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.

FTC Announces Special Open Commission Meeting on Rule to Ban Noncompetes

---

FTC Curtails Treatment Provider's Sharing Of Health Data

AHA urges Department of Labor to ‘immediately’ investigate MultiPlan

---

Privacy bill could have sweeping impact on insurers, providers

---

Lawmakers urge FTC, DOJ to scrutinize Steward Health, Optum deal

---

Lawmakers target private equity in healthcare, citing

‘rot’

Higher fines compel most hospitals to disclose prices

CMS finalizes ACA network adequacy rule

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.