Indiana lawmakers propose large fines for expensive hospital care

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Healthcare Consolidation Q4 2022: Cross-Market Mergers Continue Apace

2022 has been an active year in healthcare consolidation as well as for merger challenges and enforcement. As we approach the year end, healthcare deals continued as many entities seek to close the transactions before the new year. Increasingly, as seen in the 4th quarter, healthcare deals are shifting to cross-market transactions, making review and enforcement efforts more challenging. In case you missed it, this final Litigation and Enforcement Highlights of the year will help you catch up on some of the cross-market deals in Q4 2022 that caught our attention.

Advocate Aurora and Atrium Health

One of the most scrutinized healthcare mergers this year received regulatory approval and was completed earlier this month. Announced in May, the megamerger of Advocate Aurora, headquartered in Wisconsin and Illinois, and Atrium Health of North Carolina, combines 67 hospitals across Alabama, Georgia, Illinois, North Carolina, South Carolina, and Wisconsin. The new regional health system is named Advocate Health and is now the fifth largest nonprofit health system in the country. The merger was initially paused when the Illinois Health Facilities and Services Review Board denied the transaction for lack of details on the controlling interests of the merged entity. The issue was resolved when the parties provided more information per the board's request. Notably, while North Carolina Attorney General Josh Stein expressed concerns about the merger's effect on healthcare access in North Carolina, neither the state attorneys general nor the Federal Trade Commission challenged the merger, likely due to the difficulty in proving competitive harms from a cross-market merger spanning different states.

Despite the fact that antitrust enforcers did not bring a merger challenge, the merger may impact price and competition. Both parties to this merger have been the subject of antitrust

lawsuits arising from their respective market power. Advocate Aurora is the product of a 2018 merger between Advocate Health and Aurora Health and the resulting market power from that merger has already raised alarms in the Wisconsin area. Also in May, a private lawsuit was filed in Wisconsin federal court alleging the health system leveraged its substantial market power forced insurers to enter all-or-nothing and anti-tiering and anti-steering contract terms, and used referral restraints, noncompetes and gag clauses to suppress competition from other healthcare providers and demand higher prices for its services. Coincidentally, Atrium Health was also the target of similar allegations in the landmark case brought by the Department of Justice and North Carolina AG over its use of anticompetitive contracting terms. That case settled in 2019 with terms that prohibits Atrium from enforcing the anticompetitive clauses in contracts with insurers. What will the combination of these two hospital systems bring? Antitrust experts and economists are no doubt watching with great interest.

Deaconess Health System and Quorum Health

Another cross-market transaction involving Illinois hospitals received approval this month from the Illinois Health Facilities and Services Review Board. Deaconess Health System is set to acquire four hospitals in southern Illinois from Quorum Health for $146 million. Based in Indiana, Deaconess is a nonprofit health system that operates 12 hospitals in Illinois, Indiana, and Kentucky. Quorum Health, on the other hand, is a for-profit health system based in Tennessee with 21 hospitals across 13 states. Due to its financial struggles in recent years, Quorum had been selling off many of its hospitals to pay for its debts, including the ones being sold to Deaconess, with others to come. Given the cross-market nature of the transaction and the issue of solvency of the entity involved, this deal likely will not be challenged by antitrust enforcers and is expected to close by the end of the year.

Sanford Health and Fairview Health Services

In November, another cross-market merger was announced between Sanford Health and Fairview Health Services. Sanford operates 47 hospitals in South Dakota, North Dakota, and Minnesota. Fairview is based in Minnesota, where it operates 11 hospitals. The proposed merger will integrate the two nonprofit systems in the Midwest region under the Sanford Health brand. In this transaction, the two entities seemingly do not have overlapping service areas, and it remains to be seen whether the deal would be challenged by either federal or state regulators.

Notably, this is the third time Sanford Health has attempted at a cross-market merger deal in the past three years. In 2019, the proposed merger with UnityPoint in Iowa was called off in the negotiation stage. The following year, the deal with Intermountain Healthcare of Utah also fell through. Intermountain Healthcare, however, found its own cross-market deal with SCL Health, which closed earlier in April this year. Intermountain is a nonprofit system that operates in Utah, Idaho, and Nevada, while SCL Health is a Catholic health system with significant market shares in Colorado and Montana, as well as operations in Wyoming and Kansas. The combination of Intermountain and SCL Health formed a 33-hospital rural health system in the Rocky Mountain region and is now the 11th largest nonprofit system in the country. While that merger received extensive review from Colorado enforcers, it did not face regulatory hurdles given the lack of geographic overlap in the markets.

While the FTC and DOJ have successfully challenged and blocked several mergers this year, cross-market mergers have largely proceeded under the radar. Nonetheless, the rise of cross-market transactions in recent years warrant greater scrutiny on the market effects of these mergers. The Source researchers partnered with economists at the UC Berkeley Petris Center to study this growing trend and its potential impact on competition. As recently published in *Health Affairs*, the study found that more than half of all hospital acquisitions between 2010 and 2019 qualified as cross-market, namely involving hospitals in a different geographic market. Additionally, there is increasing evidence that cross-market mergers may have potential anticompetitive effects because they enable health systems to tie their hospitals across markets and demand higher prices from insurers. Such anticompetitive behavior are the exact allegations in the antitrust lawsuits filed against Advocate Aurora and Atrium Health. More research and studies will come in the coming year as we dive deeper on the topic and examine the price and quality effects and how to address the cross-market phenomenon. In the meantime, be sure to check out the Cross-Market Systems interactive key issue page on The Source for additional resources and the latest developments.

Employer, Hospital Tensions Rise Over Price Transparency

7th Circ. Revives Indiana Doc’s Antitrust Claims Against Univ.

HB 1175

Physician noncompete agreements. Specifies that the reasonable price of a noncompete agreement buyout may not exceed $75,000 under the following circumstances: (1) the physician’s employer is a hospital system located in Allen County; (2) the physician has completed a minimum of eight years of employment with the hospital system; and (3) the physician practices primary care and specializes in family medicine.

HB 1295

Physician noncompete agreements. Specifies a process by which a physician or employer may require binding arbitration to determine a reasonable price to purchase a release from a noncompete agreement.

SB 400

Physician noncompete agreements. Specifies a process by which a physician or employer may require binding arbitration to determine a reasonable price to purchase a release from a noncompete agreement.

SB 298

Certificates of public advantage. Defines “merger” and “merger agreement” for purposes of the certificate of public advantage (certificate) for certain hospital mergers. Requires the state department of health (state department) to actively supervise a merger. Allows the state department to enter into an agreement with a nonprofit organization or a postsecondary educational institution to study the impacts of the certificate of public advantage on the community’s health metrics and outcomes. Requires holders of a certificate to pay for reasonable charges incurred by the state department.

HB 1270

Nonprofit hospital and insurer reporting. Requires a nonprofit hospital with more than 100 beds to report annually specified financial information to the state department of health. Requires a nonprofit hospital and a health carrier to post and send certain information at least 45 days before a public forum. Modifies requirements concerning the: (1) date on which the public forum must be held; (2) topics that must be discussed at a public forum; (3) submission of questions and feedback at a public forum; and (4) use of technology to allow attendance through real time audio and video through the Internet. Requires the insurance commissioner to report to the legislative council if the federal Transparency in Health Coverage rule (federal rule) is repealed or enforcement is stopped. Requires health payers to continue to post pricing information in compliance with the federal rule after the federal rule is repealed or stopped. Modifies the definition of “health payer” for purposes of the all payer claims data base.

SB 249

Health insurance transparency. Specifies that the compliance of a practitioner and a provider facility with federal law meets the good faith estimate requirements concerning health service costs. Allows the commissioner of the department of insurance to issue an order to

discontinue a violation of a law (current law specifies orders or rules). Requires a domestic stock insurer to file specified information with the department of insurance. Prohibits a health plan from requiring a health care provider to submit a prior authorization request to a third party and requires the health plan to transmit the request to the third party through secure electronic transmission. Amends the deadline by which a health plan must respond to a nonurgent care prior authorization request. Requires a health plan to offer a health care provider that submitted a prior authorization and received an adverse determination the option to request a peer to peer review by a clinical peer concerning the adverse determination. Requires a health plan to post notice of a technical issue with its claims submission system on the health plan's Internet web site. Requires a health plan to post on its Internet web site not later than February 1 of each year: (1) the 30 most frequently submitted CPT codes in the previous calendar year; and (2) the percentage of the 30 most frequently submitted CPT codes that were approved in the previous calendar year. Establishes an approval process for a health plan's proposed premium rate increase of 5% or greater as compared to the previous calendar year. Prohibits an insurer and a health maintenance organization from altering a CPT code for a claim unless the medical record of the claim has been reviewed by an employee who is a licensed physician. Requires an insurer and a health maintenance organization to provide a contracted provider with a current reimbursement rate schedule: (1) every two years; and (2) when three or more CPT code rates change in a 12 month period. Urges the study by an interim committee of prior authorization exemptions for certain health care providers.