Third Circuit Hears Oral Arguments in High-Stakes Hackensack Meridian Appeal

All eyes are on Hackensack Meridian Health’s proposed acquisition of Englewood Healthcare Foundation as the 3rd Circuit Court of Appeals heard oral arguments in the FTC challenge last week. As healthcare entities continue to actively pursue mergers and affiliations during—and in part driven by— the coronavirus pandemic, the outcome of this New Jersey merger may have significant implications for both federal and state antitrust enforcement across the country. In this post, The Source brings you up to speed with the latest developments leading up to the high-stakes appeal and gives a sneak peek at some of the legal arguments made in front of the 3rd Circuit panel during oral arguments.

As a quick refresher, Hackensack Meridian and Englewood announced their plans to merge in October 2019. Hackensack Meridian Health is the largest healthcare system in New Jersey and Englewood Hospital is the third-largest provider of inpatient general acute care services (GAC) in Bergen County. In December 2020, the FTC filed an administrative complaint, along with a lawsuit in New Jersey district court seeking a preliminary injunction against the merger, alleging the proposed acquisition would reduce competition for GAC services in Bergen County and give Hackensack great bargaining leverage to demand higher prices from insurers, which will in turn lead to higher premiums and out-of-pocket costs and decrease the quality of care and access for patients. The district court agreed with the FTC and issued a preliminary injunction in August 2021. For detailed analysis of the FTC challenge and district court ruling, see previous coverage in Litigation and Enforcement Highlights on the Source Blog.

The preliminary injunction ruling was an encouraging win for FTC’s enforcement efforts, particularly after its recent loss in the Jefferson-Albert Einstein merger challenge in Philadelphia. In most cases, a preliminary injunction in the district court would seal the fate of the deal, leading the entities to abandon the transaction.
Despite the setback, however, the hospitals filed an appeal of the injunction with the 3rd Circuit Court of Appeals shortly after the district court opinion was released. In the appeal, Hackensack and Englewood contend that the district court erred in the geographic market definition, the likelihood of price increases, and the evaluation of the procompetitive benefits of the acquisition. Specifically, the hospitals argue that the geographic market based on county lines is an arbitrary political boundary and does not reflect commercial realities of the market. Additionally, the hospitals claim that the district court erroneously used patients’ willingness to pay as the standard, which has no bearing on insurers’ willingness to pay.

In the FTC’s reply brief to the appellant’s brief, the government reiterates that Hackensack and Englewood are direct competitors within five miles of each other and that “common ownership would eliminate that direct competition, reducing their incentive to improve quality and giving the combined hospitals the ability to demand higher prices from insurers in rate negotiations.” Additionally, the agency asserts that regardless of the market share analysis, the deal would create too much concentration and there is direct evidence the merger would have anticompetitive effects in Bergen County. In terms of the hospitals’ claims of procompetitive benefits, the FTC points out the benefits could be achieved without the merger and questioned whether any potential cost savings would be passed on to insurance companies and consumers.

In support of the FTC, multiple stakeholders, including The Source, filed amicus briefs to the 3rd Circuit. Amici ranged from state attorneys general to a long list of healthcare antitrust experts and economists.

Amicus Brief from the Coalition of State AGs

Led by California Attorney General Rob Bonta and Pennsylvania Attorney General Josh Shapiro, a coalition of 25 attorneys general urged the 3rd Circuit to uphold the preliminary injunction in their amicus brief. Bonta noted that “In California, we’ve seen firsthand the effects of a large non-profit healthcare system’s anticompetitive practices,” referring to the Sutter Health antitrust case that just concluded in August with the court approval of the final settlement, which targeted market power and resulting monopoly behavior of the Northern California hospital giant.
Because many state AGs only have merger review authority of nonprofit hospital transactions, federal authority can help fill in the gap and review transactions including for-profit deals. As a result, the decision in this case is significant in preserving overall competition in the provider market. In their brief, the coalition argues that the states have seen a wave of hospital consolidation that resulted in large healthcare systems with market power and ability to raise prices. Moreover, “mergers increasing the bargaining power of large healthcare systems result in higher prices without any substantial improvements in quality for consumers” and the hospitals’ purported benefits do not outweigh the likely anticompetitive effects of the proposed merger.

Amicus Brief from The Source and Petris Center

In the amicus brief jointly filed by The Source and the Petris Center at UC Berkeley, professors of law and economics, economists, and health policy researchers make five main arguments in support of the district court’s ruling. This brief asserts, first and foremost, that potential harms from hospital consolidation are well documented by an extensive and largely undisputed literature that demonstrate anticompetitive consolidation enables merging hospitals to gain market power which translates to immediate price effects. In terms of the antitrust analysis, the amici claim that the district court undertook the appropriate geographic market analysis with the hypothetical monopolist test in determining the relevant market definition. Furthermore, the brief argues that the court was correct in placing a high burden on the hospitals’ claims of procompetitive effects, as ample case precedents have required “extraordinary efficiencies” to justify mergers that would result in high post-merger concentration. As a result, the court properly evaluated potential anticompetitive effects on quality and innovation as the preponderance of economic evidence shows that hospital consolidation more likely decreases quality than increases it. Finally, in a rebuttal to the appellant hospitals, the amici emphasize that the approval given by the New Jersey AG and Department of Health should not be afforded significant weight because that review process focuses on charitable trust goals and does not purport to conduct an in-depth competitive analysis under antitrust merger law.

Oral Arguments Heard on December 7
During oral arguments, the 3rd Circuit panel indeed questioned why the New Jersey AG did not join the FTC antitrust challenge as did, for example, the Pennsylvania AG in FTC challenges in that state, and what the state’s approval of the proposed merger meant for the FTC case. Counsel for the FTC responded that the New Jersey AG also did not oppose the challenge and that the state authority required only a public interest analysis with respect to charitable assets and not in terms of antitrust and competition, which is the duty of the FTC under the Clayton Act.

In response to the hospitals’ argument that the patient-based geographic market definition consisting of only Bergen County patients improperly ignores patients from other neighboring areas, the FTC pointed out that the patient-based analysis is from the insurer’s perspective, and regardless of a patient-based or hospital-based market definition analysis, Bergen County passes the hypothetical monopolist test as the relevant geographic market, showing the merger is presumptively illegal. Additionally, the FTC asserts there is ample direct evidence that the merger would have anticompetitive effects in Bergen County. Specifically, as the 3rd Circuit panel acknowledged, there is insurer testimony that the merger would give the merged entities more leverage in negotiations against the insurance companies. Moreover, insurers see Hackensack as Englewood’s closest competitors, as do the hospitals themselves.

In terms of procompetitive benefits that the hospitals claim will benefit patients, such as improvement in quality of care and a $400 million investment in Englewood, the FTC said there was insufficient evidence that they will be passed to the insurers or consumers. The 3rd Circuit panel then asked what types of benefits would overcome the anticompetitive harms caused by a merger, the FTC responded plainly that there is nothing to point to because no court of appeals has found that any benefits or efficiencies have outweighed a presumptively merger.

As seen from the amicus briefs filed in this case by various stakeholders, the outcome of this appeal may have strong implications for both federal and state enforcement efforts affecting healthcare providers markets around the country. The FTC’s in-house administrative trial on the merits will begin 30 days after the 3rd Circuit rules on the appeal of the preliminary injunction. Stay tuned for the decision and more developments in the new year!
North Carolina is a state that is active in antitrust enforcement in the healthcare market. In addition to prohibiting most-favored nation clauses in provider contracts, the state is also the site of a major enforcement case that alleged anticompetitive contract practice in a lawsuit against Atrium Health (formerly Carolinas Healthcare System). Joining the Department of Justice, the North Carolina state attorney general sued the provider for using illegal anti-steering and anti-tiering clauses in its contracts with insurers, which prohibited commercial health insurers in the Charlotte area from offering patients financial benefits to use less-expensive healthcare services offered by Atrium’s competitors. The case settled when Defendants agreed to end their anticompetitive practices. Additionally, while noncompete agreements for physicians in North Carolina are not per se unenforceable, the Court of Appeals of North Carolina has recognized in several cases its potential for harm to the public health and found noncompetes unenforceable (see Aesthetic Facial & Ocular Plastic Surgery Ctr., P.A. v. Zaldivar and Calhoun v. WHA Med. Clinic, PLLC).

The North Carolina AG has also been active in enforcing merger oversight of healthcare providers in the state. State law requires prior notice to the state AG for healthcare transactions involving certain charitable or religious corporations and the written consent or court approval of the merger after review based on a criteria of public interest. In response to a wave of healthcare consolidation in North Carolina,
the state repealed its certificate of public advantage law in 2015, which some argued have contributed to increased consolidation and market power in the provider market. Additionally, Attorney General Josh Stein released a statement in 2021 criticizing and expressing concerns over the potential impact of consolidation and warned of increased scrutiny of proposed mergers by the AG’s office. For example, in HCA’s acquisition of Mission Health System, the AG imposed conditions that would permit the office to take legal action under North Carolina law should HCA fail to comply with its commitments under the consent order.

North Carolina is also a national leader in value-based payment reforms. The state implemented various alternative payment initiatives in both the public and private sectors, including Medicaid managed care alternative payment models, Medicare ACOs, BCBS North Carolina ACOs, and state employee health plan reference pricing strategy. North Carolina is on track to see alternative payment models account for 70% of healthcare payments in the state.

In health care transparency, the state legislature enacted law that requires the NC Department of Health and Human Services to publish charge information relating to the most frequently reported admissions. However, the state still lacks a legislated website such as an all payer claims database to enable consumers to make side-by-side price comparisons between providers.

What’s Ahead for 2022: Promising Healthcare Bills Pending in the California Legislature

The California legislature has passed nearly 800 bills in the 2021 session. As part of the two-year term, the legislature still has the opportunity to enact more meaningful
healthcare legislation in the second year of the 2021-2022 legislative term. In the last issue of the California Legislative Beat, we recapped the 2021 legislative session and detailed the enacted and vetoed bills that enhance healthcare delivery, ensure healthcare access and coverage, promote price transparency, and reinforce competition and enforcement. In this post, we summarize some of the key pending legislation in healthcare that have been passed in one house and will carry over to the new year, with potential to become law.

**HEALTHCARE DELIVERY EXPANSION WITH TELEHEALTH**

The legislature has recognized the need to support new healthcare delivery systems in several laws enacted this year. For example, Governor Newsom signed the Protection of Patient Choice in Telehealth Provider Act (AB 457), as well as AB 14 and SB 4, which help close the digital divide to make telehealth more accessible for all Californians. In the 2022 session, the legislature has the opportunity to make further strides in supporting telehealth access and use with two additional telehealth measures, AB 32 and AB 1102.

**AB 32: Extending COVID-19 Telehealth Flexibilities**

The COVID-19 pandemic has clearly shown, and many other bills this session have sought to address, the need to make healthcare accessible for vulnerable and disenfranchised communities. AB 32 attempts to address this need by extending the telehealth flexibilities that were issued during the pandemic. Additionally, AB 32 expands and clarifies the definition of telehealth to include not only video appointments but telephonic and audio visits as well.

Though telehealth appointments would likely decrease the costs of those otherwise-in-person visits, according to the Assembly Appropriations Committee, this measure has the potential to increase overall state and non-state costs due to an increase in supplemental health visits, which would not have taken place without telehealth.[1] For example, the bill analysis estimates $39.6 million in commercial health care premium increases paid by non-CalPERS employers.[2] Despite the cost estimates, the legislature acknowledges that significant uncertainty related to actual cost
remains.[3]

**AB 1102: Telephone Medical Advice Services**

As telehealth services continue to expand, the legislature may pass legislation that would ensure the *quality* of telehealth services. AB 1102, which passed the Assembly, would require telephone medical advice services, both in-state and out-of-state, to operate consistent with the laws governing the respective healthcare professionals’ licenses. The measure requires that all medical professionals providing telehealth services to patients in California comply with their state’s specific licensing requirements, and telephone medical advice services are also responsible in ensuring that their medical professionals are operating consistent with the laws governing their respective licenses. Furthermore, AB 1102 clarifies that the various licensing boards have the authority to enforce these standards, and the telephone medical advice services must comply with any directions or requests by the licensing boards.

In summary, AB 1102 not only improves telehealth access, but ensures the services provided are competent and quality health care with accountability measures at multiple levels, benefiting patients and further encouraging telehealth use in the state.[4]

The legislature has made great strides this year by enacting measures furthering accessible telehealth services, but it may be able to create even more robust telehealth protections by passing AB 1102 and AB 32 in the Senate come 2022.

**SYSTEM REFORM FURTHERING COST CONTAINMENT**

In addition to the telehealth focused legislation, the legislature is considering a few measures at a systemwide level that would impact both cost and quality.

**AB 1130: Establishing the Office of Health Care Affordability**

Earlier this year, the Assembly passed AB 1130, which would establish the Office of Health Care Affordability (OHCA). Assembly Member Wood, author of AB 1130 and a
few other healthcare reform bills this session, indicated, “Creating the Office of Health Care Affordability, establishing a statewide health information exchange and creating a process for the state to assess the impact of health care consolidation and other marketplace practices are essential and fundamental to creating a sustainable and equitable universal health care model.”[5] The OHCA would set a state strategy for controlling health care costs and ensuring affordability by analyzing market trends and developing data-based polices for lowering consumer costs.

Notably, a healthcare cost commission is not a novel invention, as a handful of states—Massachusetts, Maryland, Oregon, and Rhode Island—have already adopted similar initiatives.[6] AB 1130’s OHCA is arguably better since the broad legislation takes into account cost, value-based care, quality, and equity.[7] Assembly Member Wood emphasized the unprecedented nature of the measure: “This legislation would make this the most comprehensive health care cost containment initiative in the nation. The breadth of this office’s ability to analyze costs is unprecedented. And that’s exactly why getting it to this point has been the most significant challenge of my legislative career.”[8]

Though AB 1130 passed the Assembly, it passed according to party lines. The Republican opposition fears AB 1130 will make costs worse and that setting price controls for health care services will interfere with the necessary, naturally occurring rate fluctuations in the insurance market.[9] Despite the opposition, AB 1130 reflects legislation that has been urged by an overwhelming number of Californians. Enacting AB 1130 is a significant step in addressing and remedying the issue of healthcare costs concerning many Californians.

On the other hand, provisions of AB 1132 that target healthcare consolidation and would be supplementary to AB 1132, was gutted through subsequent amendments. Research has shown that higher costs for healthcare services arise from market consolidation.[10] AB 1132, as originally introduced in 2021, would have established a more robust process to oversee healthcare consolidation and anticompetitive practices to curb rising healthcare costs. However, in April, the Assembly amended the bill and removed all healthcare consolidation oversight and antitrust provisions furthering competition from the proposed legislation. The current amended AB 1132 is focused solely on care coordination for patients that have dual Medicare and
Medi-Cal coverage.

**PRESCRIPTION DRUG COST CONTAINMENT & AFFORDABILITY STRATEGIES**

Prescription drugs prices remain a major affordability issue for many consumers. This term, the legislature is considering two bills that promote affordability and cost containment of prescription drug prices at various levels. Specifically, AB 97 targets the problem of insulin affordability. In comparison, SB 521 takes aim at system-level reform to contain pharmaceutical costs.

**AB 97: Ensuring Insulin Affordability**

Reducing the cost of life-sustaining insulin is crucial for a large and growing population of Californians living with diabetes. Currently more than four million Californian adults have diabetes, and this population is likely to grow with approximately 200,000 new type 1 diabetes diagnoses each year.[11] Despite the growing population impacted with diabetes, the price for insulin has exponentially grown to triple the cost. This dire change has resulted in financial hardships for this population, and the legislature has recognized that one-fourth of the population utilizing insulin reported underuse due to the high-cost burden.[12] Due to this stark reality, Assembly Member Nazarian proposed, and the Assembly passed AB 97, which would ensure that Californians have access to medically necessary insulin by reducing the costs to obtain insulin. The measure, as currently amended, would prohibit a health care plan or health disability insurance policy[13] from imposing a deductible on insulin. In other words, AB 97 does not impose new coverage requirements; rather, the measure modifies the cost-sharing conditions of an already covered prescription drug. Specifically, enrollees would not have to meet their deductible before paying their normal copayment or coinsurance for their insulin prescription.[14]

The bill analyses note a couple of oppositional concerns which question the impact on long term cost.[15] For example, the California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America’s
Health Insurance Plans all oppose AB 97 arguing it would increase cost, reduce choice and competition, and incentivize employers to avoid state regulation by seeking alternative coverage options. Despite these concerns, AB 97 was passed 70-0 in the Assembly, and the measure is currently held under submission in the Senate.

AB 97 is also consistent with past proposed legislation that recognized the legislative need to address the growing cost of insulin. AB 2203, proposed but not passed during the last session due to shortened legislative calendar due to COVID-19, would have mandated a cap of insulin copayment amounts and authorized the attorney general to investigate insulin costs and whether additional consumer protections are warranted.[16] Though AB 97 does not go as far as AB 2203, the Senate has the opportunity to lower healthcare costs and increase access to life-sustaining insulin for a huge population of Californians by passing AB 97 in the 2022 session.

**SB 521: Medi-Cal Value-Based Arrangements with Drug Manufacturers**

In addition to targeted measures, the legislature is also considering system-level reforms to contain pharmaceutical costs. SB 521, which passed the Senate, focuses on the health needs of Medi-Cal beneficiaries by allowing the Department of Health Care Services (DHCS) to enter value-based arrangement contracts with drug manufacturers. In essence, the arrangements allow for more value-based treatment plans by providing a manufacturer rebate if the treatment underperforms based on the agreed-upon outcome metric.[17]

This contracting method is not novel. The Assembly’s bill analyses noted that other states have implemented similar efforts.[18] Furthermore, the Assembly’s bill analyses noted that “[p]ayment models emerging since passage of the federal Affordable Care Act have emphasized VBP [value-based purchasing] for achieving outcome-based quality measures [and] in December 2020, the federal Centers for Medicare & Medicaid Services (CMS) adopted a final rule to support state flexibility in prescription drug VBP.”[19] Thus, although the long-term effects on costs still need to be determined, SB 521 aligns with federal support of state VBP efforts and many other state Medicaid programs that have already adopted similar
AB 1278: Transparency of Provider and Drug Company Conflicts of Interest

AB 1278, which passed the Assembly, is a bill that would promote transparency with regards to provider conflict of interest. The measure would require physicians to post and provide patients with Open Payments database notices. The Open Payments Database is a federally mandated program maintained by CMS that requires reporting entities—manufacturers and group purchasing organizations (entities that purchase or negotiate the purchase of drugs, devices, or supplies for a group of individuals or entities)—to make specific reports regarding payments made to providers (e.g., physicians and teaching hospitals).[21] Though AB 1278 does not change the reporting requirements of the Open Payments Database, the measure increases the opportunity that the public will learn or and utilize the database since it requires physicians and teaching hospitals to communicate multiple notices of the database. Ultimately, AB 1278 will amplify the impact of the federal database in California. [22]

According to the Center for Public Interest Law (CPIL), sponsor of AB 1278, “[D]isclosure of financial conflicts of interest by doctors is a moral obligation not enforced by law. AB 1278 would remedy this problem by mandating physician disclosure of any financial conflicts of interest to their patients, and empowering patients to make better and more informed choices about their treatment.”[23] AB 1278 not only increases healthcare transparency, but also empowers patients to take control of their healthcare decisions.

In 2021, the legislature has enacted, and Governor has approved, key legislation impacting the healthcare market and healthcare quality, but the legislature can pass even additional meaningful legislation in 2022 addressing pharmaceutical costs, continued telehealth access and quality, transparency at various healthcare levels, and system-wide reforms advancing cost containment and healthcare quality. Stay tuned to the California Legislative Beat in the new year for latest developments in the state legislature.
The measure would apply to all such plans and policies that have been issued, amended, delivered, or renewed on or after January 1, 2022.

[23] Id.

The public can search the database at https://openpaymentsdata.cms.gov.

New Video Explainer Focuses on
Primary Driver of High Health Care Prices: Health Care Consolidation

Health care consolidation has been on the rise for decades, leading to higher health care prices, not higher quality. Today, two-thirds of hospitals in the U.S. are part of a larger health system; almost 1 in 3 physicians now works in a hospital-owned practice. Many regions are dominated by a single system, leaving patients and families without access to affordable, high-quality care.

Arnold Ventures recently released the second video in a series about high health care prices and the impact they have on health care costs and affordability for consumers, employers, and taxpayers. The first explainer video was released earlier this summer, along with a poll that showed that a majority of voters believe it is very important for policymakers to take action to lower health care prices, including limiting the prices hospitals can charge.

See also the Source Market Consolidation key issue page for more information.
Spotlight on State: Nebraska

This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See Nebraska page.

Nebraska has advanced several healthcare price transparency initiatives in the state. To protect patients from surprise billing, the legislature enacted the Out-of-Network Emergency Medical Care Act that prohibits providers from billing patients for medical care received from out-of-network providers or facilities in emergency situations. In addition, Nebraska patients have the ability to petition hospitals for a written estimate of average charges for health care services, which promotes transparency and facilitates price shopping. The Nebraska Right to Shop Act, enacted as part of the Direct Primary Care Pilot Program Act, requires participating insurers to make price information public, including out-of-pocket costs. The law also requires insurance carriers to provide financial incentives such as cash from shared savings to patients who choose lower cost, higher quality providers, empowering patients to choose the best value care.

Though the state has not created an all-payer claims database, the 2014 Health Care Transparency Act jumpstarted efforts with an advisory committee that would investigate the creation of an APCD, including how to facilitate the reporting of health care and health quality data, provide for the facilitation of value-based, cost-effective purchasing of health care services by public and private purchasers and consumers, and provisions regarding claims and eligibility standards.

For greater prescription drug pricing transparency, the legislature also enacted the Pharmacy Benefit Fairness and Transparency Act, putting transparency provisions in place for pharmacy benefit managers when contracting with pharmacies and prohibiting clawbacks and gag clauses.
In addition to promoting price transparency, Nebraska monitors consolidation and competition in the healthcare market by requiring nonprofit entities to provide notice to the state attorney general and health agency prior to a merger or acquisition. Applications for such transactions are subject to review and approval by the Nevada Department of Health and Human Services and in some cases, the AG. In the interest of controlling healthcare costs and ensuring continued access to care, the review is based on whether the merger or acquisition is in the public interest.

In telemedicine, Nebraska passed a law in 2017 requiring private payers to cover telemedicine services. While the laws contains a telehealth coverage provision, it does not require payment parity for telehealth services.

The Source Roundup: December 2021 Edition

This month’s Roundup focuses on articles highlighting market consolidation and healthcare affordability, which can both have important implications for patient outcomes. First, we examine articles and reports that study 1) the need for a robust administrative review process for all healthcare transactions, 2) post-merger outcomes for hospital system and patients, and 3) consolidation in the dialysis industry. Next, we highlight articles and reports focusing on growing healthcare costs and affordability that specifically examine 4) the impact of the American Rescue Plan Act of 2021, 5) changes in employer healthcare benefits and costs due to the COVID-19 pandemic, and 6) healthcare affordability rankings of all the states based on policy and outcome metrics.

Market Consolidation/Competition
Though the federal government has increased its attention on policies to promote competition in the healthcare industry, consolidation still occurs through transactions that avoid antitrust scrutiny. In “A Tool for States to Address Health Care Consolidation: Improved Oversight of Health Care Provider Mergers,” published by the National Academy of State Health Policy (NASHP), the Source’s Katie Gudiksen joined Erin Fuse Brown to explain that states have a crucial role in filling the gap in overseeing stealth health care consolidation at the state level. To assist states, the authors put forth a Model Act for State Oversight of Proposed Health Care Mergers. The model legislation emphasizes a comprehensive, administrative review process of all transactions, including preliminary review by the attorney general, a two-component comprehensive review process, and post-approval monitoring. This model act is a robust tool for all state policymakers to adopt to prevent harmful mergers and protect the public.

Two articles published this month examined the rising consolidation of healthcare facilities and their consequences. First, in “The Anatomy of a Hospital System Merger: The Patient Did Not Respond Well to Treatment,” published by the National Bureau of Economic Research, Martin Gaynor et al. conducted a case study examining the consequences of a mega-merger between two large for-profit hospital chains. The authors found that despite achievement of some of the acquirer’s post-merger aims, such as harmonization of medical records between the merging entities, the merger failed to improve profitability and patient clinical outcomes. Additionally, the researchers’ findings suggest the significance of hospital organization and internal management processes in evaluating the mergers’ claimed benefits. These findings provide a new perspective—the use of an organizational view—for antitrust policymakers and regulators to adopt when evaluating the claimed benefits of a proposed merger and its likelihood of success post-merger.

Second, in “Trends in Dialysis Industry Consolidation After Medicare Payment Reform,” published in JAMA Health Forum, Caroline E. Sloan et al. studied the impact of Medicare’s 2011 End-Stage Renal Disease Prospective Payment System (PPS) on dialysis facility acquisitions and closures. PPS converted treatment payment for end-stage kidney disease (ESKD) to a single bundled payment for dialysis treatment, which consequently left facilities unable to rely on fee-for-service payments. Though Sloan et al. found an initial spike in dialysis facility acquisitions
immediately after PPS implementation, likely due to the uncertainties attributable to the new payment reform, the authors found an overall trend of decline in acquisitions and closures. However, they found that smaller at-risk facilities were more likely to suffer closure than newer, larger, and potentially more profitable dialysis facilities, which were more likely to be acquired. Despite the increase in population of ESKD patients, the dialysis industry has become highly concentrated with only two for-profit large dialysis organizations dominating the market. With an increasing demand for dialysis and growth of the industry in general, policy makers must be vigilant in monitoring the dialysis industry because consolidation can have significant effects on the access to care and patient outcomes of ESKD patients.

**Healthcare Costs and Affordability**

The growing cost of health care coupled with the slower growth in income has caused significant difficulty for families in obtaining healthcare coverage. In a *Health Affairs* research article, “ACA Marketplaces Became Less Affordable Over Time For Many Middle-Class Families, Especially The Near-Elderly,” authors Paul D. Jacobs and Steven C. Hill examined the consequences of the American Rescue Plan Act of 2021, which sought to increase healthcare coverage and affordability by providing tax credits for consumers to purchase coverage through ACA marketplaces. Specifically, the American Rescue Plan Act eliminated, through 2022, the eligibility restriction for families with incomes greater than four times the poverty level, who did not previously qualify for tax credits. Though these subsidized premiums could temporarily reduce financial burdens for middle-class families, the program expires in 2023. Thus, without expansion of the program beyond 2023 or additional policy ensuring healthcare affordability, middle-class families will continue to face substantial financial burdens in obtaining affordable coverage, resulting in decline in healthcare coverage in this population.

Another recent report released by the Kaiser Family Foundation examined effect of the COVID-19 pandemic on healthcare coverage and costs. The 2021 Employer Health Benefits Survey noted a 4% increase in premiums for employer-sponsored health plans, which is fairly stable compared to 2020 due to lower utilization during
the pandemic. At the same time, deductibles have remained high since pre-
pandemic. Nonetheless, the pandemic has encouraged changes to employer benefits. 
For example, more employers added additional mental and behavioral health 
benefits likely due to consequences of the pandemic. Additionally, the survey found a 
significant increase in expansion of telehealth benefits, such as online counseling 
services. Though employers have pivoted and adjusted their health and employment 
benefits in the wake of COVID-19, the pandemic’s consequences are still of 
significance, and employers should be prepared to structure benefits accordingly for 
a post-pandemic world.

Not only is healthcare affordability a hot topic issue for policymakers and in the 
healthcare field, but it consistently ranks as the top issue that state residents want 
their policymakers to address. Altarum’s Healthcare Value Hub recently published 
its “Healthcare Affordability State Policy Scorecard,” which ranks states’ healthcare 
affordability based on their healthcare policy as well as actual outcomes. The four 
policy areas considered in ranking the states are: 1) curbing excess prices in the 
system; 2) reducing low-value care; 3) extending coverage to all residents; and 4) 
making out-of-pocket costs affordable. The outcomes are also ranked based on four 
factors: 1) private payer inpatient prices relative to the Medicare allowed amount; 2) 
rates of known low-value services delivered by providers; 3) percent of the 
population that is uninsured; and 4) percent of the population that forgo needed care 
due to cost. According to these metrics, Massachusetts ranked the highest among 
the states—with a score of 65.3 out of 80 total points—on their adoption of policies 
that improve healthcare affordability. California, in comparison, ranked right outside 
the top ten at 12, scoring 44.9, while Texas ranked last with a score of 17.9. The 
report also provides useful guides for each state’s policymakers on how to best focus 
their healthcare affordability reform efforts.

That concludes the last Roundup for 2021. If you find articles or reports that you 
think should be included in the monthly Roundup, please send them our way. Stay 
safe and healthy this holiday season!
Spotlight on State: Montana

This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See Montana page.

Montana promotes the use of telemedicine by providing coverage and cost-sharing parity between telemedicine and in-person services. Coverage for telemedicine services must be equivalent to the coverage for in-person services. To make telemedicine services more affordable to patients, cost-sharing requirements that are not generally applicable to in-person services may not be imposed on telemedicine services.

Montana continues to actively pursue legislation to promote price transparency, with multiple efforts focused on implementing surprise billing protections. In recent sessions, legislators introduced legislation that would have required certain health care facilities to provide cost information on services expected to exceed $500, as well as establish procedures for informing consumers about out-of-network health care costs. A similar bill would have established limits on a consumer’s out-of-network costs under certain circumstances and implemented procedures about informing consumers about the ability to opt out of services. In 2016, the state unsuccessfully attempted to create an All-Payer Claims Database (APCD), which would require health plans to submit claims information or be subject to a penalty. In another effort to improve transparency and drive down prices, the legislature proposed to study the effects of reference-based pricing on health care prices and transparency in health care pricing.

In the healthcare market, Montana exercises regulatory oversight over provider mergers by requiring pre-transaction notice to and approval from the attorney general or court for transactions involving certain public benefit or religious
corporations. The legislature repealed the state’s certificate of public advantage law in 2019. Additionally, in 2013, the legislature approved a bill to grant the commissioner of insurance rate-setting authority.

To stabilize the individual insurance market, Montana enacted the Montana Reinsurance Association Act establishing the Montana Reinsurance Association and Program. The bill also authorized the state to apply for a State Innovation Waiver and federal pass-through funding to partially finance the reinsurance program under section 1332 of the Patient Protection and Affordable Care Act (PAACA). The state received an approved State Innovation Waiver from the federal government for the period January 1, 2020 through December 31, 2024. The reinsurance program will pay insurers up to 60% of claims paid between $40,000 and an estimated $101,750 cap.

---

**FTC Restores and Implements Prior Approval Rule with Provision in DaVita Divestiture Order**

In July 2021, President Biden’s [executive order](#) called on federal agencies to strengthen antitrust enforcement in the healthcare industry to promote and revitalize healthcare competition and price transparency in the U.S. In response to the call to action, the agencies, particularly the Federal Trade Commission (FTC), have mobilized and stepped up their efforts by providing additional guidance and oversight of consolidation in the healthcare market. In this issue of Litigation and Enforcement Highlights, we take a look at the FTC’s reinstatement and implementation of the prior approval rule, the latest regulatory action that will impact consolidation in the healthcare provider market.
Reinstatement and Expansion of the Prior Approval Rule

One of the major federal regulatory actions that will impact healthcare consolidation is the FTC’s recent reinstatement of the prior approval rule. This rule allows the FTC to require a merging entity to provide notice and obtain approval before consummating future mergers and acquisitions, if the FTC has determined that the entity has pursued a merger that was considered anticompetitive. This rule may apply for a minimum of ten years in every relevant market where the FTC alleged that harm would have occurred from the proposed transaction. The FTC may institute this rule as a condition in challenged mergers that are ultimately approved, for example as a provision in a divestiture or consent order agreed to by the FTC. Importantly, the prior approval rule applies regardless of whether the challenged merger was eventually approved or consummated, i.e., the FTC may seek prior approvals even when parties abandoned a transaction. In other words, entities that saw their proposed merger challenged by the FTC on antitrust grounds will need the Commission’s permission for any future acquisition in the affected market.

Notably, the prior approval rule was a longstanding practice of the FTC until it was rescinded in 1995. Since then, the FTC has only had prior approval authority for transactions that trigger the Hart-Scott-Rodino (HSR) Act threshold, which indicates a certain level of market concentration. According to FTC Chair Lina Khan, however, “Since the FTC substantially reduced using these prior approval provisions, the agency has encountered numerous examples of companies repeatedly proposing the same or similar deals in the same market, despite the fact that the Commission had earlier determined that those deals were problematic.” As a result, having to reinitiate investigations and pursue new legal challenges placed unnecessary burden on the limited resources at the agency.

The new rule not only reinstates the original policy that was in place prior to 1995, but also goes beyond the old policy. First, the requirement is set for a minimum of ten years, instead of being capped at ten years as it did previously. Second, the new rule also applies to buyers of divested assets, rather than just the sellers pre-1995. Lastly, the Commission may seek a prior approval provision that covers product and
geographic markets beyond just the relevant product and geographic markets affected by the merger. Factors that would be relevant to this determination include 1) nature of the transaction, 2) level of market concentration, 3) the degree to which the transaction increases concentration, 4) the degree to which one of the parties had market power pre-merger, 5) parties’ history of acquisitiveness, and 6) evidence of anticompetitive market dynamics.

The Commission narrowly approved the new policy by a vote of 3-2, where Republican Commissioners Noah Joshua Phillips and Christine S. Wilson issued a dissenting statement, stating that the policy would have the effect of chilling merger activity altogether. However, broadening the agency’s oversight authority applying the prior approval rule to merging entities that have been previously investigated and flagged by the FTC for antitrust concerns could help better monitor anticompetitive mergers. The FTC applied this new authority in the case of a recent healthcare acquisition in Utah.

Implementation of Prior Approval Provision in DaVita Consent Order

While the FTC voted to restore the prior approval rule shortly after the executive order was issued in July 2021, the Commission officially announced the new policy in connection with its implementation in the divestiture order in the proposed DaVita-University of Utah Health transaction.

DaVita proposed to acquire University of Utah Health’s 18 dialysis clinics that span Nevada, Utah, and part of Idaho. The FTC filed an administrative complaint due to concern that “the acquisition would eliminate actual, direct, and substantial competition between DaVita and the University in the market for outpatient dialysis services” in the Provo, Utah area, where there are only three providers of outpatient dialysis services. According to the complaint, the proposed transaction would allow DaVita to own seven of the eight facilities in the Provo market and reduce the number of providers to only two competitors, “increasing the ability of the merged entity unilaterally to raise prices for outpatient dialysis services and reducing incentives to improve service or quality in the relevant market.”
On October 25, the FTC issued a proposed consent order that requires DaVita to divest three clinics in the Provo area to competing provider Sanderling Renal Services. In addition, DaVita is prohibited from enforcing any non-compete agreements with the University of Utah or competitor Sanderling. Most importantly, on top of the divestiture order, the FTC imposed a prior approval provision, pursuant to the newly adopted policy, that requires the dialysis chain to obtain prior approval from the FTC before acquiring any new ownership interest in a dialysis clinic anywhere in Utah for a period of ten years. As permitted under the new policy, the DaVita order extended and applied the prior approval requirement beyond markets directly impacted by the transaction. Commissioner Christine Wilson stated the FTC came to this determination because “DaVita has engaged in a pattern of acquiring independent dialysis facilities; many of these acquisitions fall below HSR thresholds and consequently escape pre-merger review, including this proposed acquisition.” With the prior approval provision, the FTC will be able to quickly identify any future anticompetitive transactions by DaVita, which is known to have a history of fueling consolidation in the industry.

Overall, the prior approval requirement is a useful regulatory tool that the FTC can use to prevent facially anticompetitive transactions and detect other anticompetitive deals that fall below the HSR reporting thresholds. Additionally, challenging anticompetitive mergers is a resource intensive endeavor. This requirement will help the Commission preserve resources already expended in investigating and understanding the competitive dynamics of a particular market in previous challenges.

Recapping the 2021 Session: Healthcare Legislation Passed in
California

In the 2021 legislative session, California’s democratic-held legislature has passed roughly 800 bills, 770 of which have been enacted after approval by Governor Newsom. A number of bills impacting the healthcare industry passed overwhelmingly in both houses, yet a couple of critical bills were vetoed. Notably, the COVID-19 pandemic, which shifted legislative focus away from healthcare costs in 2020, has amplified the various pitfalls of the healthcare system. This session, the legislature returned to propose several bills to mitigate these shortcomings and address healthcare costs and access. This post summarizes the enacted and vetoed bills that enhance healthcare delivery, ensure healthcare access and coverage, promote price transparency, and reinforce competition and enforcement.

ENCOURAGING TELEHEALTH ADOPTION AND ACCESS

Though telehealth has gained popularity with the rise of technology, virtual services gained even more prominence with the onset of the COVID-19 pandemic. This session, the legislature proposed and passed a number of bills targeting increases in telehealth services, which furthers the overarching goal of expanding healthcare delivery.

AB 457 enacts the Protection of Patient Choice in Telehealth Provider Act, which requires healthcare service plans and health insurers to inform patients of the necessary information, such as cost sharing obligation for out-of-network benefits, to make informed decisions when accessing telehealth services from third-party corporate telehealth providers. Additionally, to address fragmented care when utilizing third-party providers, AB 457 requires that any records provided through a third-party telehealth provider be provided to the patient’s primary care physician. As the bill analysis noted, by expanding telehealth services, employers and health plans stand to save due to the replacement of costly physician visits and emergency visits with less costly virtual visits. Moreover, “increased convenience may tap into unmet demand for health care, and new utilization may increase overall healthcare spending.”

[1] [2] [3]
Despite overwhelming support in both houses of telehealth-related measures, Governor Newsom vetoed SB 365, a measure that would have improved specialty telehealth care for low-income individuals insured through Medi-Cal. The bill would have required electronic consultation (e-consult) services provided by a Medi-Cal provider to be reimbursed under Medi-Cal. Under existing law, e-consult services are reimbursable for the specialist provider, but the primary care provider initiating the e-consult is not able to bill for this telehealth service. SB 365 would not only save time and money for patients but would benefit, by way of equitable reimbursement, all participating providers conducting e-consult services. Just as with the other telehealth measures that have been enacted this session, SB 365 has the potential to save money for patients and health providers by determining whether an in-person visit is necessary. Nevertheless, Governor Newsom vetoed the measure citing, in his veto message, inconsistency with the federal law’s definition of e-consult services.

In summary, telehealth is a growing area that has garnered widespread use and support. Access to telehealth will also likely increase with the legislature’s concurrent efforts in expanding broadband access. Two enacted bills, AB 14 and SB 4, aim to close the digital divide by planning, facilitating, and deploying broadband infrastructure, with a goal of providing broadband access to no less than 98% of Californians. The COVID-19 pandemic has exemplified how the massive digital divide separates Californians from all sorts of opportunities, including access to telehealth services. Streamlining access to telehealth has the potential to impact the healthcare market and costs for both the insured and healthcare entities.

Notably, these telehealth measures should not be viewed in a vacuum – these telehealth actions also impact some of the other passed bills that relate to the healthcare market.

**EXPANDING HEALTHCARE ACCESS & COVERAGE**

The Governor approved a couple of bills that impact healthcare cost by way of expanding healthcare access and benefit coverage. Notably, the impact of COVID-19 drove the legislature to enact some measures that address shortcomings of the system which the pandemic brought to light.
**SB 510** requires health plans and insurers to cover costs associated with COVID-19 testing and immunization regardless of whether the service is provided through an in-network or out-of-network provider. The measure would also apply to future diseases when declared a public emergency by the California Governor. Ultimately, SB 510 would prevent any surprise billing for “administrative fees” or out-of-pocket cost for out-of-network providers that many people seeking COVID-19 prevention previously experienced.[4]

Additionally, ensuring access to mental health care is of particular importance as the prevalence of mental health and substance abuse disorders rapidly increased during the COVID-19 pandemic.[5] While prior law and regulations have set clear timely access requirements for initial mental health and substance abuse appointments with nonphysician providers (e.g., therapists), the law did not address timely access to follow-up care. In response, the Governor signed **SB 221**, which reduces wait times for mental health follow-up care by requiring that patients be offered return appointments no more than 10 days following their previous session. Opponents of the bill cited issues of therapist shortage and concerns about quality of care given the lack of workforce, but lawmakers pushed back, and the bill received overwhelming support in both houses.[6] Notably, the law does not take effect until July 1, 2022, which enables health plans time to comply, such as hiring additional therapists.[7]

**SB 280** is another successful bill that expands healthcare coverage. The measure requires large group health insurance policies to cover medically necessary basic healthcare services, but also prohibits these insurers from using marketing practices or benefit designs that discourage the enrollment of an individual with significant health needs. Insurer violation of these requirements may be subject to administrative penalties.

---

### ENSURING TRANSPARENT & FAIR BILLING PRACTICES

In addition to legislation that would expand and clearly communicate healthcare coverage, the legislature also passed a few bills that specifically target healthcare billing and transparency to promote greater consumer control over their health care.
SB 368 systematizes and increases transparency for an insured regarding their insurance deductible and out-of-pocket maximum. Specifically, the measure requires insurers and health plans to provide an enrollee or insured the accrual balance toward their annual deductible and out-of-pocket maximum during any month in which benefits were used. Moreover, the service plan or insurer is required to maintain a system that allows for an enrollee or insured to request their most up-to-date accrual balances from their service plan or insurer at any time.

In addition to insurance transparency, two other enacted bills target hospitals’ obligations in communicating fair billing policies to patients and the general public. AB 532 strengthens existing law—which requires hospitals to maintain understandable written policies regarding discount payments for qualified patients—by requiring that hospitals establish a systematized process of notifying patients of these written policies. Additionally, these written patient notices must include the internet addresses of specific health consumer assistance entities, information regarding Covered California and Medi-Cal eligibility, and the hospital’s list of shoppable services. The notice is required to be provided at the time of service if the patient is conscious and able to receive such notice. Significantly, hospitals will be required to automatically (i.e., not upon specific request, as prior law allowed) provide uninsured patients with an estimate of charges for services and an application for financial assistance or charity care.

While AB 532 focuses on hospital transparency in disclosing discounted payment options to qualified patients, AB 1020 increases patient eligibility for hospital financial assistance. AB 1020 expands eligibility for charity care and discounted payments by raising the income level for financial assistance from 350% of federal poverty level (FPL) to 400% FPL. Furthermore, similar to AB 532’s systematized notice requirements, AB 1020 requires hospitals to display notice of their policy for financially qualified and self-pay patients on the hospital’s website. Additionally, AB 1020 prohibits a hospital from selling patient debt to a debt buyer, unless specified conditions—such as sending patient notice of the debt along with the hospital’s financial assistance options—are met.

In summary, all these enacted bills promote and require fair billing and transparent costs for healthcare services, providing greater protection for patients.
ENFORCING FAIR PRACTICE & CONSUMER PROTECTION

The legislature was also successful in enacting various enforcement measures promoting fair healthcare competition. The existing Unfair Competition Law (UCL) authorizes various government entities with enforcement authority to protect consumers and promote fair business practices. SB 461 gives concurrent authority to the county counsel of any county in which a city has a population more than 750,000 people to bring actions under the UCL. According to Senator Cortese, the author of the bill, “SB 461 will close an enforcement gap and enable these county counsels to better protect consumers and promote fair competition. The bill also aligns with other important consumer protection statutes in California, such as the False Advertising Law, which broadly authorizes county counsels to combat deceptive business practices.” [8] With this enactment, anticompetitive healthcare practices will be better monitored and enforced due to the wider scope of government enforcement authority.

In addition to government and regulatory entities, healthcare consumer interests are further advanced through consumer advocacy initiatives. Prior law established the Consumer Participation Program, which allows the Department of Managed Health Care (DMHC) to award consumer advocates for their contributions—on issues such as unfair billing patterns—to DMHC regulations that impact a significant number of healthcare consumers. This program has been in existence for more than 15 years, and the newly enacted AB 326 would extend the operation of the program indefinitely. Since the establishment of the program, DMHC approved 57 Petitions to Participate and 38 Applications for an Advocacy Award.[9] For example, during the 2019-2020 fiscal year, DMHC awarded three Advocacy Awards to Health Access of California (HAC), including for its contribution to DMHC’s adoption of regulations related to health care plan compliance, financial solvency of certain organizations, and prescription drug coverage transparency.[10] Given the established track record of the Consumer Participation Program, extending the program indefinitely will incentive consumer advocates to further represent and promote interests of healthcare consumers.
SUPPORTING PHARMACEUTICAL CHOICE AND PATIENT AUTONOMY

In the prescription drug market, the legislature passed and the Governor approved a few bills that would help ensure the quality and value of pharmaceutical care given to patients. Specifically, the legislature focused on measures that enhance pharmacist autonomy and consumer choice.

Two enacted measures, SB 362 and AB 1064, support pharmacist and pharmacy-employee autonomy. First, **SB 362** addresses the negative impact of performance quotas, a fixed number of duties (e.g., prescriptions filled), on pharmacies.[11] Quotas are quantitative corporate metrics used by some pharmacies, e.g., CVS, Walgreens, and Rite Aid, to evaluate pharmacist-employee performance.[12] While these metrics may be helpful in measuring large-scale employee performance, reports spanning the decade found negative implications, including patient death, due to these quotas.[13] Specifically, SB 362 prohibits a chain community pharmacy, a chain of 75 or more stores in California under the same ownership, from establishing a quota to measure a pharmacist or technician’s performance of duties.

Second, **AB 1064** works to expand pharmacist scope of practice. AB 1064 authorizes pharmacists to initiate and administer any vaccine approved or authorized by the U.S. Food and Drug Administration (FDA) for persons three years of age and older, including the COVID-19 vaccine. Prior law required that the vaccine be listed as **routine** immunization for it to be independently initiated and administered by a pharmacist. AB 1064 is yet another bill enacted this session that supports and recognizes the significant role of pharmacists, especially during the COVID-19 pandemic.

Aside from regulation of pharmacists, **AB 347** promotes patient and prescriber drug choice by adding protections, including a step therapy exception request and appeal process, to the current Utilization Management protocols. Step therapy protocols, where the enrollee is required to first try and fail alternatives before coverage is available for the initially prescribed medication, help health plans and insurers control costs.[14] AB 347 strikes a balance between the common use of step therapy and ensuring timely access to treatments by requiring health plans or insurers to
expeditiously approve a step therapy exception if specific criteria are satisfied. Ultimately, AB 347 preserves the cost control mechanism of step therapy while ensuring timely access to necessary medication for patients.

Finally, SB 524 as passed by the legislature would have curbed anticompetitive behavior in the pharmaceutical industry, but the Governor vetoed the measure. SB 524 proposes to prohibit healthcare service plans or health insurers from engaging in “patient steering,” by requiring an enrollee or insured to have their pharmacy services provided by a specific pharmacy, which is usually owned by the pharmacy benefit manager (PBM) or health plan.[15] The legislature found that such practices “[are] designed to eliminate competition and can result in higher costs for the patient and for the healthcare system as a whole.”[16] SB 524 would have given patients greater healthcare autonomy by selecting their own pharmacies “to ensure they receive quality care and are not steered to increase profit margins for PBMs.”[17] Though Governor Newsom acknowledged these goals, he vetoed the bill, citing lack of clarity in what business entities and relationships are intended to be affected since the bill did not define “agent” or “corporate affiliate,” which could lead to misinterpretation or lack of enforceability. Currently, SB 524 is in the Senate, and consideration of the Governor’s veto is pending.

The legislature has passed an outstanding number of measures this session and still has the opportunity to pass additional meaningful healthcare measures in 2022, year two of the 2021-2022 legislative term. Specifically, as of this writing, the legislature has a number of pending healthcare related bills that have passed at least one house. Some notable measures include AB 97 (addressing insulin affordability), AB 1130 (establishing the Office of Health Care Affordability), and AB 1132 (prohibiting anticompetitive healthcare contracting practices). Stay tuned to California Legislative Beat next month for a discussion of these measures and their outlook in the 2022 legislative session.
This is when a corporation contracted with a health care service plan provides health care services exclusively through a telehealth platform.


Id. at 1-2.

Id. at 5.
New Documentary Exposes the Alarming Trend of Hospital Monopolies and the Impact on Costs

The new film InHospitable is a timely documentary that follows patients and activists as they battle UPMC, a multi-billion dollar nonprofit hospital system that was making vital care unaffordable for hundreds of thousands of vulnerable patients in western Pennsylvania. The film highlights the urgency of holding large health systems accountable for their significant role in our broken healthcare system. Slated to have its world premiere on November 13th at DOC NYC, anyone in the U.S. can watch it online from November 14 – 28. Tickets are available here for in-person viewing or streaming.

See Synopsis below:

InHospitable follows patients and activists as they band together to fight UPMC, a multi-billion dollar nonprofit hospital system that was limiting vital care for
hundreds of thousands of vulnerable patients in western Pennsylvania. Few are aware that in the past several years many nonprofit hospitals around the country have been building healthcare empires and amassing huge amounts of wealth and political power at the expense of the surrounding residents.

The story of *InHospitable* illustrates this alarming trend and turns the lens on the seemingly unwinnable battle between the Goliath UPMC and the patients, hospital workers, community activists, labor leaders, journalists, and politicians – almost all of them women – who built a grassroots movement to literally fight for their lives. UPMC, a multi-billion dollar nonprofit hospital system, has been building a healthcare empire in Western Pennsylvania for years. In 2019, their corporate feuding with competitor Highmark left hundreds of thousands of patients without vital care.