New Jersey GOP Calls for Probe of State Worker Health Costs

The FTC says it’s getting tougher on hospital consolidation. Antitrust experts aren’t buying it

---

New Jersey health systems cancel merger

Q2 2022: Antitrust Enforcement Actions Flourish Against Healthcare Consolidation and Anticompetitive

Contracting

It's been a busy month in healthcare antitrust land, both for federal regulators and private plaintiffs, as we saw an explosion of enforcement actions challenging both proposed mergers and anticompetitive conduct that stemmed from previous mergers. From New Jersey to Utah, large health systems such as HCA are being increasingly scrutinized and coming under fire for garnering and using their market power in anticompetitive ways.

Merger Challenges

Fresh from its appeals court win in the Hackensack Meridian and Englewood merger challenge, the Federal Trade Commission (FTC) is continuing its momentum and kicking off the summer with a new pair of enforcement actions filed against proposed mergers.

RWJBarnabas & Saint Peter's Healthcare System (New Jersey)

New Jersey health systems are again in the spotlight following the blocked Hackensack merger last month. RWJBarnabas Health (RWJBH) and Saint Peter's Healthcare System announced their plans to merge back in September 2020. Similar to the Hackensack case, the deal had obtained approval from the New Jersey attorney general and Superior Court Judge Lisa Vignuolo opined that the transaction "will serve in the public interest and the public good."[1] RWJBH is the largest academic health system in New Jersey with 12 hospitals and strong collaborations with Rutgers Robert Wood Johnson Medical Schools. Saint Peter's Healthcare System is a Catholic system that includes Saint Peter's University Hospital in New Brunswick, which is less than one mile from RWJBH.

In the administrative complaint, the FTC alleges the acquisition will give RWJBH a 50% market share for general acute care services in Middlesex County and eliminate head-to-head competition between the entities, leading to higher insurance premiums, co-pays, deductibles, or other out-of-pocket costs. Additionally, due to the state's certificate of need law, entry of other providers will be limited and likely

insufficient to counteract the anticompetitive effects of the acquisition. To halt the merger, the FTC plans to file a lawsuit in the New Jersey District Court for a preliminary injunction pending the administrative trial in November.

HCA Healthcare & Steward Health Care (Utah)

Also facing FTC challenge this month is HCA Healthcare's proposed acquisition of five hospitals in Utah from Steward Health Care. HCA and Steward are both for-profit systems and based in Tennessee and Texas, respectively. In Utah, HCA operates eight hospitals, six of which are in the Wasatch Front region around Salt Lake City, making it the second largest system in the region. Steward, on the other hand, is the fourth largest system in the same region with five hospitals. According to the FTC, the two rival hospital systems vigorously compete with each other to keep costs down. The agency argued that the proposed merger is likely to substantially lessen competition for general acute care services in at least four counties with already highly concentrated healthcare markets. Specifically, the merger would increase the Herfindahl-Hirschman Index ("HHI") by more 200 points to 2,500, which is presumptively unlawful. Additionally, the acquisition would eliminate Steward as a low-cost provider and give HCA greater bargaining power with insurers to demand higher reimbursement rates, which would be passed on to consumers in the form of increased premiums, deductibles, co-pay, and out-of-pocket expenses.

Along with the administrative complaint, the FTC filed suit in the District Court of Utah for a preliminary injunction against the merger pending the administrative trial scheduled for December. The parties also stipulated to the court's entry of a temporary restraining order that would prevent the entities from consummating the transaction until after the court rules on the motion for preliminary injunction.

Anticompetitive Conduct

More and more studies and enforcement actions indicate that consolidation among healthcare providers gives rise to greater market and bargaining power, which providers leverage to their advantage to demand anticompetitive terms in insurer

contracts that in turn impact prices. A pair of recent private actions stem from alleged abuse of market power that resulted from recent mergers.

HCA Healthcare (North Carolina)

HCA Healthcare's continued acquisitions and expansion around the nation are bringing not only merger challenges from federal regulators, but also lawsuits from private parties. Following *Davis v. HCA and Mission Health*, a class action lawsuit filed in North Carolina state court last August, a very similar second lawsuit was filed this month against the health system by the city of Brevard, North Carolina. Similar to *Davis*, the action seeks class action status and claims antitrust violations that stem from HCA's acquisition of Mission Health in 2019. While *Davis*, filed in Buncombe County Superior Court, specifically alleges the 2019 merger allowed HCA to use its monopoly power to inflate prices in Asheville, this new case claims similar allegations in seven North Carolina counties.

Filed in federal district court, the complaint alleges the 2019 merger allowed HCA to use its monopoly power to inflate prices in Asheville and seven surrounding counties in North Carolina. According to the complaint, even prior to the acquisition, Mission Health had used its monopoly power in the Asheville region to demand anticompetitive terms in insurer contracts since 1995. This market power was shielded from antitrust scrutiny due to a certificate of public advantage (COPA), which was repealed by state law in 2016. With the merger with HCA, the combined entities now have increased market power with control of more than 85% of general acute care (GAC) market in the Asheville region and over 70% of the market of surrounding counties. Using this increased leverage, the health system continued the anticompetitive scheme used by Mission Health, forcing insurers to enter contracts that include all-or-nothing, anti-tiering and anti-steering, and gag clauses. The complaint requests damages and an injunction against such anticompetitive practices.

Advocate Aurora (Wisconsin)

In Wisconsin, a similar class action was filed against Advocate Aurora, a nonprofit health system that operates in Wisconsin and Illinois. Brought by Uriel Pharmacy, a self-insured employer, the federal lawsuit alleges Advocate forced insurers to enter

all-or-nothing and anti-tiering and anti-steering contract terms. In addition, the plaintiffs claim Advocate Aurora uses "a combination of acquisitions, referral restraints, noncompetes and gag clauses to suppress competition from other healthcare providers" and expand its monopoly power. With its must-have hospitals, the health system was able to demand higher prices for its services compared to other providers. The complaint cites the example of the price of joint replacement surgery, which costs $62,538 at Advocate Aurora hospitals, $21,000 higher than the price at a competitor hospital just five minutes away.

The allegations of Advocate Aurora's market power and resulting price increases are the latest illustration of the impact consolidation has on healthcare price and quality. Similar to the HCA and Mission Health merger which gave rise to the allegations in that lawsuit, Advocate Aurora's antitrust case also followed its merger of Advocate Health Care and Aurora Health Care in 2018. The system also plans to further expand and merge with Atrium Health, a cross-market merger which was announced just last month and raising eyebrows of many antitrust experts.[2]

As seen in these recent cases, merger activity among healthcare providers contributes to greater market power and are thus closely connected with anticompetitive practices that result from such power and leverage. More legal actions are thus challenging healthcare systems both pre- and post-merger. Not only are federal regulators stepping up in response to Biden's executive order last summer calling for greater antitrust scrutiny and enforcement, private parties and healthcare consumers across the country have taken notice following the high-profile antitrust actions against Sutter Health. This new wave of actions against large health systems like HCA and Advocate Aurora is a step in the right direction to rein in provider monopolies and rising healthcare prices.

For detailed information and the latest development on these new cases, stay tuned to our monthly Litigation and Enforcement Highlights. Additionally, the Major Cases page on The Source provides an overview of key decisions and pending cases in both merger and anticompetitive conduct challenges.

[1] Dave Muoio, RWJBarnabas Health, *Saint Peter's integration deal wins NJ approval, awaits FTC signoff*, Fierce Healthcare (May 17, 2022).

[2] Tara Bannow, *Advocate Aurora-Atrium's mammoth merger: Experts split on whether federal regulators will challenge the deal*, Stat Plus (May 11, 2022).

FTC v. RWJBarnabas Health & Saint Peter's Healthcare System

RWJBH is the largest academic health system in New Jersey with 12 hospitals and collaborates with Rutgers Robert Wood Johnson Medical Schools. Saint Peter's Healthcare System is a Catholic system that includes Saint Peter's University Hospital in New Brunswick, which is less than one mile from RWJBH. While the deal had obtained approval from the New Jersey attorney general and superior court, the FTC challenged the proposed acquisition, alleging it will give RWJBH a 50% market share for general acute care services in Middlesex County and eliminate head-to-head competition between the entities, leading to higher insurance premiums, co-pays, deductibles, or other out-of-pocket costs. Additionally, due to the state's certificate of need law, entry of other providers will be limited and likely insufficient to counteract the anticompetitive effects of the acquisition.

The entities abandoned their plans to merge shortly after the FTC's challenge.

FTC sues to block hospital acquisitions in New Jersey, Utah

---

6 hospital, health system deals called off this year

S 1428

This bill, the “New Jersey Public Option Health Care Act,” creates the New Jersey Public Option Health Care Program in the Department of Health. The bill requires the Commissioner of Health, in consultation with the Commissioner of Banking and Insurance, to establish and implement the program, which will provide a comprehensive health insurance coverage option to every State resident who enrolls in the program. The health insurance coverage offered by the program shall compete in the market with insurance offered by private health insurers. Last Session Bill Number: S1947, A5029.

New Jersey health systems get state approval to merge

The Source Roundup: May 2022 Edition

This month in The Source Roundup, we cover articles and reports that examine: 1) the effect of private equity acquisition of hospitals; 2) the latest trends on hospital prices; and 3) ACA marketplace premiums at the state level in the last 3 years. Additionally, we highlight several cost containment strategies studied in recent reports, including 4) a progressive taxing proposal co-authored by The Source team, 5) establishing a state cost commission in California with lessons from other states, and 6) purchaser-led efforts to reduce healthcare costs.

Consolidation and Competition

On the topic of consolidation and competition, Marcelo Cerullo, et al. report on financial performance of short-term acute care hospitals after private equity acquisition in the new *Health Affairs* article Financial Impacts and Operational Implications of Private Equity Acquisition of US Hospitals. The authors analyze changes in 176 hospitals' financial performance from 2005 to 2014. Overall, financial performance of these hospitals improved after the acquisition, but markers of hospital capacity and staffing metrics did not. Specifically, private equity acquisition of a hospital saw an average of $432 decrease in cost per adjusted discharge and a 1.78% increase in operating margin. At the same time, private equity acquisition was found to be associated with decrease in total beds and staffing, increased inpatient utilization, and decreased ratio of outpatient to

inpatient charges.

Healthcare Prices and Premiums

Fair Health's key findings in FH® Healthcare Indicators and FH® Medical Price Index report that hospitals have increased prices for initial hospital care and emergency room visits more than other types of care. Out of the six hospital procedure categories studied, professional evaluation and management (E&M) had the greatest percent increase in charge amount index (seven percent) and negotiated rates (five percent). The report also highlights an immense growth in telehealth service, which increased by 41,919 percent from 2015 to 2020. On the other hand, utilization decreased between 2019 to 2020 for all other healthcare facilities studied. Among all the places studied, telehealth has the highest percentage of medical claim lines in 2020. More medical claim lines were submitted for females than males, but the gap was narrower in some places like retail clinics, urgent care clinics, ambulatory surgery centers, and emergency rooms.

Hospital prices paid by private health plans varied by different geographic regions in the U.S, according to a new *Health Affairs* article. In Trends in Hospital Prices Paid by Private Health Plans Varied Substantially Across the US, RAND researchers Zachary Levinson, Nabeel Qureshi, Jodi L. Liu, and Christopher M. Whaley found commercial health plans pay higher prices than public payers for hospital services. Data from the Healthcare Provider Cost Reporting Information System from 2012 to 2019 shows hospital prices for commercial health plans in 2012 averaged 173% of what Medicare was paying. Additionally, while average commercial-to-Medicare price ratios were mostly stable, trends varied greatly across hospital referral regions (HRRs). In particular, the study shows that California dominates the 19 regions that saw the highest growth in hospital prices paid by private insurers, with 11 regions that made the list. Moreover, out of the 11 regions in California, eight were in Northern California, revealing consolidation effects which has increased antitrust scrutiny on systems with market power like Sutter Health.

In the latest Urban Institute report Marketplace Competition and Premiums, 2019–2022, John Holahan, Erik Wengle, and Claire O'Brien examine Affordable Care

Act (ACA) marketplace premiums at the state and rating region levels. In that period, the researchers found that premiums fell around the country, with a decrease of 1.8 percent in national average benchmark premiums between 2021 and 2022. By comparison, there was a premium increase of four percent in the employer-sponsored insurance market over the same period. The national average contradicts the variation of premiums across and within states. The variation is most affected by higher unemployment rates due to Covid-19 and by the types and numbers of insurers participating in a rating region, which increased from 198 to 288 between 2020 and 2022 in the 58 regions explored in the report.

Cost Containment

High healthcare costs adversely affect patients with delays in necessary care, decreases in wage growth, increases in federal spending that could lead to higher taxes, and increases in disparities in healthcare access. While state policy makers focus on regulations that would restore healthcare competition and force prices down, The Source's Katherine L. Gudiksen and Jaime S. King, along with co-author Darien Shanske, discuss Can Taxes Help Address High Health Care Prices? In this new piece for *Health Affairs*, the authors argue that taxation can be a more-targeted tool to lower healthcare costs and propose a progressive tax on provider rates. The proposal would tax excessive provider prices but adjust for market differences such as certain rural hospitals and only apply in highly concentrated markets. The proposal also considers possible legal challenges and acknowledges the exact tax rate would be achieved through an iterative process.

In California, healthcare premiums have grown by 300 percent in the last 20 years. The state has proposed to establish a new Office of Health Care Affordability (OHCA) to monitor and address rising healthcare costs. In Health Care Cost Commissions: How Eight States Address Cost Growth published by the California Health Care Foundation, Glenn Melnick examines other states' healthcare cost commissions and identifies six key universal components from those cost commissions that California could learn from. Melnick specifically looks at how the eight state cost commissions (1) establish authority for the program, (2) establish a

governance body and administrative infrastructure, (3) set targets for cost growth and delivery system reform, (4) collect data to measure and monitor cost growth at the payer level, (5) collect necessary data at the subpayer level to identify and analyze cost drivers, and (6) develop and implement strategies and procedures to enforce targets. Additionally, the report discusses other important factors that could ensure greater effectiveness of California's potential healthcare cost commission, including greater transparency around spending trends and cost drivers, inclusive stakeholder processes around challenges and opportunities, and broad authority for enforcement.

In a Commonwealth Fund report, Sarah Klein focused on purchaser-led efforts to reduce rising healthcare costs. According to Tackling High Health Care Prices: A Look at Four Purchaser-Led Efforts, U.S. employers have failed in their efforts to reduce prices they pay for employees' health insurance benefits, partly because they lack enough employees to make changes in local markets. Some employers lack sufficient negotiation tactics, while others avoid asking employees to change how they receive their care. Resultantly, employees' costs rise as employers shift cost burdens onto them. The author analyzes four purchaser-led initiatives to reduce costs, including direct negotiations with health care providers, employee incentives to seek care from higher-quality, lower-cost providers, and transparency efforts to call attention to high prices. Klein concludes that transparency of medical claims data is "paramount" and that employers should partner and align their interests with other stakeholders, including the government, in order to scale these strategies to gain leverage in healthcare markets that lack competition. Finally, the author acknowledged that greater widespread change may require policy reform, such as legislation to bar anticompetitive contract terms, capping prices for out-of-network care, and establishing a national all-payer claims database (APCD).

That concludes this month's Roundup. If you find articles or reports that you think should be included in the monthly Roundup, please send them our way.