The Source Roundup: May 2024 Edition

Healthcare Cost and Spending

[Promoting Value-Based Healthcare Decisions: A Case Study of Shared Savings Programs in New Hampshire and Maine] (*Pepperdine Policy Review*)

Christopher LaCreta and Lawson Mansell

Shared savings programs (SSPs) are an emerging policy solution to combatting the rise of healthcare costs. SSPs enable patients to compare prices and receive incentives for saving money on some elective services. Researchers from Pepperdine University's School of Public Policy recently published results from their case study on the disparities between SSPs in Maine and New Hampshire. Both states passed legislation to enact SSPs between the years of 2019 and 2022 but the case study found that New Hampshire's program outperformed the fully insured competitive market in both New Hampshire and Maine, and saved patients 183 times more than participants in Maine's program within the same time span. Researchers from the study interviewed a variety of stakeholders and policy experts who identified potential disparities in program outcomes and explained the importance of aligning incentive structures amongst stakeholders when designing similar programs in the future.

[Federal Legislation and State Policy Efforts Promote Access To and Use of Discounted Cash Prices] (*Health Affairs Forefront*)

Jonathan Wolfson, Josh Archambault, Christopher M. Whaley, Cynthia Fisher, and Ge Bai

The Department of Health and Human Services has made it mandatory for U.S. hospitals to increase transparency by requiring hospitals to disclose their charges, negotiated prices, and discounted cash prices for all services. This move is aimed at empowering patients and insurance sponsors to compare prices and thereby reduce healthcare spending. Keeping in line with these efforts, the U.S. House of Representatives recently passed H.R. 5378 to solidify these regulations, while the Senate has introduced S.B. 3548 to focus on discounted cash prices. Cash prices are often lower than negotiated rates and state-level policies like deductive credits can better incentivize the use of cash prices. A new article in *Health Affairs'* Provider Prices in the Commercial Sector series assesses these two bills and emphasizes how the potential Senate bill can promote competition and affordability through incentivizing discounted cash prices. Overall, the authors call for lawmakers to continue adopting measures that will improve price transparency and provide more affordable access to healthcare for patients.

Basic Health Programs: An Alternative to Public Options (*The Commonwealth Fund*)

Naomi Zewde, Coleman Drake, and Adam Biener

More than 20 years after their inception, states have begun implementing public option health plans in their Affordable Care Act marketplaces. Public options are proposals that increase the public sector's regulation and management of insurance products across markets. These types of health plans have been enacted so far in Washington state and Colorado but have faced difficulties in attaining their goals of improving affordability and reducing overall health care costs. Alternatively, some states have created

Basic Health Programs (BHPs) to replace marketplace coverage for residents with low incomes who are eligible for premium subsidies. This new article analyzes the evolution of Washington's public option rollout against that of BHPs and found that public options struggle to achieve their affordability targets when they lack sufficient network participation or enrollment. However, BHPs do not face those same challenges since BHPs contract with safety-net providers at Medicaid-like rates. Due to these reasons, BHPs provide an affordable consumer option with minimal out-of-pocket costs while keeping costs low for the state and federal government.

Market Consolidation and Antitrust Enforcement

Matching Competition Policy in the U.S. Healthcare Industry to Address a New Generation of Challenges in Provider Markets (*Washington Center for Equitable Growth*)

Barak D. Richman

Antitrust policy has become an increasing concern in the U.S. healthcare industry. For decades, many felt that a lack of antitrust policy in the healthcare field was affecting competition, pricing, and ultimately, quality of care for patients. All of this was predicted to change when the Biden administration enacted their July 2021 "Executive Order on Promoting Competition in the American Economy." Thus far, the changes that have stemmed from the executive order have made some improvements, but Barak Richman argues that they are not enough. In his new issue brief for the *Washington Center for Equitable Growth*, Richman outlines how the U.S. hospital sector succumbed to market consolidation and discusses the key competition challenges

affecting the current market. The brief ends by presenting several solutions that policymakers can utilize to improve antitrust policies including engaging with the Centers for Medicare and Medicaid Services in competition policy and bolstering fiduciary duties via the Employment Retirement Income Security Act of 1974.

Hospital Consolidation and Physician Unionization (*New England Journal of Medicine*)

Kevin Schulman and Barak Richman

The post-Affordable Care Act era in the U.S. healthcare system has been led by hospital consolidation and the acquisition of physician practices by large corporate entities resulting in a dramatic shift to physician employment structures. Currently, over half of physicians are employed by either hospitals or other corporate entities which has spurred a concurrent rise in physician unionization efforts. The desire for unionization has grown out of concerns over staffing, burnout, and the quality of patient care. This new article by Kevin Schulman and Barak Richman discusses the tie between these two emerging parallel trends. While unionization provides an opportunity for physicians to negotiate fair wages and address non-wage-related issues such as job satisfaction and professional autonomy, it also presents added strategic considerations to be affected. As the situation evolves, the authors note that it remains important for policymakers and physicians to monitor the growth of unionization efforts in order to evaluate their effectiveness in achieving their stated goals and to address the potential harms associated with this current era of healthcare restructuring.

Ten Things to Know About Consolidation in

Health Care Provider Markets (*KFF*)

Zachary Levinson, Jamie Godwin, Scott Hulver, and Tricia Neuman

In 2022, national health spending comprised almost one-fifth of the U.S. GDP, reaching $4.5 trillion, and is projected to continue outpacing GDP growth until at least 2031. The ultimate result of this trend lies in outsized costs for individuals, employers, states, and the federal government. Recently, policymakers have shifted their attention to healthcare consolidation's potential impacts on care costs and quality of care. While consolidation tactics, namely mergers and acquisitions, have the potential to improve efficiency and provide support for healthcare workers, it also risks eradicating competition, resulting in monopolies that create higher costs for consumers. As the Federal Trade Commission (FTC) shifts their focus to litigating and regulating the practice of healthcare consolidation, the authors of this article summarize ten key points for the public to know about provider consolidation. Among their points, they highlight the prevalence of consolidation, its effects on prices and quality, and potential policy options to foster broader competition within the healthcare marketplace.

Recent Trends in Hospital Market Concentration and Profitability: The Case of New Jersey (*Journal of Hospital Management and Health Policy*)

Rose Lu, Sujoy Chakravarty, Bingxiao Wu, and Joel C. Cantor

The U.S. healthcare system relies on private negotiations between insurance companies and hospitals to set hospital prices. Researchers assessed changes in hospital financial margins in New Jersey during a period of sustained

consolidation activities to better understand the impact of the recent increases in hospital market consolidation in a new study in the *Journal of Hospital Management and Health Policy*. The study assessed market concentration and operating margins for eight hospital market areas (HMAs) from 2010 to 2020 and examined the associations in trends between these measures. The results confirmed that the New Jersey hospital market underwent increasing consolidations during the study period and demonstrated a need for continued scrutiny over proposed consolidation activity, rigorous antitrust enforcement, and healthcare price and quality monitoring and regulation in highly concentrated markets by state and federal governments.

Healthcare System Mergers and Investments

A Call to Arms: Private Equity and the US Healthcare System (*British Journal of Anaesthesia*)

Irim Salik

The rise in private equity influence over the U.S. healthcare system has led to a lot of analysis and rampant discussion. While private equity acquisitions of hospitals were once predicted to result in the reduction of regulatory burdens, administrative efficiency, improvements to revenue cycle management, financial gains for doctors, and a shifted focus from administrative metrics to patient care quality, the result hasn't quite met up to these predictions. This new article in the *British Journal of Anaesthesia* dives into the discordance between the high expectations that were previously predicted for private equity's entrance into the American healthcare system with the rampant criticisms against firms for favoring investor

returns at the expense of patient care quality and physician wellbeing. The author further discusses private equity's role in healthcare market consolidation and explores how rapid consolidation to change healthcare delivery has been marred with unmet expectations.

How Do Regulatory Costs Affect Mergers and Acquisitions Decisions and Outcomes? (*Journal of Banking and Finance*)

Baris Ince

The impact of increased regulation in healthcare mergers and acquisitions has become an increasingly more prevalent hot topic in the healthcare competition space. A new article in the *Journal of Banking and Finance* argues that government merger and acquisition regulations make it substantially more expensive for companies to do business. Specifically, the author finds that when looking within the same industry, big companies with high regulatory costs are more likely to buy other companies, while small companies with high regulatory costs are more likely to be bought. However, when companies across different industries merge, regulatory costs are less substantial and impactful. The author introduces a variety of econometric techniques to quantify these findings and argues that regulatory costs play a big role in merger and acquisition decisions which ultimately affects how much money shareholders will walk away with in these deals and the attractiveness of the overall transaction.

Quality and Price Transparency

Empowering Employer Purchasers: Recommendations to Support Market Transparency and Health

System Performance (*Health Affairs*)

Caroline Pearson, Kevin McAvey, Mairin Mancino, Frederica Stahl, and Kalyani Thampi

The mounting growth of U.S. healthcare costs increasingly threatens the financial stability of both employers and consumers, with employers lacking the necessary tools and market influence to effectively manage and negotiate healthcare costs on behalf of their staff. In the latest post to *Health Affairs'* Provider Prices in the Commercial Sector Series, The Peterson Center on Healthcare and Manatt Health Strategies engaged with major employers and healthcare purchasers to understand what data they needed to better their vendor contracting and network negotiation efforts. Among their needs, employers highlighted the importance of data availability, usability, and translation in aiding their purchasing decisions. The authors of this piece suggest steps such as strengthening employers' rights to access their own data, improving the availability of usable market price and utilization data, and supporting employers in translating healthcare data to make informed decisions as crucial steps to addressing the healthcare cost crisis. Ultimately, improving data accessibility and translation for employers can potentially improve market competition while creating a more transparent and accountable healthcare system for all.

Medical Debt in US Linked with Worse Health, More Deaths (*JAMA*)

Emily Harris

It is estimated that approximately 20 million Americans (or about 8% of US adults) currently have medical debt of at least $250, with the majority owing more than $1000 for medical expenses. This article reports on a new study that found that unpaid medical bills may be resulting in

worsened physical and mental health outcomes, including shortened lifespans, for medical debtholders. The study, which examined data from 93% of U.S. counties found that for every 1-percentage point increase in medical debt (defined as bills sent to a third-party debt collector or assigned to a creditor's internal collections department), there were 18 more physically and mentally unhealthy days each month per 1000 people after accounting for sociodemographic factors. Medical debt was also found to be deadly with it being partially linked to more premature deaths resulting from a myriad of causes including cancer, heart disease, and suicide. The author emphasizes how healthcare professionals have a responsibility to mitigate the burden of medical debt on patients with the most financial needs and suggests possible policy solutions including ending hospital litigation against patients and suggests nonprofit hospitals investing their tax benefits back into their communities.

Industry Payments to US Physicians by Specialty and Product Type (*JAMA*)

Ahmed Sayed, Joseph S. Ross, and John Mandrola

Financial conflicts of interest have long influenced physician prescribing patterns and have been found to also affect patients' trust in medical professionals. Nevertheless, the trend has persisted with many physicians still facing financial conflicts of interest in their prescribing practices. As a result of these trends, the Physician Payments Sunshine Act created the Open Payments database in August 2013, which created a repository of industry payments to health care professionals. A new article in *JAMA* examined the distribution of payments within and across specialties and the medical products associated with the largest total payments. Payment calculations included cash and noncash equivalents for

consulting services, non-consulting services, food and beverages, travel and lodging, entertainment, gifts, grants, charitable contributions, and honoraria made to physicians for the period of August 2013 to December 2022. Orthopedics, neurology and psychiatry, and cardiology were among the specialties who received the most payments, with each specialty netting over $1 billion in payments for the nine-year period.

California Legislature Considering Bills to Ease CHFFA Hospital Loan Repayment

Introduction

In February 2024, lawmakers in California introduced Assembly Bill 2098 and Assembly Bill 2637. Both bills would make changes to loans offered by the California Health Facilities Financing Authority (CHFFA), an important entity that helps struggling California hospitals. These loans are often essential to communities because they help the local hospitals get back onto sound financial footing.

Background

The California Legislature created CHFFA in 1979 to provide financial help to hospitals and other healthcare providers via loans that are funded through the issuance of tax-exempt bonds. The financing can be used for a variety of operational costs, but state law limits these bonds to a two-year period.

2024 California Legislation

The two bills introduced this session would relax some of the requirements of CHFFA bonds, including the time frame to repay the loans.

AB 2098 would amend the California Health Facilities Financing Authority Act to extend the repayment requirements for loans given to hospitals. The Act currently requires standard CHFFA loans to be repaid beginning 18 months after the date of the loan; this legislation would bump the start date back to 24 months. The bill would also require loans to be at 0% interest and would give 72 months to repay the loan, instead of the current two-year window. At an April 16 hearing, California State Assemblymember Eduardo Garcia, sponsor of the bill, testified that the bill would extend a lifeline for hospitals by extending the repayment timeline of CHFFA bridge loans. This extended timeline is especially important given the current state of distress of many California hospitals and the importance of these hospitals to often underserved areas. During the hearing, the Committee voted unanimously to pass the legislation and referred the bill to the Committee on Appropriations.

AB 2637 would remove the current requirement that a loan made through CHFFA to a hospital for working capital be repaid within 24 months. According to the author of the bill, this limitation has "resulted in some hospitals seeking financing being turned away." At a committee hearing regarding the legislation on April 23, testimony was given by Assemblymember Pilar Schiavo, the bill sponsor, stating that CHFFA has a number of programs that assist hospitals by finding the financing they need to improve infrastructure, equipment, and by connecting hospitals to private investors and loans, and that the current two-year loan repayment terms limits what CHFFA can do. The Assemblymember noted the challenges hospitals faced due to the pandemic and that allowing loans to be paid off over a longer window of time will reduce financial pressures. The Executive Director of CHFFA, Carolyn

Aboubechara, testified about the role CHFFA played in helping hospitals weather the pandemic, and the need for long-term working capital finance assistance. Committee Chair Mia Bonta stated concerns about letting hospitals stretch out operating loans over decades, noting that this may make them more financially tenuous in the long run and could result in harmful consolidation. Assemblymember Schiavo responded by noting that if hospitals don't get the financing they need through CHFFA, they will have to go out to the market and get their financing with potentially worse terms. Director Aboubechara testified that the two-year restriction has been in place since the 1980s – at the time there was a belief that there wouldn't be a need for long-term working capital loans, but the healthcare environment has changed significantly since then. The Director stated that CHFFA staff does an analysis, as do investors, to make sure hospitals aren't getting themselves into situations they can't handle. At the hearing, the Committee unanimously passed the bill and referred it to the Assembly Appropriations Committee.

Why are so many hospitals distressed at this time?

Hospitals have shown significant financial stresses since the start of the Covid epidemic. While rising labor costs, inflation, aging infrastructure, and low reimbursements have been a continuing part of the problem, hospitals faced additional problems specific to the pandemic. These problems include continuing supply shortages, provider shortages aggravated by Covid-related burnout issues, and increases in volume of care as patients catch up on care postponed during the crisis. While Covid-19 relief funds helped in the short-term, these funds have expired, leaving hospitals to deal with the continuing problems on their own.

While recent research shows that the hospital industry is in a better overall financial state in 2024 than it was in 2022 and early 2023, a significant number of individual hospitals continue to lose money. In 2024, the majority of hospital had

positive operating margins and were making a profit, but 40% of hospitals are still losing money.

Importance of local hospitals

The closure of any hospital can have negative ramifications for a community, but these problems are exacerbated in rural areas where there may be no other hospitals nearby to serve patient needs. Additionally, in these areas, the hospitals are often the largest (and best paying) employer, so their closure can have significant economic impacts, as unemployment rises and good paying jobs vanish, affecting the entire economy with a loss of local spending on goods and services. Research also shows that when a hospital closes, care delivery in surrounding hospitals is negatively affected.

Why public support could be crucial

Over a quarter of merger and acquisition proposals included a hospital or health system in financial distress. Hospital mergers lead to an increase in hospital prices, and consumers bear the price effects of hospital mergers in the form of reduced wages. A significant number of studies found no change or worse quality of care after consolidation. There are increased patient safety issues at hospitals acquired by private equity, and private equity acquisitions lead to higher charges, prices, and societal spending.

Despite the potential harms arising from consolidation, if struggling hospitals don't get an infusion of cash, they may fail entirely. Communities that completely lose access to hospital services when the hospital closes are likely worse off than having a hospital with high prices and questionable quality of care. If public programs like CHFFA can continue to succeed, it may allow facilities to remain open without an acquisition by private equity or larger system.

In summary

When hospitals fail, in can have a profound negative impact on local communities. The California Health Facilities Financing Authority Act provides funding to assist struggling hospitals get back on sound footing. AB2098 and AB2637 are looking to make evolutionary, not revolutionary, changes to how CHFFA loans operate, but these changes could help to provide more needed relief to beleaguered facilities.

The Source Team Co-Authors Research Article Examining Impacts of Cross-Market Hospital Mergers

A new research article examining the impact of "cross-market" hospital mergers on prices and quality published in Health Services Research has been co-authored by The Source's own Jaime King, Katherine Gudiksen, Alexandra Montague, and Thomas Greaney, along with our long-time collaborators, Daniel Arnold, Brent Fulton, and Richard Scheffler, from The Petris Center at UC Berkeley.

The study is the first to measure the impact of cross-market hospital acquisitions on quality and the first to identify price effects from multiple cross-market acquisitions (i.e. serial acquisitions). The study used commercial claims data from the Health Care Cost Institute and quality measures from Hospital Compare to analyze the effect of cross-market mergers on prices and quality. The study added to a growing body of research showing price increases for transactions that cross geographic markets and found that the effects were significantly increased for systems that acquired 4 or

hospitals during the study period (2011 to 2017) with no measurable increase in quality measures, including mortality and readmission rates for heart failure, heart attacks and pneumonia. The analysis also indicates that serial acquirers are significant contributors to estimated cross-market price effects. The research highlights the need for more antitrust scrutiny of cross-market mergers, given the evidence that cross-market hospital mergers lead to price increases with no quality effect.

Recent lawsuits focus on key competition issues

This spring, court cases are dealing with a variety of issues relevant to healthcare marketplace competition issues. These include a Federal Trade Commission's (FTC's) action to block a sale of hospitals in North Carolina, examining the fiduciary duties employer-sponsored health plans have in selecting drug plans, and looking at the acceptability of non-compete clauses in physician contracts.

FTC Files suit in North Carolina

In February, the FTC authorization of a suit to block Novant Health's proposed acquisition of two hospitals owned by Community Health Systems (CHS) in North Carolina. On March 25, the FTC acted on that authorization by filing a request for a preliminary injunction with the United States District Court for the Western District of North Carolina to block the sale. In its complaint, the FTC stated that the sale would "would irreversibly consolidate the market for hospital services in the Eastern Lake Norman Area in the northern suburbs of Charlotte." In the filing, the FTC argued for the

injunction for two reasons: one, that the deal was unlawful "because it would result in a combined entity with an eye-popping 64% share of the market in the Eastern Lake Norman Area" where "The Supreme Court has held that mergers are presumptively unlawful if they result in a single entity controlling a 30% market share." And two, that the deal "would immediately wipe out … competition" between Novant Huntersville and Lake Norman Regional "reducing defendants' incentives to invest in quality and leaving fewer options for patients." The Court has scheduled an evidentiary hearing for the case on April 29.

Class action suit filed over high employee drug costs

Also in February, a class action suit was filed in the United States District Court for New Jersey against Johnson & Johnson (J&J) in its capacity as the sponsor of employee group health and prescription drug plans, claiming breaches of fiduciary duties and other violations under the Employee Retirement Income Security Act (ERISA), which establishes a duty to prudently manage employee benefit plans. The suit claims that J&J violated its fiduciary duty to keep health plan drug prices reasonable, and that lack of oversight resulted in higher premiums, higher out-of-pocket costs and limits on employee wage growth, which harmed its beneficiaries (e.g. employees).

The suit gives specific examples of markup for costs of particular medications, and claims that an analysis shows that J&J agreed to a 498% markup for drugs when compared to pharmacy acquisition costs. The suit mentions J&J failure to use prudence in the selection of a Pharmacy Benefit Manager, a failure to negotiate better pricing terms, and a failure to use prudence in prescription drug plan design as failures to meet ERISA fiduciary obligations. The suit raises questions about an employer's duty in selecting and overseeing health plan vendors, which include PBMs. These relationships can be tricky for employers to manage, as they often aren't able to

review the terms of contracts between PBMs and drug manufacturers, creating challenges for employers to be good stewards of benefit plans. Fiduciary duties under ERISA do not necessarily require using the lowest cost vendor – other factors can be considered including claims processing, drug formulary selection, and network access – simply showing that the plan paid high rates for drugs would not be enough to establish a violation of a fiduciary duty. This case could potentially open the door for other lawsuits over excessive healthcare prices (beyond just pharmaceutical benefits) for self-funded employers.

Physician non-compete clauses coming under increased scrutiny

Non-compete clauses are terms, typically in an employment contract, stating that an employee (i.e. a physician) will not compete with his or her current employer (i.e. current practice group or hospital) within a geographic area for a limited amount of time. Physician non-compete clauses raise concern among antitrust enforcers and lawmakers, as they can stifle competition among health systems, allowing dominant systems to control the market for needed healthcare providers. They can also harm patients when their physician of choice is forced to leave a geographic area. Many states have passed laws either forbidding or limiting non-compete provisions, and there is an ongoing push to reconsider them. State courts are also grappling with this issue. Both the FTC and Congress have been considering federal action on this topic, and antitrust law can be used to pursue the issue.

In February of this year, two hospitals in the Trinity system (St. Joseph's Hospital in Syracuse, NY, and Holy Cross Hospital in Fort Lauderdale, FL) sued North American Partners in Anesthesia in Federal Court claiming that the anesthesia group's use of physician noncompete clauses violate antitrust laws and suppresses competition. According to the suits, the defendant's use of noncompete and non-solicitation clauses in contracts with providers prevented anesthesiologists and nurse

anesthetists from working directly for the hospitals, allowing the defendant to "demand exorbitant payments for critical and understaffed patient services." The suits claim the Anesthesia group offered to waive the non-competes to allow the hospital to employ the providers directly, but "demanded an exorbitant multi-million payment" to do so. The Trinity hospitals claim the suit is necessary for them to be able to offer employment to the anesthesia providers. In 2019, a Trinity hospital in Michigan filed a similar suit regarding noncompete clauses against Anesthesia Associates of Ann Arbor, which was ultimately settled out of court.

There has been pressure for states to ban non-compete clauses for some time, and states currently take a wide variety of approaches. In 2023, Indiana enacted Senate Bill 7 to add restrictions on physician noncompete agreements and Minnesota passed legislation preventing new non-compete agreements for all workers, although the ban was not retroactive. Also in 2023, the FTC proposed a rule to ban the imposition of non-compete clauses. Furthermore, the American Medical Association voted in 2023 to oppose non-compete contracts for physicians. While parties are open to contest individual noncompete clauses, there is pressure to ban them entirely, but as is so often the case, approaches will vary from state to state unless the Federal government chooses to step in.

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Healthcare System Mergers and Investments

Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21 (*Health Affairs*)

Ola Abdelhadi, Brent D. Fulton, Laura Alexander, and Richard M. Scheffler

The awareness for private equity's influence on the healthcare sector continues to grow and be quantified. Generally, there has been concern among parties in the health care system regarding the rate at which private equity firms have been acquiring physician practices, creating antitrust, quality, and pricing concerns within the broader health system. A new *Health Affairs* study estimated the local market share of private equity firms within ten physician specialties at the Metropolitan Statistical Area (MSA) level and found that private equity-acquired physician practices increased from 816 across 119 MSAs in 2012 to 5,779 across 307 MSAs in 2021. Single private equity firms were found to hold significant market share reaching as high as over 50% in some MSA specialty markets. The authors use this paper to call out to the FTC, state regulators, and policy makers to apply closer scrutiny over these acquisitions.

Health System Transformation

Vertical Integration and the Transformation of American Medicine (*The New England Journal of Medicine*)

Dhruv Khullar, Lawrence P. Casalino, and Amelia M. Bond

Over the past decade, the United States has seen a significant rise in the acquisition of physician practices by hospitals, which has led to a substantial number of physicians becoming hospital employees. Such arrangements can have meaningful impacts on both the quality and cost of healthcare. While vertical integration is assumed to have benefits such as improved patient outcomes through improved care coordination, research has shown that the primary effect has been increased health care prices due to the strong negotiating power of these institutions. In a new opinion piece in the *New England Journal of Medicine*, the authors dive deeper into this topic and discuss the FTC and DOJ's updated antitrust guidelines concerning market concentration and competition. While gradual changes are being made, the authors call for further research to be pursued on the consequences of the acquisitions of physician practices by hospitals. The authors suggest that the key to relieving the ongoing tension between healthcare integration and competition requires us to improve our understanding of the implications of these acquisitions on all interested parties.

The Effect of Health-Care Privatization on the Quality of Care (*The Lancet*)

Benjamin Goodair and Aaron Reeves

Over the past four decades, many global healthcare systems have shifted from public ownership to privatization by outsourcing health care services to the private sector. The rationale behind these shifts have often been to enhance the quality of care through increasing competition and promoting patient-centered approaches. However, researchers from the University of Oxford recently challenged these assertions. This study describes the findings of a meta-

analysis which reviewed literature on the trend towards privatization, specifically focusing on high-income countries. The study found that that shifting towards private ownership tended to create higher profits through the selective intake of patients and reductions to staff numbers but was simultaneously correlated with worse health outcomes for patients. Better knowledge regarding the effects of healthcare privatization can help policymakers to make better decisions regarding healthcare delivery and ensure that patients don't get left behind during system reforms.

Healthcare Cost and Spending

Trauma Center Hospitals Charged Higher Prices for Some Nontrauma Care Than Non-Trauma Center Hospitals, 2012–2018 (*Health Affairs*)

Daniel P. Kessler, Richard Sweeney, and Glenn A. Melnick

Rising hospital prices have been the largest driver of rising health care prices, which have subsequently also led to an increase in health care spending and insurance premiums. While trauma center hospitals offer both trauma and non-trauma services, they hold a unique position because they often maintain a monopoly over trauma services in certain areas. A new study published in *Health Affairs* looked into how trauma center-designation affected the price of of nontrauma services. Researchers concluded that trauma centers often charged higher prices for nontrauma inpatient admissions and emergency department visits when compared with non-trauma centers. Understanding the drivers of price could provide important insights for policymakers and experts to consider when trying to tackle continuing health care and insurance pricing issues.

Payer Type and Emergency Department Visit Prices (*JAMA Open Network*)

Jacob R. Morey, Richard C. Winters, Aidan F. Mullan, John Schupbach, and Derick D. Jones

Health care costs pose a financial barrier for many U.S. residents, particularly due to the lack of price transparency that prevents patients from shopping around and negotiating rates. A new study in *JAMA Open Network* investigated the transparency and variation in pricing for emergency department visit facility fees. Researchers used datasets from hospitals who were compliant with the Center for Medicare and Medicaid Services' (CMS) Hospital Price Transparency rule to compare list prices, cash prices, and negotiated rates for ED Visits across varying medical decision-making levels. They found that Managed Medicaid rates were consistently the lowest, followed by Medicare Advantage rates, cash prices, and private insurance rates. Overall, they also found that hospital rating and size were associated with higher prices and rates. These findings indicate significant variation in pricing structures across payers which holds implications for healthcare policy, reimbursement model and cost reform.

Congress Has the Opportunity to Deliver Health Care Price Transparency (*Health Affairs Forefront*)

Christopher M. Whaley, Jared Perkins, and Ge Bai

A new article in *Health Affairs Forefront* zeroes in on the growing frustration among patients and employers over the lack of transparency in U.S. healthcare pricing when purchasing health benefits. This article is the latest in *Health Affairs Forefront's* series on Provider Prices in the Commercial Sector, which discusses and assesses physician,

hospital, and other health care provider prices in the private-sector markets and their contributions to overall spending. Authors discuss how bipartisan efforts in Congress have aimed to strengthen transparency rules by pushing hospitals and insurers to enhance price transparency with bills like the Lower Costs, More Transparency Act, and the Health Care PRICE Transparency Act 2.0. While both bills require disclosures of negotiated rates and cash prices for services, with penalties for noncompliance, the authors note continuous concerns regarding data accuracy and the effectiveness of some provisions with watered down language. Ultimately, the authors note that despite its criticisms, expanded price transparency has the potential to empower consumers, promote competition, and improve healthcare affordability and quality.

Accountable Care Organizations

Update on the Medicare Value-Based Care Strategy: Alignment, Growth, Equity (*Health Affairs Forefront*)

Douglas Jacobs, Purva Rawal, Michelle Schreiber, Dora Lynn Hughes, Elizabeth Fowler, and Meena Seshamani

Medicare plays an arguably significant role in transitioning the U.S. healthcare system towards value-based payment models which prioritizing quality and efficiency. This new article is the latest in *Health Affairs' Forefront* series on Accountable Care for Population Health, which has sought to understand, design, support, and measure patient-centered, cost-efficient accountable care. The authors discuss the Centers for Medicare and Medicaid Services' (CMS) strategy on alignment, growth, and equity to drive this transition

towards value-based payment models. Among CMS' priorities, the organization is attempting to have broad participation in accountable care organizations (ACOs) by 2030, addressing health disparities through value-based models in in underserved communities, enhancing data sharing, and incentivizing providers to address the social determinants of health. CMS' strategy represents a commitment towards high-quality, equitable, and accountable care within the Medicare system which may, in turn, create broader impacts on the adoption of value-based practices throughout the American healthcare system.

Measuring Value in Healthcare: Lessons from Accountable Care Organizations (*Health Affairs Scholar*)

Chenzhang Bao and Indranil R. Bardhan

Accountable care organization (ACO) programs consist of groups of physicians, hospitals, and health care providers who jointly provide coordinated, patient-focused care. Despite existing for over a decade, few conclusions have been drawn regarding the value of the care that is delivered by ACOs. In this new study, researchers assessed the value of ACO organizational characteristics and the social determinants of health (SDOH) using a novel measure of healthcare value by using data envelopment analysis. Among their findings, the researchers concluded that the value of ACOs has stagnated in recent years and suggest that ACOs should strive for a "skinny in scale, broad in scope" approach to improve the future value of ACOs. Ultimately, the findings suggest that ACOs should be incentivized to work with local communities and enhance care coordination for vulnerable patient populations.

Health Policy Trends

Changes in Health Care Workers' Economic Outcomes Following Medicaid Expansion (*JAMA Network*)

Sasmira Matta, Paula Chatterjee, and Atheendar S. Venkataramani

There has been limited information regarding the ways in which changes in health sector finances impact economic outcomes among health care workers, especially lower-income workers. Researchers in a new study published in *JAMA Network* sought to understand whether health care workers benefited from improved health sector finances. Specifically, they sought to understand the association between state adoption of the Affordable Care Act's Medicaid expansion and health care workers' annual incomes and benefits. Medicaid expansion was associated with higher incomes but only among those who were in higher-earning occupations. This finding indicates that improved health sector finances may expand economic inequality among health care workers of varying income levels.

The Impact of Scope-of-Practice Restrictions on Access to Medical Care (*Journal of Health Economics*)

Jiapei Guo, Angela E. Kilby, and Mindy S. Marks

Opioid use disorder differs from other drug use disorders because it is treatable with the use of medications such as methadone, buprenorphine, or naltrexone. A new study published in the *Journal of Health Economics* assessed the impact of scope-of-practice laws in the provision of medication assisted treatment (MAT) for opioid use disorder. Researchers considered two natural experiments generated by policy changes at the state and federal levels

which allowed nurse practitioners increased practice autonomy and prescribing power. They concluded that both experiments indicated that liberalizing prescribing authorities led to larger improvements in access to care. Specifically, they suggest that expanding the prescribing authority of nurse practitioners could serve to reduce urban-rural disparities in health care access and could also increase access to care provided by physicians.

Implications for Public Health Regulation if *Chevron* Deference is Overturned (*JAMA*)

Sahil Agrawal, Joseph S. Ross, and Reshma Ramachandran

The legal community has been buzzing with speculation ever since the U.S. Supreme Court heard oral arguments on January 17, 2024, for a case that will ultimately decide the fate of *Chevron* deference in the U.S. *Chevron* deference is a longstanding administrative law principle that requires courts to defer to agencies' reasonable interpretations of ambiguous statutes. In this new *JAMA* article, the authors argue that regulatory agencies like the FDA and CMS may soon be limited from using their expertise to interpret public health statutes. The Supreme Court's final ruling, which is expected to be released this summer, could have significant implications for medicine and public health, ultimately affecting the ability of agencies to issue informed and responsive regulations. Overturning *Chevron* could lead to increased legal challenges and uncertainties, which may thereby inhibit agencies' abilities to enforce regulatory standards. The authors argue that this trend could ultimately chip away at the public's trust in scientific institutions and impede efforts to address emerging and existing public health challenges.

Pharmaceutical Costs and Competition

[Prescription Drug Dispensing and Patient Costs After Implementation of a No Behavioral Health Cost-Sharing Law] (*JAMA Health Forum*)

Ezra Golberstein, James M. Campbell, Johanna Catherine Maclean, Samantha J. Harris, Brendon Saloner, and Bradley D. Stein

On January 1, 2022, New Mexico implemented a new law that eliminated cost-sharing for mental health and substance use disorder (MH/SUD) treatments in state-regulated plans, and was thought to potentially reduce a barrier to the commercially insured. A new study in *JAMA Health Forum* sought to investigate this question further, by specifically looking at whether out-of-pocket spending and dispensing of prescription drugs changed after the law was implemented. Researchers assessed prescription data from 47,229 individuals using a difference-in-difference analysis to examine dispensing and cost data for MH/SUD medications. They found that the behavioral cost sharing law was associated an 85.6% reduction in patient spending per medication while the volume of medications dispensed was unchanged. The authors argue that New Mexico's law suggests that cost-sharing for MH/SUD treatments can greatly reduce patient spending on medications.

California Lawmakers Seek to

Increase Oversight of Healthcare Transactions Involving Private Equity and Hedge Funds with AB-3129

The California Legislature wrapped up its annual introduction period for new bills on February 16. Among the wide swath of proposed health care bills, one, in particular, has caught the attention of many legal experts and players in the health care field. AB-3129 was introduced by Assemblymember Jim Wood and Attorney General (AG) Rob Bonta on the last day of the introduction period. It proposes sweeping regulations around how private equity firms and hedge funds can participate in owning and managing healthcare facilities. The introduction of the bill comes amidst nationwide concern regarding the effects of private equity acquisitions in the health care market.

In this month's California Legislative Beat, we take a deeper dive into better understanding what this bill says, the impacts this bill could have on the health care market and competition, and the general reactions to the bill so far.

Background on the Issue

The influence and impact of private equity and hedge fund ownership of the healthcare market has increasingly become a topic of interest for both state and federal law makers, as the practice has grown expansively in the past decade. According to Pitchbook, in 2023 alone, 780 private equity deals were announced or closed in the health care space. While this volume was a decline from the 2022 deal year, it was still the third-highest year on record.

While some see the growing influence of private equity and

hedge fund ownership as a positive way to inject funds into struggling health care practices, others have scrutinized these transactions for a variety of reasons including the creation of market monopolies.

Nationwide, we have been seeing a trend towards increasing regulation and oversight over healthcare transactions, with 24 states enacting laws related to health system consolidation and competition in 2023. Both states and federal agencies have been delving into the impacts of private equity and hedge fund ownership of the healthcare system. In the past quarter alone, Oregon introduced legislation to tighten restrictions on the corporate practice of medicine, the U.S. Senate Budget Committee launched a bipartisan investigation into the impacts of private equity ownership of hospitals, and the Federal Trade Commission (FTC) held a virtual workshop to examine the role of private equity in healthcare. New merger guidelines issued in 2023 by the Federal Trade Commission and Department of Justice are another indication that the Federal government is more closely examining proposed health system mergers. The finalized guidelines provide an overview of the factors and frameworks agencies use when reviewing mergers and acquisitions across varying sectors.

The FTC has also taken more targeted action against private equity firms in recent months. In September 2023, the agency launched a lawsuit against U.S. Anesthesia Partners Inc. (USAP) and private equity firm, Welsh, Carson, Anderson & Stowe in Texas for allegedly executing a multi-year anticompetitive scheme to consolidate anesthesiology practices in the state. The roll-up of these practices allegedly created a monopoly over anesthesia services in Texas and drove up prices for patients.

California has also faced problems originated by private equity-owned health care companies. Prospect Medical Holding, a private equity-backed hospital chain, recently faced Congressional scrutiny and national media attention for

allegedly profiteering. Meanwhile, Pipeline Health, another private equity-backed hospital chain, went bankrupt and closed a hospital in Chicago but still owns and runs hospitals in Southern California.

What the Bill Says

If passed, AB-3129 will require the AG's approval for health care acquisitions or changes of control that involve a private equity group or hedge fund and a healthcare facility or provider group. The bill is similar to existing laws that require healthcare non-profits to provide and obtain written consent from the AG before a transfer or sale, but would expand that oversight to include acquisitions of for-profit health care entities, including health care facilities and provider groups, by private equity firms.

Under this new bill, private equity groups and hedge funds will be required to provide written notice and obtain written consent from the AG prior to a change or control or acquisition. The notice must be provided at the same time as other state or federal agency notifications, and at least 90 days before the change in control or acquisition is to take place.

After the notice is provided, the AG has 60-days to grant approval for these transactions after making an assessment regarding relevant factors such as whether the acquiring party has sufficient funds to operate in the market for three or more years, and ensuring the transaction will continue to maintain health care access to the local community. The AG may deny these requests if there is a substantial likelihood for the transaction to have anticompetitive effects or if it would affect the access and availability of health care services.

The bill also has a special carveout for proposals involving non-physician providers who generate an annual revenue below $4M or involve fewer than ten providers and provider groups

who generate less than $10M in annual revenue. Transactions involving groups who meet these criteria are not subject to AG approval, but still require notice to be given.

Keeping in line with California's existing bans on the corporate practice of medicine, the bill prohibits private equity groups and hedge funds from being involved in any manner that would control or direct a physician or psychiatric practice. Likewise, physicians and psychiatric practices will not be allowed to enter into agreements where private equity firms or hedge funds control their practice in any form.

If implemented, AB-3129 will be a further extension of California's growing regulations over health care transaction oversight. In some ways, this bill can be seen as an extension of the authority given to California's Office of Health Care Affordability (OHCA) to collect and review notices of material transactions. OHCA, however, does not have the authority to block a transaction; they must go to court or use the authority of another state agency to block a transaction. AB-3129 would give further the AG the authority to approve, deny, or impose conditions on a transaction without court approval. Parties can request that the AG reconsider a decision that denies consent or imposes conditions. AB-3129 would also allow the parties to seek subsequent judicial review of the Attorney General's final determination

Criticisms of AB-3129

Opponents of AB-3129 have asserted that the new bill could bring about the very outcomes that it seeks to protect against. Specifically, some lawmakers believe that the added restrictions will make it more difficult for struggling healthcare systems to find buyers and stifle the deals that are currently keeping some facilities open. The push to restrict private equity acquisitions alongside the existing non-profit limitations lead some to fear that some practices may be headed towards bankruptcy if this law is enacted. They

argue that the negative effects of private equity investments are blown out of proportion, and that for every publicized private equity failure, there are hundreds of transactions that have actually provided support and resources to the broader health care landscape.

Moreover, others believe that the process is duplicative of the existing OHCA review regulations, and will serve to add increased costs, complexity, and timelines for affected parties which could ultimately lead to a "chilling" effect on the California healthcare investment market. These new restrictions alongside existing prohibitions are believed to potentially have wider reaching effects by upending management service organization (MSO), operating, shareholder, and other business agreements.

Lastly, those who oppose AB-3129 feel that the legislation provides an inappropriate amount of power to the AG and are in favor of rolling back the AG's power. Those who challenge the bill state that the standards and definitions in the law are currently unclear as they stand, and ask for more clarified definitions when it comes to terms and phrases such as "anticompetitive effects," "public interest," and "significant effect on access or availability of healthcare services to the affected community."

Arguments in Support of AB-3129

Assemblyman Wood, who is also a dentist by training and in his last term, expressed interest in this issue because his district has been impacted by these types of acquisitions. Specifically, the Assemblyman has noted that a single investor has bought up several nursing homes in his rural district and has argued that while each deal is small individually, when taken together, they have a significant impact. The AG has also backed the legislation because he believes that it will help to crack down on the alleged profiteering within this space.

While some argue that private equity-backed transactions have the potential to improve efficiency in the health care system, research indicates that the resulting market consolidation can result in reduced competition, and increased costs for patients, without a commensurate improvement in patient care. By giving the AG greater oversight power, supporters seek to ensure greater scrutiny over deals that could potentially have anticompetitive effects or negatively affect healthcare access and costs in the communities where these facilities operate.

Given the current climate surrounding private equity and hedge fund investments into the healthcare market, there has been a growing push to strengthen existing California bans on the corporate practice of medicine. Increasingly, advocates have been trying to assert the delineation between corporate decision-making and the ability of providers to exercise their professional medical judgments, in the hopes that it will solve systemic issues including increased physician burnout. In a press release, Assemblyman Wood asserted that his bill was "essential and critical" because it could also protect physicians from outside influences interfering with their practice of medicine.

What Comes Next

If AB-3129 is passed by the end of September 2024, it would go into effect on January 1, 2025, potentially giving investors limited time to exit the market, if they choose to.

AB-3129 was introduced on February 16 and was referred to both the Health and Judiciary Committees March 11. *The Source* anticipates that this bill will be discussed in committee hearings soon.

Stay tuned as we will continue to track this bill and provide updates as it moves through the legislative process.

Patients File Class Action Suit Claiming Healthcare Merger Resulted in Unfair High Prices

The preponderance of research evidence demonstrates that a lack of meaningful healthcare market competition is bad for consumers – resulting in higher prices, and insurance premiums, without a commensurate increase in quality of care. New merger guidelines issued in 2023 by the Federal Trade Commission and Department of Justice are just one indication that the Federal government is more closely examining proposed health system mergers. Increased regulatory scrutiny, among other factors, appears to be causing a slow-down in healthcare merger activity. In addition to merger challenges by state and federal antitrust enforcers, private parties can also use antitrust law to sue for treble damages from mergers of behavior of dominant companies that unreasonably restrain trade.

On February 5, 2024, a group of Wisconsin citizens filed a class action suit in the United States District Court for the Eastern District of Wisconsin on behalf of Commercial Health Plan Members against Aurora Health Care and Advocate Aurora Health (AAH), claiming "AAH has engaged in anticompetitive methods to restrain trade and abuse its market dominance for the purpose of foreclosing competition and extracting unreasonably high prices from Wisconsin commercial health plans and their members."

PARTIES TO THE SUIT

Defendant Advocate Aurora Health was formed via a 2018 merger of Wisconsin-based Aurora Health and Illinois-based Advocate Health, creating, at the time, a network of 27 regional hospitals and over 500 sites of care. In December 2022, Advocate Aurora merged with North Carolina-based Atrium Health, creating a systems with 67 hospitals called Advocate Health – the fifth-largest nonprofit health system in the U.S.

The plaintiffs (the Shaws) are Wisconsin residents who have received treatment through AAH that the suit describes as inadequate and expensive. Plaintiffs are bringing the suit "individually and on behalf of all others similarly situated."

DETAILS OF THE CLAIMS

The case is claiming that AAH has committed restraint of trade, monopolization, and attempted monopolization in violation of the Sherman Act and Wisconsin antitrust law. In addition to the supposed violations of the law, the plaintiffs are asking the court to certify the proposed class, and award damages and other relief.

Specifically, the suit claims AAH's market dominance allows them to engage in behaviors that drive up costs, including insisting on all or nothing, anti-steering and anti-tiering language in insurance contracts (preventing insurance companies from creating networks to achieve cost savings), as well as refusing to deal with plans that use reference-based pricing. The suit also claims that AAH engages in anticompetitive conduct with providers by using non-competes, referral restrictions, and gag clauses.

In addition to having a significant overall market share, the suit claims AAH's ability to engage in anticompetitive conduct is exacerbated by its ownership of "must-have" healthcare facilities, and a dominant ownership of many local specialty services in eastern Wisconsin.

Plaintiffs claim that the extreme prices AAH can charge to insurers due to their vast market power are passed on to the public through higher premiums, deductibles, and co-pays. With a competitive healthcare market, the suit contends that there would have been a savings of hundreds of millions of dollars in recent years for health plans and their members.

SIGNIFICANCE

This case is similar to Uriel Pharmacy Health and Welfare Plan v. Advocate Aurora Health, Inc., No. 22-CV- 610 (LA) (E.D. Wis.) filed on May 24, 2022. In that case, the plaintiff, a self-insured employer, is claiming that anticompetitive practices by AAH (including all-or-nothing, anti-steering/anti-tiering, and gag clauses) made possible by its monopoly power constitute a violation of federal and state antitrust laws, and have resulted in higher prices for its services compared to other providers.

If cases like *Shaw* and *Uriel* become part of a successful trend of employers and now patients bringing suits challenging high post M&A hospital prices, it would yet another disincentive for healthcare megamergers, and would represent a positive step towards more competitive healthcare markets.

The Source Roundup: March 2024 Edition

Health Policy Trends

- **The 2024 CHCF California Health Policy Survey (*California Health Care Foundation*)**

  Jen Joynt, Rebecca Catterson, Emily Alverez, Larry Bye, Vicki Pineau, and Lin Liu

The California Health Care Foundation released results from its fifth annual California Health Policy survey. Researchers from the California Health Care Foundation and NORC at the University of Chicago surveyed a representative sample to assess Californian's views and experiences on a myriad of health care topics. This year's survey yielded a number of key findings. Among them, researchers found that there is a high level of dissatisfaction with mental health care access, and that Californians, especially those with low incomes, were continuing to face burdens created by high health care costs and medical debt. Many Californians also reported being concerned about the effects of the weather and environmental factors on their health, and reported waiting for health insurance authorizations before they could receive doctor-approved care.

Healthcare System Mergers and Investments

- **Certificates of Public Advantage: A Valuable Tool or Diminishing Allure? (*Mitchell Hamline Law Journal of Public Policy and Practice*)**

Abdur Rahman Amin

Antitrust in the healthcare sector has become a growing concern for the Biden administration, who have prioritized enforcement by hiring more antitrust lawyers and tasked the FTC and DOJ to investigate merger activity. In this new paper, the author providers a brief primer on key federal

antitrust laws and regulations and assesses the current regulatory landscape of antitrust enforcement broadly, while making recommendations for better ways forward in the healthcare sector. Present merger and acquisition activity has created a system where the ten largest American health care systems now control over 25% of the national market. Against this landscape, the author engages in a discussion of the merits and criticisms of certificates of public advantage (COPAs), a type of antitrust exemption mechanism that lays at the heart of current antitrust controversies. While COPAs offer a method of state control over hospital mergers, they bear potential long-term costs including reduced quality and raised prices due to decreased competition, and thus, requires strong regulation and the addition of potential new approaches.

- **Equity Investment in Physician Practices: What's All This Brouhaha?** (***Journal of Health Politics, Policy and Law***)

Mark V. Pauly and Lawton Robert Burns

Since the passage of the Affordable Care Act in 2010, the U.S. healthcare system has experienced a boom in equity-based investments in physician practices – but this trend isn't novel. In this new article in the *Journal of Health Politics, Policy and Law*, the authors assess the current investment wave against an initial wave of equity-led financings from the 1990s, specifically looking at the parallels and divergences between the two eras. While the 1990 market was more heavily influenced by public equity and physician practice management company (PPMC) investments and the current market is more private equity-centric, the authors discuss similarities in the eras including driving forces, acquisition dynamics, and models to achieve market penetration. The paper ends by delving deeper into private equity investments by asking how these

investments may differ from the standard, determining whether they lack and confer competitive advantages, and assessing whether physician practice investments offer opportunities for "super-normal profits." Overall, the authors determine that trends from the 1990s may be likely to repeat and call out the private equity threat as being "overblown."

- **Cross-Market Mergers with Common Customers: When (and Why) Do They Increase Negotiated Prices? (*arXiv*)**

Enrique Ide

Cross-market mergers of supplies to intermediaries that bundle products for consumers have often been viewed as controversial. In this new paper, the author uses modeling to argue that two products can be complements for the consumer but substitutes for intermediaries and applies their findings to explain why cross-market hospital mergers raise healthcare prices. Cross-market hospital mergers involve hospitals in distinct geographies or diagnostic markets and have been contentious because they have been subject to limited antitrust enforcement despite findings showing that they have led to increases in insurance reimbursement rates with minimal increases in quality. Ultimately, the analysis finds that in the healthcare context, products can be complements for consumers but substitutes for intermediaries, helping explain why cross-market hospital mergers result in higher prices, and that reviewers should put a greater focus on mergers involving specialized providers.

The Source Team Examines Changes to the Final 2023 Merger Guidelines

For Health Affairs Forefront, the Source's Katherine Gudiksen and Jaime King have analyzed changes from the draft version to the final 2023 Merger Guidelines released by the Federal Trade Commission (FTC) and Department of Justice (DOJ). In a previous Health Affairs Forefront piece, Source staff examined the draft guidelines. This new post examines key elements of the new guidelines, concluding that while the final version better aligns the Guidelines with the underlying antitrust laws and caselaw, the Guidelines create more grey area for companies to demonstrate that mergers do not violate antitrust laws. Nonetheless, the development of the Merger Guidelines follow increased attention on harmful consolidation in many industries by the Biden administration and FTC and DOJ. The Guidelines provide important transparency into the process by which the FTC and DOJ will analyze proposed mergers in the wake of decades of widespread consolidation and new market conditions in health care.

The Source will continue to follow merger challenges brought by the FTC and DOJ under the 2023 Merger Guidelines.

FTC Files Suit to Block Sale of North Carolina Hospitals

to Novant

On January 25th, 2024, the Federal Trade Commission (FTC) announced that it had authorized a suit to block Novant Health's proposed acquisition of two hospitals owned by Community Health Systems (CHS) in North Carolina. Nearly a year ago, in February of 2023, Novant Health and Community Health Systems (CHS) signed an Asset Purchase Agreement for Novant to pay $320 million to acquire two North Carolina hospitals from CHS.

Novant is currently one of the largest hospital systems in the southeastern United States, and already owns a local hospital that serves more patients than any other local hospital. CHS is a for profit healthcare system operating over 70 hospitals and many other care sites in 15 states, but has reportedly been experiencing financial difficulties in recent years.

According to the FTC's administrative complaint, the deal would give Novant close to 65% of the local inpatient general acute care services market, which "would likely increase annual healthcare costs by several million dollars", according to the FTC's press release. The complaint asserts many claims that are typical of horizontal mergers between hospitals in the same geographic market. Specifically, the FTC alleges that because there are few alternatives for inpatient care in the area, the merger will result in millions of dollars in increased healthcare costs by eliminating the price competition that currently exists between CHS and Novant. The FTC also states that the merger would reduce Novant's incentive to compete to attract patients by improving its facilities, service offerings, and quality of care and would likely lead to worse outcomes for nurses and doctors, and "life or death consequences for patients."

A transaction that significantly increases concentration in a highly concentrated market is presumptively illegal under

Guideline 1 of the 2023 Merger Guidelines that were issued by the FTC and DOJ in December 2023. In the complaint, the FTC alleges that this transaction would increase the Herfindahl-Hirschman Index (HHI, a measure of market concentration calculated by summing the squares of the individual firm's market shares) would increase by more than 1000 points, leading to a post-acquisition HHI significantly about 3500. The 2023 Merge Guidelines include a structural presumption of illegality of a market HHI greater than 1800 and a change in HHI of more than 100 from a transaction. While the presumption of illegality can be rebutted or disproved, if the FTC's market definitions are accurate, this transaction would greatly exceed those thresholds and would likely harm competition in the area. According to the FTC, the complaint will be filed in the U.S. District Court for the Western District of North Carolina to halt the transaction pending an administrative proceeding.