HB 2362 A -A19 STAFF MEASURE SUMMARY

Joint Committee On Ways and Means

Prepared By: Tom MacDonald, Budget Analyst
Meeting Dates: 6/18, 6/21

WHAT THE MEASURE DOES:

Defines key terms, including "health care entity" and "material change transaction." Allows Oregon Health Authority (OHA) to approve, approve with conditions, or deny a material change transaction of entities that had $25 million or more in net patient revenue in preceding three fiscal years or before transaction, or will result in one entity having increase in net patient revenue of $10 million or more. Exempts from material change transaction long term care facilities and residential care facilities, entities that collaborate on clinical trials or graduate medical education programs, medical service contracts, and affiliations among entities that do not affect corporate leadership, governance, or control, or are required to advance value-based payments. Requires OHA to develop criteria approved by the Oregon Health Policy Board for the consideration of requests by health care entities to engage in a material change transaction and procedures for the review of material change transactions. Specifies a material change transaction involving health insurers is to be submitted first to Department of Consumer and Business Services (DCBS), which is required to then notify OHA to conduct the review. Specifies evaluation criteria, including impacts on costs, access, health equity, health outcomes, and competition. Specifies public notice and hearing requirements. Creates and specifies a review process for entities to submit a request for material change transaction from OHA. Authorizes review board to request information from an entity seeking material change transaction; prohibits requesting entity from providing requested information if deemed privileged or confidential; exempts information from disclosure if disclosure causes harm to public, violates existing public records law, or is not currently subject to disclosure (ORS 705.137). Permits OHA to conduct examinations and investigations to enforce provisions of the measure. Allows an entity party to a disapproved transaction to seek legal remedy under current law (ORS 183). Requires OHA to prescribe fees sufficient to carry out administration of review process. Authorizes OHA and DCBS to impose civil penalties for violations of material change transaction review requirements. Requires OHA to commission study of the impact of health care consolidation in the state every four years and specifies requirements of analysis. Requires first study to be commissioned by September 15, 2026. Takes effect on 91st day following adjournment sine die.

ISSUES DISCUSSED:

- Timing and urgency of the measure
- Health care access and affordability
- Impact on prices after market consolidation
- Innovation and care coordination among health care providers
- Oregon Health Authority's capacity to implement measure
- State government role beyond existing anti-trust and other laws

EFFECT OF AMENDMENT:

-A19 Revises the revenue test required for a material change transaction. Transactions that meet the threshold occur when at least one party had average revenue of $25 million or more in the preceding three fiscal years, and another party had an average revenue of at least $10 million in the preceding three fiscal years. Requires review board members to file and make public conflict of interests and restricts OHA's ability to share information deemed confidential. Includes that a new contract would qualify as a material change transaction only if it meets the revenue test. Requires OHA to issue a proposed order and allow the parties and the public a reasonable opportunity to make written exceptions. March 1, 2022 is established as the operative date for OHA's authority to

review and approve material change transactions.

BACKGROUND:

Research indicates market concentration in the United States among hospitals, physician organizations, and health insurers increased between 2010 to 2019 (Fulton, 2017; Furukawa, 2020). This trend is partially attributable to mergers among hospitals and health systems (horizontal integration), along with independent and small physician groups joining larger groups or being directly employed by hospitals or acquired by hospitals (vertical integration). In 2018, more than half of all physicians and 72 percent of hospitals were affiliated with one of 637 health systems, with nonprofits accounting for 440 hospital systems (Furukawa, 2020).

Hospital mergers may create efficiency gains from eliminating excess capacity, relieve acquired hospitals from financial difficulties, increase bargaining leverage with suppliers of drugs and devices, and improve care integration (MACPAC, 2020). Consistent with these incentives, hospitals have been consolidating into larger systems over several decades. Research suggests hospitals with larger market shares can negotiate higher reimbursement from commercial insurers, with price increases exceeding 20 percent when mergers occur in such markets. Of interest are the effects of hospital and provider consolidation on access, quality, costs, and market competition. Related are the implications of health insurer concentration in a geographic market and insurers' ability to negotiate rates (prices) with hospitals and providers, and the correlated effects on insurance premiums.

States have put forward a range of policies to address consolidation, including enforcing antitrust laws, restricting anticompetitive barriers, and regulating provider and health insurer rates. Massachusetts' Health Policy Commission analyzes proposed health care mergers for the state's attorney general and the public. Oregon's Insurance Commissioner reviews and approves insurers' rates for regulated commercial market health benefit plans.

House Bill 2362 directs the Oregon Health Authority to examine and monitor the competitiveness of the health care market, and approve or deny mergers, acquisitions, and affiliations among hospitals, insurers, and provider organizations.