AMERICAN ECONOMIC LIBERTIES PROJECT

Tools to Challenge Big Medicine:

A Guide for State Lawmakers

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ABOUT THE AUTHOR

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INTRODUCTION

America's healthcare system is built on a concentration of corporate power that puts patient care in the hands of giant, for-profit businesses. Many Americans find their health coverage claims denied arbitrarily, drug prices are growing out of control, and large healthcare companies routinely post massive profits. These problems have their origins in many different parts of our healthcare system: hospital systems that provide poor service or charge outrageous prices, middlemen like pharmacy benefit managers manipulating drug prices for profit, or predatory private equity firms looking to cut back spending on patient care. The U.S. pays more for healthcare per capita than almost all other countries and does not receive a similar quality of care or experience positive health outcomes.

While the federal government can and must play an important role in regulating and fixing America's healthcare system, state governments have many tools and powers at their disposal to block healthcare consolidation, control drug prices, prevent absentee corporate control, ensure high levels of patient care, and protect healthcare workers. Hospitals are subject to state regulation, many aspects of pharmaceutical markets are not preempted by federal law, state antitrust law can specifically target healthcare as an important sector, and states can implement a range of policies to support healthcare workers or limit the influence of predatory investors.

This toolkit breaks the problem into several categories and outlines practical steps that state lawmakers can take to reform different aspects of American healthcare to improve health outcomes, the affordability of care, price transparency, and fairness in healthcare markets. Where applicable, we note model legislation that has been adopted or proposed.

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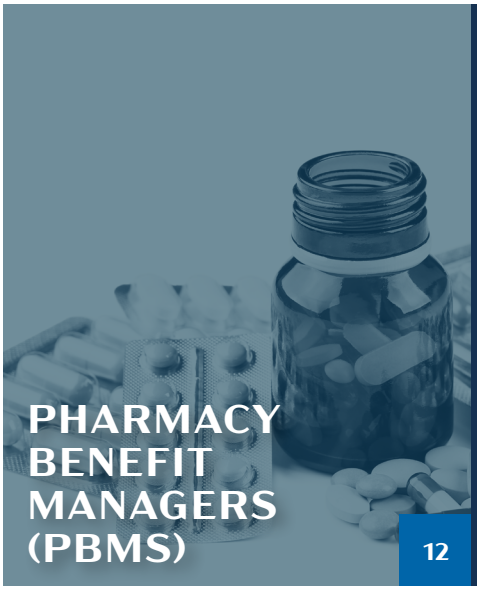

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Hospitals are at the core of healthcare, providing a range of not just emergency care but also specialty care for more serious conditions. However, hospital prices have been rising for decades, with patients finding themselves paying surprise bills based on insurance coverage gimmicks, paying large list prices for hospital services, or even unable to see what the hospital charges for different services.

In addition, the past few decades have seen waves of hospital mergers that have degraded the quality of care, led to layoffs of essential healthcare workers, eliminated key hospital departments, and in many cases outright closed hospitals. At the same time, hospitals in many regions overcharge for a variety of health services, and provide substandard care, by virtue of their monopoly position as the only hospital in the area, taking advantage of state and federal regulations that restrict the construction of competing hospitals and provide them with an antitrust exemption.

HOSPITALS

Strengthen State Enforcement of Hospital Mergers

THE PROBLEM

Hospitals large and small often pursue mergers or acquisitions. These merging hospitals often argue that these mergers are needed to save the failing finances of one of the hospitals, putting them on better footing in a merged system, or they claim that a larger, integrated hospital system will improve the quality of care.

Hospital mergers have been shown to increase prices by eliminating competition between the two hospitals.[1] Hospital mergers often also reduce access to care, as merging hospitals are likely to close non-profitable or ostensibly "redundant" care units.[2] Without the pressures of competition for patients, hospital consolidation contributes to worse health outcomes, including higher mortality rates.[3] Finally, by reducing the number of healthcare employers in a region, consolidation gives hospitals greater bargaining power over their employees and reduces pay for healthcare workers.[4] Furthermore, many hospital mergers are not just between hospitals that directly compete with one another, but are rather "cross-market" mergers, in which the hospitals are looking to gain bargaining power against insurance companies to be able to increase prices.[5]

The problem has only gotten worse in recent years, with a hospital merger frenzy beginning during the Obama administration. With the belief that hospitals or large physician groups would be more efficient under universal healthcare coverage, the government pushed for "integration across the continuum of care" by offering financial incentives in the 2010 Affordable Care Act (ACA). While the annual number of announced buyouts peaked at 60 in the few years before the ACA was signed into law, they rose to 74 in 2010, 86 in 2011, and hit 115 in 2017.

Mergers, including hospital mergers, are illegal under federal law where the "effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."[6] However, when merging or acquiring, hospitals only need to report the transaction to the

1 Zack Cooper, Stuart Craig, et al., "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," *The Quarterly Journal of Economics*, February 2019, https://pubmed.ncbi.nlm.nih.gov/32981974/.

2 Rachel Mosher Henke, Kathryn Fingar, et al., "Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas," *Health Affairs,* October 2021, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00160.

3 Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, "Death by Market Power: Reform, Competition, and Patient Outcomes in the National Health Service," *American Economic Journal: Economic Policy*, 2013, https://pubs.aeaweb.org/doi/pdfplus/10.1257/pol.5.4.134.

4 Elena Prager and Matt Schmitt, "Employer consolidation and wages: Evidence from hospitals," Washington Center for Equitable Growth, February 2019, https://equitablegrowth.org/working-papers/employer-consolidation-and-wages-evidence-from-hospitals/.

5 Brent Fulton, Daniel Arnold, et al., "The Rise of Cross-Market Hospital Systems and Their Market Power in the U.S.," *Health Affairs,* November 2022, https://pubmed.ncbi.nlm.nih.gov/36343312/.

6 15 U.S. Code § 18 – Acquisition by one corporation of stock of another, Cornell Law School Legal Information Institute, accessed March 13, 2023, https://www.law.cornell.edu/uscode/text/15/18.

Federal Trade Commission if it is valued over a certain amount, $111.4 million as of 2023,[7] and the Federal Trade Commission is not allowed to share the information from those notifications with state attorneys general. As a result, stretched federal antitrust regulators are often unaware of potentially harmful hospital mergers and acquisitions. And even when they are notified, federal antitrust agencies are not allowed to share merger notifications with state and local enforcers.[8]

THE SOLUTION

State legislatures can pass laws with a clear authority for the attorney general to solicit input, review healthcare mergers, and block any consolidations based on a comprehensive examination of the health and equity effects of the healthcare merger.

Such legislation should accomplish two things:

- First, state hospital and healthcare merger legislation should require notification to the attorney general of any merger or acquisition between healthcare providers, regardless of their size. This would ensure both that the attorney general has the necessary information, and it would prevent hospital consolidation through a series of small acquisitions of, for example, physicians' practices.

- Second, the legislation should allow the attorney general to block a hospital merger not just if it harms competition itself, but also if an investigation deems the merger likely to negatively affect the standard of care in the community. This would be particularly important to block the harms stemming from cross-market mergers, for example.

Model Legislation: The proposed Keep Our Care Act (Senate Bill 5241) in Washington State requires both (a) notification to the attorney general for any healthcare merger or acquisition within the state, and (b) a review of the merger's effects on the quality and equity of care.[9]

7 "HSR threshold adjustments and reportability for 2023," Federal Trade Commission, February 16, 2023, https://www.ftc.gov/enforcement/competition-matters/2023/02/hsr-threshold-adjustments-reportability-202.

8 See Mattox v. FTC, 752 F.2d 116 (5th Cir. 1985) and Lieberman v. FTC, 771 F.2d 32 (2d Cir. 1985).

9 "Keep Our Care Act Resource Center," ACLU Washington, accessed March 13, 2023, https://www.aclu-wa.org/KOCA; House Bill 1809, Washington State Legislature, 2021-2022, https://app.leg.wa.gov/billsummary?BillNumber=1809&Chamber=House&Year=2021; Senate Bill 5241, https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Senate%20Bills/5241.pdf?q=20230404070323.

HOSPITALS

Require Hospital Price Transparency

THE PROBLEM

Patients often find themselves unable to know what hospital services will cost them, sometimes even for routine services that hospitals perform dozens of times a day. Hospitals don't generally make their price information public, instead simply informing patients the cost after providing care. Even when hospitals do publicly post pricing information, it is often not in a form that is easily comparable between hospitals, particularly not for patients. As of January 2021, federal law requires hospitals to post their pricing information, but a majority of hospitals are still not in compliance.[10]

Not only does this create a confusing and frustrating experience for patients, but opaque hospital pricing distorts competition between hospitals in the same region, and hospitals use this lack of transparency to keep prices high.

THE SOLUTION

Partly because of the ineffectiveness of the federal hospital price transparency rule, states should enact requirements for hospitals to list their prices publicly in a consumer- and patient-friendly format. Legislation could require listing prices for the most common procedures on a publicly available website, in language that patients can easily understand, in order to compare between providers. Transparency will allow patients with high-deductible plans in particular to manage their healthcare costs.

Model Legislation: Indiana's Senate Bill 5 requires hospitals, ambulatory surgical centers, and urgent care facilities to post certain healthcare services and prices on their websites, and it requires the disclosure to policyholders of commissions, fees, and brokerage fees to be paid in the selling of group health insurance.[11]

The legislation bars the inclusion of a provision in a health provider contract to prohibit the disclosure of claims data to an employer. This is also known as prohibition of the "gag rule" on claims data. The final part of the bill gives the Indiana Department of Insurance (DOI) the authority to request information and proposals for the creation of an all-payer claims database (APCD). That database gives employers and other stakeholders tools to control and analyze healthcare costs through claims data.

10 Victoria Bailey, "Only 25% of Hospitals Are Complying with the Price Transparency Rule," Recycle Intelligence, February 8, 2023, https://revcycleintelligence.com/news/only-25-of-hospitals-are-complying-with-the-price-transparency-rule.

11 Indiana Senate Bill 5, https://in-proxy.openstates.org/2020/bills/SB0005/versions/SB0005.06.ENRH.

HOSPITALS

Repeal Certificate of Public Advantage (COPA) Laws

THE PROBLEM

Today, 18 states have "certificate of public advantage" (COPA) laws, which allow merging hospitals to apply for a COPA, which exempts them from state and federal antitrust laws, in exchange for more direct state regulatory oversight. While advocates often argue that this removes a regulatory barrier to creating a more efficient, merged hospital system that will improve the quality of care and patient experience, the track record indicates the opposite. Hospital mergers, including those approved under a COPA, tend to increase prices, limit access to care, and decrease competition between healthcare providers. Of the COPAs that have been approved thus far in the United States, a majority have created a single-hospital monopoly.[12] The Federal Trade Commission, barred from enforcing the antitrust laws against hospitals granted this exemption, has criticized COPA laws for almost as long as they have existed.[13]

State oversight of COPA hospitals also tends to be weak. As the FTC has said, "Experience and research demonstrate that COPA oversight is an inadequate substitute for competition among hospitals, and a burden on the states that must conduct it."[14]

THE SOLUTION

By repealing COPA laws, state legislators would enable state and federal antitrust regulators to review proposed mergers for anti-competitive effects and take remedial action to protect patients and workers.[15]

However, given that many harmful hospital mergers have already been approved and carried out under COPA laws, COPA oversight is the only remaining mechanism to require public accountability from these monopoly hospitals. As a result, any repeal of COPA laws should grandfather in the COPA regimes for already-consummated hospital mergers.

12 Federal Trade Commission, "FTC Policy Perspectives on Certificates of Public Advantage," Staff Policy Paper, August 15, 2022, https://www.ftc.gov/system/files/ftc_gov/pdf/COPA_Policy_Paper.pdf.

13 Ibid.; FTC Press Release, "FTC to Study the Impact of COPAs," Federal Trade Commission, October 21, 2019, https://www.ftc.gov/news-events/news/press-releases/2019/10/ftc-study-impact-copas; Federal Trade Commission, "A Health Check on COPAs: Assessing the Impact of Certificates of Public Advantage in Healthcare Markets," June 18, 2019, https://www.ftc.gov/news-events/events/2019/06/health-check-copas-assessing-impact-certificates-public-advantage-healthcare-markets.

14 Federal Trade Commission, "FTC Policy Perspectives on Certificates of Public Advantage."

15 Ibid.

HOSPITALS

Repeal Certificate of Need Laws

THE PROBLEM

Thirty-five states have "certificate of need" (CON) laws requiring government approval before healthcare corporations can create, acquire, or expand facilities. Dating back to the 1970s, CON laws were intended to prevent the construction of excess hospital capacity, which was feared would lead to unnecessary spending on redundant services and overcharging on the fewer patients each facility would take under their care. In particular, the 1974 National Health Planning and Resources Development Act withheld federal funding from states that did not adopt CON laws. This law was repealed in 1986, but most states have retained their CON statutes.

CON laws have effectively become tools for legacy hospitals to avoid competition by abusing a regulatory barrier to entry; existing systems can simply fight the regulatory approval, rather than having to compete with a new facility. CON laws also restrict antitrust regulators' ability to stop a merger or demand a divestment from combining hospitals. For all the same reasons that hospital consolidation is harmful for patient care, CON laws are as well. Research has indicated that CON laws increase overall patient expenditures and elderly mortality.[16]

Similar to COPA laws, federal antitrust regulators have long criticized CON laws as protecting the market power of legacy hospitals.[17]

THE SOLUTION

By repealing CON laws, state legislators can restore competitive pressures to hospital markets, which research shows results in higher quality, more affordable care. Without CON laws, new hospitals could be constructed more easily where either the existing hospital is not providing quality care or where there is no existing hospital.

16 Christopher J. Conover and James Bailey, "Certificate of need laws: a systematic review and cost-effectiveness analysis," *BMC Health Services Research*, 1-29, August 14, 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7427974/.

17 Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws, January 11, 2016, https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf.

HOSPITALS

Set Standard Rates for Healthcare Services

THE PROBLEM

Healthcare costs in the United States are out of control, creating significant financial burdens for patients and government payers. Because many hospitals and healthcare providers have consolidated pricing power over the market, and because healthcare is so essential that most patients will pay regardless of cost, consistent year-over-year price increases have become the norm, putting pressure on both patients and public health programs.

THE SOLUTION

States should shift to setting standard prices for certain healthcare services. One effective way to do this would be for states to adopt an "all-payer" system, under which the state government sets prices for specific healthcare services and procedures. An independent public body sets rates, and all payers, private and public, pay the same price for the same service at the same hospital. Further, hospital revenues, and the growth of health spending overall, are capped.

Another, less comprehensive solution is to cap the prices that state health insurance plans will reimburse providers. State lawmakers can establish a system called "reference-based pricing," which pegs the maximum amount reimbursable for all inpatient and outpatient services to a certain multiple of Medicare reimbursement rates. This would set a ceiling on the maximum prices that providers would be able to charge for certain services.

Model Legislation:

Maryland currently operates an all-payer system, which has increased hospital quality while effectively constraining costs, to the order of $1.4 billion in Medicare spending in its first five years.[18] Implementing such a system requires a Medicare waiver.

In 2016, Montana's state employee health plan implemented a reference-based pricing system that set the maximum reimbursement for all inpatient and outpatient services to an average of 234% of Medicare payments. Two years after its adoption, the system saved an estimated $15.6 million, relative to if it had not been put into place.[19] State lawmakers in other states could write similar requirements into statute.

18 Madeline Jackson-Fowl and Willem Daniel, "Understanding the Success behind Maryland's Model," *Delaware Journal of Public Health*, 34-35, December 2019, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8389156/.

19 Julie Appleby, "'Holy Cow' Moment Changes How Montana's State Health Plan Does Business," Kaiser Health News, June 20, 2018, https://khn.org/news/holy-cow-moment-changes-how-montanas-state-health-plan-does-business/.

PHARMACY BENEFIT MANAGERS (PBMs)

Pharmacy benefit managers (PBMs) are middlemen in pharmaceutical markets. They were originally created to process drug claims for health insurance companies, but today they do much more, including decide which drugs are covered by insurance, bargain with pharmaceutical companies to determine drug prices, and decide which pharmacies are in a health insurer's network. On top of this, they own physical, mail-order, and specialty retail pharmacies of their own, and they manage pharmaceutical benefits for government programs like Medicare Part D and Medicaid. With such immense control over drug prices in the United States, PBMs are responsible for many of the problems in our country's pharmaceutical care system.

The top three PBMs — Caremark, Express Scripts, and OptumRx — manage 80% of drug claims in the United States. With this market power, they chronically under-reimburse community pharmacies for drugs. States have also found that PBMs have overcharged taxpayers for administering Medicaid drug benefits, sometimes by hundreds of millions of dollars.

Furthermore, the top PBMs are "vertically integrated" into the largest health insurance corporations, complete with their own mail-order pharmacies. Caremark is owned by pharmacy chain CVS, which also owns health insurer Aetna. The PBM Express Scripts is owned by insurer Cigna, and PBM OptumRx by insurer UnitedHealth. So as a patient going to an independent pharmacy, your health insurer owns the PBM deciding which drugs are covered and how much they cost, and also might own the competing pharmacy down the street.

As a result, when dealing with Medicaid, Medicare, employer health plans, and pharmacists, PBMs have a built-in incentive to self-deal. The more a PBM can overcharge taxpayers through a health plan like Medicare or Medicaid, and then under-reimburse the independent pharmacies that they compete with — pocketing the difference between the two — the more money they make.

However, state governments can and have regulated PBMs over the past two decades, aiming to limit many of the most harmful PBM practices by increasing transparency, preventing PBMs from taking an extra cut of profits, and prohibiting them from steering patients toward their own pharmacies.[20]

20 It should be noted that there is some legal dispute over state legislation to regulate PBMs. The federal Employee Retirement Income Security Act (ERISA) governs all employee benefit plans, including health insurance, and preempts state regulation. Federal courts have reached different conclusions regarding the extent to which state regulation of PBMs is preempted by ERISA.

PBMs

Prohibit Spread Pricing by PBMs

THE PROBLEM

"Spread pricing" is when PBMs charge payers like Medicaid more money than they reimburse a pharmacy for that medication. The PBM keeps the difference, the "spread," as profit.[21] PBMs have been known to refer to spread pricing as "differential pricing" or "risk mitigation pricing," even though there is no meaningful way in which this compensation structure manages business risks.

To explain: When a patient goes to fill a prescription, they pay the pharmacy a certain amount, and the rest is covered by insurance, whether a government plan like Medicaid or private health insurance. However, many PBMs reimburse the pharmacy one amount for the insurance's portion of the costs, but then turn around and charge the patient's insurance plan more than that as reimbursement for the pharmacist's services. The PBM keeps the difference. This is one way that PBMs are compensated, with the primary alternative being a transparent administrative fee paid by the insurance plan.

The use of spread pricing is particularly a problem for government healthcare plans like Medicare and Medicaid, in which the insurance plan is often capped by a "medical loss ratio" to a maximum amount of administrative costs and profits relative to patient care and benefits. Insurance plans, however, are allowed to consider the money paid through spread pricing to count as spending on care, allowing the PBM and insurance company to earn excess profits and prevent the state from covering more beneficiaries.

THE SOLUTION

PBMs should not be able to charge the insurance plan more for a drug benefit than the amount they reimbursed the pharmacy. This would ideally lead to PBMs being primarily compensated through a straightforward and transparent administration fee from insurance plans.

Model Legislation: Virginia § 38.2-3467 prohibits a carrier or PBM from conducting spread pricing, requiring that the pharmacy must be reimbursed the same amount as was charged to insurance.[22]

21 National Community Pharmacists Association, "Spread Pricing 101," https://ncpa.org/spread-pricing-101.

22 Code of Virginia § 38.2-3467, https://law.lis.virginia.gov/vacode/title38.2/chapter34/section38.2-3467/.

PBMs

Establish Minimum Reimbursement Rates for Independent Pharmacies

THE PROBLEM

Related and in addition to spread pricing, PBMs have also been known to reimburse independent pharmacies less than the pharmacy's costs of filling the patient's prescription, sometimes reimbursing independent pharmacies less than the PBM's own mail-order pharmacy. This makes it nearly impossible for independent pharmacies to make a profit and stay in business, and PBMs are only able to do this because of their concentrated power over pharmaceutical benefits.

THE SOLUTION

PBMs should not be able to reimburse pharmacies for less than the cost of fulfilling a prescription or dispensing a drug. This would ensure that independent pharmacies are paid fairly and able to compete on a level playing field.

In designing this policy, to prevent pharmacies from artificially inflating their costs to earn more revenue, the minimum reimbursement rates could use NADAC-plus pricing. This would tie pharmacy reimbursement rates to the National Average Drug Acquisition Cost (NADAC), a database of drug costs maintained by CMS, plus the state Medicaid plan's dispensing fee or spread.

PBMs

Require Equal Reimbursement for Independent and PBM-Affiliated Pharmacies

THE PROBLEM

When patients go to an independent pharmacy, the pharmacy is reimbursed by the PBM representing the patient's insurance company. However, the largest PBMs (OptumRx, Express Scripts, and CVS Caremark) all have their own mail-order or retail pharmacies, and PBMs will often offer different reimbursement rates for those drugs than they offer to their own pharmacies. This puts the independent pharmacy at an unfair disadvantage, and as a result many prescriptions are unprofitable for independent pharmacies to fulfill, and many struggle to stay in business.

THE SOLUTION

To avoid conflicts of interest and ensure a level playing field between independent and PBM-owned or affiliated pharmacies, PBMs should be required to offer the same reimbursement rates to nonaffiliated pharmacies as they do to their own.

Model Legislation: Oklahoma's 2019 Patient's Right to Pharmacy Choice Act includes provisions that prohibit PBMs from reimbursing independent pharmacies differently than they reimburse PBM-owned or affiliated pharmacies.[23]

23 Okla. Stat. tit. 36, § 6962(B)(3).

PBMs

Prohibit PBMs From Steering Patients to Their Own Pharmacies

THE PROBLEM

The largest PBMs own mail-order or retail pharmacies, but they are also responsible for reimbursing the independent pharmacies that compete with their own pharmacies. As a result of this conflict of interest, PBMs use a variety of tactics to steer patients away from independent pharmacies and direct business to their own mail-order pharmacies, which often provide worse service for essential prescriptions. Patient steering tactics can be direct, like requiring that patients use the PBM's pharmacy, or indirect, like using patient data to push patients toward their own pharmacies or ensuring that patients pay more to use an independent pharmacy than a PBM-owned one.

THE SOLUTION

Patients should have a free and fair choice of pharmacy, and independent pharmacies should be able to compete with PBM-affiliated pharmacies on a level playing field. State law should entirely prohibit PBMs from requiring patients to use their own pharmacy, and prevent PBMs from using patient data to steer patients and make them pay more to use another pharmacy.

Model Legislation: Georgia's 2019 Pharmacy Anti-Steering and Transparency Act.[24]

24 O.C.G.A. § 26-4-119.

PBMs

Adopt "Any Willing Pharmacy" Laws

THE PROBLEM

Many PBMs adopt a series of discriminatory arrangements to favor certain pharmacies over others, either because the PBM owns and operates their own mail-order pharmacy or because the PBM has favorable contract terms with certain pharmacies. As a result, PBMs have been known to steer patients towards their own mail-order pharmacies by refusing to deal with independent pharmacies, reimbursing independent pharmacies at a lower rate, or otherwise erecting barriers to using other pharmacies with a patient's insurance.

THE SOLUTION

States can adopt laws to require that PBMs honor fair contractual terms with "any willing pharmacy" that meets the requirements of a patient's healthcare plan. These provisions will bar PBMs from cutting other pharmacies out of an insurance plan's coverage or otherwise providing unfairly favorable terms to certain pharmacies, ensuring that patients are able to use their preferred pharmacy.

Model Legislation: N.J. Stat. § 17:48-6j, a 2017 New Jersey law, requires that pharmacy benefit managers and distributors sell to "any willing pharmacy" that meets the requirements of a health insurance plan.[25] This means that PBMs can't do business exclusively to pharmacies they either own or have discriminatory contractual relationships with.

25 N.J. Stat. § 17:48-6j, https://codes.findlaw.com/nj/title-17-corporations-and-institutions-for-finance-and-insurance/nj-st-sect-17-48-6j.html.

PBMs

Require Drug Rebate Pass-Throughs

THE PROBLEM

One of the core functions of PBMs is to negotiate drug prices with drug manufacturers, in theory to make drugs cheaper for patients. In practice, PBMs tend to negotiate not the list price for a drug but rather rebates (discounts) from drug manufacturers, which decrease the net price of a drug after the rebates are applied. In theory, these discounts should be passed on to the patient and their insurance company to decrease the effective price. However, PBMs often do not pass these rebates on, such that the patient sees none of those benefits at the pharmacy counter.

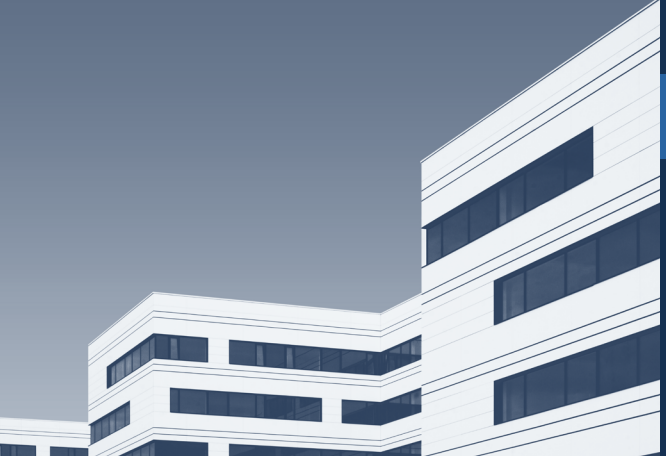
Furthermore, PBMs generally negotiate these rebates as a percentage of the drug's list price. This means that the PBM will get a larger rebate for a more expensive drug, and the PBM has an incentive to choose and negotiate discounts for costlier drugs rather than cheaper equivalents. As a result, the PBM is often selecting more expensive drugs for the patient in order to get a higher rebate, and then the PBM does not even pass the rebate on to the patient.

THE SOLUTION

State lawmakers can require that PBMs pass on to patients 100% of the rebates that they negotiate with drug manufacturers. This will immediately reduce the cost of drugs for many patients, and it will eliminate or reduce PBMs' incentives to select more expensive drugs for insurance coverage.

Model Legislation: West Virginia HB 2263 requires PBMs to pass through 100% of rebates to the patient at the pharmacy counter.[26]

26 West Virginia HB 2263, https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=HB2263%20SUB%20ENR.htm&yr=2021&sesstype=RS&billtype=B&houseorig=H&i=2263.



PBMs

Establish PBM Oversight Through State Insurance Commissions

THE PROBLEM

For the above regulations regarding PBMs to be effective, enforcement mechanisms need to be in place to monitor and ensure compliance, establish and levy penalties, and if necessary, revoke PBMs' certification to operate within that state.

THE SOLUTION

This could easily be solved by placing PBMs under the certification authority and oversight of state insurance commissioners, who would be able to monitor PBMs' compliance with state regulations and punish violations.

Model Legislation: Oklahoma's 2019 Patient's Right to Pharmacy Choice Act places responsibility for enforcing the Act with the state insurance commissioner, and provides the commissioner authority to penalize PBMs' violations.

CORPORATE PRACTICE OF MEDICINE

Healthcare is an essential, and deeply personal, service that all Americans need. Whereas the landscape of American healthcare has historically been mostly independent hospital, physician, and pharmacy practices, today healthcare is increasingly dominated by Big Medicine. Giant conglomerates like UnitedHealth Group and CVS have been acquiring more and more segments of the healthcare system, across insurance, pharmacy benefit management, pharmacy services, direct physician services, and claims processing. Other independent practices are rapidly being acquired by private equity investors looking to turn a quick profit by hiking prices and cutting expenditures on care.

State governments can limit or reverse this trend by adding requirements for corporate ownership of medical practices, disclosure requirements for investors seeking to acquire healthcare providers, or direct state oversight to determine whether potentially harmful corporate ownership should be allowed in the first place.

As one doctor recently said, "You can't serve two masters. You can't serve patients and investors."[27]

27 Dr. Michael Rains, "How Private Equity Is Ruining American Health Care," Bloomberg BusinessWeek, May 20, 2020, https://www.bloomberg.com/news/features/2020-05-20/private-equity-is-ruining-health-care-covid-is-making-it-worse#xj4y7vzkg.

CPOM

Enact and Enforce Corporate Practice of Medicine (CPOM) Laws

THE PROBLEM

Medical practices across the country — specialty care clinics, pharmacies, dental practices, and others — are being bought up by distant investors looking to profit from the high costs of healthcare in the United States, but with little concern for the quality of care that patients receive. These investors might be large, established healthcare systems or private equity investors looking to cut costs and maximize billing. In either case, ownership of more and more of American healthcare is falling into the hands of profit-seeking businesspeople rather than healthcare professionals concerned with the well-being of the patients entrusted to them.

Corporate practice of medicine (CPOM) laws require that certain types of medical practices be owned and operated by licensed medical professionals. These laws were meant to avoid the commercialization of medical care, to prevent the conflict of interest between corporate profits and medical professionals' obligations to their patients, and to prevent management from interfering with healthcare professionals' medical judgment.[28] Most states have CPOM laws to prohibit corporate ownership, but a near-universal set of exceptions provides loopholes that allow investors to circumvent these regulations.

Most notably, private equity funds often make their healthcare investments through a physician management company (PMC) or management services organization (MSO). This typically means having a "friendly physician" remain as the legal owner of the medical practice, while a separate, corporate-owned MSO receives all the excess compensation in return for management "services."[29] While this in effect is nearly indistinguishable from private equity ownership, this arrangement is legal in most states.

28 American Medical Association Advocacy Resource Center, "Issue brief: Corporate practice of medicine," 2015, https://www.ama-assn.org/media/7661/download.

29 For an example of corporate guidance for circumventing these laws, see Matt Wilmot, Wes Scott, and Ethan Rosenfield, "Corporate Practice of Medicine Doctrine: Increased Enforcement on the Horizon?" Nelson Mullins, January 17, 2023, https://www.nelsonmullins.com/idea_exchange/blogs/healthcare_essentials/enforcement/corporate-practice-of-medicine-doctrine-increased-enforcement-on-the-horizon.

THE SOLUTION

States can implement and strengthen CPOM laws to close these loopholes, which have allowed private equity and others to acquire medical practices.[30] States should be careful to close the common loopholes used to circumvent these laws by, for example, having a physician owner in name only. This would protect healthcare and medical practices from predatory private equity investors and ensure that doctors can maintain professional and health-centered relationships with their patients.

30 For discussion of these solutions, see Zhu, Jane M., Hayden Rooke-Ley, and Erin Fuse Brown. "A Doctrine in Name Only-Strengthening Prohibitions against the Corporate Practice of Medicine." The New England journal of medicine (2023), https://www.nejm.org/doi/full/10.1056/NEJMp2306904.

CPOM

Limit Private Equity Investments in Healthcare

THE PROBLEM

Private equity firms, a category of investors known for aggressively slashing costs and increasing prices to increase the short-term value of the companies they manage, have been investing heavily in healthcare in recent years. From hospitals[31] to nursing homes,[32] private equity's influence on healthcare is clear from the many documented instances of chronic understaffing, poor patient outcomes, bankruptcies, and sky-high profits for investors. While not all private equity is harmful by nature, private equity and similar investors present serious risks to the quality of care that patients can expect.

THE SOLUTION

States can pass laws prohibiting private equity investors from acquiring or transferring ownership of healthcare investments without the approval of the state government, to ensure that the investment or transfer does not harm the quality of care, the availability of services, or present risks of consolidation.

Model Legislation: California's proposed SB-977 would prevent private equity funds from acquiring healthcare systems without approval from the state attorney general.[33]

31 Peter Elkind and Doris Burke, "Investors Extracted $400 Million From a Hospital Chain That Sometimes Couldn't Pay for Medical Supplies or Gas for Ambulances," ProPublica, September 30, 2020, https://www.propublica.org/article/investors-extracted-400-million-from-a-hospital-chain-that-sometimes-couldnt-pay-for-medical-supplies-or-gas-for-ambulances.

32 Yasmin Rafiei, "When Private Equity Takes Over a Nursing Home," *The New Yorker,* August 25, 2022, https://www.newyorker.com/news/dispatch/when-private-equity-takes-over-a-nursing-home.

33 California SB-997 (2020), https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB977.

CPOM

Require Local Pharmacy Ownership

THE PROBLEM

The landscape of pharmacies in the United States has shifted in the past generation, as healthcare giants like CVS and Walgreens have mostly displaced local, independent pharmacies. This occurred with the assistance of some unfair advantages, and many of these large healthcare conglomerates continue to use a series of unfair tactics to push independent pharmacies out of the market, including:

- Using their own PBM to under-reimburse pharmacies;
- Using their PBM to steer patients away from independent pharmacies and toward their own; and
- Clawing back reimbursements paid to independent pharmacies.

Nor are the large chain pharmacies necessarily effective at providing care. During the rollout of the Covid-19 vaccine, West Virginia was the only state to opt out of a federal partnership with CVS and Walgreens to distribute the vaccine. The state instead relied on existing relationships with a network of independent pharmacies and outpaced the rest of the country in vaccinating residents of long-term care facilities.[34]

THE SOLUTION

State lawmakers could reverse this trend by requiring that pharmacies be locally owned by a registered pharmacist. Such a law would put control of pharmaceutical care in the hands of a licensed healthcare professional rather than a distant corporation.

Model Legislation: North Dakota has required local pharmacy ownership since 1963, and requires that only registered pharmacists may own and operate pharmacies within the state.[35] The sole proprietor of a pharmacy in North Dakota must be a registered pharmacist. As a result of this law, there are no chain pharmacies in North Dakota today.

34 Yuki Noguchi, "Why West Virginia's Winning the Race the Get COVID-19 Vaccine Into Arms," NPR, January 7, 2021, https://www.npr.org/sections/health-shots/2021/01/07/954409347/why-west-virginias-winning-the-race-to-get-covid-19-vaccine-into-arms.

35 North Dakota State Board of Pharmacy, https://www.nodakpharmacy.com/pdfs/Lawbook41316.pdf.

LABOR AND HEALTHCARE CONSOLIDATION

Healthcare makes up a large fraction of the American economy. However, workers across the sector — from home health aides to chiropractors to surgeons — often find themselves cornered by dominant employer power. Obstacles to union organizing suppress worker wages; noncompete agreements trap doctors, nurses, and many others into lower paying jobs than they could otherwise get; and large healthcare systems dominate entire regions such that workers have few, if any, opportunities to seek better positions or leverage competing job offers for better working conditions or pay.

State governments can amend many of these problems by regulating the dominant position of healthcare systems in labor markets, by banning exploitative employment agreements like noncompetes or training repayment agreement provisions (TRAPs), and by directly bolstering the rights of healthcare workers to organize unions.

LABOR & CONSOLIDATION

Strengthen Antitrust Monopsony Enforcement for Healthcare Workers

THE PROBLEM

Many corporate or dominant healthcare systems use their positions in labor markets to suppress wages, degrade working conditions, provide worse benefits, and prevent workers from switching jobs to pursue better opportunities. This "monopsony" power occurs when a buyer has power — in this case, the healthcare systems use their power as a buyer of labor to harm workers.

Traditional antitrust law tends to ignore this sort of anti-competitive behavior and abuse. Guided by a "consumer welfare standard" for the past 40 years, federal antitrust law primarily seeks to intervene when consumers are harmed by higher prices, but generally ignores when workers are hurt through anti-competitive business and employer practices.

Similarly, many employers in healthcare use their advantaged bargaining position relative to healthcare workers to create unfair and anti-competitive employment terms. These include:

- Noncompetes, which prohibit employees from switching to work for competing healthcare providers, closing off important employment opportunities;
- No-poach agreements, in which different employers agree to not hire each other's employees, so that healthcare workers have fewer opportunities;
- Arbitration agreements, which prevent employees from having access to justice in court; and
- Training Repayment Agreement Provisions (TRAPs), which require that healthcare workers pay their employers back for the costs of their own training. These are particularly common in healthcare.

THE SOLUTION

To diminish employers' unfair control over healthcare labor markets, states can incorporate specific standards into any potential state antitrust law to enforce against the harms and abuses from monopsony power.

In strengthening antitrust protections for workers, states can also clearly state that unfair and anti-competitive employment practices — such as noncompete agreements, no-poach agreements, arbitration agreements, or training retention agreements (TRAPs) — are plainly prohibited as an abuse of dominance by the employer.

LABOR & CONSOLIDATION

Strengthen Healthcare Workers' Rights to Organize

THE PROBLEM

Transforming hospital jobs and making them sustainable for workers and the economy will require workers to have a voice and increased bargaining power. Workers are entitled to form unions and collectively bargain for better wages and conditions without fear of discrimination from their employers. Nevertheless, healthcare workers often find that hospitals and other healthcare employers, even nonprofit ones, repeatedly violate their right to unionize. While they have sought relief before the National Labor Relations Board, they have not always been successful.

Legislators and the public have the right to expect cooperation from nonprofit or other publicly supported hospital systems when workers choose to organize. State legislators must step up to support and elevate workers' efforts to improve their labor conditions.

THE SOLUTION

To strengthen workers' rights to organize, states can pass and enforce labor peace laws. If the state or local government is funding a local project or facility, the state can require the operator of the project or facility to enter into labor peace agreements and abide by certain labor obligations. These can include:

- Requiring an employer to recognize a union based on signed cards, rather than by the results of a full union election;
- Requiring the employer to remain neutral and not express negative opinions or preferences about union organizing; and
- Requiring the employer to allow workplace access to union organizers.

With many nonprofit and publicly supported hospitals, the state can intervene in this way to ensure that healthcare workers are able to organize their workplaces and seek fair compensation for their work.

LABOR & CONSOLIDATION

Ban Noncompete Agreements

THE PROBLEM

Noncompete agreements — which restrict workers' ability to be employed by a competitor of their current employer if they leave their job, often within a certain geographic distance — are a key way that healthcare employers prevent workers from changing jobs or using the threat of working for a competitor as a way to leverage higher pay, better benefits, or better working conditions. Particularly in the case of dominant hospital systems or corporate healthcare providers, workers bound by noncompetes find it impossible to switch jobs and yet remain in their field.

While noncompetes are harmful generally, the problem is most acute in healthcare, where large numbers of doctors and nurses are subject to noncompete agreements that trap them in their jobs.

THE SOLUTION

State legislators should ban the enforcement of noncompete agreements. Any such prohibition should include any "effective" noncompete agreement by another name. Such agreements that should also be prohibited include:

- Training repayment agreement provisions (TRAPs), which require that employees pay their employers back for the cost of their training. Such agreements prevent employees from being able to leave for better opportunities in their field, or outside of it.

- Notice period provisions, which require employees to give excessive notice before leaving for another job opportunity, limiting their effective ability to switch jobs.

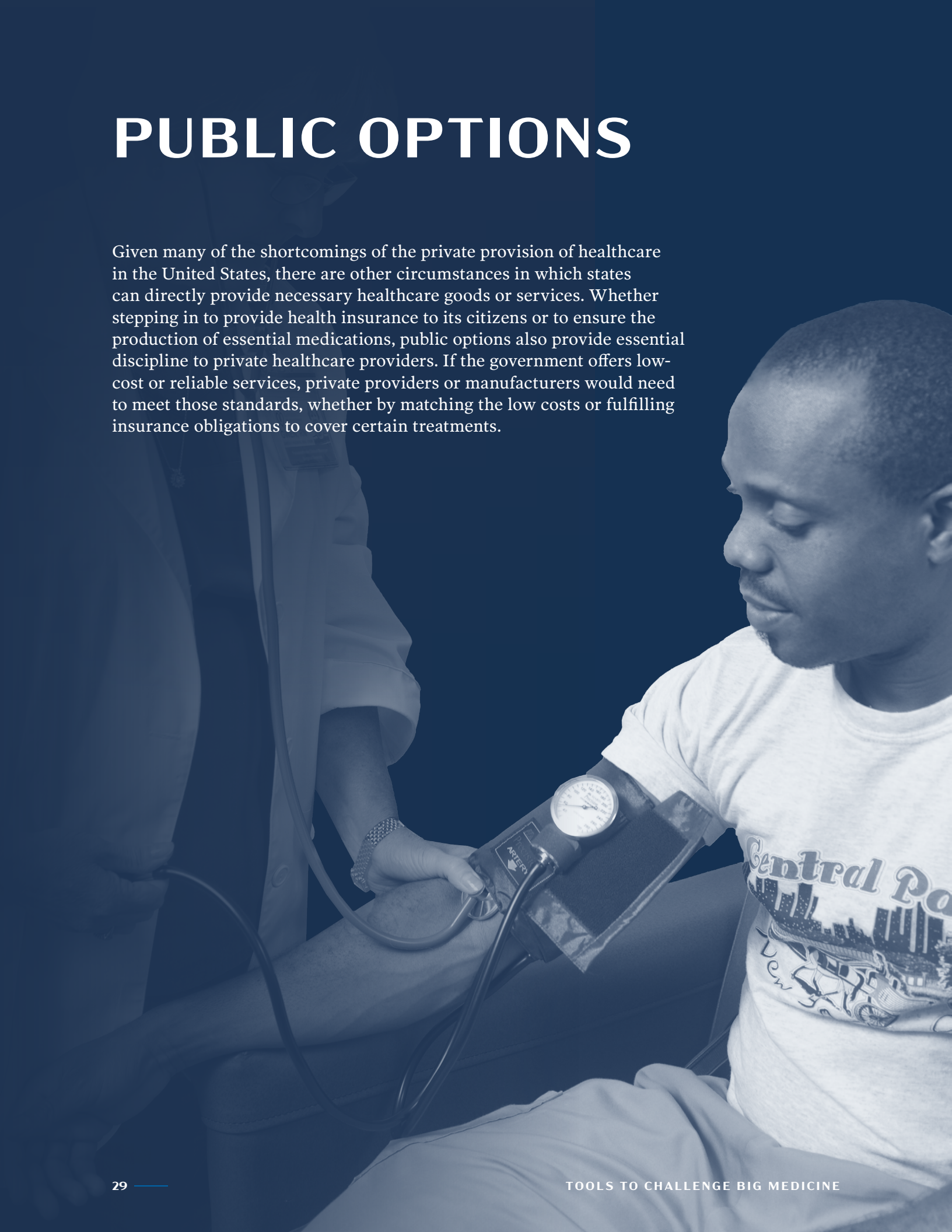
Any law should also require that employers notify their current and past employees that any noncompete they had previously signed is no longer enforceable.

Model Legislation: California's proposed AB 747 would ban noncompete agreements and other effective noncompete agreements.[36]

36 California AB 747, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB747.

PUBLIC OPTIONS

Given many of the shortcomings of the private provision of healthcare in the United States, there are other circumstances in which states can directly provide necessary healthcare goods or services. Whether stepping in to provide health insurance to its citizens or to ensure the production of essential medications, public options also provide essential discipline to private healthcare providers. If the government offers low-cost or reliable services, private providers or manufacturers would need to meet those standards, whether by matching the low costs or fulfilling insurance obligations to cover certain treatments.



PUBLIC OPTIONS

Establish a Public Insurance Option

THE PROBLEM

With successive reforms to the American healthcare system attempting to attain universal healthcare, American health insurance is still a patchwork of different government and private programs, ranging from Medicare for the elderly, Medicaid for low-income Americans, the VA for veterans, employer-sponsored private insurance for those of working age, as well as many health insurance plans on private state exchanges that were created by the 2010 Affordable Care Act. Despite these efforts, about 10% of the American population remains uninsured.[37]

Just as troubling, even those with insurance coverage often find it less reliable than expected. Insurance companies looking to maximize their profits will often deny claims for health procedures or services that they are obligated to pay for,[38] or make patients and doctors jump through a range of bureaucratic hoops in order for their insurance to pay for covered services.

THE SOLUTION

State lawmakers can respond to this problem by establishing a public insurance option, following recent laws in Washington (2019), Nevada (2021), Colorado (2021), and Minnesota (2023). While the insurance would not be a free public benefit, it would have key benefits:

- First, without the profit-maximizing incentives of most private health insurance companies today, a public insurance option would serve as a reliable source of health insurance for citizens who have found coverage repeatedly denied incorrectly by private health insurance plans.

- Second, the existence of a public insurance option that upholds honest insurance and claims practices would impose discipline on private insurance companies in the state. For fear of losing customers and employers to a public plan that reliably and honestly provides coverage, private insurance would instead need to honor their coverage commitments to patients.

37 Jennifer Tolbert, Patrick Drake, and Anthony Damico, "Key Facts About the Uninsured," Kaiser Family Foundation, December 19, 2022, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=The%20uninsured%20rate%20dropped%20in,to%202021%20(Figure%201).

38 For example, see David Armstrong, Patrick Rucker, and Maya Miller, "UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings," ProPublica, February 2, 2023, https://www.propublica.org/article/unitedhealth-healthcare-insurance-denial-ulcerative-colitis; Mari Devereaux, "Health systems see increasing claim denials as payer 'delay tactic,'" Modern Healthcare, November 21, 2022, https://www.modernhealthcare.com/insurance/insurance-claim-denial-rates-rising-health-systems-struggle.

PUBLIC OPTIONS

Implement Public Drug Manufacturing

THE PROBLEM

Through manipulation by pharmaceutical companies and pharmacy benefit managers, many essential medications have become more and more expensive over the years despite no real improvements. Insulin, for example, costs very little to make and is essential for diabetics to survive, but American patients find themselves paying thousands of dollars per month for it.[39]

THE SOLUTION

State governments could solicit bids for their own contracts to manufacture key medicines, allocating their own budgets toward producing medicines that cost very little to make but are currently unreasonably priced in private markets.

Model Legislation: California has allocated $50 million of the state budget to produce low-cost insulin through a 10-year contract with nonprofit drug manufacturer Civica.[40]

39 Dzintars Gotham, Melissa J. Barber, and Andrew Hill, "Production costs and potential prices for biosimilars of human insulin and insulin analogues," *BMJ Global Health*, 2018, https://gh.bmj.com/content/3/5/e000850.

40 Emma Bowman, "California enters a contract to make its own affordable insulin," NPR, March 19, 2023, https://www.npr.org/2023/03/19/1164572757/california-contract-cheap-insulin-calrx.

AMERICAN ECONOMIC LIBERTIES PROJECT

The American Economic Liberties Project is a new, independent organization fighting against concentrated corporate power to realize economic liberty for all, in support of a secure, inclusive democratic society.

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