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Strategies to Address Corporate Consolidation in Health Care:

Transaction Oversight and Transparency of Ownership and Control

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Testimony of Erin C. Fuse Brown submitted to the Joint Health Coverage, Insurance and Financial Services Committee of the Maine Legislature on LD 1972: An Act to Enhance Transparency and Value in Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions

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Joint Health Coverage, Insurance and Financial Services Committee of the Maine Legislature

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[1]The opinions and conclusions expressed in this testimony are the author's alone and do not necessarily reflect those of Brown University, the Brown University School of Public Health, or any of the research sponsors.

[2]The Center for Advancing Health Policy through Research (CAHPR) at the Brown University School of Public Health is dedicated to generating research that informs policies aimed at reducing costs, improving patient well-being, and driving meaningful transformations in U.S. health care delivery. Our work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact. While this testimony is not a research publication, it is informed by relevant research conducted by CAHPR and its affiliates.

Chairs Bailey and Mathieson and members of the committee, thank you for the opportunity to testify on state strategies to address corporate consolidation in health care. My name is Erin Fuse Brown, and I am a professor of health policy at the Brown University School of Public Health. I have worked with the National Academy for State Health Policy to develop model legislation for states to address health care consolidation and corporatization.[1] This model, like LD 1972, strengthens state oversight of material health care transactions and transparency in ownership and control.

States are urgently seeking tools to address rampant health care consolidation, which is the main driver of rising prices and spending. Increasingly, consolidation is led by for-profit corporate investors, including private equity firms, large insurance companies, and retail chains. These transactions often escape federal antitrust review, so states are stepping up to fill the gap, providing critical oversight of major ownership changes that affect local health care markets.[2]

Today, nearly one in four community hospitals is for-profit,[3] most are part of large chains,[4] and nearly 80% of physicians are employed by hospitals or other corporate entities.[5] UnitedHealth Group, through its Optum subsidiary, now controls about 1 in 10 U.S. physicians.[6] Private equity firms have acquired large numbers of physician practices, sometimes controlling 30–50% of a specialty in a single market.[7] In Maine, the Portland hospital market is considered highly concentrated, the 21st most highly concentrated market in the country.[8]

Despite this dramatic shift in care delivery, the web of corporate owners, shell companies, and investors remains almost entirely opaque.[9] Many firms use management services organizations, or MSOs, to gain control over practices without technically owning them.[10] As a result, patients, purchasers, and regulators often have no way to identify who owns their provider. We cannot regulate what we cannot see.

Consolidation by corporate investors often results in higher costs,[11-19] changes in staffing composition, reduced wages,[11,20,21] worse outcomes,[22,23] and reduced access [24-27]—especially in underserved communities. Yet federal and state oversight mechanisms are limited. Physician practice acquisitions typically fall below federal reporting thresholds [28] and escape antitrust scrutiny.[29] Reviews by State Attorneys General tend to focus on nonprofit hospital mergers and may not account for corporate consolidation or broader effects on quality, access, workers, or equity.[2] Litigation is costly, so only the largest deals are challenged.

LD 1972 would change this. It expands transaction oversight to include not only nonprofit hospital mergers, but also sales of their real estate assets, practice acquisitions via MSOs, and service closures. It vests review authority with the Department of Health & Human Services and the Office of Affordable Health Care, so that transactions are evaluated for their impact on the public interest, access, competition, quality, equity, and the workforce.

The bill also improves transparency by requiring health care entities to disclose ownership and control structures, including relationships with investors. This is critical to understanding and overseeing the health care landscape. Other states—including Oregon, Massachusetts, Indiana, and New Mexico—have

enacted similar policies, and Oregon has used its review process to stop harmful mergers and impose conditions to protect the public interest.

If enacted, LD 1972 would make Maine a national leader in health care transaction oversight and ownership transparency. Thank you for the opportunity to testify. I'm happy to answer any questions.

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