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May 29, 2024

RE: Docket No. ATR 102, Request for Information on Consolidation in Health Care Markets

The Coalition of State Rheumatology Organizations (CSRO) is comprised of nearly every active state rheumatology society in the nation, representing over 40 states, with a mission of advocating for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist.

We thank the Department of Justice, the Department of Health and Human Services, and the Federal Trade Commission ("the agencies") for their attention to the important issues of consolidation and private equity in healthcare and their interest in ascertaining how those trends impact the practice of medicine. We hope that the perspective of practicing rheumatologists will be helpful to the agencies as they determine next steps.

Although the agencies' request for information (RFI) covers the range of transactions conducted by private equity funds, health systems, and private payers, it is worth noting that transactions conducted by each of these entities come with distinct challenges. For example, acquisitions by hospital systems may create undue consolidation, while acquisitions by private equity may reduce the quality of care if the private equity management interferes with the practice of medicine. Finally, acquisitions by payers may create both undue consolidation *and* care quality issues, as well as antitrust concerns. **Because of its wide-ranging impact, the latter category – acquisition of medical practices by insurers – is by far the most concerning for physicians and the most pernicious for our healthcare system as a whole**.

<u>Private Equity</u>

Private equity investment partnerships have taken an increasing interest in infusion, which is a service that rheumatology patients have high reliance on since many biologics to treat rheumatoid arthritis are administered via IV infusion. Private equity firms are increasingly investing in medical services organizations (MSOs) with office-based infusion operations, but the real-world impact of these partnerships is partially dependent on a particular state's regulatory framework. Some states have stringent laws around who can

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operate a medical practice, which has driven private equity investors to freestanding infusion centers that have no "attached" medical practice.

Quantifying the impact of this is complex. On the one hand, private equity-backed, freestanding infusion centers may drive physician practices out of communities if the physician-led infusion center cannot compete. On the other hand, private equity backed infusion centers may have the capital to remain in rural and underserved areas for years before they become self-sustaining in terms of revenue. The average independent physician practice cannot afford operating at a loss for that duration, without any additional source of external funding. Thus, private equity may increase community-based access to infusion services in certain areas. However, the negative impact of private equity in rural communities is also well-documented: there have been instances of such firms investing in rural hospitals only to have the hospital close within a few years, leaving that community without access to hospital-based care within any reasonable distance.

It is worth noting that ongoing reductions to physician reimbursement in federal health programs such as Medicare have been a major contributor to the financial instability of independent practices. The American Medical Association estimates that reimbursement for Medicare physicians declined by 26% from 2001 to 2023, when one adjusts for inflation in practice costs. That has made it impossible for independent practices to take financial risk or to compete for staff with large, well-funded systems, whether funded by private equity or otherwise.

Concerns regarding the erosion of autonomy and the potential for interference in clinical decision-making are legitimate and there are certainly high-profile examples of bad actors. P**olicymakers should seek to create policies that prohibit interference with clinical decisions by those without a direct duty of care to the patient, regardless of how the bad actor is organized in terms of funding**.

<u>Notable Transactions</u>

In response to the agencies' question about notable transactions, we would like to highlight the experience of one of our members in California. After being in network with UnitedHealthcare for several decades, this rheumatologist received a notification in December 2022 – after open enrollment periods had ended – from UnitedHealthcare that his reimbursements would be reduced by 40% across the board. This reduction would have left the practice in the red on every service provided to UnitedHealthcare enrollees. The notification was

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take-it-or-leave-it, with no opportunity to negotiate, and required an opt-out by January 15, or the practice would be deemed to have accepted the new rates. The practice ultimately decided this reimbursement level was not workable, so they were forced to opt out of the network. As a result, the practice had to inform its affected patients and try to identify and contact other rheumatology practices over the year-end holidays, so that patients would not suffer any interruption in infusions or other needed care.

Notably, Optum, which is a subsidiary of UnitedHealth Group, had just set up a clinic of its own just two miles away the year before. That clinic had a rheumatologist on site once a week, who would refer to a bigger Optum-owned center in the area. This scenario illustrates the self-dealing that occurs between these integrated entities. In this case, through offering reimbursement rates so low as to be unsustainable, the parent entity leveraged its network to drive out providers in competition with a clinic owned by its subsidiary. Since meaningful negotiation is not an option, the independent practice has only two options in this scenario: find a way to stay afloat with the drastically reduced rates or opt out of the network. Either way, the parent entity wins and the medical provider loses, while the patient may find themselves scrambling to find another provider. In those cases, **there should be a firewall in place between related entities to prevent self-dealing.**

Consolidation

That anecdote raises the issue of consolidation, which each of the agencies has been very active on during recent years. UnitedHealth alone reportedly has over 2,600 subsidiaries and 90,000 employed or affiliated physicians – approximately 10% of all doctors in the United States. Many of its subsidiaries are the kinds of businesses that should be dealing at arms' length with an insurer, but it is impossible to verify whether that is in fact happening. When the pharmacy, the specialty pharmacy, the pharmacy benefit manager, the health insurer, and even the physician all share a single corporate parent, the usual safeguard of potentially adverse interests leading to more robust negotiations and competition all but disappears.

Indeed, at least one pharmacy benefit manager (PBM) is now even entering into cobranding partnerships with two drug companies – the very entities that the PBMs claim to police. Even where there is a contractually adversarial position between PBMs and drug companies, patients do not seem to benefit in the form of improved access or reduced out-of-pocket costs for medications. But in a case where the PBM and the drug company join forces, any contractual distance between the two is obliterated and it is difficult to see how patients

benefit from the resulting restriction in their treatment options. For that reason, we hope that the Federal Trade Commission will closely scrutinize such arrangements. In the past, the FTC has done just that: in the late 1990s, for example, the FTC entered into a settlement agreement to address antitrust concerns resulting from Merck's vertical integration with Medco, a PBM. At the time, the Director of the FTC's Bureau of Competition noted that Merck's acquisition of the PBM "has reduced competition in the market for pharmaceutical products" and that Medco's favorable treatment of Merck products resulted in consumers having been "denied access to the drugs of competing manufacturers."[1] There is no reason to believe that the underlying anticompetitive dynamics have changed in the intervening decades.

Foundational Questions

Regardless of consolidation levels or funding sources, we urge the agencies to begin by clearly delineating the answers to two foundational questions, because that will inform the needed next steps in terms of policy and enforcement:

(1) **Who is the primary "consumer" in our healthcare market?** In our view, it should be the patient.

(2) **Who owes a duty of care to the patient?** Physicians and other healthcare professionals have a legal duty of care to the patient. Non-medical entities such as insurers functionally practice medicine through aggressive utilization management protocols that override clinician discretion. Since this does not technically qualify as the practice of medicine, however, the insurer bears no responsibility for any resulting harm to the patient and thus has little incentive to prioritize the patient's well-being over its responsibility to shareholders and investors. That must change.

In closing, we thank the agencies for the willingness to take a closer look at the impact of consolidation and private equity on the practice of medicine. If you need any additional information, please don't hesitate to reach out.

[1] Federal Trade Commission: "Merck Settles FTC Charges that Its Acquisition of Medco Could Cause Higher Prices and Reduced Quality for Prescription Drugs" (Aug. 27, 1998). Available: https://www.ftc.gov/news-events/news/press-releases/1998/08/merck-settles-ftc-charges-its-acquisition-medco-could-cause-higher-prices-reduced-quality.

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