



A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts

By Katherine L. Gudiksen, Erin C. Fuse Brown, and Johanna Butler*

Rampant consolidation in nearly every state has created dominant health care systems that can use anticompetitive contracting practices to charge supracompetitive prices, especially to commercial insurance plans. With COVID-19 expected to accelerate the consolidation of health care providers, state policymakers are searching for tools to curtail the abuse of market power by dominant health providers. To create a more level playing field for negotiations, the National Academy for State Health Policy has developed a model act, [*Prohibiting Anticompetitive Contract Terms in Health Care Contracts*](#), that bans anticompetitive contract terms using states' consumer protection and antitrust laws. This report describes how the model act can give states essential tools to help them rein in rising health care costs.

Overview

Rising health care costs from provider consolidation represent a critical financial challenge for states. High health care costs present states with policy tradeoffs – leaving costs unchecked means fewer state resources to invest in other priorities, such as social determinants of health, health equity, and other, non-health areas such as education and infrastructure. Private-sector employers and individuals who purchase insurance reel under increased premiums driven in large part by rising hospital costs. Without effective tools to slow the growth of health care costs, health spending will continue to threaten public and private resources in every other area.

A primary driver of rising health care costs is the wave of health care consolidation that gives consolidated providers market leverage to raise prices unhampered by competitive forces.¹ Nearly all major metropolitan hospital markets are highly concentrated.² Nationwide, as of 2018, more than half of all physicians and 72 percent of hospitals were affiliated with a health system.³ Evidence suggests that provider consolidation leads to higher hospital and physician prices and higher total expenditures – all while having little to no impact on improving quality of care, reducing utilization, or improving efficiency.⁴

Rampant consolidation has created dominant health systems that can use anticompetitive contracting practices to charge supracompetitive prices, especially to commercial insurance plans.⁵ As the COVID-19 pandemic will likely accelerate consolidation of health care providers with strained resources,⁶ policymakers are searching for ways to limit the impact of increased provider market power on health care costs. In many states, it is not enough to try to prevent consolidation from occurring through pre-merger review because most state and metropolitan markets are *already* highly concentrated. In these already consolidated markets, states need tools to curtail the abuse of market power by dominant health providers.

Although state attorneys general may be able to prosecute anticompetitive behavior — such as the use of anticompetitive contracting provisions by dominant systems — under current antitrust authority, legislation prohibiting these contract clauses is necessary to improve state enforcement authority and disrupt the distorted bargaining dynamic between health insurers and powerful providers. State officials

have routinely heard that insurers lack proper leverage to negotiate contract terms to reduce hospital and physician costs. To address the harms from anticompetitive contract provisions and create a more level playing field for negotiations, the National Academy for State Health Policy (NASHP) has developed a model act, [*Prohibiting Anticompetitive Contract Terms in Health Care Contracts*](#). The model act prohibits four common anticompetitive contract terms, making the use of these provisions presumptively unlawful under a state’s consumer protection and antitrust laws.

Anticompetitive Contracting Practices by Consolidated Entities

One of the primary ways that dominant providers raise prices is through **anticompetitive health plan contracting**,⁷ in which powerful provider groups and health systems exploit their market power to demand terms in their contracts with health insurance plans. When health care markets become consolidated, a dominant health system may control multiple hospitals, multi-specialty physician practices, clinics, and ancillary service providers. Due to network adequacy laws, some services or providers are considered “must-haves,” such as a hospital with a neonatal intensive care unit or trauma facility, for a health plan to offer a commercially viable provider network. Health plans must ensure their provider networks are robust enough for their members to have access to essential services.

Insurers typically have two options for containing costs in competitive contracting:

- Exclude high-cost, low-value providers from the network, or
- Give consumers an incentive to choose more cost-effective alternatives.⁸

Consolidated health systems leverage their market power in negotiations with insurers because the insurer cannot afford to exclude must-have providers from its network. Dominant health systems can use all-or-nothing negotiations to raise prices for all of their affiliated providers by threatening to prevent any of their providers from participating in the insurer’s network unless the insurer accepts the prices and terms set by the health system. These types of distorted negotiations between providers and insurers directly contribute to higher costs for states, employers, and patients. The four contracting practices that have raised the most concern among antitrust enforcers and lawmakers, and those that are targeted in the NASHP model act, are: (1) all-or-nothing contracting; (2) anti-tiering or anti-steering clauses; (3) most-favored-nation clauses; and (4) gag clauses.

All-or-nothing contracting: Health systems may use all-or-nothing provisions to leverage the status of their must-have providers or facilities in highly concentrated markets to demand higher payment rates for the entire system, including those providers in more competitive locations and specialties.⁹ An all-or-nothing provision requires the health plan to contract with all providers in that system or none of them. The insurer then faces a difficult choice – include all of the health systems’ facilities and providers in the network (even those of lower value or where there are other competitive choices) or lose all of them, which means the plan will not have a commercially viable provider network anywhere the health system has a must-have provider. By bargaining on behalf of all its affiliates, a powerful health system can thus raise the prices for its less desirable providers by tying them to must-have providers.

Anti-tiering or anti-steering clauses: Tiered networks and steering incentives are cost-saving strategies used by insurers to encourage patients to seek higher value care. When using tiered networks, insurers place providers into tiers based on price and quality and then offer patients financial incentives, typically through lower cost-sharing, to choose providers from a higher-value tier. When health systems use *anti-tiering*, they require a health plan to place that system’s facilities or providers in the most preferred tier, even if the health system’s providers do not meet the insurers’ cost or quality standards for the highest-value tier. In the case of anti-steering provisions, the health system may forbid the insurer from using cost-sharing incentives to steer patients to other providers, even if they offer better value. Dominant

health systems use anti-tiering or anti-steering provisions to stop health plans from implementing these cost-control measures and thereby avoid competition.

Gag clauses: Gag clauses may prevent either party in a contract from disclosing terms of that agreement, including prices, to a third party. While many states have laws requiring insurers to disclose out-of-pocket costs to enrollees, only a few states have laws allowing patients, plan sponsors (such as an employer), or even state regulators to obtain negotiated price or quality information.¹⁰ As a result, patients and employers may be unable to access necessary information to make informed choices between providers, both for individual health care services and network inclusion. The lack of transparency from gag clauses and the mistaken notion that prices are trade secrets:¹¹

- Undermine price transparency tools for consumers;
- Decrease plan sponsors' ability to push back on rising prices; and
- Make it more difficult for policymakers to understand how health care markets are operating in their state.

Gag clauses may be especially insidious when used in conjunction with other anticompetitive contract terms. For example, they may be used to hide the magnitude of variation in provider rates and therefore obscure the effects of an anti-steering clause.

Most-favored-nation (MFN) clauses: Unlike the other contract clauses included in the NASHP model, most-favored-nation clauses are typically used by a dominant insurer, sometimes in concert with a dominant health system. MFN clauses, sometimes called “pricing parity” or “price protection” clauses, are contractual agreements in which a provider or health system agrees not to offer lower prices to any other insurer. Dominant insurers thus ensure that they are getting the best prices. At first glance, these terms may appear to be pro-competitive because the health system is agreeing to lower their contracted prices with the insurer if the health system accepts a lower price from one of its competitors. Effectively, however, MFNs ensure that no rival insurer can negotiate with the health system to offer a novel insurance product (e.g., a narrow network) at lower rates. In addition, MFNs may allow insurers and providers to collude to raise prices. Insurers can accept an anticompetitive price increase from a dominant provider without competitive disadvantage because the insurer can pass the increase through to consumers in the form of higher premiums, as long as they know all competitors must also pay the same or higher rates.¹²

State Antitrust Enforcement: A Resource-Intensive, Insufficient Solution

Recent lawsuits by state and federal antitrust enforcers and private plaintiffs have exposed how dominant health systems use contracting practices to increase prices and limit the ability of payers to control costs.¹³ High-profile cases by then-California Attorney General Xavier Becerra against Sutter Health¹⁴ and North Carolina Attorney General Josh Stein against Atrium Health¹⁵ targeted those dominant health systems' use of anticompetitive terms in their health plan contracts, including all-or-nothing bargaining, anti-tiering, and anti-steering clauses that prevented private health plans from using financial incentives to encourage patients to choose lower-cost providers, and gag clauses that barred health plans from sharing price and quality information with patients.

While state attorneys general can use existing antitrust enforcement authority to address the anticompetitive contracting, bringing a case is resource-intensive, lengthy, and can be difficult to prove. Even if a settlement imposes conduct remedies and monetary penalties against the dominant health system, settlements avoid trial and do not establish legal precedent for future enforcement actions.¹⁶ As Emilio Varanini, deputy attorney general in the antitrust section of the California Department of Justice, has argued, “while litigation can blaze the way for addressing such anticompetitive conduct, ultimately legislation may be a far more effective tool for carrying out competition as a policy goal.”¹⁷ Beyond

easing enforcement, in states that have passed legislation curtailing one or more of these contracting practices, one of the key benefits is that it alters the bargaining dynamic between powerful providers and health insurers by strengthening the ability of insurers' to resist providers' anticompetitive terms (and less-powerful providers' ability to resist dominant insurers' most-favored nation terms). NASHP's model act builds on lessons learned from these recent, high-profile legal cases and gives states a tool to prohibit anticompetitive contract clauses through legislation.

Prohibiting Anticompetitive Contracting through NASHP's Model Act

The NASHP model act also prohibits health care providers, health insurers, and plan administrators from demanding, soliciting, or agreeing to any health care contract that contains anticompetitive contract terms. The model specifically prohibits all-or-nothing, anti-steering, or anti-tiering, MFNs, and gag clauses, however it gives a state's insurance commissioner or attorney general the ability to add other clauses through regulation that may result in anticompetitive effects. This flexibility is important as dominant health care entities' contracting strategies may evolve to protect their market share and raise prices in response to these prohibitions. The model renders these prohibited contract clauses null and void and presumptively unlawful.

Although there is growing evidence that these health care contract provisions are used anticompetitively and pose a serious threat to competition, there could be pro-competitive uses of these clauses and, in some specific cases in health care markets, they may be used to lower costs.¹⁸ To allow for potential pro-competitive uses of these contract provisions, the model act does include a waiver process where the attorney general or insurance commissioner could approve the use of these contract terms if the benefits outweigh the harms. The regulating state agency is authorized to promulgate rules on which arrangements may be eligible for waivers, such as accountable care organizations, value-based payment arrangements, or those involving rural or other safety-net providers.

The NASHP model is designed to give enforcement authority to both the attorney general and the insurance commissioner in order to ensure broad enforcement and oversight of health system behavior and health care contracts. The attorney general and the insurance commissioner would have the authority to investigate, audit, and review any documents to ensure compliance with the law and to impose penalties for violations under state Unfair and Deceptive Acts or Practices (UDAP) laws. Importantly, the model also includes a private right of action to allow parties injured by these contract clauses to recover damages.

Conclusion

In highly consolidated markets, dominant health systems use their market power to demand anticompetitive terms in their contracts with health insurers, thus increasing prices and thwarting health insurers' cost-containment efforts. In the post-pandemic world, state policymakers face limited state resources and rising health care consolidation. The NASHP model act provides policymakers with a tool to prevent already consolidated entities from further exploiting their market power to raise prices and restrict competition. A legislative ban will ease antitrust enforcement and eliminate the resource-intensive, fact-specific determination of harm in litigation. Legislation prohibiting anticompetitive contract terms will level the playing field between health insurers and dominant health systems, giving insurers the bargaining leverage to resist price demands of dominant systems and to direct patients to higher-value options. The NASHP model is an important step in state efforts to mitigate the harms that result from the significant consolidation in provider and insurer markets over the past decades, while also preparing states for the expected rise in consolidation after the pandemic.

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Notes

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