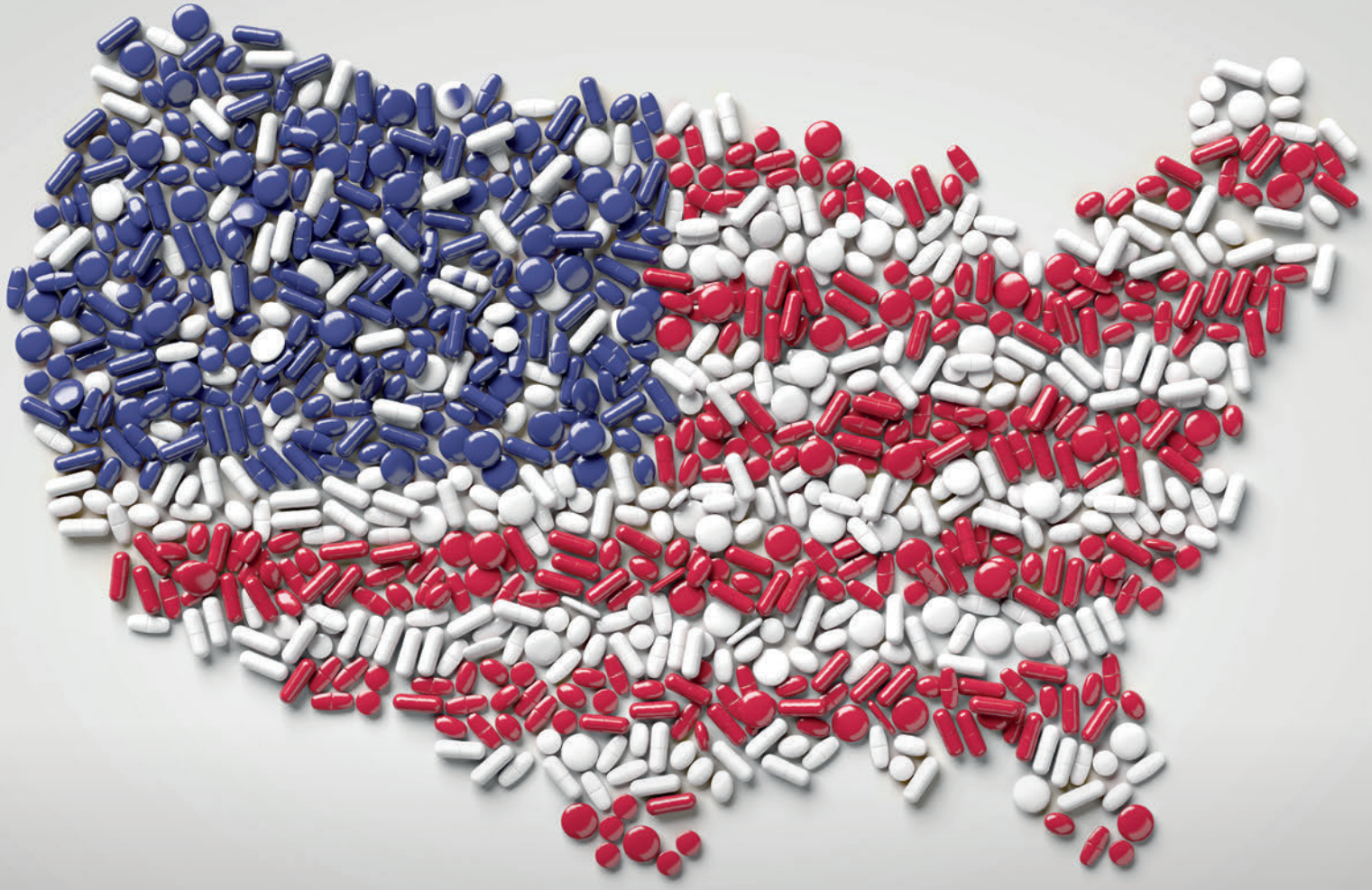
STATE ATTORNEYS GENERAL USE ALL OF THE TOOLS IN THEIR TOOLKITS TO PROTECT THE PUBLIC IN HEALTHCARE MARKETS



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I. INTRODUCTION

Healthcare markets operate very differently than other markets, and state attorneys general are especially positioned to monitor and enforce antitrust laws in these distinct markets. For example, consumers often utilize healthcare services whether they want to or not and sometimes on an emergency basis. They also trust and rely on physicians and other providers to guide them on what services they need and where they should obtain them. Further, most consumers do not pay directly for healthcare services, but rather use a third party to negotiate access and payment. The prices for the services are not transparent and are often unknown until the services are provided and payment is made by the third party. Services for hospital care are frequently provided by non-profit providers who have been funded by the community, and in return have a mission to provide high quality affordable healthcare services. Consumers also obtain healthcare services locally, wherever possible, so they can avoid the time and expense of travel, remain close to home, and have support of family and friends. Given the importance, complexities, and local nature of healthcare services, state attorneys general pay close attention to their markets and are active enforcers.

Antitrust enforcement in healthcare markets requires state attorneys general to think outside the box and use their unique set of tools to protect the public. State attorneys general, unlike their federal counterparts, wear many hats and focus not only on protecting competition, but also on protecting charitable assets and the health and welfare of the public. They also work alongside other state agencies to ensure high quality healthcare services are available to consumers. Recent actions by state attorneys general discussed below exemplify just how active state attorneys general are in healthcare markets and how they use their unique tools to tackle complex issues of concentration and competition.

II. RECENT STATE ATTORNEYS GENERAL ANTITRUST CASES IN HEALTHCARE MARKETS

State attorneys general bring cases on their own and also in coordination with federal antitrust authorities. They assert claims under both state and federal antitrust laws. For example, in March 2018, in a state-only action under state law, the California Attorney General filed a civil action[2] with the Superior Court of San Francisco against Sutter Health alleging violations of California's Cartwright Act. The California Attorney General asserts three causes of action under the Cartwright Act: price tampering and fixing; unreasonable restraint of trade; and combination to monopolize. In his complaint, the California Attorney General seeks injunctive relief and disgorgement of overcharges to restore competition in healthcare markets in California. The action was consolidated with a previously filed action[3] by the UFCW and Employers Benefit Trust ("UBET") against Sutter Health.

2 Complaint, *People of the State of California v. Sutter Health*, No. CGC-18-565398 (Cal. Super. Cnty. S.F. March 29, 2018).

3 Complaint, *UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al.*, No. CGC-14-538451 (Cal. Super. Cnty. S.F. April 2014)

Sutter Health is a non-profit corporation and the largest and most dominant health care provider in Northern California, with at least 24 separately licensed hospitals; physician organizations with more than 5000 members; medical research facilities; region-wide home health, hospice and occupational health networks; and long-term care centers. In 2016, Sutter Health controlled 4311 acute care beds.[4] Sutter Health obtained its dominance through a series of mergers and acquisitions beginning in 1990 and continuing through the year 2000, including its merger with Summit Hospital in 2000, which California challenged unsuccessfully under Section 7 of the Clayton Act.[5]

The California Attorney General alleges Sutter Health used its market dominance in Northern California to engage in anticompetitive contractual practices, which have resulted in higher healthcare costs in Northern California than in other areas of the state.[6] A 2018 study found unadjusted inpatient procedure prices are 70 percent higher in Northern California than Southern California, corresponding to hospital market concentration being 110 percent higher in Northern California than in Southern California.[7] The Attorney General alleges the increased healthcare costs have negatively impacted the general economy of Northern California and the state as a whole.[8] Higher costs for employers have been passed through to employees in the form of higher premiums, deductibles, co-insurance, and other out of pocket costs.[9] The alleged anticompetitive contractual practices include requiring that all Sutter Health Hospitals and healthcare providers throughout Northern California be included in health plan networks; prohibiting health plans from giving incentives to patients that encourage them to use the healthcare facilities of Sutter Health's competitors – even when said competitors could offer higher quality healthcare and/or lower pricing; and requiring that health plans not disclose Sutter Health's inflated prices for its healthcare services to anyone before the services were utilized and billed.[10]

The California Attorney General also claims Sutter Health's ability to impose anticompetitive contract terms in all of its agreements with health plans and its ability to charge supra-competitive prices to self-funded payors on a system-wide basis is direct evidence of Sutter Health's market power and obviates any need for further analysis of competitive effects in defined markets, being a *per se* violation of the Cartwright Act.[11] Nonetheless, the Attorney General defines the relevant product market as a cluster of general acute hospital services (including inpatient and outpatient services) as well as ancillary services made available for purchase by health plans and self-funded payors.[12] The relevant geographic markets are those areas in which health plans must have one or more general acute care hospitals with sufficient capacity to reasonably handle the anticipated healthcare requirements of the health plan enrollees located in the region.[13]

On March 14, 2019, the court denied Sutter Health's motion for summary adjudication of Count 1, which alleged price tampering and fixing in violation of the Cartwright Act, finding vertical price tampering may be actionable under the Cartwright Act and doesn't need to rise to the level of price fixing. It also denied summary adjudication of Count 3, which alleged combination to monopolize in violation of the Cartwright Act, finding that combination to monopolize under the Cartwright Act does not require specific intent as would be required for a monopolization claim under Section 2 of the Sherman Act. Noting that the Cartwright Act is not derived from the Sherman Act, but rather from the laws of other states and that they differ in wording in scope, the court held an agreement to monopolize under the Cartwright Act is prohibited if it constitutes an unreasonable restraint of trade.[14] On June 13, 2019, the court denied Sutter Health's Motion for Summary Judgment with respect to Count 2 and Counts 1 and 3.[15] A three month trial is currently scheduled to begin September 4, 2019.

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4 Complaint, *People of the State of California v. Sutter Health*, No. CGC-18-565398 (Cal. Super. Cnty. S.F. March 29, 2018), ¶ 46.

5 *Id.* ¶¶ 47-49

6 *Id.* ¶ 9.

7 *Id.* ¶ 8.

8 *Id.* ¶ 38.

9 *Id.* ¶ 5.

10 *Id.* ¶ 35.

11 *Id.* ¶¶ 73-75.

12 *Id.* ¶ 77.

13 *Id.* ¶ 91.

14 Order, *UFCW & Employers Benefit Trust v. Sutter Health*, No. CGC-14-538451 (Cal. Super. March 14, 2019).

15 Order, *UFCW & Employers Benefit Trust v. Sutter Health*, No. CGC-14-538451 (Cal. Super. June 13, 2019).

In another state-only case, in August 2017, the State of Washington filed a complaint[16] against Franciscan Health System ("CHI Franciscan"), The Doctors Clinic, A Professional Corporation, and WestSound Orthopaedics, P.S. The complaint resulted from an investigation of complaints filed by consumers about price increases on the Kitsap Peninsula. In its complaint, Washington brought claims under the Sherman Act Section 1, Clayton Act Section 7, and the Washington State Consumer Protection Act ("CPA"). This case differed from other healthcare challenges because not only did Washington bring a conduct case, it was also challenging a consummated merger and requesting the unwinding of the transaction as part of its relief. The unique geographic market of the Kitsap Peninsula, which requires ferries to cross the sound, made market concentration particularly concerning to the State of Washington.

The complaint alleged that WestSound, The Doctor's Clinic and CHI Franciscan were each other's closest competitors for orthopedic services before their respective deals. In July 2016, CHI Franciscan acquired the assets of WestSound Orthopaedics, a seven-physician practice based in Silverdale.[17] Just two months later in September 2016, CHI Franciscan established an affiliation with The Doctors Clinic ("TDC"), a multispecialty practice with over 50 physicians, based in Silverdale with seven other locations throughout Kitsap.[18] These two deals resulted in a combination of the three largest providers of orthopedic physician services in the Kitsap Peninsula orthopedic physician services market. The affiliation agreement between TDC and CHI Franciscan allowed TDC to receive CHI negotiated reimbursement rates with payors, and CHI acquired certain ancillary services from TDC.[19] The parties still remained as separate entities. In Washington's complaint they cite an email between CHI Franciscan executives that said the WestSound acquisition would allow CHI Franciscan to grow its surgery cases, which was the "fastest way to increase its bottom line."[20] The complaint further highlights contracts between CHI Franciscan and a major payor that allege what appear to be double-digit percentage price increases for arthroscopic shoulder, ACL, and knee surgeries post acquisition.[21]

The TDC Affiliation and the WestSound Acquisition established market power in the Kitsap Peninsula, including the Bainbridge and Fox Islands ("KP/BI") market, for Orthopedic Physician Services, with a combined market share of over 63 percent in TDC's 75 percent service area, and a combined market share of over 55 percent in KP/BI.[22] The geographic market definition here was incredibly unusual because Kitsap is a peninsula, a visit to competing providers required consumers to drive a longer distance and incur a toll to visit providers across the Tacoma Narrows Bridge, or endure the waiting, sailing time, and expense of a round-trip ferry voyage to visit providers.[23]

CHI Franciscan asserted two main defenses: failing or flailing firm, and single entity. The court ruled that the failing firm defense could apply to Section 7, but not to a Section 1 *per se* claim, noting that there is a high evidentiary burden to satisfy the defense.[24] The court did conclude under a Section 1 rule of reason analysis, that defendants may put forth the flailing firm evidence as part of their burden to show procompetitive effects, justifying otherwise anticompetitive conduct. After Washington won the partial motion for summary judgment on the Section 1 claim,[25] they were successful in negotiating a consent decree with CHI Franciscan.[26] The consent decree entered by Washington has some unique provisions. It requires CHI Franciscan to pay $2-$2.5M which will be put into *cy pres* funds that healthcare entities such as FQHCs, Planned Parenthood, and free clinics can apply for to provide consumer access to healthcare on the Peninsula.[27] TDC is allowed to remain in a

16 Complaint, *State of Washington v. Franciscan Health System, et al.*, No. 3:17-cv-05690 (W.D.WA Tacoma August 31, 2017).

17 *Id.* ¶ 75.

18 *Id.* ¶ 75.

19 *Id.* ¶¶ 44-45.

20 *Id.* ¶ 88.

21 *Id.* ¶ 87

22 *Id.* ¶ 72.

23 *Id.* ¶ 38.

24 Order on Defendants' Motion for Partial Summary Judgment, *State of Washington v. Franciscan Health System, et al.*, No. 3:17-cv-05690 (W.D.WA Tacoma March 1, 2019).

25 *Id.*

26 Consent Decree, *State of Washington v. Franciscan Health System, et al.*, No. 3:17-cv-05690 (W.D.WA Tacoma May 13, 2019).

27 *Id.* ¶ 78.

PSA with CHI Franciscan, but payors can elect to contract separately for TDC's orthopods, and adult PCPs and can re-open current contracts.[28] The decree allows TDC physicians to receive quality incentive payments. CHI is required to sell a majority interest in the ASC; if unable, Washington may seek appointment of a divestiture trustee.[29] Physicians in Kitsap have to notify patients of other lab/imaging options available outside of CHI Franciscan.[30] Finally, there is a prohibition on future contracts with physician groups in Kitsap that have physicians in the same specialty, except for hospital-based physicians.

In November 2018, in another state-only action, the Massachusetts Attorney General's Office resolved its concerns over the merger of two major Massachusetts health systems, Beth Israel Deaconess Medical Center and Lahey Health System through a settlement filed in the Massachusetts Superior Court.[31] The Attorney General's investigation raised concerns that the effect of the transaction may be to substantially lessen competition in the sale of health care services in certain geographic areas of the Commonwealth, increase total health care costs in the Commonwealth and have an adverse effect on access to healthcare services, particularly for vulnerable populations.[32] Beth Israel Deaconess Medical Center was an 8 hospital system serving communities around Boston, while Lahey Health was a 5 hospital system serving communities in eastern Massachusetts. The merger was also reviewed by the Massachusetts Health Policy Commission, which issued a report finding that the merger would increase market concentration substantially, and that the merged entity would have significantly enhanced bargaining leverage with commercial payers enabling it to substantially increase commercial prices.[33] The Health Policy Commission referred its report to the Massachusetts Attorney General which, after its own investigation, entered into a 10-year settlement with the parties. The settlement provides for a 7-year price constraint that guarantees price increases will stay below the Commonwealth's set goal to control the cost of total medical spending and avoid more than $1 billion in potential cost increases. It also provides that all facilities currently participating in MassHealth[34] must continue to do so, demands $70 million in funding for various public health initiatives over an eight-year period, and requires an independent monitor for 10 years to ensure compliance with the settlement.

In June 2017, after eight months of investigation, the North Dakota Attorney General's Office jointly filed a complaint with the Federal Trade Commission challenging Sanford Health's proposed acquisition of Mid Dakota Clinic.[35] After two years and favorable decisions for enforcers in the District Court and the Eighth Circuit Court of Appeals, Sanford Health abandoned the proposed acquisition of Mid Dakota Clinic and the challenge to the transaction was dismissed. This case was significant to North Dakota because the Bismarck-Mandan area was already a highly concentrated market. In this market Sanford Health and Mid Dakota Clinic ("MDC") were the two largest providers of adult primary care physician ("PCP") services, pediatric services, OB/GYN services, and general surgery physician services. Sanford operated one of only two general acute care ("GAC") hospitals in the Bismarck North Dakota area, the other being CHI St. Alexius Health. Yet Sanford viewed MDC as its "main clinical competitor" in the Bismarck-Mandan area.

Sanford Health, a not-for-profit, was a 217-bed hospital employing 160 physicians and 100 advanced practice providers. MDC operated six clinics in Bismarck and employed 61 physicians and 19 advanced practice practitioners. Sanford was the largest private employer in the Bismarck-Mandan area, which is true for many large healthcare systems in smaller communities and often a challenging factor for state enforcers. Post-Transaction, Sanford would control 75 percent of the market for PCP services, over 80 percent of the market for pediatric services, over 85 percent of the market for OB/GYN services, and 100 percent of the market for general surgery physician services. The resulting Herfindahl-Hirschman Index value ("HHI") far exceeded the 2,500-point threshold and 200-point change that lead to a presumed likelihood of enhanced market power — and presumptive illegality.[36]

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28 *Id.* ¶¶ 53-56.

29 *Id.* ¶ 67.

30 *Id.* ¶ 74.

31 Assurance of Discontinuance, *Commonwealth of Massachusetts v. Beth Israel Lahey Health, Inc.*, No. 2018-3703 (Mass. Sup. Ct. November 29, 2018).

32 *Id.* ¶ 2.

33 *Id.* ¶ 3.

34 The health coverage programs administered by the Massachusetts Executive Office of Health and Human services to benefit low- and moderate-income people in the Commonwealth of Massachusetts, including the Medicaid Program and Children's Health Insurance Program.

35 Complaint, *Federal Trade Commission and State of North Dakota v. Sanford Health, et al.*, No. 1:17-cv-00133 (D.N.D. June 23, 2017).

36 *Id.* ¶ 38 "The change in HHI for PCP services was 2,793, for pediatric services it was 3,333, for OB/GYN services it was 3,391, and for General Surgery Physician Services it was 4,800."

Sanford asserted two main defenses; powerful buyer and ease of entry. Initially Sanford argued that the presence of Blue Cross Blue Shield of North Dakota ("BCBSND"), a dominant buyer, should be considered when defining the market. The court disagreed, stating that the presence of BCBSND could only be used as defense.[37] The court further noted that "[although BCBSND has a statewide share of 55-65 percent of the commercial health insurance market, its market share has declined in the last several years. Significantly, evidence showed that BCBSND does not consider CHI a viable alternative to either Sanford Health or Mid Dakota, and, most importantly, that BCBSND could not construct a marketable health plan in the Bismarck-Mandan area without the merging entity.]"[38] The court was unpersuaded that BCBSND would circumvent any resulting anticompetitive effects from the merger. The court stated that, "Sanford was unable to meet either common applications of a "powerful buyer defense" — (1) a buyer's ability to use its leverage to sponsor entry or vertically integrate; or (2) where there are alternative suppliers post-merger, a buyer is able to obtain lower prices from suppliers."[39] This is despite Sanford's claim that they "promise" not to demand higher reimbursements rates from BCBSND post transaction. This was another argument the court found unpersuasive and unsupported by caselaw as something to be considered in the analysis.

In launching its second defense, Sanford argued that CHI would be motivated to introduce new competition for the physician service lines at issue and this would counteract the anticompetitive effects of the proposed merger.[40] Sanford contended that CHI, then the fourth-largest healthcare system nationwide, would be a "much stronger competitor" to Sanford than MDC was currently.[41] The court, while noting that a decline in referrals may incentivize CHI to add physicians in the four service areas, found the evidence did not establish that the Bismarck-Mandan area's population is sufficient to support a significant increase in the total number of physicians for these service lines.[42] Ultimately, the court did not find that Sanford had established that entry by CHI would be timely, likely, or sufficient to counteract the near-monopoly resulting from the proposed transaction.[43] Sanford asserted that the transaction would create significant efficiencies, and most of these savings would be derived from the 340B drug program because Sanford would switch from a Disproportionate Share Hospital ("DSH") to a Rural Referral Center ("RRC") under the 340B program.[44] The FTC argued that the 340B savings should not be considered because it was not within the relevant market, while Sanford countered this by claiming that market-specific efficiencies make no sense when the merger involves integrated healthcare systems.[45] The court did not directly address whether efficiencies need to be specific to the relevant market, instead focusing on the Merger Guidelines commenting that "the lesser the adverse competitive effects, the greater the weight ascribed to efficiencies," to support its' decision that the monetary and quality efficiencies are insufficient for overcoming the presumption of illegality.[46]

In another case brought jointly with a federal partner, the State of North Carolina and the Department of Justice ("DOJ") filed a joint complaint[47] against Carolinas Healthcare System ("CHS")[48] for a Section 1 conduct violation in June 2016, with the final judgment entered in April 2019.[49] The complaint alleged that CHS used its market power in negotiations with insurers to contract for clauses that restricted steering and tiering to comparable lower cost providers or higher quality alternatives within the health plan designs.[50] This resulted in insurers' inability to offer narrow network plans that included only CHS competitors or offer tiered networks that featured hospitals that compete with CHS in the top

37 Opinion ¶¶ 9, 17, *Federal Trade Commission and State of North Dakota v. Sanford Health*, et al., No. 1:17-cv-00133 (D.N.D. December 15, 2017).

38 *Id.* ¶¶ 103-104, 111.

39 *Id.* ¶¶ 39.

40 *Id.* ¶ 139.

41 *Id.* ¶ 140.

42 *Id.* ¶ 149.

43 *Id.* ¶ 152.

44 *Id.* ¶ 89.

45 *Id.* ¶ ¶ 32-33.

46 *Id.* ¶ 36.

47 Complaint, *U.S. and North Carolina v. Charlotte-Mecklenburg Hospital Authority*, No. 3:16-cv-00311 (W.D.NC Charlotte Division June 9, 2016).

48 The health system changed its name to Atrium Health during the almost three-year litigation.

49 Order, *U.S. and North Carolina v. Charlotte-Mecklenburg Hospital Authority*, No. 3:16-cv-00311 (W.D.NC Charlotte Division April 24, 2019).

50 Complaint, *U.S. and North Carolina v. Charlotte-Mecklenburg Hospital Authority*, No. 3:16-cv-00311 (W.D.NC Charlotte Division June 9, 2016), ¶¶ 3, 12.

tiers.[51] CHS was and is a dominant hospital system in Charlotte, North Carolina, and the largest healthcare system in North Carolina.[52] In addition it is one of the largest non-for-profit healthcare systems in the United States.[53] CHS operated nine other general acute-care hospitals in Charlotte and owned, managed or had strategic affiliations with more than forty hospitals in the Carolinas allowing it to exert market power in its dealings with commercial health insurers.[54] CHS was claimed to have used this market power to negotiate higher reimbursement rates that were above the rest of the market, limit the number of insurance offers, and restrict consumer choice.[55]

In addition to requirements to limit steering and tiering, CHS also allegedly imposed restrictions in its contracts with insurers that limited insurers from providing truthful information to consumers about the value (cost and quality) of CHS's healthcare services compared to CHS's competitors.[56] The Complaint alleged that these restrictions regarding transparency were an indirect restriction on steering that circumvented patients from obtaining information that would allow them to make healthcare choices based on available prices and quality information.[57] CHS maintained and enforced steering restrictions in its contracts with Aetna Health of the Carolinas, Inc., Blue Cross Blue Shield of North Carolina, Cigna Healthcare of North Carolina, Inc., and United Healthcare of North Carolina Inc.[58] These insurers, combined, provided coverage to 85 percent of the commercially insured residents of the Charlotte area.[59] In some instances, the contract language prohibited steering outright.[60] For example, CHS secured a contractual obligation from one insurer that it "shall not directly or indirectly steer business away from" CHS.[61] In other instances, the contract language gives CHS the right to terminate its agreement with the insurer if the insurer engages in steering, providing CHS the ability to deny the insurer and its enrollees access to its dominant hospital system unless the steering ends.[62] CHS argued that steering restrictions were beneficial and procompetitive, that CHS's prices were higher due to a superior product and consumer loyalty, that insurance companies were still able to steer, that no insurance companies had asked to remove steering restrictions from contracts, and CHS had never refused to eliminate these provisions.[63]

In CHS's Motion for Judgment on the Pleadings, it didn't contest the existence of a contract, combination, or conspiracy, instead it argued that there was no unreasonable restraint of trade imposed. The court applied a rule of reason analysis weighing all the factors of the case to determine whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition.[64] The court found that DOJ and North Carolina had alleged direct evidence of market harm with enough specificity that their claim for a violation of Section 1 is plausible and that they sufficiently alleged facts that plausibly could support the conclusion that CHS's steering restraints are an unreasonable restraint on trade.[65] Some of the key findings by the court were that CHS had significant market power citing to their almost 50 percent market share, that an insurer selling insurance in the Charlotte area must have CHS as a participant in at least some of its networks to have a viable product in the area, and that there are significant barriers to entry for new hospital systems.[66]

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51 *Id.*¶ 7.

52 *Id.*¶ 2.

53 *Id.* ¶¶ 1-3.

54 *Id.*

55 *Id.* ¶¶ 11-12.

56 *Id.* ¶ 13.

57 *Id.*

58 *Id.* ¶ 16.

59 *Id.* ¶ 15.

60 *Id.* ¶ 16.

61 *Id.*

62 *Id.*

63 CHS Motion for JP

64 Order, *U.S. and North Carolina v. Charlotte-Mecklenburg Hospital Authority*, No. 3:16-cv-00311 (W.D.NC Charlotte Division March 30, 2017), P. 12.

65 *Id.* p. 14.

66 *Id.* pp. 14-15.

The Final Judgment entered in April 2019 by the parties is for a term of ten years with an exception for termination in five years, given notice to the court that the Final Judgment is no longer necessary.[67] It includes specifics about prohibited conduct and permitted conduct. As part of the Judgment, CHS is not allowed to enforce or attempt to enforce language in existing insurer contracts that would restrict insurers from steering patients, using tiered networks, and providing transparency about cost and value.[68] The only time CHS could use the language would be to protect against Carve-outs.[69] It included a prohibition on CHS's prior approval of an insurers new benefit plan unless Co-branded.[70] The Judgment also prohibits CHS from requiring inclusion in the most preferred tier of benefit Plans unless Co-branded.[71] Finally, CHS cannot penalize, or threaten to penalize, an Insurer for (i) providing (or planning to provide) Transparency; or (ii) designing, offering, expanding, or marketing (or planning to design, offer, expand, or market) a Steered Plan.[72]

III. CONCLUSION

Consolidation and concentration continue in healthcare markets. Given the importance, complexities and local nature of healthcare, state attorneys general will continue their active enforcement in healthcare markets. They will use all the tools in their toolkits to ensure consumers have access to high quality affordable healthcare services at reasonable prices.

67 Order, *U.S. and North Carolina v. Charlotte-Mecklenburg Hospital Authority*, No. 3:16-cv-00311 (W.D.NC Charlotte Division April 24, 2019), P. 16.

68 *Id.* p. 7.

69 *Id.* pp. 7, 9.

70 *Id.* p. 7.

71 *Id.* pp. 7-8.

72 *Id.*

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