700 care sites and 139 hospitals across 28 states.[112] Other examples include the $3.9 billion acquisition of Health Management (71 hospitals) by Community Health Systems (135 hospitals) in 2014, and the 2013 merger of Dallas-based Baylor Health Care System and Temple-based Scott & White Health, where post-merger the combined entity comprised 43 hospitals and more than 6,000 affiliated physicians.[113]

Cross-market deals recently received more interest from regulators and enforcers. While the DOJ and FTC have not yet released detailed guidelines for evaluating cross-market mergers, the 2023 proposed Merger Guidelines include language that could be used to challenge them.[114] Importantly, in 2023, the DOJ[115] and the FTC[116] withdrew from their respective healthcare policy statements dating back to 1993, calling them outdated.[117] These statements identified some types of transactions that were exempt from antitrust challenges, which has allowed large health systems to acquire small hospitals in other markets.[118] Additionally, in September 2021, the FTC expressed interest in cross-market deals, reporting that their effects will be part of FTC's review of large merger deals.[119]

While federal antitrust enforcers have yet to test legal strategies for challenging cross-market mergers in courts, some state enforcers have scrutinized some mergers identified as cross-market mergers and have conditioned their approvals.

Case Spotlight – Cross-Market Transactions

California (2020-2022)

Despite being limited to reviewing only nonprofit hospital transaction, the California Attorney General has broad authority to review healthcare transactions for a variety of factors, including competition, access to care, and quality. The state Attorney General recently reviewed the cross-market effect of several transactions and imposed competitive impact conditions (i.e., a price freeze or caps on post-merger price increases for the merged entity) to address potential cross-market price effects, and quality and access impact conditions.[120]

- Exercising its statutory approval power over nonprofit entities, the Attorney General recently imposed conditions on the affiliation between Cedar-Sinai Health System and Huntington Memorial Hospital, healthcare providers from different geographical markets in Southern California.[121]
- The final conditions outlined in a settlement agreement include a five-year price cap to prevent post-affiliation price increases, separate negotiation teams, and mandatory arbitration when negotiations with insurers.[122]
- The settlement also banned certain terms in their contracts with insurers, including all-or-nothing clauses that would require insurers to contract with both Cedars-Sinai and Huntington Memorial, and anti-tiering and anti-steering clauses that would prevent insurers from steering patients away from these entities.[123]
- Other cross-market transactions in California were required to comply with restrictions on price increases and to maintain certain services, such as by having a minimum number of emergency room, intensive care, and obstetrics beds.[124]

Minnesota (2023)

The state Attorney General began to investigate whether to challenge a proposed merger between Fairview Health Services (based in Minnesota) and Sanford Health (based in South Dakota) before the two systems abandoned their plans in July 2023.[125]

Stealth Consolidations and Private Equity Involvement in Healthcare

Antitrust enforcers have shown increased interest in addressing the risk serial acquisitions pose to competition in healthcare markets, especially in transactions involving private equity firms. In amending the Clayton Act in 1950, Congress explicitly stated that Section 7 reaches serial acquisitions.[126] Specifically, the House Report noted that "control of the market . . . may be achieved not in a single acquisition but as the result of a series of acquisitions."[127] Even though federal law addresses serial acquisitions, until recently these transactions were left unchallenged. Recently, several studies demonstrated that private equity transactions in healthcare have grown exponentially, and have linked these deals to higher healthcare prices and lower quality of care, especially in markets where these firms have a strong presence.[128] Specifically, one study notes that from 2012 to 2021, private equity acquisitions of physician practices went from 75 deals in 2012 to 484 deals in 2021—more than a six-fold increase in only ten years.[129] While some private equity firms have obtained significant national market shares in areas such as emergency physician outsourcing and air ambulance, the primary strategy for most private equity firms has been to reach a strong presence in local or regional markets.[130] Examples of local markets dominated by a private equity firm abound.[131]

In their comments to the 2023 proposed Merger Guidelines, a group of state attorneys general highlighted their concerns with the recent trend of private equity firms engaging in stealth consolidation by acquiring multiple smaller companies that either compete against each other or are vertical in nature, and then combining the acquired companies for resale. Specifically, the state attorneys general noted that these roll-ups pose high risk for competition and often are below the reportable thresholds.[132] Similarly, several authors call for more action from antitrust enforcers and policymakers.[133]

Case Spotlight – Private Equity

FTC (2023)

In an unprecedented case, the FTC sued the private equity fund Welsh Carson, its affiliates, and its investment company, U.S. Anesthesia Partners in the Southern District of Texas challenging the so-called "roll up" strategy often employed by private equity firms investing in healthcare markets. The FTC's complaint outlines an alleged scheme detailing a roll-up strategy with ongoing buy-outs in an effort to consolidate more than a dozen competing anesthesiology physicians groups in Texas.[134] This is an allegation of cross-market harm. The litigation is pending.

Legal Background: Plaintiffs Face an Enormous Burden to Demonstrate Anticompetitive Harms of Contract Clauses

Addressing the harms of anticompetitive contract clauses through litigation is challenging. Though anticompetitive contract clauses are actionable under federal and state antitrust laws, plaintiffs face difficulties proving these contractual practices are anticompetitive. This likely served as a deterrent to antitrust enforcement through private litigation. The plaintiff bears a hard burden to prevail in challenging anticompetitive contractual practices, which requires defining a market and showing market power for a violation of either Section 1 or 2 of the Sherman Act.[135] For example, the plaintiff has to prove that the contract between an insurer and a healthcare provider must have either collusive effects (enabling horizontal-direct competitors to raise prices) or exclusive effects (foreclosing rivals from entering the market or significantly raising their costs). As such, the plaintiff has to show either actual effects (such as price increases occurring after the contract term was adopted) or engage in a challenging exercise to show that the defendant possesses durable market power (i.e., maintain a strong presence in a market), which requires in-depth economic analysis to define the relevant product and geographic markets. Additionally, the defendants can rebut by showing substantial procompetitive benefits (anti-steering clauses may allow health systems to spread fixed operating costs across more services and reduce the cost of highly specialized services—for example, an orthopedic department may use anti-steering to reduce costs for specialized care and increase referrals).

Case Spotlight - Anticompetitive Contracts

Michigan Case Led to Legislation Banning MFN clauses (filed in 2010; settled in 2013)

The DOJ and the State of Michigan filed an antitrust lawsuit against Blue Cross Blue Shield of Michigan (BCBSM) alleging that BCBSM used MFN clauses to prevent other insurers from negotiating lower prices with hospitals.[136] The dominant insurer, BCBSM, prevented other insurers from entering and competing in local markets. The lawsuit was dismissed after the Insurance Commissioner in Michigan issued an order banning MFN clauses. Michigan later enacted laws banning MFNs in any healthcare provider contracts.

California's Sutter Litigation: *Sidibe v. Sutter Health* (first filed in 2012, on appeal); *UBET and State of California v. Sutter Health*[137] (filed in 2014, settled in 2021)

In 2012, class action plaintiffs sued Sutter, claiming that anticompetitive contracting practices inflated their premiums and co-pays.[138] The case in now pending on appeal to the Ninth Circuit.[139]

The California Attorney General's lawsuit alleged that Sutter took advantage of its dominance when it used all-or-nothing provisions, anti-steering provisions and anti-tiering provisions, and gag clauses. The settlement[140] requires Sutter to: (1) pay $575 million, (2) limit what it charges patients for out-of-network services, (3) increase transparency, (4) halt measures that deny patients access to lower-cost plans; (5) stop all-or-nothing deals, (6) cease anticompetitive bundling of services and products, (7) cooperate with a court order monitor, and (8) define integration to include patient quality of care.[141]

North Carolina Case Settlement Supports Notion that Anti-Steering Provisions Violate the Sherman Act (filed in 2016, settled in 2019)

The DOJ and the State of North Carolina filed a complaint against Carolinas Health System (CHS) (renamed Atrium Health)[142] for including anti-steering provisions in its contracts with every major insurer in the Charlotte area. Since insurers need to include CHS in their networks, these provisions reduced competition, limited lower-cost options for employers purchasing health insurance, and restricted financial incentives for patients using less expensive healthcare services offered by the hospital's competitors. In the settlement reached in 2019, CHS agreed to not use or enforce any anti-steering provisions. CHS made no admission of liability.

Outcome in Pennsylvania's Litigation May Serve as a Deterrent to Others (2019)

In February 2019, Pennsylvania filed a petition to modify a consent decree with UPMC and Highmark, two vertically integrated healthcare systems. The consent decree entered in July 2014 required the Commonwealth to protect the public from UPMC's and Highmark's contract dispute. Pennsylvania alleged that UPMC, a nonprofit healthcare system, failed to fulfill its charitable responsibilities, violating various state laws. The Commonwealth's relief included a prohibition on UPMC from engaging in restrictive contracting practices (MFN, anti-tiering, anti-steering, gag clauses, all-or-nothing and exclusive contracting). UPMC and Highmark agreed to enter into a ten-year contract that ended their longstanding dispute, and Pennsylvania dismissed its litigation without prejudice.

Waves of Litigation in North Carolina Involving HCA Healthcare and Mission Health (filed in 2022 and 2023)

North Carolina filed a similar lawsuit accusing HCA Healthcare (HCA) of anticompetitive behavior similar to Sutter's contracting practices.[143] HCA is the nation's largest for-profit hospital system in both revenue and number of hospitals, with over 180 hospitals in twenty-one states. The litigation is pending. Two additional litigations are pending: a private class

action pending in North Carolina state court,[144] and a consolidation action of two municipalities and two counties in North Carolina.[145]

APPENDIX: Healthcare Transaction Notification Laws in Select States

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
Washington RCW 19.390.030 (2019)	Attorney General	60 days' prior notice	Hospitals, hospital systems, and provider organizations	Merger, acquisition, contracting affiliations	Out-of-state entities: $10M in revenue from WA patients	No
Rhode Island 23 RI General Laws §§ 23-17.14 (2022)	Attorney General and Department of Health	180 days- Transaction cannot proceed until approved.	Hospitals	Change of ownership or control of a hospital that results in one entity controlling 20% or more of the voting rights or assets of the hospital, or a new partner gaining or acquiring a controlling interest or vote in the hospital	None	Affordability and issues of market share especially as they affect quality, access, and affordability of services
Oregon OR Revised Statutes 415.500 (2021)	Health Authority	180 days pre-closing	Hospitals, health professionals, health insurance carriers and managed care organizations, other entities that provide healthcare or services	Merger, acquisition, corporate affiliations, transactions to form management services organizations, contracts or affiliations that impact access to essential services	One entity ≥$25 million in revenue in prior 3 fiscal years, other entity ≥$10 million in revenue in prior 3 fiscal years	Access to affordable healthcare

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
New York Public Health Law article 45-A (2023)	Department of Health	30 days pre-closing	Any healthcare facility, physician practices and groups, health insurance carriers, management services organizations	Merger, acquisition, affiliation, and many forms of change-in-control transactions Covers a single transaction or series of transactions within a 12-month period	Transaction must result in a healthcare entity increasing in-state revenues by $25 million or more	No
Nevada NV Revised Statutes 598A.370 (2022)	Attorney General, Commissioner of Insurance	30 days pre-closing	Group practice or health carrier	Mergers, consolidations or affiliations; certain acquisitions	None	No
Minnesota MN Statutes, section 145D.01 (2023)	Attorney General and Department of Health	60 days pre-closing (≥$80 million) 30 days pre-closing ($10-80 million)	Hospitals, medical foundations, provider group practices, and captive professional entities	Merger, sale, or asset transfers of 40% or more Covers a single transaction, or a series of actions within a 5-year period	≥$80 million subject to notice and waiting; $10-80 million subject to notice only	Access to affordable and quality care

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
Massachusetts MA General Laws ch. 6D § 13 (2012)	Attorney General, Center for Health Information and Analysis, Health Policy Commission	60 days pre-closing	Hospitals, providers, health insurance carriers	Merger, acquisition, or affiliation of provider/provider organization and health insurance carrier; Merger or acquisition of a hospital/ hospital system; Acquisition of insolvent provider organizations; and Mergers or acquisitions of provider organizations resulting in the organization having a near-majority of market share in a given service or region	None	Impact to state's healthcare cost growth benchmark
Illinois 740 IL Compiled Statutes 10/7.2a (2023)	Attorney General	30 days pre-closing	Hospitals, outpatient surgery centers and provider organizations with 20 or more healthcare providers	Merger, acquisition, contracting affiliations	None for in-state entities; $10 million or more in annual in-state patient revenue for transactions involving an out-of-state entity	No

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
Connecticut CT General Statutes § 19a-486i (2014, amended in 2018)	Attorney General and Office of Health Strategy	30 days pre-closing	Hospitals, hospital systems, group practices, captive professional entities, medical foundations or other entities affiliated with a hospital or hospital system	Merger, consolidation, certain acquisitions, change in employment of all/nearly all physicians, or other affiliation of a group practice with: 1) another group practice that results in a practice of 8 or more physicians, or 2) a hospital/hospital system or other entity controlled by a hospital/hospital system	None	Cost effectiveness of healthcare services (for hospital transactions) § 19a-639
California Knox-Keene Act § 1399.65 (2018)	Department of Managed Care	Transaction cannot proceed until approved	Health care service plan	Merger, consolidation, acquisition, change in control by another health care service plan or a health insurer	None	No
California (*rule-making underway - chart reflects proposed rules*)	Office of Health Care Affordability	90 days pre-closing	Payers, providers (with 25 or more physicians; smaller if the organizations are high-cost outliers), or fully integrated delivery systems	Mergers, acquisitions, corporate affiliations	$25 million, or transactions that increase annual any healthcare entity not party to the transaction by either $10 million or more	Impact on costs for payers, purchasers, or consumers

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
California Cal. Corp. Code §§5914 and 5920 (1996)	Attorney General	20 days pre-closing	Non-profit hospitals and other non-profit healthcare entity	Transfer of material amount of assets or control to a non-profit or for-profit entity	None	No

Endnotes

[1] King, et al., *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States*, THE SOURCE ON HEALTHCARE PRICE & COMPETITION (June, 2020) (a report from the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley including an analysis of data from the American Hospital Association Annual Survey, SK&A Office Based Physicians Database from IQVIA, and Managed Market Surveyor File from Health Leaders Inter Study (accounting for approximately 800 healthcare transactions throughout the country over the last decade).

[2] In this report, the term "healthcare providers" includes hospitals, health systems, physicians, and other clinicians who provide healthcare services and care to patients. "Healthcare transactions" includes mergers, acquisitions, or other type of contractual affiliations involving healthcare providers. "Antitrust enforcers" encompasses both state attorneys general enforcing antitrust laws and their federal counterparts, the Department of Justice and the Federal Trade Commission.

[3] Some examples include: Southwest Washington Medical Center affiliated with Peace Health (2010); Swedish Health Services become an affiliate of Providence Health & Services (2012); Highline Medical Center and Harrison Medical Center became part of the Franciscan Health System (2013); Pacific Medical Centers and Providence Health & Services affiliated (2015); Providence Health &Services and St. Joseph System affiliated to become Providence St. Joseph Health (2016); The Doctors Clinic and CHI Franciscan Health affiliated (2016); CHI Franciscan and Dignity Health became CommonSpirit Health (2019); CommonSpirit Health acquired Virginia Mason, to be known as Virginia Mason Franciscan Health (2021); MultiCare acquired Yakima Valley Memorial Hospital, which was renamed MultiCare Yakima Memorial Hospital (2023).

[4] *See e.g.,*Karyn Schwartz *et al*., *What We Know About Provider Consolidation*, KAISER FAMILY FOUND. (Sept. 2, 2020); *see also*, DAVID DRANOVE & LAWTON R. BURNS, BID MED: MEGAPROVIDERS AND THE HIGH COST OF HEALTH CARE IN AMERICA (2021); Nicholas C. Petris Center at the School of Public Health, University of California, Berkeley, *Consolidation in California's Health Care Market 2010-2016: Impact on Prices and ACA Premiums* 44 (2018); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175 (2004).

[5] Samuel M. Chang, et al., *Examining the Authority of California's Attorney General in Health Care Merger*, California Healthcare Found., (Apr. 2020).

[6] Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals* (Washington Ctr. for Equitable Growth, Working Paper, 2018) (finding evidence of negative wage growth among skilled workers following recent hospital mergers).

[7] For example, after a merger, providers may see more patients per day without an increase in wages. *See generally*, Carley Thornell, *Physicians report that organizational and technology changes are among the biggest burnout factors*, athenahealth, (July 2, 2021) (reporting on findings from 799 physician respondents between October and December 2020).

[8]Other state agencies are authorized to engage in merger review through laws governing charitable trusts, nonprofit corporations, health and safety, and certificate of need programs. Certificate of need programs regulate how certain healthcare providers get state approval before building facilities, or offering new or expanded services, such as increasing the number of licensed hospital beds. *See e.g*., National Conference of State Legislature, *Certificate of Need State Laws*, Jan. 1, 2023.

[9] *See generally*, Issue Brief, Katherine L. Gudiksen, Alexandra D. Montague, and Jaime S. King., Mitigating the Price Impacts of Health Care Provider Consolidation, Milbank Memorial Fund 9 (Sept. 2021).

[10] *See e.g*., *id.* at 3 (noting that these clauses allows a health system to "compound the negotiating leverage of one or more must-have providers, allowing the health system to demand supracompetitive rates" ("pricing above what can be sustain in a competitive market").

[11] *Id.* (noting how these clauses may help health systems to "demand placement in the most favorable tier in a tiered network to contract with a health plan, even if some or all of their facilities do not meet the cost or quality metrics for inclusion in that tier. Additionally, health systems using anti-steering clauses may even limit the ability of insurers to give softer steering signals, like listing preferred providers on their websites.").

[12] *Id.*

[13] ANDREW C. SELDEN, MERGERS AND ACQUISITIONS: UNDERSTANDING THE ANTITRUST ISSUES, 405 (4th ed. 2015).

[14] *See generally*, Jamie Godwin, et al., *Understanding Mergers Between Hospitals And Health Systems In Different Markets*, KAISER FAMILY FOUND. (Aug. 2, 2023) (listing cross-market mergers and other relevant articles); Jamie S. King & Erin V. Fuse Brown, *The Anti-Competitive Potential of Cross-Market Mergers in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 43, 45 (2018).

[15] At the federal level, the Consolidated Appropriations Act prohibits insurers and group health plans from entering into agreements that include a gag clause. Insurers and health plans must annually submit an attestation of compliance with the requirement. *See* U.S. Dep't of Labor, Faqs About Affordable Care Act And Consolidated Appropriations Act, 2021 Implementation Part 57, EMP. BENEFITS SEC. ADMIN. (2023) (discussing prohibition on gag clauses on price and quality information in healthcare provider agreements). Additional state oversight may still be helpful.

[16] Andrew S. Boozary, et al., *The Association Between Hospital Concentration and Insurance Premiums in ACA Marketplaces*, 38 HEALTH AFF. 668, 672 (2019) (finding that areas with the highest levels of hospital market concentration had annual premiums that were, on average, five percent higher than those in the least concentrated areas).

[17] *See e.g.*, Prager & Schmitt, *supra* note 6; Martin Gaynor, et al., *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LIT. 235, 236 (2015); Brent D. Fulton, *Health Care Market Concentration Trends in the U.S.: Evidence and Policy Responses*, 36 HEALTH AFFS. 1530, 1531 (2017).

[18] *See generally*, Nancy D. Beaulieu, et al., *Changes in Quality of Care After Hospital Mergers and Acquisitions*, 382 NEW ENG. J. MED. 51 (2020); Hannah Neprash & J. Michael McWilliams, *Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence*, 82 ANTITRUST L. J. 551 (2019).

[19] Thomas L. Greaney & Richard M. Scheffler, *The Proposed Vertical Merger Guidelines and Health Care: Little Guidance and Dubious Economics,* HEALTH AFFS. FOREFRONT (Apr. 17, 2020); Leemore Dafny, Kate Ho & Robin S. Lee, *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286, 287 (2019).

[20] Gudiksen, et al., *Mitigating the Price Impacts*, *supra* note 9, at 4.

[21] RICHARD M. SCHEFFLER, ET AL., *MONETIZING MEDICINE: PRIVATE EQUITY AND COMPETITION IN PHYSICIAN PRACTICE MARKET 15-16 (2023)*, ("SCHEFFLER I") (evaluating market penetration across ten physician practice specialties within markets across the U.S., the impact on market shares and concentration, and on prices and expenditures).

[22] Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, 77 MED. CARE RSCH. AND REV. 538 (2019) (The authors analyzed 29 quality measures reported to the Center for Medicare and Medicaid Services' Hospital Compare database for 2008 to 2015 to test whether vertical integration between hospitals and physicians or increases in hospital market concentration influence patient outcomes. In their findings, they note that "increased market concentration is strongly associated with reduced quality across all 10 patient satisfaction measures").

[23] RCW § 19.390.030.

[24] Colorado, Connecticut, Hawaii, Massachusetts, Rhode Island and Washington require pre-merger notification from all hospitals to the attorney general. Notice of transaction involving physicians group is required in Connecticut, Massachusetts, Nevada, Oregon, California and Washington.

[25] Senate Bill 5688 (2022); Senate Bill 5241 (2023-24) (pending bill in committee). In January 2023, Washington estimated that 14.5 staff would be needed to carry out the program.

[26] Minnesota Statutes, section 145D.01 (2023).

[27] When these impacts are likely triggered in the initial review process, the HPC may conduct a cost and market impact review (CMIR). When HPC conducts a CMIR, the agency needs to identify if healthcare providers have a dominant

market share, and charge prices and incur expenses that are materially higher. The comparison is made to the median prices charged by, and the median total medical expenses for all other providers, for the same services in the same market. *See* HEALTH POLICY COMMISSION, TECHNICAL BULLETIN FOR 958 CMR 7.00: NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS. (Setting forth the methodology for the calculation of Materially Higher Price). For some examples of CMIR s*ee e.g.*, Massachusetts Health Policy Comm'n, *Massachusetts Health Policy Commission Review of The Proposed Merger of Lahey Health System; CareGroup and its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; and Each of their Corporate Subsidiaries into Beth Israel Lahey Health; AND The Acquisition of the Beth Israel Deaconess Care Organization by Beth Israel Lahey Health; AND The Contracting Affiliation Between Beth Israel Lahey Health and Mount Auburn Cambridge Independent Practice Association*, Sept. 27, 2018.

[28] Oregon has statutory requirements governing its reviews, see Oregon Revised Statutes 415.500. OHA also published an analytic framework, outlining the methods, performance measures, and sources of information it uses to review transactions. OREGON HEALTH AUTHORITY, HEALTH CARE MARKET OVERSIGHT ANALYTIC FRAMEWORK, Oct. 2022.

[29] *See* Nonprofit Health Facility Transaction Notices, Public Meeting On The Proposed Change In Control And Governance Of Good Samaritan Hospital, available at https://oag.ca.gov/charities/nonprofithosp#sam-decision.

[30] N.Y. Pub. Health Law §§ 4550 et seq.

[31] MASSACHUSETTS HEALTH POLICY COMM'N REVIEW, *supra* note 27, at 1. A cost and market impact review prospectively assesses the impact of a proposed transaction. According to HPC, Massachusetts was the first state to conduct a policy-oriented, prospective review of the impact of healthcare changes, distinct from an administrative determination of need or law enforcement review of antitrust or consumer protection concerns.

[32] As of November 27, 2023, HPC had not yet determined whether it will conduct a CMIR for six transactions. The agency received notice of these transactions from September 21, 2023 to November 3, 2023. The notice of material changes list is available at: https://www.mass.gov/info-details/transaction-list-material-change-notices; Final CMIR reports are available at: https://www.mass.gov/lists/transaction-list-cost-and-market-impact-reviews#final-cmir-reports.

[33] As of October 31, 2023, OHA approved four transactions, approved four transactions with conditions, and determined that one transaction was exempt from review. Two comprehensive reviews were in process. Of note, the information is available in several languages.

[34] Employee Retirement Income Security Act of 1974 29 U.S.C. § 1144(a) (2012). The Employee Retirement Income Security Act of 1974 ("ERISA") restricts state health policy initiatives. Specifically, Section 514 of ERISA preempts state laws that "relate to any employee benefit plan." *Id*. As a result, many states attempted to carefully craft legislation to avoid ERISA preemption. *Id*. States have less ability to regulate or oversee the practices of and coverage provided by self-insured employer plans. *Gobeille v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936 (2016) (holding that ERISA pre-empts Vermont's healthcare reporting scheme because it "interferes with the uniformity of, plan administration." (internal citations omitted)). See also RCW 48.43.005(31), which defines "health plan" and excludes several categories of health plans, such as plans governed by ERISA.

[35] *See generally*, Gudiksen, et al., Mitigating the Price Impacts of Health Care Provider Consolidation, *supra* note 9, at 4.

[36] At least twenty states, including Washington, ban most-favored-nations clauses. WASH. ADMIN. C.§ 246-25-045 (prohibiting MFN clauses in contracts between a healthcare provider or facility and a certified health plan). For example, in Washington, the Insurance Commissioner enforces this prohibition when reviewing the provider contracts and provider compensation agreements that health carriers that are required to filed for his review. *See* RCW 48.43.730(2). "Health carriers" are defined in RCW 48.43.005(30). As another example, New York requires the Insurance Commissioner to review any contract between an insurer and a healthcare provider that includes a MFN provision for potential anticompetitive harm.

[37] Second Substitute Senate Bill 5393 (2023); Engrossed Second Substitute House Bill 1160 (2021).

[38] MASS. GEN. LAWS 1760, § 9A.

[39] NEV. REV. STAT. ANN. 598A.440.

[40] Connecticut Substitute House Bill No. 6669 § 19.

[41] 8 Texas Insurance Code §§ 1458.001 and 1458.101 (2023).

[42] AB-1091 (2023).

[43] LD 1708 (2023).

[44] Bill S1124 (2022-23).

[45] S6973 2023-2024. The bill is pending in committees (https://www.nysenate.gov/legislation/bills/2023/S6973). There is also a companion bill-A3148 2023-2024 (https://www.nysenate.gov/legislation/bills/2023/A3148).

[46] For the definition of health carrier, the statute references the same definition used in section 38a-591 of the Connecticut general statute. CONN. GEN. STAT. ANN. § 38a-591a, (25) (2023) ("Health carrier' means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health care center, a managed care organization, a hospital service corporation, a medical service corporation or any other entity providing a plan of health insurance, health benefits or health care services.").

[47] *See* 8 Texas Insurance Code §§ 1458.001 and 1458.101 (2023). ("Provider network contract" means a contract between a contracting entity and a provider for the delivery of, and payment for, health care services to a covered individual." The definition of providers includes: an advanced practice nurse; a physician; a physician assistant; a professional association composed solely of physicians; a single legal entity authorized to practice medicine owned by two or more physicians; a nonprofit health corporation certified by the Texas Medical Board; a partnership composed solely of physicians; and a physician-hospital organization that acts exclusively as an administrator for a provider to facilitate the provider's participation in health care contracts.).

[48] NEV. REV. STAT. ANN. § 598A.440. ("'Provider of health care' means: (1) A physician or other health care practitioner who is licensed or otherwise authorized in this State to furnish any health care service; or (2) An institution providing health care services or other setting in which health care services are provided, including, without limitation, a hospital, surgical center for ambulatory patients, facility for skilled nursing, residential facility for groups, laboratory and any other such licensed facility.").

[49] The statute defines "Carrier" as "an insurer licensed or otherwise authorized to transact accident or health insurance . . . ; a nonprofit hospital service corporation . . . ; a nonprofit medical service corporation . . . ; a health maintenance organization . . . ; and an organization entering into a preferred provider arrangement."

[50] *See* KATHERINE L. GUDIKSEN, ET AL., *PREVENTING ANTICOMPETITIVE CONTRACTING PRACTICES IN HEALTHCARE MARKETS, THE SOURCE ON HEALTHCARE PRICE & COMPETITION 4*, Sept. 2020.

[51] *Id.*

[52] *Id.*

[53] *Id.*.

[54] See Letter from Rob Bonta, Cal. Att'y Gen., Brian L. Schwalb, D.C. Att'y Gen., and Matthew J. Platkin, N.J. Att'y Gen., to Lina Khan, F.T.C. Chair (Apr. 19, 2023) at 5-6 ("*AG Comments on Non-compete Ban"*) (discussing additional concerns with non-competes in healthcare).

[55] Mackenzie Bean, *How noncompete clauses can sever patient-provider relationships*, BECKERHOSPTIALREVIEW.COM, Mar. 18, 2019.

[56] *See generally*, Emily McGrath and Tara Oakman, *Noncompete Agreements for the Health Care Workforce Put Profits over Patients*, THE CENTURY FOUNDATION, Jan. 19, 2023, https://tcf.org/content/commentary/noncompete-agreements-for-the-health-care-workforce-put-profits-over-patients/.

[57] Letter from Elizabeth Warren & Christopher Murphy, United States Senators, to Joseph Simons, Chairman, Federal Trade Commission (July 22, 2020).

[58] Federal Trade Commission (February 19, 2023). Proposed Rule: Non-Compete Clause Rule, available at https://www.federalregister.gov/documents/2023/01/19/2023-00414/non-compete-clause-rule.

[59] The FTC relied on its powers under Sections 5 and 6(g) of the FTC Act (15 U.S.C. §§ 45, 46(g)), which prohibits "[u]nfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce . . . ." Criticism from many stakeholders abound regarding the proposed rule and its application. See e.g., Letter from Melinda Reid Hatton, Gen. Counsel and Secretary, Am. Hosp. Assoc., to Lina M. Khan, Chair, F.T.C., (Feb. 22, 2023).

[60] RCW § 49-62 (2019). While Washington's statutory ban on certain non-compete agreements outlines situations in which non-competes are not enforceable, it preserves the common law reasonableness test, enabling workers to argue that their non-compete bans are unenforceable for other reasons.

[61] Non-Compete Agreements (wa.gov).

[62] Like Washington, Colorado, Illinois, and the District of Columbia banned non-competes for lower wage earners.

[63] ME. REV. STAT. tit. 26, § 599-A; MD. CODE ANN., Lab. & Empl. § 3-716; N.H. REV. STAT. ANN. § 275:70-a; R.I. GEN. LAWS § 28-59-3; VA. CODE § 40.1-28.7:8; WASH. REV. CODE ANN. § 49.62.020; Or. REV. STAT. ANN. § 653.295.

[64] S.B. 3035, 2023 Leg., 93rd Sess. (Minn. 2023); OKLA. STAT. tit. 15, § 217; N.D. Cent. Code § 9-08-06.

[65] California state law affords numerous protections to workers and competition through its antitrust law known as the Cartwright Act (CAL. BUS. & PROF. CODE §§ 16700-16770), the Unfair Practices Act (CAL. BUS. & PROF. CODE §§ 17000 et seq.), the Unfair Competition Law (CAL. BUS. & PROF. CODE §§ 17200 *et seq.*), Labor Code (Cal. Labor Code § 432.5) and non-compete restrictions (CAL. BUS. & PROF. CODE §§ 16600-16602), among others. SB 699 was signed on September 1, 2023, and AB1076 was signed on October 13, 2023.

[66] S.B. 699, 2023-2024 Reg. Sess., Gen. Ass. (Ca. 2023). A.B. 1076, 2023-2024 Reg. Sess., Gen. Ass. (Ca. 2023). Violations of California's CAL. BUS. & PROF. CODE § 16600 are redressable under California's Unfair Competition Law ((CAL. BUS. & PROF. CODE § 17200, et seq.).

[67] R.I. GEN. LAWS ANN. § 5-37-33(2016); 6 Del. C. § 2707(1983); MA ST 149 § 24L (2021); N.H. RSA § 329:31-a (2016)(physicians); N.H. RSA § 326-B:45-a (2018) (nurses).

[68] West Virginia Physicians Freedom of Practice Act W. VA. CODE ANN. § 47-11E-2 (a)-(b) (2023).

[69] CONN. GEN. STAT. § 20-14p. (2023); TENN. CODE ANN. § 63-1-148 (2023).

[70] COLO. REV. STAT. § 8-2-113. For decades, Colorado has permitted liquidated damages but disallowed injunctive relief as a remedy for violations of physician non-compete provisions. See *Wojtowicz v. Greeley Anesthesia Servs.*, P.C., 961 P.2d 520, 522 (Colo. App. 1997).

[71] FLA. STAT. ANN. § 542.336 (2023).

[72] S.B. 7, 123rd Gen. Ass., Reg. Sess. (In. 2023).

[73] *Id.*

[74] TEX. BUS. & COM. CODE ANN. § 15.50 (2023).

[75] N.M. STAT. ANN. § 24-1I-2 (2021).

[76] S.D. Codified Laws § 53-9-11.1(2021) (amended 2023).

[77] AL. ST. § 8-1-190 (a) (2016). Under Alabama statutory law, "professionals" are exempt from non-compete agreements, which serve to restrict competing activity within a defined geographic area and time period. The law does not define the term "professional." Alabama courts have found that professionals include physicians and physical therapists. Other healthcare professionals who practice independently, have direct patient contact, and are separately licensed might also be found to fall under the professional exemption.

[78] H.B. 1950, 192nd Gen. Ct. (Ma. 2021).

[79] S.B. 6748, 2023-2024, Reg. Sess. (N.Y. 2023).

[80] Sherman Antitrust Act, 15 U.S.C. §§ 1-7. Enacted in 1890, the Sherman Act is used to challenge various anticompetitive practices, such as mergers, wage suppression, agreements among competing businesses to fix prices, and anticompetitive contracting clauses.

[81] Clayton Antitrust Act, 15 U.S.C. §§ 12-27. Enacted in 1914, the Clayton Act reaches further by explicitly prohibiting anticompetitive mergers and other types of anticompetitive practices, not clearly addressed by the Sherman Act.

[82] Another antitrust statute is Robinson-Patman Act of 1936 also known as Anti-Price Discrimination Act, Pub. L. No. 74-692, 49 Stat. 1526 (codified at 15 U.S.C. § 13). Seldom enforced, the Act addresses price discrimination by prohibiting sellers from treating their competing customers differently regarding prices, terms of sale, or marketing support.

[83] Federal Trade Commission Act, 15 U.S.C. §§ 41-58. The FTC Act created the FTC in 1914, and the Act grants to the FTC its regulatory authority.

[84] H.R. REP. No. 1418 (2020); Competitive Health Insurance Reform Act of 2020, 15 U.S.C. § 1011 (2020).

[85] Hart-Scott-Rodino Antitrust Improvements Act, Pub. L. No. 94-435, 90 Stat. 1383 (1976) (codified in 15 U.S.C § 18a (1976)).

[86] Premerger Notification Office Staff, *HSR threshold adjustments and reportability for 2023*, FTC.GOV (Feb. 1, 2023).

[87] DRAFT MERGER GUIDELINES, (U.S. DEP'T OF JUST. & F.T.C. 2023).

[88] *See generally*, Public Comments of Attorneys General of 15 States and Territories on Labor Market Issues in Response to the July 29, 2023 Request for Comments on the Draft Merger Guidelines; Public Comments of Attorneys General of 19 States and Territories in Response to the July 29, 2023 Request for Comments on the Draft Merger Guidelines, (September 18, 2023), (19 states signed onto the general comments, and 15 states signed onto the labor-specific comments) (*"AG Comments"*); Labor and Equity Comments from Attorneys General in Response to Request for Information on Merger Enforcement (Apr. 21, 2022).

[89] *Parens patriae* refers to the Attorney General's authority to bring proceedings on behalf of the public. Pennsylvania used its *parens patriae* authority in *Commonwealth of Pennsylvania v. Geisinger Health System Foundation*, Levinston Health Care Foundation, (no.1:13 CV-02647-YK, Nov.1).

[90] See e.g., *State v. LG Elecs., Inc.*, 375 P.3d 636, 641 (Wash. 2016) (the Washington Supreme Court declined to follow federal law where the language and structure of the Washington's Consumer Protection Act (CPA) departs from otherwise analogous federal provisions); *see also In re Cipro Cases I & II*, 61 Cal. 4th at 160-61 ("[T]he Cartwright Act is broader in range and deeper in reach than the Sherman Act.").

[91] F.T.C., OVERVIEW OF THE MERGER RETROSPECTIVE PROGRAM IN THE BUREAU OF ECONOMICS n.5.

[92] *See e.g.*, *St. Alphonsus Med. Ctr. Nampa, Inc. v. St. Luke's Health Sys.*, Ltd., 778 F.3d 775, 784 n.10 (9th Cir. 2015) (stating that the "two-stage model" of healthcare is the "accepted model"); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 342 (3d Cir. 2016) (stating that when using the hypothetical monopolist test the court must also look "through the lens of the insurers"); *FTC v. Advoc. Health Care Network*, 841 F.3d 460, 471 (7th Cir. 2016).

[93] *See e.g.*, Cory Capps, David Dranove, and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, 59 J. OF HEALTH ECONS. 139 (2018); Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending* 33 HEALTH AFFS.756 (2014).

[94] *See United States v. AT&T, Inc.*, 916 F.3d 1029, 1032 (D.C. Cir. 2019) ("unlike horizontal mergers, the government cannot use a short cut to establish a presumption of anticompetitive effect through statistics about the change in market concentration, because vertical mergers produce no immediate change in the relevant market share.").

[95] Steven C. Salop, *Invigorating Vertical Merger Enforcement,* 7 YALE L. J. 1742 (2018).

[96] The FTC ordered six insurance companies to provide information and health claim data for fifteen states: Colorado, Florida, Georgia, Indiana, Illinois, Kentucky, Maine, Missouri, Montana, Nevada, New Hampshire, New Mexico, Ohio, Oklahoma, and Texas.

[97] Michael G. Vita, *Physician Group and Healthcare Facility Merger Study*, F.T.C. (2021).

[98] *See generally*, Greaney & Scheffler, Proposed Vertical Merger Guidelines, *supra* note 19. *See also In the Matter of Renown Health*, 111 F.T.C. 0101, No. C-4366 (2012). (The FTC challenged the acquisition of two cardiology physician groups by the largest health system in Reno, Nevada, on horizontal grounds because the combined entity

employed 88 percent of the active cardiologists in the area. The case resolved with a consent decree prohibited the merged entity from enforcing anticompetitive contractual provisions with cardiologists.).

[99] The antitrust enforcers claimed that the merger would combine two competitors in a market for the sale of first-pass claims editing solutions, resulting in UnitedHealth having more than a 90 percent share of the market. The enforcers also claimed that vertical harms would arise from UnitedHealth gaining control over Change's EDI clearinghouse and using that control to disadvantage rival insurers. As such, the merger would give UnitedHealth the ability and incentive to use rivals' claims data for its own benefit, which in turn would lessen competition in the markets for national accounts and large group commercial health insurance, Additionally, it would give UnitedHealth the ability and incentive to withhold innovations and raise rivals' costs to compete in those same markets for national accounts and large group plans.

[100] Clayton Antitrust Act, 15 U.S.C. § 18 (2019).

[101] *Washington v. Franciscan Health System*, No. C17-5690 BHS, 2018 WL 1256866 (W.D. Wash. Mar. 12, 2018).

[102] *Id.*

[103] The consent decree, also includes other contract changes and notice requirements.

[104] *See, e.g.*, Deborah Haas-Wilson, *Competitive Effects Analysis of Proposed Centene-Magellan Transaction*, Oct. 21, 2021, available at https://www.dmhc.ca.gov/Portals/0/Docs/DO/CenteneMagellan/RedactedFinalHaas-WilsonReport-AccessibleUpdated.pdf?ver=2021-10-15-125037-443 (expert report).

[105] DMHC Approves Centene's Acquisition of Magellan with Conditions to Protect Consumer, DMHC.CA.GOV, (Dec. 30, 2021).

[106] Brent D. Fulton, Daniel R. Arnold, Jaime S. King, Alexandra D. Montague, Thomas L. Greaney & Richard M. Scheffler, The Rise of Cross-Market Hospital Systems and Their Market Power in the US, 41 HEALTH AFFS. 1652-55 (2022) (sharing concerns with the increase in cross-market hospital systems, which warrants further scrutiny because of the anticompetitive impact of these system exert when negotiating with common customers). Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, supra note 19; *See also* Lawton Robert Burns and Mark V. Pauly, *Big Med's Spread*, 101 MILBANK QUARTERLY 287 (2023) (discussing how different studies measure different types of cross-market activity but the results are fairly consistent).

[107] *Id*. *See also* Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, supra note 19; Burns, et al., and Mark V. Pauly, *Big Med's Spread*, *supra* note 106.

[108] See e.g., Gregory S. Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L. J. 253 (2013) (Engaging in a literature review on cross-market mergers, the authors recognize the need for further discussion about cross-market hospital mergers. The authors discuss, among others, a 2002 DOJ business review letter regarding a proposal by the Michigan Hospital Group (MHG) under which seven geographically dispersed hospitals in Michigan sought to engage in joint contract negotiations. In response, DOJ explicitly recognized the possibility that hospitals could increase their overall bargaining leverage by increasing the number of networks with which they could threatened a health plan, noting —"[A]lthough the [health] plans recognized that MHG's hospital members serve distinctly different local geographic areas and thus are not substitutes to provide hospital services for those areas, a small number of plan representatives expressed the concern that the MHG hospitals might be able to increase their bargaining leverage with health plans by refusing to contract except through MHG." The authors point out that DOJ's conclusion that MHG's proposal was unlikely to significantly reduce competition, was based in large part on the DOJ's understanding that there would be efficiencies associated with the proposed joint contracting and that the hospitals would not be negotiating on an exclusive basis. *Id*. at 257-259); *See, also*, Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, *supra* note 19 (discussing previous studies addressing the impact of cross-market healthcare mergers).

[109] *See, e.g.*, Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, supra note 10 (noting findings in prior research that combinations of nearby similar rivals leads to higher prices); Matt Schmitt, *Multimarket Contact in the Hospital Industry*, 10 AM. ECON. J.: ECON. POL'Y 361, 385 (2018); Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, 48 RAND J. ECON. 579, 580 (2017).

[110] Fulton, et al., supra note 106 at 1659.

[111] *See* William J. Kolasky, Deputy Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Just., Address Before the George Mason University Symposium, Conglomerate Mergers and Range Effects: It's a Long Way from Chicago to Brussels (Nov. 9, 2001) (distinguishing horizontal and vertical mergers from conglomerate mergers (which encompass cross-market deals), the Deputy Assistant remarked that the merging entity in "conglomerate mergers," do not have the ability and incentive to raise prices and restrict output, but can generate significant efficiencies).

[112] Steve Dubb, "Record Merger Creates Nation's Largest Nonprofit Catholic Healthcare Company," NPQ, (Feb. 6, 2019).

[113] *See* Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, *supra* note 19 n.3.

[114] The guidelines include the language "tend to create a monopoly" suggesting more antitrust scrutiny if a proposed transaction appears to put an emerging party on the path towards becoming a monopoly, even if not directly competing.

[115] Press Release, U.S. Dep't of J., Office of Public Affairs, Justice Department Withdraws Outdated Enforcement Policy Statements, (Feb. 3, 2023).

[116] Press Release, F.T.C., Federal Trade Commission Withdraws Health Care Enforcement Policy Statements (July 14, 2023).

[117] Press Release, U.S. Dep't of J., *supra* note 115.

[118] Alexandra D. Montague, et al., *Considerations for state-imposed conditions on healthcare provider transactions*, 11 Frontiers in Pub. Health n. 45 (2023).

[119] Holly Vedova, *Making the Second Request Process Both More Streamlined and More Rigorous During this Unprecedented Merger Wave*, FTC.GOV, (Sept. 28, 2021).

[120] *See e.g.*, Press Release, California Office of the Att'y General, Attorney General Bonta Conditionally Approves of Sale of Adventist Health Vallejo (October 5, 2021) (listing as quality impact conditions— the appointment of an evaluation team to conduct a comprehensive survey of the quality of care at San Jose Behavioral to ensure past concerns have been resolved; and as access impact conditions— Adventist Vallejo must continue to serve patients under 18 years old for 10 years); Press Release, California Office of the Att'y General, Attorney General Bonta Conditionally Approves Affiliation Agreement Between Methodist Hospital and USC Health System (June 3, 2022); *See also* Amy Y. Gu, California AG considers Cross-Market Effects in Merger Review and Conditional Approval of USC Health System and Methodist Hospital Affiliation (July 14, 2022) (The author discusses the competitive impact analysis of the transaction, and summarizes some of the conditions imposed on transaction— 1) Prohibition of anticompetitive contracting practices (for 10 years with potential 3-year extension); 2) Price cap: Annual price increases for contract renewals not to exceed 4.8% per year (for 5 years with potential 3-year extension); 3) Monitor and Reporting. It further notes that other imposed conditions address access and quality.).

[121] Press Release, California Office of the Att'y General, Attorney General Becerra Conditionally Approves Affiliation Agreement Between Cedars-Sinai and Huntington Memorial Hospital (Dec. 10, 2020).

[122] *Id.*

[123] Jaime S. King, et al., *Antitrust's Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power*, 74 HASTINGS L. J. 1057, 1068 (2022) (describing the anticompetitive contractual practices conditions in the Sinai case and other transactions, including the imposed conditions); *see also*, Fulton, et al., *supra* note 106 at 1059.

[124] *See* Nonprofit Health Facility Transaction Notices, Good Samaritan Hospital, *supra* note 29.

[125] The Office of Minnesota Att'y General Keith Ellison, Sanford Health and Fairview Health Services, (The parties announced their merger in 2022, with the intent of closing the deal in 2023. In January 2023, as part of reviewing the proposed transaction, the Attorney General hosted a series of community meetings to directly gather feedback. The community meetings were open to the press and the public and livestreamed on Attorney General Ellison's Facebook Page. The parties set different proposed closing dates, which were further postponed with no specific dates, but they agreed to give the Attorney General a 90-day advanced notice.).

[126] Clayton Act, 15 U.S.C. § 18 (1914) prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly.

[127] H. R. REP. No. 1191, pt. 1, at 8 (1949); *see also* H. R. REP. No. 1775, part 2, at 4-5 (1950), ("that "[w]here several large enterprises are extending their power by successive small acquisitions, the cumulative effect of their purchases

may be to convert an industry from one of intense competition among many enterprises to one in which three or four large concerns produce the entire supply."); FED. TRADE COMM'N, THE MERGER MOVEMENT: A SUMMARY REPORT (1948), at 6-7, 19 ("In appraising the over-all effect of mergers on economic concentration, it must be constantly borne in mind that they tend to become cumulative over a period of time. In other words, each year's mergers are superimposed upon a structure of economic concentration which has been built up over many past years.").

[128] *See e.g.*, Laura M. Alexander, et al., *Private Equity's Entry into Healthcare Reveals Gaps in Competition Policy*, CPI ANTITRUST CHRONICLE (2022); RICHARD M. SCHEFFLER, ET AL., *SOARING PE INVESTMENT IN THE HEALTHCARE SECTOR: CONSOLIDATION ACCELERATED, COMPETITION UNDERMINED, AND PATIENTS AT RISK, THE AMERICAN ANTITRUST INSTITUTE & THE PETRIS CENTER AT THE SCHOOL OF PUBLIC HEALTH*, UNIVERSITY OF CALIFORNIA, BERKELEY (May 18, 2021) ("Scheffler II"); Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm*, THE N. Y. TIMES, July 10, 2023; ERIN FUSE BROWN, ET AL., *PRIVATE EQUITY INVESTMENT AS A DIVINING ROD FOR MARKET FAILURE: POLICY RESPONSES TO HARMFUL PHYSICIAN PRACTICE ACQUISITIONS* (2021); Ashvin Ghandi, YoungJun Song & Prabhava Upadrashta, *Private Equity, Consumers, and Competition: Evidence from the Nursing Home Industry* (Mar. 16, 2023) (unpublished manuscript), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3626558; Atul Gupta, et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* (Nat'l Bureau of Econ., Working Paper No. 28474, 2021), https://www.nber.org/papers/w28474; Diana Moss, *What Does Expanding Horizontal Control Mean for Antitrust Enforcement? A Look at Mergers, Partial Ownership, and Joint Ventures,* American Antitrust Institute (Nov. 4, 2020), https://www.antitrustinstitute.org/wp-content/uploads/2020/11/Moss_Horizontal-Control_11.4.20.pdf.

[129] SCHEFFLER I, *supra* note 21, at 4 (discussing concentration of physician services in local markets following private equity acquisitions below HSR Act reporting thresholds).

[130] *See* SCHEFFLER II, *supra* note 128, at 31-32; Alexander, *supra* note 128, at 5-6 (providing examples of private equity firms obtaining market power in healthcare specialties in local and regional markets).

[131] *See AG Comments, supra* note 88, at 20 *(citing to various sources*).

[132] *AG Comments, supra* note 88, at 19.

[133] See e.g., RICHARD M. SCHEFFLER, ET AL., *MONETIZING MEDICINE*, *supra* note 21 (setting policy steps that would strengthen antitrust competition enforcement and healthcare policy in physician practice markets). *See also* FUSE BROWN, ET AL., *PRIVATE EQUITY INVESTMENT supra* note 128, at 2, 16 (noting specifically that "policy responses could focus on antitrust enforcement, merger review, and prohibitions on anticompetitive physician contracting practices").

[134] *Id*.

[135] 15 U.S.C. § 1. Section 1 of the Sherman Antitrust Act prohibits contracts, combinations, and conspiracies "in restraint of trade," which in healthcare often occur in contracts between providers and insurers. 15 U.S.C. § 2. Section 2 of the Sherman Antitrust Act prohibits monopolization, attempted monopolization, or conspiracy to monopolize.

[136] *United States v. Blue Cross Blue Shield of Michigan,* 665 F. Supp. 2d, 809 (E.D. Mich. 2011).

[137] *UEBT v. Sutter Health* was a class-action lawsuit filed in 2014 in state court in San Francisco. *The People of California v. Sutter Health* was a lawsuit filed by then-Attorney General Xavier Becerra in 2018 in state court in San Francisco, and the case was promptly consolidated with the *UEBT* case. Sutter settled the consolidated state case in 2019 just before opening statements.

[138] *Sidibe v. Sutter Health* was a class-action lawsuit filed in 2012 in federal court in San Francisco, which is part of the Northern District of California. Before trying the case in early 2022, the district court dismissed it twice and had both dismissals reversed on appeal. In 2022, Sutter took the federal case to trial and won a unanimous jury verdict.

[139] Health insurance plan purchasers' appealed multiple lower court rulings and a March 2022 verdict in Sutter's favor. Specifically, the jury had rejected antitrust claims by a certified class of roughly 3 million premium insurance payers alleging that Sutter illegally forced insurers to agree to anticompetitive contract terms blocking plans that steered patients to lower-cost hospitals, or required them to contract for services at Sutter's more expensive hospitals in order to get access to the medical care members needed.

[140] Final J., *UFCW & Employers Ben. Trust v. Sutter Health,* No. CGC-14-538451, 2021 WL 5027181 7, 18 (Cal. Super. Aug. 27, 2021).

[141] Press Release, California Office of the Att'y General, Attorney General Bonta Announces Final Approval of $575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices (Aug. 27, 2021).

[142] *United States v. Charlotte-Mecklenburg Hosp. Auth.,* No. 316CV00311RJCDCK, 2019 WL 2767005 (W.D.N.C. Apr. 24, 2019).

[143] Press Release, Att'y Gen. Josh Stein, Attorney General Josh Stein Demands Answers from HCA Over Cancer Services (Sept. 29, 2023).

[144] *Davis v. HCA Healthcare, Inc.*, No. 21 CVS 3276, 2023 WL 3120813 (N.C. Super. Apr. 27, 2023).

[145] *In re Mission Health Antitrust Litigation*, 2022 WL 20437003.

Washington State Health Care Authority

Thank you for attending the Universal Health Care Commission meeting!