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.

The Source Roundup: April 2024 Edition

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.

Class Action Antitrust Suit Claims University of Pittsburgh Medical Center Used Monopsony Market Power to Suppress Healthcare Workforce Conditions

On January 18, 2024, Victoria Ross, a former University of Pittsburgh Medical Center (UPMC) nurse, filed an antitrust class action suit in the US District Court for the Western District of Pennsylvania against UPMC. The suit claims UPMC used its "monopsony power to prevent workers from exiting or improving their working conditions, to suppress workers' wages and benefits, and to drastically increase their workloads, through a draconian system of mobility restrictions and widespread labor law violations that lock employees into sub-competitive pay and working conditions."

Parties to the Suit

According to the suit, the UPMC system includes over 40 hospitals (making it the 18th largest hospital chain in the nation), and employs over 95,000 workers, making it the largest private sector employer in Pennsylvania. The plaintiff class includes licensed practical nurses, nurses, medical assistants, registered nurses, nurse assistants and orderlies currently or formerly employed at UPMC facilities providing in-patient care.

Details of the Claim

The plaintiffs claim that UPMC used noncompete clauses and do-not-rehire blacklists, and suppressed labor law rights to

prevent unionization. The plaintiffs allege that these practices are a violation of Section 2 of the Sherman Act that prohibits monopolization and attempted monopolization. An economist cited in the suit claims that UPMC workers' wages fell at a rate of 30 to 57 cents per hour for every 10% increase in UPMC's market share, relative to comparable hospital workers. Plaintiffs allege that the staffing ratios at UPMC have been decreasing, even as staffing ratios have been increasing at other Pennsylvania hospitals. The suit claims that if UPMC had been subject to competitive market forces, it would have had to pay more to attract workers and raise staffing levels to avoid degrading the care it provides to patients. The suit also claims UPMC acquired its market power through anticompetitive acquisitions of competitors, facility shutdowns, and by preventing expansion of rivals. The complaint claims that these business practices allowed UPMC to gain monopsony power in the related labor market that it used to suppress wages and benefits, increase workloads, degrade workplace conditions, and prevent workers from seeking other employment.

Plaintiffs will have to show that UPMC used its monopsony power to limit worker mobility, and used anticompetitive employment practices to suppress workers' wages, degrade work conditions, and prevent unionization. The complaint follows a similar complaint filed by two unions in May 2023 to the Justice Department asking for an investigation of potential antitrust violations by UPMC.

Effects of Healthcare Marketplace Power on Healthcare Workers

While much attention has been paid to the harms caused to patients and employers by extreme market power of health systems (including higher costs and lower quality of care), this case highlights the potential harm that can befall healthcare workers in markets without meaningful competition. For example, a recent study by Prager and Schmitt found that where mergers significantly increase hospital concentration,

four years after the merger "nominal wages were 6.8% lower for nurses" than they would have been without the merger. That study concluded that there is "evidence of reduced wage growth in cases where both (i) the increase in concentration induced by the merger is large and (ii) workers' skills are industry-specific."

Increased Enforcement Attention on Monopsony Power and Harms to Workforce

This case follows revisions to the Merger Guidelines that were made by the Federal Trade Commission (FTC) and Department of Justice in December 2023. Specifically, Guideline 10 states that when a merger involves competing buyers, including employers as buyers of labor, the FTC and DOJ can assess the impact of this merger with the aim of protecting competition in all forms. In the discussion of guideline 10, the Agencies state that "where a merger between employers may substantially lessen competition for workers, that reduction in labor market competition may lower wages or slow wage growth, worsen benefits or working conditions, or result in other degradations of workplace quality." While the merger guidelines are specific to how the FTC and DOJ review proposed transactions, the recognition of the potential harms of monopsony power on workers align with the claims made in this case.

Monopsony antitrust litigation against employers claiming wage suppression is rare, but not unheard of. For example, in 2006, Pat Cason-Merenda, RN filed suit against the Detroit Medical Center claiming that they colluded with seven other hospitals to suppress the wages of more than 20,000 nurses, which was ultimately settled when the hospitals agreed to pay $90 million dollars. However, the UPMC cases seem to take a unique approach by adding a claim that, in addition to holding down wages, UPMC used its monopsony power to restrict job mobility (via noncompete agreements and "do not hire" blacklists) and to prevent unionization.

The Source will monitor the case for relevant developments.

The Source Roundup: February 2024 Edition

Healthcare System Mergers and Investment

- **Models for Enhanced Health Care Market Oversight – State Attorneys General, Health Departments, and Independent Oversight Entities** (***Milbank Memorial Fund***)

Erin C. Fuse Brown, Katherine L. Gudiksen

The Source's own Katherine L. Gudiksen co-authored this report for the *Milbank Memorial Fund* with Eric C. Fuse Brown, which assesses the tools state policy makers are using to address harmful health care market consolidation. Specifically, the report focuses on how states have broadened review authority by expanding the existing authority of the Attorney General (or other state agencies) and providing supplementary oversight entities with an added authority to review health care transactions. The authors assessed applicable state statutes and regulations and interviewed state policy makers for their assessment. Based on their findings, the authors present a set of recommendations and considerations for policymakers that are aimed at strengthening the oversight authority of health care transactions.

- **Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition** (***JAMA***)

Sneha Kannan, Joseph Dov Bruch, Zirui Song

Researchers from Harvard University and the University of Chicago recently studied whether private equity acquisitions of hospitals had an impact on quality of care and patient outcomes. The group studied data from 100% Medicare Part A claims for over 660,000 hospitalizations at 51 private equity-acquired hospitals against data for over 4 million hospitalizations at 259 non-private equity acquired hospitals for the period of 2009 to 2019. Ultimately, the study found that private equity-acquired hospitals were generally associated with increased hospital-acquired adverse events, such as falls and infections, despite a likely lower-risk pool of admitted Medicare beneficiaries. These findings raise concerns about the implications of private equity acquisitions on the delivery of healthcare, suggesting that they may be correlated with poorer quality inpatient care.

Healthcare Coverage Alternatives

- **Looking AHEAD to State Global Budgets for Health Care** (***The New England Journal of Medicine***)

Suhas Gondi, Karen Joynt Maddox, Rishi K. Wadhera

Despite the Center for Medicare and Medicaid Innovation's (CMMI) projection that the Affordable Care Act (ACA) would result in a net savings of $3 billion over its first decade, the Congressional Budget Office (CBO) recently

reported that the program actually increased federal healthcare spending by $5.4 billion. As we enter the ACA's second decade, the Centers for Medicare and Medicaid Services (CMS) have developed an ambitious plan to make improvements. The State Advancing All-Payer Health Equity Approaches and Development (AHEAD) model is a voluntary state model that is focused on curbing cost growth, improving population health, and advancing health equity over the next 10 years. This article examines the strengths and limitations of AHEAD's goals, assesses CMS' likeliness to meet their goals, and provides some policy and implementation recommendations. As the U.S. works towards payment-reform, AHEAD could be a crucial strategy towards netting federal healthcare savings while improving population health.

- **Next Steps for Engaging Specialty Care in ACO Models** (***Health Affairs Forefront***)

Asher Wang, Katie Huber, Jonathan Gonzalez-Smith, Frank McStay, Mark B. McClellan, Robert S. Saunders

This article is the second in a two-part *Health Affairs* series on how differences in specialty care providers and practices should inform accountable care strategies. Picking up where they last left off, the authors of this article outline a set of recommendations that can help accountable care models achieve effective specialty care. Considerations and recommendations for achieving change are organized under three overarching strategic themes which include: providing data and facilitating data sharing for enhanced specialty and primary care coordination; expanding financial levers to support specialty care participation and collaboration in population-based and longitudinal models; and implementing non-financial reforms to increase

support and reduce burdens for specialist engagement in accountable care.

- **Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016-17** (***Health Affairs***)

Adrianna McIntyre, Mark Shepard, Timothy J. Layton

While health insurance premiums have been widely thought to pose barriers to health coverage, the authors of this study assessed whether financially negligible monthly premium payments (<$10/month) also created administrative burdens that negatively impacted coverage. A study of 2016-17 health insurance marketplace data from Massachusetts found that introducing nominal monthly payments negatively affected enrollment for the following year when compared with plans that maintained a $0 premium. On average, plans with nominal premiums saw enrollment decrease by 14% which was largely attributable to terminations for non-payment. Overall, even financially nominal premiums act as financial and administrative barriers to enrolment and could be addressed through policy changes.

- **Why Cost Sharing on Its Own Will Not Fix Health Care Costs** (***JAMA Internal Medicine***)

Anna D. Sinaiko, Benjamin D. Sommers

A new Viewpoint article in *JAMA Internal Medicine* has raised skepticism over whether high-cost sharing with high-deductible health plans (HDHPs) will fix the U.S.' recurring issue of high health care costs. Since the pandemic, health care utilization has largely returned to pre-pandemic levels as private sector health insurance costs have simultaneously increased. On average, premiums

for employer-based family coverage have increased by 20% over the past 5 years. HDHPs, which can be linked to pretax health savings accounts, have been posited as a potential solution. The belief is that if patients have more skin in the game, they will avoid unnecessary care, shop for lower-priced services, and reduce health care inflation. The authors of this article are not convinced by such arguments and discuss how this approach will not meet its targets and may result in adverse harms for many high-need patients.

Quality and Price Transparency

- **Benchmark and Performance Progression: Examining the Roles of Market Competition and Focus** (***Journal of Operations Management***)

Xin (David) Ding

Despite spending almost 20% of its GDP on health care in 2020, the U.S. ranked last in administrative efficiency and healthcare outcomes among high-income countries. To address this situation, the Centers for Medicare and Medicaid (CMS) brought forth value-based programs which tied medical reimbursements, in the way of penalties or incentives, to performance benchmarks. This study examined the effect of these benchmarks on healthcare delivery and patient outcomes by assessing hospital performance in terms of technical efficiency, clinical quality, and patient experience over time. Ultimately, the author found that while benchmarking does lead to hospital performance improvements, its effects diminish as hospitals approach performance frontiers. Moreover, they also found that technical efficiency was impacted by market competition and that focus had a curvilinear positive effect on progression rates.

- **Playing by the Rules? Tracking U.S. Hospitals' Responses to Federal Price Transparency Regulation** (***Journal of Healthcare Management***)

Sayeh Nikpay, Caitlin Carroll, Ezra Golberstein, Jean Marie Abraham

Beginning in 2021, most U.S. hospitals were required by the Centers for Medicare and Medicaid Services (CMS) to increase transparency for consumers by publishing pricing information on their websites at the risk of receiving noncompliance penalties. This study assessed hospital compliance with the new rule after the first year of enactment across a random sample of 470 hospitals. By early 2022, almost 90% of hospitals had complied with the consumer-shoppable data requirement and 46% of hospitals had posted both machine-readable and consumer-shoppable data. Generally, the study found a trend among hospitals towards compliance. Progressively increasing compliance can foster greater price transparency and has the potential to elevate future policy discussions on price variations, affordability, and the impacts of healthcare market regulation.

And with that, we conclude this month's roundup. If you find articles or reports that you think should be featured, please send them our way.

The Source's Katherine L.

Gudiksen co-authors report on health care market oversight

The Milbank Memorial Fund has published a report titled "Models for Enhanced Health Care Market Oversight – State Attorneys General, Health Departments, and Independent Oversight Entities" authored by Erin C. Fuse Brown and The Source's own Katherine L. Gudiksen.

The report looks at tools state policymakers are using to address harmful health care market consolidation, focusing on how states have expanded the review authority of the Attorney General (or other state agencies), and have given authority to review transactions to additional oversight entities. The authors reviewed applicable state statutes and regulations, and interviewed state policymakers, to create recommendations and considerations for policymakers to strengthen oversight authority of health care transactions.

Read more here.