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**Senate Committee on Health
Informational Hearing
Health Care Market Consolidations: Impacts on Cost, Quality and Access
March 16, 2016
1:30 p.m., Room 4203**

Purpose

The purpose of this informational hearing is to bring state and national experts before the Senate Committee on Health to discuss the impact of health care mergers and concentration on California's health care market. The Committee will explore policy options to minimize the negative impact on cost, quality and access to care for Californians when there is a lack of competition due to overconcentration in the health care marketplace.

This hearing is one in a series of hearings of the Senate Committee on Health to examine health care costs and cost containment strategies. In March of 2014, the Senate Committee on Health convened health care experts to discuss factors that contribute to the growing cost of health care in California and efforts to make care more affordable. At a second hearing in February of 2015, the Committee heard testimony related to some of the major cost drivers in the health care system, including pharmaceuticals, hospital costs, and the effects of geographic location on contracting. On March 18, 2015 the Committee met to educate members and the public about the effect of health care costs on consumers. A link to materials from past hearings can be found at <http://shea.senate.ca.gov/informationalhearings>.

Introduction

Extensive consolidation already exists in both the provider and health insurance markets. These trends will continue as new payment models develop in response to implementation of the Affordable Care Act (ACA). The ACA calls for increased levels of coordination among providers, payers, and employers, and mandates new payment models such Accountable Care Organizations (ACOs). According to a recent publication on antitrust and health care by the California HealthCare Foundation (CHCF), California health care providers and insurers are

consolidating to remain viable. These activities range from complete consolidation through mergers, to joint ventures, to simple clinical integration with no financial integration at all.

To maintain competition, many experts are calling for initiatives beyond traditional antitrust enforcement. There are a variety of strategies states can employ to promote competition in the health care market, including transparency initiatives and expanding authority of regulators to monitor and enforce against anticompetitive behavior.

Health care economists indicate that the market power of certain health care providers is a major driver of price increases and health care spending. A study on the impact of health care market power on premiums for products available in 2014 through Covered California conducted by researchers at the University of California, Berkeley found that the concentration of medical groups and hospitals had an impact on premium rates in California's 19 health insurance rating regions. The researchers found that the concentration of health plans did not have an impact on premiums. They did find that reducing hospital concentration to levels that would exist in moderately competitive markets could reduce overall premiums of more than 2% and in three regions by more than 10%. The study authors found that while increasing concentration in hospital markets is occurring nationally, medical group concentration is more specific to California. The authors recommend that policy makers monitor and promote competition to ensure Covered California consumers have access to affordable health plans.

Background on Antitrust Enforcement

Antitrust authorities examine consolidated entities because antitrust offenses almost always raise the prices paid by consumers for goods or services. Even relatively small price increases can have tremendous overall effects statewide. When state or local governments pay too much for goods or services because of antitrust violations, either taxes must be increased or government services must be reduced.

There are three bodies of federal antitrust laws: The Sherman Antitrust Act, the Clayton Act, and the Federal Trade Commission Act. All are used by state and federal governments to review the effects on competition from health care entity conduct and consolidations. Another federal law, the Hart-Scott-Rodina Act (HSR), requires advanced notification to the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) of large proposed mergers and acquisitions before they are finalized. Businesses may not merge with or acquire other businesses when the effect may be substantially to lessen competition. Under HSR, the FTC and the U.S. DOJ review most of the proposed transactions that affect commerce in the U.S. and are over a certain size, and either agency can take legal action to block deals that it believes would "substantially lessen competition." Because the FTC and U.S. DOJ share jurisdiction over merger review, transactions requiring further review are assigned on a case-by-case basis depending on which agency has more expertise with the industry involved. The FTC and U.S. DOJ have issued Statements of Antitrust Enforcement Policy in Health Care that provide guidance on activities that are violations and activities that will not be challenged under antitrust laws.

California's Department of Justice (DOJ)

California's DOJ, headed by the Attorney General (AG), houses an antitrust division where attorneys, investigators, and legal analysts are devoted to antitrust investigations and litigation. California and federal antitrust laws prohibit unwarranted restraints on free and open competition in commerce. These laws allow the AG to bring civil and criminal legal actions against individuals and businesses acting in restraint of trade. Anyone injured by an antitrust offense may recover from the wrongdoer an amount that is three times the damages suffered. In 2012, California DOJ issued civil investigative demands to a number of California plans and providers as part of the AG's focus on the impact of consolidation of services on medical care costs to consumers. The *Wall Street Journal* reported that Dignity Health, Scripps, Sharp, Sutter and Cottage health systems were all sent subpoenas. The article states that the AG appears to be focusing on whether the systems' "tie-ups with physicians, as well as ownership of hospitals, have given them the market power to boost prices in a way that violates antitrust law."

The Cartwright Act is a California specific antitrust statute, but it does not give the AG the authority to approve or deny a merger. The following three activities are examples of activities that are illegal under the Cartwright Act:

- **Price-fixing.** An informal understanding between competitors concerning prices is illegal. The agreement need not set specific prices; any agreement affecting price levels is illegal.
- **Tying arrangements.** When a seller requires a buyer to purchase a product that the buyer does not want in order to be allowed to buy a product that the buyer does want. Tying is generally illegal if the seller has some degree of control over the market for the product that the buyer wants.
- **Monopoly.** When a business unfairly keeps others from competing with it. Growth through superior ability and efficiency is not illegal. However, a business with significant market power may not, without legitimate business justification, take actions that exclude or handicap its competitors.

The AG also is required to review and make recommendations with regard to public utility mergers and acquisitions. The California Public Utilities Commission (PUC) approves mergers and acquisitions of public utilities. Public Utilities Code section 854(b)(3) requires the PUC to request an advisory opinion from the AG regarding whether competition will be adversely affected and what mitigation measures could be adopted to avoid this result when approving mergers, acquisitions or direct or indirect control of any public utility organized and doing business in California.

Nonprofit Hospital Mergers

California's charitable trust law, unlike the Cartwright Act, requires the AG's consent for any sale or transfer of a health care facility owned or operated by a nonprofit corporation whose assets are held in public trust. The charitable trusts section of the DOJ is tasked with protecting

the public's interest in the property and assets committed to charitable purposes in California through registration, education and enforcement. The AG must consider whether the transaction may tend to create a monopoly or substantially lessen competition.

Daughters of Charity

In December of 2015, the AG granted conditional approval of a change of control and governance of the Daughters of Charity Health System to Integrity Inc., with conditions to ensure essential healthcare services for the communities serving the six health facilities included in the transaction. This has been described by the AG as the largest and most complex nonprofit hospital transactions in California history. DOJ conducted an in-depth review of the transaction, including five Health Care Impact Statements by an independent health care expert, six public meetings, and a public comment period.

Under the system restructuring and support agreement, for at least the first three years of the 15-year agreement, the health system will continue to operate as a nonprofit public benefit corporation. After three years and before the expiration of the agreement, Integrity Inc. can exercise their option to purchase the health system. Conditions of the agreement include requirements for facilities to operate as hospitals offering emergency services and other facilities to operate as nursing homes for specified periods of time, investments in capital improvements, commitments to serve Medi-Cal and charity care patients, and all of the facilities will be required to submit an annual report to the AG describing in detail their compliance with the conditions.

Sutter-Summit Merger

A past merger between Sutter and Summit hospitals (two hospitals located 2.5 miles apart in the Oakland-Berkley region of the San Francisco Bay Area) which resulted in price increases and may be anticompetitive according to a 2008 working paper titled "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction." This retrospective study by the Bureau of Economics of the FTC assessed whether antitrust enforcement matter was appropriate. Claims data from three large health insurers were used to compare the post-merger price change for Sutter and Summit to the price change for a set of control group hospitals. The results of the retrospective show that Summit's price increase was among the largest of any comparable hospital in California, indicating this transaction may have been anticompetitive. However, a full determination of whether antitrust enforcement was appropriate would require an analysis of impact on quality and if Summit was a "failing firm." This additional analysis was beyond the scope of the retrospective.

The California AG unsuccessfully tried to block the merger through antitrust litigation. The U.S. District Court for the Northern District of California rejected the challenge, indicating that the applicable product market and geographic market were defined too broadly and failed to identify the specific services that competed with each other or the geographic area where the competition took place. The Federal Court Judge ruled that "Allowing Summit and Alta Bates to merge will assure that Summit can continue to serve its community, while prohibiting the proposed merger will have the effect of causing the third largest hospital in the East Bay to cease to exist."

Drug Companies

Many health care purchasers are concerned by the continued trends of pharmaceutical company mergers. With fewer innovative drugs coming to market and patents expiring, pharmaceutical companies often look to mergers and acquisitions over new major investments in research and development (R&D). Industry observers raise concerns about the implications of these acquisitions to R&D and the possibility that companies may be purchasing rights to drugs to substantially increase prices. A *Wall Street Journal* article describes a \$1.4 billion purchase of Cadence Pharmaceuticals maker of Ofirmev pain injections (described as the “crown jewel” of the deal) by Mallinckrodt PLC. After the price increase, hospital systems were spending as much as \$55,000 a month on the drug, up from \$20,000 to \$25,000 a month. The state’s role in monitoring and enforcement of these activities appears to be limited.

According to the AG’s website, going back to at least 2000, the AG, often working with similar officials in other states, has obtained hundreds of millions of dollars from many large pharmaceutical companies accused of various antitrust violations. This money has been used for consumer refunds and to support various programs that benefit the general public. One of the most recent cases involved "illegally blocked" cheaper generic substitutes for the patented brand-name cholesterol-reducing drug. The case was one of the country's first legal actions challenging pharmaceutical companies for "product hopping," a strategy to block generic competition by making slight changes to the formulation of an existing patented drug. The settlement agreement requires the companies to cease illegal efforts to block generic competition and to pay the states approximately \$22.5 million dollars. In California, the Department of General Services, Medi-Cal, and the Department of Corrections were supposed to be reimbursed for overcharges.

Another settlement had to do with the withholding from the market a generic version of a prescription oral contraceptive. California, together with thirty-three other states and the District of Columbia, challenged the action. After the litigation, the agreement was voided, and the two companies began competing with one another, resulting in a 20% drop in the price of the contraceptive within just one month. The company agreed to a ten-year consent decree barring similar agreements, and requiring the payment of civil penalties and the prosecutors’ attorney fees.

Health Plans and Insurance Companies

There are at least four health insurance company mergers currently under consideration nationally with implications in California: Blue Shield of California’s acquisition of Care 1st, Aetna’s acquisition of Humana, Anthem’s acquisition of Cigna, and Centene’s acquisition of Health Net. Nationally, these mergers, if approved, will reduce the top five plans to three. Anthem’s acquisition of Cigna would make it the largest health insurance company putting United Health into second place. An August 2015 analysis by Cattaneo and Stroud of the impacts of the proposed mergers on California indicates that there would be minor changes in enrollment numbers resulting in three plans representing 55% of the market, but there will also be fewer competitors in many counties. With the Anthem-Cigna merger competitiveness is reduced in 31 counties, and Aetna-Humana reduces competitiveness in eight counties. The study concludes that major concentration has already occurred prior to the currently proposed mergers and/or acquisitions. However, the proposed transactions further exacerbate the concentrations.

Additionally, there will be a reduction of competing plans in the majority of California counties, which will likely result in increased contracting pressure on delegated medical groups. In California, the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) both have authority in approving health plan and insurer mergers.

Health Care Service Plans

Under the Knox Keene Health Care Service Plan Act of 1975, licensed health care service plans (health plans) must give notice to the DMHC director for approval of any mergers or acquisitions of controlling interests, which are considered material modifications to the plan. A notice of material modification of its operations or any plan contract is required to be filed as an amendment to the license application. Any nonprofit health plan that intends to restructure its activities, as defined, must secure approval from the DMHC director. The Knox-Keene Act describes the rules that nonprofit health plans must follow when restructuring or converting their activities from nonprofit to for profit. As part of the approval process, the nonprofit health plan must submit a public benefit program that identifies activities to be undertaken.

Health Insurers

The Insurance Commissioner has the duty to monitor competition in the insurance industry, including any attempts to monopolize the insurance business. The Insurance Commissioner may refuse to allow transactions if they will substantially lessen competition or are otherwise a restraint on competition or monopolization attempt. Under the Insurance Code, the burden of compliance is on the applicant for a permit to operate an insurance business, rather than on the government or complaining party. CDI regulations specify the documents to be submitted by a health insurer to the Insurance Commissioner and the fees to be paid, when an insurer mergers into another insurer.

Public Meetings

At three out of the four public meetings held by DMHC with respect to the four mergers described above, DMHC indicated that it is not required to hold such meetings as part of its review of the material modification. DMHC also announced that it examines proposed mergers to ensure enrollees of all plans involved in the transaction are protected and have continued access to appropriate health care services, and examines organizational and corporate structure, administrative capacity changes, health care delivery system changes, product or subscriber changes, the effect of the transaction on financial viability of the plan, the financing for the transaction and its impact on consumers. In its public hearing announcement for the Centene-Health Net merger, CDI cites existing law, which provides broad authority for the department to determine if the transaction would lessen competition in insurance in this state or create a monopoly. CDI has recently announced a hearing of the Cigna-Anthem merger under which all health insurance market segments, including administrative service segments will be reviewed, and the impacts of the merger on competition, premiums, out-of-pocket costs, networks, network designs and quality.

DMHC held a public meeting on June 8, 2015 to give stakeholders an opportunity to comment on what it should consider in its review of the acquisition of Care1st Health Plan by Blue Shield of California. As reported by the DMHC director at the June 17, 2015 meeting of the department's Financial Standards Solvency Board, two events came to the public light in March relevant to this merger: the Franchise Tax Board revoked Blue Shield's tax exempt status as of August 2014; and Blue Shield's proposed purchase of Care1st for approximately \$1.2 billion. The spotlight on these two issues prompted significant public interest in DMHC's review of the transaction. A fundamental question in this transaction was whether it is a restructuring or a conversion. Article 11 of the Knox-Keene Act applies to restructuring or conversion of a non-profit only to the extent that the plan has held or currently holds assets subject to a charitable trust obligation. DMHC consulted with the AG and other concerned individuals. Ultimately, the director determined that Article 11 did not apply, and on October 8, 2015, DMHC announced its approval of the acquisition along with 25 plan undertakings agreed to by Blue Shield. Controversy over the undertakings followed the announcement when Blue Shield and the DMHC had different interpretations of one of the undertakings. A letter from the DMHC director to Blue Shield stated, "Blue Shield will provide a minimum of \$14 million per year to the Blue Shield Foundation, AND, the Blue Shield Board, in its discretion and based on a Board-approved process, will determine any additional contribution the plan will make to the foundation in any given year. Although reasonable people may disagree about the meaning of the language in Undertaking 21, the DMHC's expectation in approving the transaction was that Blue Shield would increase its overall charitable contributions to improve health care delivery in California..." Consumer advocates were critical of the final disposition of the approval raising concerns that Blue Shield's assets are subject to charitable trust obligations, there is a history of unreasonable premium rate increases, Medi-Cal revenue is not reinvested in Medi-Cal product lines, that multibillion dollar reserves are stockpiled, and not enough of a commitment has been made to the Blue Shield Foundation.

DMHC held a public meeting seeking stakeholder input on the Centene-Health Net merger on December 7, 2015. CDI held an extensive hearing on January 22, 2016. Advocates attending both hearings urged regulators not to allow the merger to proceed unless the companies can show that no harm to California consumers will come and that lower prices and better care will be realized. Specifically, advocates have called for improved quality ratings, a commitment to Medi-Cal and Covered California, support for safety-net providers, improved access in rural and underserved communities, increased transparency and improvements in the system as a whole. Advocates also called on regulators to restrict rate increases that are unjustified. Provider and patient groups also raised questions about premium impacts, restricted networks and impacts on timely access to care. Legal scholars and economists were also invited to weigh in at the CDI hearing and referenced recent studies that found that higher health insurance concentration was associated with lower hospital prices but, even if insurers are able to negotiate lower provider reimbursement rates, there is substantial evidence that these cost savings might not be passed on to employers and consumers in the form of lower premiums. Neither regulator has made a decision with respect to this merger.

DMHC held a public meeting on January 4, 2016 of the Acquisition of Humana Inc by Aetna Inc and CDI is considering holding a hearing. At the DMHC meeting, advocates urged DMHC to deny the applications for material modification unless the companies can show this merger not

only does no harm to consumers, but that consumers will actually benefit in the form of lower premiums, lower out-of-pocket costs, higher quality care, and reduced health disparities over a sustained period. Advocates stated that Aetna has had a troubling track record in California's commercial market, one that reflects a lack of respect for California law as well as basic consumer protections.

On March 4, 2016 DMHC held a public meeting on the Anthem-Cigna merger at which DMHC director Rouillard indicated that the department would review the material modification for implications on quality, timely access, grievances, independent medical reviews, provider directories, claims payments and mental health parity. Similar to the other merger public meetings, advocates, providers and patient groups raised similar concerns about quality, access, lower payments and premium rate increases. CDI will hold a hearing on this merger on March 29, 2016.

Nonregulated Transactions

The CHCF report identifies more recent hospital-physician transactions that do not undergo review by regulatory agencies. In July 2014, three San Diego physician groups merged to create a physician network to partner with Scripps Health hospital network. The collaboration was touted as providing a countywide network of high-quality physicians across a wide range of specialties as well as a broad primary care network. In April of 2014 a large Santa Rosa-based medical group agreed to merge a majority of its operations into St. Joseph Health's Annabel Medical Group, a fast growing system with several hospitals.

UFCW & Employers Benefit Trust v. Sutter Health

In this case a self-funded payor sued a group of providers, on behalf of a putative class of all California self-funded payers, alleging that the providers' various written and oral contracts with network vendors, such as the health plan, contained anticompetitive terms that insulated them from competition and drove up the cost of health care in violation of the Cartwright Act and the unfair competition law. The providers moved to compel arbitration of the self-funded payor's complaint, relying on an arbitration clause in the provider contract signed by the providers and the plan. The trial court denied the provider's motion, concluding that the self-funded payor was not bound to arbitrate its claims pursuant to an agreement it had not signed or seen. The case is still pending.

Massachusetts

Massachusetts has led the way to expanded coverage even before the passage of the ACA. Like the rest of the nation, Massachusetts has been grappling with unsustainable health care costs. In 2010, Massachusetts enacted the Small Business Health Care Relief Act, to increase transparency, promote tiered or limited network products and reform unfair contracting practices. Specifically, as it relates to unfair, anticompetitive contracting, the law prohibits carriers from

entering into agreements or contracts with health care providers that:

- Limit the ability of carrier to have a limited or tiered network;
- Require all members of the group to be on the same tier;
- Require all groups or facilities to be included on an all or nothing basis;
- Require providers to participate without the right to opt out at least 60 days before a new plan is submitted for approval;
- Require or permit carriers or providers to alter or terminate a contract to affect parity with other carriers or providers or based on a tiered network;
- Limit the ability of either the carrier or the health care provider from disclosing the allowed amount and fees of services to an insured or insured's treating provider; or
- Limit the ability of either the carrier or the provider from disclosing out-of-pocket costs.

The Massachusetts Health Policy Commission (HPC) was established in 2012, and is an independent state agency governed by an 11-member board representing a diversity of health care expertise. The HPC develops health policy to reduce overall cost growth while improving quality of care, and monitoring the health care and payment systems in Massachusetts. Responsibilities of the HPC include establishing annual statewide health care cost growth benchmarks, assessing the impact of health care market changes on cost, quality, and access, investing in community hospitals, and overseeing the development and implementation of performance improvement plans.

Included in the Massachusetts law is a certification requirement for patient centered medical homes and ACOs, a requirement for provider organizations to file notices of material changes with the HPC, and permission for the HPC to engage in comprehensive reviews of particular health care transactions anticipated to have significant impact on health care costs or market functioning. The resulting Cost and Market Impact Reviews (CMIRs) provide a public report detailing findings of the HPC, which can include referral of the CMIR to the AG or other state agencies.

Hospital acquisition of physicians and the transition from independent or affiliated practices to employment models and alternative payment models focused on promoting accountable care are significant trends in Massachusetts and nationally and are the type of transactions that are reviewed by the HPC. The registration of provider organizations (RPO) program collects information regarding the operations and structure of provider organizations such as ownership, contracting and clinical relationships, facilities and sites, and rosters of physicians. All provider organizations receiving significant commercial revenue or that enter into risk-bearing contractual relationships are required to register with the HPC. Information collected through this process contributes to health system monitoring and improvement.

Other State Approaches

There are many publications and forums examining the potential problems that can arise when there is a lack of competition in the health care market. Many experts have suggested private and public policy approaches that could promote a more competitive market. The discussion that

follows are some, but not all, approaches that have been included in at least two publications written by legal scholars from the University of California San Francisco, University of California Hastings and Georgia State University College of Law.

All-Payer Claims Databases - Private health care prices are difficult to know and different plans pay the same provider different prices for the same service, sometimes in the same geographic areas. Furthermore, nondisclosure agreements, trade secrets claims, and highly complex billing mechanisms shroud health care prices in a veil of secrecy. States can address these barriers by requiring disclosure of the information to a state entity. About a third of all states currently require disclosure of health care claims to an All-Payer Claims Database (APCD).

Overseeing health care integration - States can take a more active role overseeing health care integration, particularly commercial ACOs, by creating Certificate of Authority programs. Key considerations include: determining which state entity will oversee the certification; whether certification will be mandatory or voluntary; whether to require antitrust and solvency reviews; what price and quality disclosures to require; and whether to incentivize integration by granting antitrust immunity and exemptions to other state laws. Certification programs also allow states to review the features of any particular ACO both prior to certification and on an ongoing basis. Gathering historical and ongoing price and quality data will enable states to monitor market dynamics, inform future decisions regarding integration, and support antitrust enforcement actions. To date, three states have established Certificate of Authority programs for commercial ACOs – Texas, Massachusetts, and New York.

Increase Scrutiny and Regulation of Anticompetitive Behavior – By directly addressing restrictive practices that create anticompetitive effects, it may be possible to break up the market power of dominant parties. As a result, other players in the healthcare market would have more power to demand and respond to competitive and transparent pricing, allowing for increase in both market based and regulatory solutions.

Rate Oversight - To date, six states, have established a rate oversight commission: Delaware, Maryland, Massachusetts, New York, Pennsylvania, and West Virginia. Perhaps the most prominent example of such a body is Massachusetts' HPC. In terms of rate oversight, HPC has some regulatory authority, with the ability to require providers that exceed cost growth benchmarks to implement performance improvement plans and fine them if the provider fails to comply. Along with HPC, rate oversight commissions in Delaware, New York, and Pennsylvania have authority to analyze price and cost data and make recommendations. The commissions in Maryland and West Virginia have additional authority to approve and set inpatient and outpatient rates and limit hospitals' total revenues. In 2015, Colorado established a health care cost containment commission with a three-year mandate to study the drivers of health care cost growth, analyze the state's APCD and insurance rate review data, and make recommendations to the Legislature.

Conclusion

There is not one single state agency or body in California focused and resourced to monitor the health care market for anticompetitive practices with authority to block actions that raise prices of health care without commensurate quality or value. The DOJ has an important role with respect to antitrust enforcement and approval of transactions affecting charitable assets but

antitrust litigation is time and labor intensive and not always successful. Both DMHC and CDI have important responsibilities in overseeing the entities they regulate, but they have differing authority when it comes to monitoring for anticompetitive behavior. CDI appears to have broad authority whereas DMHC has more limited authority. Furthermore, many health care consolidations are not regulated at all. There can be some positive impacts of consolidation with regard to care coordination, improved quality, group purchasing and shared information technology investments. However, the ACA requirement that almost all Americans have health coverage at a time of unsustainable health care cost growth that makes health care unaffordable for many and constrains government budgets, makes it clear that more needs to be done to address rising health care costs.