



## **FTC and DOJ Host Listening Forum on Effects of Mergers in Health Care Industry - April 14, 2022**

Doha Mekki:

Good afternoon, everyone. Welcome to the DOJ's and FTC's second of four public listening forums on the firsthand effects of mergers and acquisitions. Today, we'll hear from members of the public about the effect of mergers and acquisitions in the healthcare industry in particular. I want to thank the businesses, consumers, and organizations that are bringing items to our attention today. I also want to thank the FTC for their support in this project and for helping to host today's event. For those who are unable to join us live, the public comment period remains open through April 21st, 2022, and all are welcome, and in fact, encouraged to submit formal comments@regulations.gov.

It is my great honor to open the second session. Sessions like this one give us direct access to affected stakeholders, including our invited speakers and members of the public who have chosen to sign up and share their views today. We are doing our part to go outside of the beltway. Washington DC is far away for so many Americans, it's important for agency leaders to connect with people on the ground. Doing so helps us broaden our understanding of how mergers impact the overall economy.

Today's speakers are experts with on the ground experience about the impacts of mergers and acquisitions in the healthcare industry. They're a critical complement to the academic, legal and economic experts we hear from regularly. The session solicit input alongside our public comment process. I can't underscore enough that the comment period is still open with a deadline of April 21st. No matter your viewpoint, we want to hear from you. We care what you think and we need to hear from you that's why we encourage anyone and everyone with a viewpoint to submit a comment. We will read every single one. We are already reviewing the hundreds of comments we've received so far.

We are incredibly excited about the level of public engagement we've seen so far. Our first listening session was incredibly insightful, and we're on pace to receive orders of magnitude more public comments than the agencies did during the 2010 review of the merger guidelines. And that's just stage one. The agencies plan to release a draft of the revised guidelines for public comment and undertake further dialogue and debate on that as well. Along the way, we'll continue to engage with stakeholders across the economy. It's a tremendous amount of work, but it's worth it. And it's incredibly important that we revise the guidelines to better fit the modern economy.

As we undertake this work, we are eager to hear from you, including during today's listening forum. As we work with our partners at the FTC to ensure that consumers and patients, healthcare providers and healthcare workers receive the full benefits of competition in healthcare markets.

As we all know, healthcare is an important part of the US economy and we know that steady, affordable access to care can mean life or death for so many. It is crucial that our healthcare markets remain competitive and free of unlawful conduct. Competitive healthcare markets give patients access to medicine at affordable prices. They offer hospitals that offer quality care and better choices of doctors. These markets are fundamental to our lives and the lives of our families. If companies are engaging in harmful anti-competitive mergers, the antitrust division has an obligation to enforce the law to the fullest extent possible. And we're not just talking about dollars and cents here, we're talking about quality of care and access to care. We are talking about the ability to purchase medicine and health insurance.

We also see the harms of anti-competitive consolidation across the many dimensions of the modern economy, including healthcare. Concentrated market structures can harm patients downstream at the same time that they harm healthcare workers upstream. Everyone loses except the extracted powerful firms in the middle.

Ensuring our healthcare markets remain competitive is essential to our livelihood or the livelihood of the nation. That is why it remains a priority for public antitrust enforcement and why this afternoon's listening forum is so important. The antitrust division's mission is to promote competitive markets by bringing wrongdoers to justice through both criminal and civil enforcement of the antitrust laws. We are pursuing matters that impact competition and healthcare across all of our programmatic areas. Our civil program is actively pursuing healthcare matters and our criminal program has an ongoing investigation into cartel activity among generic drug providers. We take healthcare competition seriously.

With that, we should turn to the speakers we came to learn from today. For today's listening forum, we have a robust group of speakers from across the industry joining us as well as additional speakers who will be present virtually. I'll start with Joe Thon. My colleague Chair Khan will save for comments for the end, so that we can preserve as much time as possible to hear from our speakers. We have some folks who have prepared remarks for us today. And after a brief discussion, we'll open things up to the public before Chair Khan closes. Let's go ahead and hear from our first speaker. I'll turn things over to you, Joe.

Joseph Thon:

Thank you very much. Good afternoon, everybody. My name is Joe Thon, and I'm a registered nurse for St. Joseph's Regional Medical Center, 120-year-old hospital in Lewiston, Idaho. I've been employed with the hospital since July 25th, 2005. Thanks for allowing me to share the story of our hospital's transition. One thing that unites doctors, nurses, techs, and custodians is when you work in healthcare, you spend a lot of time reminiscing about the good old days. And that was even true back in the good old days when I joined St. Joe's in 2005. You see, at the end of 2002, the small Catholic healthcare system owned St. Joe's. They were called the sisters of Carondelet.

They merged to a larger Catholic healthcare system named Ascension Health. And a lot of people I respected were not happy about the new changes. The hospital had previously been allowed to make its own purchasing decisions and decisions that affected our community under the old guard, but Ascension had centralized those decisions 1,800 miles away in Saint Louis, Missouri, which was Ascension's headquarters. As I understood it, our local leadership wanted to align with a smaller system closer to home to restore the independence and autonomy that we once had.

Importantly, we felt like we had a lot going for us in those days at St. Joe's. We were the biggest hospital with the highest level of emergency care of any hospital between Boise, Idaho, and Spokane Washington approximately 425 miles apart. I remember meetings about a decade ago when we were

Ascension when we were told that we had enough cash on hand to operate for about 240 days without any revenue coming in at all. We had merged into Ascension after the Carondelet health system's credit rating was downgraded, but that had nothing to do with our hospital. We were one of the strongest hospitals in the Ascension network.

Our leadership felt like it would be better off without the bean counters in St. Louis controlling our money. Our local board members wanted to align with the healthcare system that would be closer to understand the needs of our community. We supported our local leadership, longtime members of the community whose judgment we all trusted. I think most of us who worked at St. Joe's were not suspicious at all when the company that agreed to purchase us in June of 2015, Capella Healthcare Inc, was a for profit health system based in Nashville, even further away than Ascension, or that Capella was owned by a Chicago private equity firm. We also were not alarmed at all when Capella turned around two months later and announced it was selling off to an Alabama real estate firm during the discernment process.

was a medical properties trust, nor were we too concerned when we learned that these transaction had somehow left our hospital under the control of a company RCCH, that was owned by a New York private equity firm, Apollo Global Management. We would experience two or more ownership changes after that with a rural hospital chain called LifePoint that Apollo bought in 2018. And then in 2021, Lifepoint spun off our hospital with 17 other LifePoint hospitals and 61 longterm acute hospitals formerly owned by Kindred Healthcare and a new company called ScionHealth.

As you can imagine, to say our employees in our community, they are left uncertain of the direction of our hospital would be a little bit of an understatement. What's all that mean for the employees? Well, first off, there are fewer and fewer of us. Under Ascension, the hospital had more than a thousand employees. Now, we've got about 700. 62 employees were downsized just months after the merger closed in 2017. Employees who stayed got squeezed. The cost of our insurance benefits went way up while our coverage went down. We lost several benefits altogether, such as our extended illness bank hours, or in other words, sick pay. We lost pension pay and health retirement arrangement accounts as well.

Staffing was reduced, in addition. Most of our nursing units lost secretaries. Most reduced the amount of CNAs and the patient ratios to register nurses went up on most units as well. What this means is that the nurses and surgical techs answer the phones, coordinate communication between departments and perform a number of administrative tasks that take precious time away from our patients. It's also chaotic on a daily basis.

As a result, the registered nurses formed a union and voted to be represented by the Teamster's local 690 at Spokane, Washington affiliated with the International Brotherhood of Teamsters. The company fought hard for nearly two years to give us our first contract.

Another big change since the merger has been outsourcing. Many departments from the cafeteria to anesthesia and billing and even our internal medicine doctors have been outsourced since the change to for profit. Cheerleaders for the cafeteria contractor that took over proudly told us that they were giving the employees a 40 cent an hour raise. But what they didn't tell us is that they were changing their employee benefits and healthcare insurance premiums to now over \$400 every two weeks. How's anyone supposed to pay for that when they're making 11.15 an hour?

Another example of outsourcing is there's now no night shift pharmacy causing delays in patient care, adding more work to registered nurses and taking away safety barriers to patients in emergent situations. Most of the outsourcing has caused a loss of staff due to benefits or pay offered by the new outsource company. People have chosen to leave our hospital or community to avoid taking pay cuts.

What's this mean for you as a patient? As a patient, you may have longer wait times before your call light is answered you may need to use a bathroom or when you need pain medicine. We've had more falls occurring at our hospital as well since the loss of staff. Maybe your visitors will not be able to eat in the cafeteria as it now has reduced hours and doesn't even stay open during daytime hours. Maybe you have a question on your bill only to be transferred to a billing company on the Eastern side of the United States and given the runaround.

Several studies have shown evidence of increased mortality with registered nurse shortages as well. It's simple, better staffing equals better care. In fact, our hospital has lost so many employees that we have an entire unit shut down currently for almost two years now. Not enough staff to open it up. This translates to during a pandemic patients coming to our emergency department may need to be transferred to other hospitals far away not because we don't have rooms, but because we don't have the staff to take care of the patients. This also results in rationing of care to patients with elective procedures based on the amount of emergent, patients that are in the hospital system at one time. If there is enough staff to take care of the emergent patients, there's not enough staff to take care of the elective patients as well.

How does this affect our community? In October of 2019, the hospital began negotiations with Regence Blue Shield of Idaho, a healthcare insurance company, providing insurance to more than 15,000 people in our community as a hospital was not getting the premiums they wanted. They announced that they were going to remove the hospital from Regence's network on January 16th, 2020.

What does that mean? That means that all non-emergent services such as tests, office visits and elective surgeries would be billed at an out of network payment rate. Only emergent services would be billed as an in network, such as heart attacks and strokes. People were going to be forced to change in the middle of their treatment to find new facilities, new doctors, new places to have their elective procedures done. The hospital in Regence did eventually come to an agreement with only slight delays in patient care. The uncertainty was extremely stressful to the community and members with chronic illnesses and babies on the way. Probably up with time right now.

Doha Mekki:

Thank you so much, Joe. I'm going to turn it over to Ms. Tyler next.

Joseph Thon:

Thank you. (silence)

Kelley Tyler:

Yes. Thank you, Assistant Attorney General Kanter and Chair Khan for holding this important forum. My name is Kelley Tyler. I'm a registered nurse at Mission Healthcare in Asheville, North Carolina, and a member of National Nurses United, the nation's largest nurses union. I'm here today to share the devastation our community has experienced since HCA healthcare, the world's largest and wealthiest hospital corporation bought Mission in 2019. Prior to HCA, Mission was well known for its excellent cardiovascular, pediatric and neuro trauma care in Western North Carolina. Mission provides care to the vast majority of our community, serving somewhere between 75% and 91% of the population.

Before HCA took over, Mission was a source of pride. It was also a draw for many of our older residents who have moved here for retirement knowing there was an excellent healthcare system nearby. I worked at Mission for over 37 years and have been shocked and horrified by the cuts and services and rising costs for our patients since the takeover.

Services like rural cancer care, wheelchair and seating clinics have been completely cut. HCA has shuttered primary care clinics and driven out hundreds of doctors and nurses. Our more vulnerable populations have suffered, especially seniors who are often forced now to drive over an hour for their needed care. Many of the physicians we have lost have yet to be permanently replaced. Travel and temporary providers feel a hole, but they're not always familiar with system protocols. Providers and nurses living in an area are vested in a community. There's care. There's love present with permanent staff in a hospital. HCA has also taken its hatchet to charity care, geriatric services, security, and even hospital chaplains.

Before the sell to HCA, my unit of 36 patients had 13 RNs and five CNAs. That's a one nurse to three patient ratio with a nursing supervisor having the ability to support our unit. Now, we have 44 patients with nine RNs, four CNAs and a supervisor. That's a one to five ratio in the best of conditions.

Unfortunately, the reality is often more like a one to seven ratio. This only allows eight minutes per patient each hour with little to no assistance. We're not able to give the best quality care in the situation. Nursing under these circumstances is more like factory work. While HCA has reduced our well loved and regarded system to a shell of its former self, the company has increased the cost of care. In the year following the merger, healthcare prices shot at 10%. We see patients approached by bill collectors while they're still in recovery. Many patients complain to the state attorney general about being balanced billed and of harassment by HCA's in-house debt collection firms for bills they don't even owe.

How is HCA able to do this? Our patients don't any other option, but to go to Mission. We believe HCA uses its monopoly over western North Carolina to get our healthcare system, then send the profits back to executives in Wall Street shareholders. HCA not only owns hospitals, but also doctors' offices, clinics, their own staffing firm and supply chain companies, debt collection agencies and a nursing school. How can a corporation be allowed to influence and control all aspects of healthcare?

Unfortunately, what's happening in Western North Carolina is not an isolated incident. Across the country, HCA is known to short staff, cut care, and in some cases eliminate non-emergency services. It's not just that HCA is pursuing monopolies or market control, it's what they're doing to communities once they achieve it. We urge the FTC to modify its procedures around mergers and acquisitions to protect communities like Asheville from companies like HCA. Thank you very much for your time.

Doha Mekki:

Thank you so much, Ms. Tyler. We're going to go to Dr. Shapiro next.

Dr. Michael Shapiro:

Thank you. My name is Michael Shapiro. I'm a professor of surgery at Rutgers New Jersey Medical School and a practicing general surgeon. I've spent most of my life doing organ transplantation. Throughout my career, I've seen firsthand the way that hospital consolidation is hurting doctors, nurses, and most importantly, patients. I'm not so naive as to not recognize that healthcare is an industry, but the role of hospitals and networks is different than other industries. The goal is to provide care to patients in the community rather than to maximize profits. Most are in fact 501(c)(3) organizations. Mergers and consolidation should be viewed through the lens of providing patient care.

I began my career at Boston's Beth Israel Hospital and worked there for almost 20 years when in 1996 it merged with the New England Deaconess Hospital across the street. Both were major teaching hospitals for Harvard medical school. The Beth Israel Deaconess merger made little sense in terms of patient care, but came as consolidation in the Boston area accelerated as a result of the Peter Brigham Mass General Hospital partners healthcare merger. The partners' merger itself interrupted existing

collaborative clinical and research relationships with doctors at the Beth Israel. In particular, I had a collaborative research relationship with a surgeon at the Brigham and was assisting them in one of their advanced transplant procedures. And we were both instructed by our leadership that we had to dissolve that collaboration because we were now "enemies."

Immediately, problems with the Beth Israel Deaconess merger were apparent. The two hospitals were culturally very different, and management struggled to unite the two. The merged hospital at one point was losing a million dollars a month. Hospital employees from cleaning staff to physicians dealt with layoffs and/or pay cuts. The faculty physicians of which I was one were put at great risk. We were told that our pay could be adjusted plus or minus 10% per quarter, ultimately potentially suffering a 40% decrease in salary on an annual basis. Within three years, every transplant surgeon between the two merged hospitals left save for one who was on the verge of retiring. This not only decimated the departments and temporarily interfered with the hospital's ability to do transplants, it meant that patients in the Boston area were unable to access their own doctors for continued care many of whom they'd been seeing for as long as the decade.

At one point, the Massachusetts attorney general described the merger as a hospital in free fall. Other staff noted that we were closing operating rooms and recovery rooms and could not provide the kind of care that we had been famous for. I was one of the transplant surgeons who left the Beth Israel Deaconess and moved to New Jersey to what is now known as Hackensack Meridian Health. Many on this call may know that name because the third circuit just upheld the FTC's ruling against the Hackensack Meridian Englewood Health Hospital merger.

I worked at Hackensack for 14 years before leaving there, and watched as the hospital took control over healthcare for large chunk of Northern New Jersey. It's the dominant healthcare provider in Bergen County, which has a population approximately the same as that of Rhode Island. They now control approximately 30% of all hospital beds in their eight county region. And similarly, RWJBarnabas controls another 30%.

Following their acquisition of multiple hospitals, they were known to under resource programs in order to minimize costs at the expenses of quality care. There appeared to be more concerned about return on investment than on patients and they closed specialty clinics in order to divert uninsured or underinsured patients away from Hackensack. As Hackensack Meridian has expanded and my own personal healthcare to Englewood and had the merger gone through, I would've found myself back in the same place.

To summarize, consolidation in healthcare often is bad by deemphasizing the relationships between hospitals and the community they serve. The corporatization of the delivery of care maximizes services provided based on ROI rather than on demonstrated community need. The mergers decrease both patient and provider options for care and employment and they've increased costs by changing the power relationship between the system and the payers. I'm very encouraged by the FTC and DOJ's efforts to reconsider how the agencies review proposed mergers, and I'd encourage you to do so with the harms of hospital consolidation in mind. Thank you.

Doha Mekki:

Thank you, Dr. Shapiro. Next, we'll go to Dr. Li.

Dr. Mitchell Li:

Thank you for this opportunity to comment Chair Khan and Assistant AG Kanter. I'm a practicing emergency physician and founder of the advocacy group, Take Medicine Back. I'm here to speak on behalf of my physician colleagues who are silenced by fear of retaliation and anti-competitive contract

language often preventing them from serving patients in their own communities. Physicians are further silenced through a systematic bypassing of due process rights. Meanwhile, immigrant physicians who depend on work visas are even more vulnerable.

Executives of consolidated staffing groups have climbed to the highest ranks of our specialty societies further intimidating physicians from speaking out. My specialty and the only defacto universal medical safety net in the United States is at risk of collapse due to consolidation and leverage buyouts by private equity. In the ER, I have the privilege of serving the Native American community at Cherokee Indian hospital as a contracted physician in Western North Carolina. The only tertiary referral center for this community is HCA Mission that you just heard about along with several smaller LifePoint hospitals.

As you just heard from the few nurses unionized at these systems testify, these hospitals are severely understaffed. 223 physicians fled Mission since the HCA takeover according to the Asheville watchdog. Mergers and acquisitions are disproportionately harming rural and underserved communities many of which do not have the resources to fight back.

I completed my emergency medicine residency in 2017 at Ascension Hospital, one of the most consolidated tax exempts hospital systems in the country. When I began my residency in 2014, the ER was staffed by an independent group, which was quickly acquired by a staffing firm called TeamHealth, the same group that according to North Carolina Corporate Practice of Medicine laws illegally staffs all of the regional HCA and LifePoint hospitals in Western North Carolina.

Culture shifted starkly after the acquisition to that of an assembly line, to the point where the image of a rat on a wheel became the unofficial mascot of our residency program. Corporate metrics now plague ERs across the country. Imagine being reprimanded for taking a moment to comfort a mother after the death of her child because of a failure to meet impossible metrics in an understaffed emergency department. This is the daily experience of many emergency physicians.

In 2017, the year I graduated from residency, TeamHealth was acquired by the PE firm Blackstone. Shortly thereafter, TeamHealth was in the news for predatory billing practices suing a working poor and garnishing their wages while patients suffer, my profession's name has been tarnished. In 2019, the New York Times reported Blackstone backed TeamHealth and KKR backed Envision were behind a deceptive \$28 million ad campaign by an organization calling itself, Doctor Patient Unity opposing implementation of the No Surprises Act. Meanwhile, physicians working for TeamHealth Envision have no access to what is actually billed or collected in their names.

Last week Secretary Becerra directed the Department of Health and Human Services to evaluate how providers, billing practices impact affordability of care and debt. When studying this issue, I asked the FTC, DOJ and HHS to make an important distinction. I am not a provider. I am a physician. I took an oath to patients. Corporations did not. Please do not conflate us or refer to us with the same vague provider term whose origin hails from Nazi Germany where it was first applied to Jewish physicians as a mechanism to demean them.

The future of the emergency medicine workforce is also in peril. As deeply indebted medical students enter residency, HCA claims to be the largest supplier of graduate medical education in the United States. Documents acquired by staffing groups reveal an explicit intent to replace the expertise of board certified emergency physicians with non-physician practitioners increasing corporate profits while decreasing quality and expertise and placing patients at risk. This is often accomplished by charging a full physician rate even when patients are not seen by a physician under the false pretense of supervision, a practice which we refer to as deceptive notional supervision. It quickly becomes clear that the intention of this overproduction of emergency physicians indoctrinated into the corporate milieu during their formative years is not intended to relieve a physician shortage, but rather create regional labor monopolies.

During the early stage of the pandemic while physicians were risking their lives with inadequate personal protective equipment, TeamHealth cut physician hours and pay despite over \$100 million in CARES Act bailouts. At the same time, increasing resentment from the public due to perceived greed of physicians has contributed to moral injury in a broad demoralization of the emergency medicine workforce. This story is not unique. It is estimated that nearly 50% of emergency physicians are now employed by a private equity backed staffing group. UnitedHealth, the insurance company, is now the largest employer of physicians in the country. With these mergers and acquisitions in medicine, we are seeing a rapid decline in the quality of our safety net in our entire healthcare system with a corresponding increase in cost that is simply not sustainable. Thank you.

Doha Mekki:

Thank you so much, Dr. Li. I'll turn next to Dr. Feldman.

Dr. Madelaine Feldman:

Thank you so much for inviting me to participate. My name is Madelaine Feldman and I'm a practicing rheumatologist in New Orleans. I'm also currently the president of this

Speaker 1:

... coalition of state rheumatology organizations. Over the years, consolidation has led to three pharmacy benefit managers controlling the formularies for 80% of the American people. A formulary is a list of the medications that are covered by insurance, and if an expensive drug is not on that list, no matter how great it is, no one will take it. Now that the big three PBMs have merged with some of the largest health insurance companies, we have an oligopoly with unbridled power that has resulted in a broken system, rife with apparent and maybe not so apparent antitrust behaviors, such as restraint of trade, conflict of interest, as well as numerous anti-competitive behaviors, all shrouded in a pattern of obfuscation and lack of transparency. This has created a huge black box, the PBMs protect with threats of increased premiums and drug prices, if anyone tries to pull back the curtain. This consolidation has left employers, patients, and their doctors with mandated formularies often with the highest price drugs preferred on the formulary over generic and lower priced alternatives.

In rheumatology for example, there are three drugs that have the same mechanism of action that treat rheumatoid arthritis. The price of 30,000 a year, 65,000 a year and 70,000 a year. Guess which one can't get on the formulary? The cheapest one, and that affects my patients directly as their co-insurance is often a percentage of the list price. A leaked recording of a pharmacy tech from a big PBM told an employer's representative that a \$10,000 a month metastatic prostate cancer drug was on the formulary, but the \$400 generic was excluded. The tech went on to talk about all the other brand name drugs included on the formulary while excluding the generics. And now that the big three PBMs are owned by or owned one of the large health insurance companies, self-insured and fully funded businesses have little choice of PBMs. They probably have never heard about smaller transparent PBMs, because the big three pays huge commissions to health insurance brokers to send the business to them.

Now, while manufacturers are not innocent in the ever rising drug pricing crisis, the power of the PBM oligopoly has created a situation where the greatest fear for a manufacturer is being dropped from the formulary, and it drives behavior because of the fierce competition to stay on formulary year after year, manufacturers pay ever increasing kickbacks to the PBMs, and the easiest way to maximize your kickback is raise the list price of the drugs, and this is not helpful to my patients in one bit. Additionally, manufacturers also fear selling drugs to any entities that might be in competition with the big three. In a recent interview, Mark Cuban stated that he's having a hard time getting some



manufacturers to sell their drugs to his new drug discount company for fear of being kicked off the formulary. I'm not an attorney, but it certainly sounds at the very least like a tacit restraint of trade associated with anti-competitive behavior, and while it's not technically price fixing, all the manufacturers know not to do anything that will reduce the kickbacks to the PBMs, such as reducing the price of the of medicine.

And finally, there is an inherent conflict of interest because the big three PBMs are publicly traded, their fiduciary responsibility is to their shareholders, not to the ultimate healthcare consumers, such as the employers, state plan sponsors, or God forbid we'd even bring the patients into this conversation. This leads the big three to construct formularies for profit and maintain that profitability through utilization management tools like frivolous and repeated prior authorizations, non-medical switching and step therapy, all of which has been shown to harm the patient, not only in their health, but in their pocketbook. All of these behaviors should make a seriously wonder why payments to PBMs from drug companies continue to have safe harbor from anti kickback law. Thank you so much.

Doha Mekki:

Thank you very much. Now I'll go next to Mr. Barringer.

Mr. Barringer:

Thank you for having me. Thank you to the FTC and the DOJ. First of all, my deep respect on my fellow speakers here today, physicians and healthcare specialists make my life possible. I'm very proud to provide a different perspective that of a patient who lives day to day taking and purchasing medicine from an anti competitive industry. When I was very young, I was diagnosed with type one diabetes in 1996. I started taking hemolog insulin, the same insulin I take now. At that time it was around \$20 per vial. Today, it is nearly \$300 per vial. I take three vials a month. The manufacturing costs remain under \$10 per vial. There have been no meaningful change in the formula. In that time, there has been no meaningful breakthroughs in research and development, yet the price increases dramatically. Many people point to different reasons for this PBMs insurance company's policy.

The singular simple fact is that insulin manufacturers are setting this list price. Nobody does it for them and they set it high because they can, because there is no one to tell them not to. I bring this up because a contributing reason for the huge price increase in insulin products is a lack of competition in other anti-competitive practices. The vast majority of the insulin market is controlled by just three companies. The previous speaker mentioned a big three, I have a different big three, and that is Eli Lilly, Novo Nordisk and Sanofi. I think about those companies every single day, because they're the only ones who can make the liquid that I have to take every day to not die. They control 90% of the insulin market. And on the surface, it seems like these three companies should be in direct competition. I'm sure there are other products out there that only have three manufacturers and they compete in lower price and drive innovation, but that just doesn't happen here.

In fact, these three companies, I'll say it again, Eli Lilly, Novo Nordisk and Sanofi operate more in line as an oligopoly or a cartel. They manipulate the market to their favor. They fix the price of insulin. They gouge diabetics to death. The only difference between a true monopoly and this insulin triopoly is that instead of just one, there are three CEOs making huge profits off the backs of dying people without any consequence, without any penalty, without anyone telling them that they cannot do that anymore. Humalog from Eli Lilly and Novalog from Novo Nordisk are equivalent products. I've used both. They should compete in price. They don't. They have a history of increasing their prices in lockstep. They have a long history of doing this. Sometimes they do so on the same day and for the same amount, the same

can be said about Levemir and Lantus, two other insulin products that are equivalent and should be in direct competition, but they're not.

These companies, Eli Lilly, Novo Nordisk and Sanofi, they bar other competition from entering the market with frivolous lawsuits and threats about their intellectual property. With these inflated profits, insulin manufacturers are able to do a lot of things. They're able to hire lobbyists. They're able to influence policy and they're able to do whatever it takes to ensure that they're going to be allowed to continue this vicious cycle. No one tells them not to, no one's stopping them. This is not a normal product. Please understand that this is not a normal product. I don't have options. There are two insulins on the market that I can use, that is it. This is not a normal product where I can abstain from purchasing if I just can't afford it. I pay or I die, and the fact is I have to pay a lot all the time for the of my life because no one will tell them to stop.

This is life under an anti-competitive practice. This is life for 7 million insulin dependent Americans and many more abroad. This is life every day, and it doesn't seem like it's changing anytime soon. And I urge you to prove me wrong. In my view as a patient, these companies are price fixing in plain view and should be investigated. I urge the FTC and the DOJ to not let this happen to other pharmaceutical industries. There are many more medicines out there that don't have a lot of options. There are many more medicines out there that people have to take every day for the rest of their lives, or they will die. These are real consequences. These are things that we have to think about all the time. We don't get a break. We don't take a vacation, nothing, we pay or we die. I urge the FTC and the DOJ to not let this happen to other pharmaceutical industries.

And I urge the FTC and the DOJ to stop it from happening to us. These three companies continue on with no penalty. They're going to continue and more people are going to have to ration their insulin. More people are going to die. And it's so frustrating, if I can be honest with you. It's so frustrating to feel like nobody is on our side. I urge the FTC and the DOJ to investigate these insulin manufacturers. I urge the FTC and the DOJ. I'll say it again, don't let this happen to other industries, force them to compete and if they don't, force them to face a massive penalty, they deserve it. Thank you so much for your time and thank you for your listening.

Doha Mekki:

Thank you so much. I'll go next to Dr. Belcher.

Dr. Michelle Belcher:

Thank you Doha. Good afternoon Chacon, and assistant attorney general of cancer and staff. I am Michelle Belcher, the National Community Pharmacists Association's current president and the proud owner of Grants Pass Pharmacy in Grants Pass, Oregon. Grants Pass Pharmacy has been in the community since 1933, and is the last remaining independent pharmacy in the area. It has an old fashioned [inaudible 00:39:05] and an extensive gift area. We are a combo shop pharmacy that specializes in hospice and long term care and offers multiple adherence packaging systems. NCPA represents America's community pharmacist, including 19,400 independent community pharmacies. Our members represent 67 billion of the healthcare marketplace. We employ 215,000 individuals and providing an extensive set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers, and they continue to be on the front lines, providing vital COVID 19 vaccines and antiviral treatments.

At the same time, the three largest PBMs control 80% of the health plan pharmacy benefit market, and are vertically integrated upstream with the three largest insurance providers, Aetna, Cigna, and United Health. And down stream with mail order and retail pharmacies that compete directly with

independent pharmacies. Vertical consolidation in our industry has created a perverse environment where one competitor sets another competitor's prices, dictates their competitor's reimbursements, uses their competitor's data to steer their patients to own pharmacies and limits where and what consumers can buy. As a small business owner and an advocate for my patients, I can say with certainty, vertical consolidation in our industry has limited access to care, stifled innovation and increased prices for consumers.

All of these harms start with PBMs, offering take it or leave it contracts to independent pharmacies. These contracts and the related provider manuals and rate sheets serve as a stepping off point for PBM anti-competitive activity and consumer deception, while PBMs claim to be saving money and reducing the cost of drugs, you have to look no further than Medicare Part D and how PBMs have used these contracts to squeeze independent pharmacies and Medicare Part D beneficiaries over the past decade. I know you have probably heard it before but it is worth repeating. CMS reported that between 2010 and 2020, PBMs increased direct and indirect remuneration fees by 107400%. In Medicare, DIR fees inflate the amount that seniors pay for prescription drug at my pharmacy counter, because the amount seniors pay is supposed to be based off of the true cost of the drug, not an inflated number that is later reduced.

Ask yourselves this, if you have parents or grandparents who are Medicare Part D beneficiaries, have they ever received money back from their insurer for overpayment of their copay or co-insurance based on a PBMs inflated drug price at the counter? I doubt it. Vertical consolidation has also led to PBMs steering patients to Aetna, Cigna and United Health owned pharmacies, unfortunately to the detriment of patient health. Steering often involves so-called specialty drugs, which PBMs define as drugs used to treat complex and chronic medical conditions that require lab monitoring, additional patient education, adherence, support, and administration technique training.

Services provided regularly by my pharmacy and many like mine. Unfortunately, for patients who are on these drugs, PBMs often steer them to PBM mail order pharmacies that cannot provide any of these services. Lastly, PBM contracts are predatory. Recently, I have learned that one PBM in response to CMSs proposed rule to change DIR, sent a contract amendment for 2023 that will compensate independent pharmacies 10% below a pharmacist's wholesale acquisition cost. Provides no dispensing fee and assesses a 75 cent performance pool fee. And I have seen studies in Arkansas, Oklahoma, and Florida that demonstrate PBMs pay their own pharmacies more than independent pharmacies for the same drugs. How can that be? When mail order and vertical consolidation are supposed to create efficiencies and cost savings. Thank you for allowing me this time to speak with you today. I hope that you will see that our industry is in desperate need of regulatory oversight and that without it, small businesses will continue to be put out of business and consumers will be harmed. Thank you.

Doha Mekki:

Thank you for that account. We'll wrap up today with Dr. Canale.

Dr. Canale:

Hello. Good afternoon. Thank you so much to the FTC and the DOJ for this opportunity. I can no longer do this. I am not sleeping. I am anxious and exhausted. My brain hurt and my... are overwhelm. I will still because our family need this, and I don't want to be selfish and put us in the financial bind, but I can no longer do this. I told him, and then my husband said, "You need to leave. We will figure it out, but you must leave before you harm yourself or someone else." Delta woman and assistant attorney general, I was my family sole income. I was scared for our future, and yet I handed my letter of resignation for my

manager position at a national chain. And then I started to see more clearly. It is true that pharmacy has not been okay for the last 10 to 20 years, but at that moment it dawned on me, this indivisible [inaudible 00:45:36], pharmacy wasn't a crisis.

And for my particular view, pharmacist stagnation and student from chain pharmacist, national original were drowning and beaten down. They were stuck in this environment that could only be characterized as chaotic, an environment birthed by a lot of those toxic culture of mental, physical, and emotional abuse and minimal pay in spite of massive profit and the lack of patient center healthcare models from chain pharmacies, and unfortunately greed, by not just any greed, won't fuel back on checking reimbursement practice from certain PBMs and the denomination of the market through acquisition of competitors and vertical integration of chain pharmacies and payers. And there was nowhere else to go. The opportunities for employment other than chain pharmacies had become more rare. New business innovation were barely occurring, and the existing one were dying just as our fellow independent pharmacist. And although I speak in the past, this is still our reality today. But the dilemma in this obstinate realm is not just for pharmacy practitioner.

Our patients are also feeling the outcome. They're all experiencing difficulties in assessing care. The choice of pharmacies are impacted by higher costs, the lack of new ways to optimize their health, the disappearance of no chain pharmacies and the massive also exodus of pharmacy employees due to poor working conditions, which have been nationally discussed through the movement I have created, hashtag [inaudible 00:47:27] is not working. Yes, we can bring numerous arguments regarding the causes of this particular predicament, but we all understand or at least should be realizing that the diseased threat stack of pharmacy is intensified by what bring us here today.

The imbalance in the payment structure in pharmacy, the scheme of monopolizing the market, owning more than 80% of the system is a lot of power just for only three heads, and ultimately the lack of accountability of those who are creating the skills. My passion has always been, it will always be in community pharmacy. My patients needed me. They needed to be the focus of my practice, but it was no longer the case even with my best effort, and I needed a system to be fair. So who is to blame for breaking my oath as a healthcare professional, who saw to put her patient wellbeing above all, is me, my patient or the system? You'll be the judge. Thank you so much for your time.

Doha Mekki:

Thank you so much. Chacon, do you want to share some thoughts?

Chacon:

Yeah. Thanks Doha. Look, first, I just want to thank all of you so much for coming and speaking with us and sharing such deeply moving and gripping testimony, both DOJ and FTC are routinely having to review these mergers and I think sometimes in the type of hyper-technical analysis that comes to us, these types of real life stories and real life experiences get totally lost, and so it's just so incredibly important that we're getting to hear from you all and that you all are sharing your expertise with us. I think we obviously review mergers across the economy. The healthcare sector is, I think it's fair to say one of the most critical since... as we've heard from you all. Here we are really seeing the life and death stakes of the decisions that are being made around here.

I think another thing that your testimony has really surfaced is that the types of potential consolidation, monopoly problems that we may be seeing in healthcare aren't just isolated to one corner of the industry or the other corner of the industry, it's really across the board and systematic in a way that we really need to be vigilant across the board, being it at the hospital level, at the PBM level, at the pharmacy level. And so I think that's an incredibly important lesson for us as well. And I think

another thing that your testimony has also underscored is just the incredible variety of ways that firms with market power can use that power, right? And it becomes extremely difficult for enforcers to be able to police all of the subtle ways in which those firms are using their power in all sorts of anti-competitive ways, which I think makes it especially important for us to be stopping anti-competitive and illegal mergers on the front end.

So, we're not then encountering a situation where firms have already acquired that power and are able to exercise it in all these sorts of ways. I'll say, the FTC regularly reviews hospital mergers. In particular, we have a decades long program where the agency has been able to block many anti-competitive hospital mergers, but it's clear that there's a lot more work to be done. One thing that we often hear from hospital executives that are trying to get their deal through is that the merger will be efficient, and that it'll lower cost and let them improve quality. I think, as we've heard from several of you, sometimes that cost cutting can come at the expense of quality of care and that we can also see the ways in which these mergers are letting these firms exercise that power in ways that both disadvantage patients and healthcare.

And so I think it's clear that we need to be appropriately skeptical of those types of claims that we hear. I think we also need to be mindful that efficiencies are only relevant to patients whose preferred hospitals remain open. I think we've seen how waves of mergers across the country have contributed to the decline in hospital beds in the United States, where we went from 1.5 million beds in 1975 to now 900,000 a few years ago. And I think we saw during the pandemic how that decrease in capacity really contributed to the strain of our hospital system and contributed to the stresses and not being able to respond to that, which also underscores how we need to be thinking about how reduction in capacity is affecting long term resilience. And that even if there may be short term efficiencies, we need to also be thinking about the long term resiliency and the ability of our hospital systems to be responsive, especially in moments of shocks or pandemics.

I think it's clear from hearing about the testimony around PBMs that the type of vertical integration that we've seen may have changed incentives and created conflicts of interest in ways that it sounds like is even leading to instances of patients lacking access to lifesaving drugs. And so I think we need to be very skeptical of those types of efficiency claims that are being made, not just with horizontal mergers, also these types of vertical acquisitions and be mindful of the types of conflicts of interests that can emerge. And lastly, I think I'll just share that your testimony underscored for me how it's not just patients that are suffering, but it's also healthcare workers that are suffering. And so and as much as these types of mergers are reducing the employment opportunities for healthcare workers, allowing employers to dictate wages and degrade working conditions, be it in the pharmacy context or physician context, or in the context of nurses or healthcare workers, that this is also a very real harm.

And I know both DOJ, including under Doha's leadership and the FTC, I've been looking very closely at some of these mergers with an eye to understanding what are the effects on workers? What are the effects on labor markets? And I think much of what we've heard today really just underscores the importance for us to continue doing that and building out that work. So, I'll just thank you all again. I know it can take a lot of courage to come to these types of forums and share your experience, especially when... as we heard from Michelle, some can also face the threats of retaliation. So, I really am just so, so grateful that you all took the time and can assure you that the agencies are really going to be learning from everything that you've shared with us today, and hopefully we'll be able to implement it in what we do going forward. So, thank you.

Doha Mekki:

I'd only echo all of those sentiments. I'm blown away by your bravery, and I can't express enough how grateful our agencies are to all of you for sharing your experiences after mergers and acquisitions in the healthcare industry. I'd only echo all of Chacon's very good observations and only add that I'm struck by these accounts about the corporatization of care and the commoditization of work. And I think you guys have done a great job of surfacing for us the really special ways in which the healthcare industry can be harmed, right? For patients, for workers, for doctors and physicians and nurses and others who participate in the care economy, but also how many ways it checks the boxes for other kinds of mergers that are routinely found to be unlawful, right?

There's the reduction in research, right? Dr. Shapiro's account of that, I found extremely sobering. There's the worst benefits after a merger, the staffing shortages, the myriad ways in which we routinely say this merger might harm competition. And so thank you for surfacing these issues and reminding us about why this initiative to rethink how we approach mergers in this industry in particular is very important. I'm now going to turn the mic over to Peter Kaplan to facilitate the public speakers portion of the meeting.

Peter Kaplan:

Thank you. Deputy Assistant Attorney General

Peter Kaplan:

Becky. I want to remind our next speakers that the FTC is recording this listening forum, which may be maintained, used, and disclosed to the extent authorized or required by applicable law regulation or order. And it may be made available in whole or in part in public record and accordance with the FTCs rules. Each speaker will be given two minutes to address chair Khan, assistant attorney general. I'm sorry, deputy assistant attorney general, Mecky and staff for both agencies in the public today. With that, our first speaker today is Sue Sedory, Sue.

Sue Sedory:

Thank you. Good afternoon. I am Sue Sedory, executive director and CEO of the American College of Emergency Physicians. On behalf of our 40,000 members. We appreciate this opportunity to share what we're hearing about mergers and acquisitions in emergency medicine and the impact of consolidation on emergency physician practices, both on the physicians and their patients. The impact is very real, particularly in light of the high rate of acquisition by hospitals, health systems, and corporate entities, such as private equity and health insurance companies. To inform our response today, we distributed and received over 110 responses to a questionnaire to our members asking about their firsthand experiences with acquisitions while some noted a positive impact in negotiating, more fairly with insurance companies, most noted numerous anti-competitive labor related effects, including reduced wages and or non cash benefits. Infringement on their due rights processes, interference with physician autonomy to make independent medical decisions benefiting patients, and an ability to find a job or undo imposed restrictions on their ability to switch jobs, a shift to use less skilled healthcare workforce jeopardizing patient care.

Specific to the labor market competition. 63% indicated that the merger made it more difficult to find or keep a job for wages. 60% indicated that their compensation had been reduced with most experiencing a pay cut of more than 20% and of the 40% who experienced no change in pay or raise after the merger, many noted that their overall hours were cut. We will be submitting these comments in our recommendations to the FTC and the DOJ and urge that the guidelines from evaluating mergers must include a detailed assessment of these types of labor related impacts. And once the guidelines are

revised, it is important to investigate mergers that have led to these anticompetitive and harmful practices, updated guidelines without weight is only half a solution. Thank you.

Peter Kaplan:

Thank you. Thank you, Sue. Our next speaker is Dr. Gillian Schmitz, Dr. Schmitz.

Dr. Gillian Schmitz:

Good afternoon. I'm Dr. Gillian Schmitz, the president of the American College of Emergency Physicians. Many people aren't aware that emergency medicine physicians work in a variety of employment models while some are employed directly by hospitals. Many are employed by independent entities, a contract with the hospital to provide emergency department coverage. 24/7. Lately a high number of these independent practices have been acquired by hospitals, health systems and corporate entities, such as private equity and health insurance companies. The recent questionnaire we put out to members clearly demonstrated the negative firsthand impacts of acquisitions on our workforce. More than half indicated their medical decision making autonomy was negatively impacted by merger or acquisitions of their employer. Emergency physicians trained for years. And are highly skilled in diagnosing and treating medical conditions in the most urgent situations, interference in their medical decision making can significantly impact safety and quality of care for patients. More than half indicated their due process rights were worsened or were eliminated after a merger. Due process plays a foundational role in ensuring a physician can carry out their promise to patients without fear of retribution or termination by their employer.

Further erosion and contracts following acquisition is a significant concern. Many said the working conditions in their large national physician groups or hospital systems have them considering quitting medicine altogether. They feel trapped in a system that does not respect their autonomy or mental wellbeing and have no other options available for them and their families. A significant exodus of emergency physicians from the workforce threatens the healthcare safety net that emergency medicine providers and the two years have shown how important that net is. We urge FTC and DOJ to include detail review of these types of labor related impacts in its updated guidelines and follow through on investigating those mergers that have led directly to the anti-competitive and harmful practices impacting our livelihoods. Thank you.

Peter Kaplan:

Thank you, Dr. Schmitz. Our next speaker is Lois Uttley, Lois.

Lois Uttley:

Yep. Thank you so much. I'm Lois Uttley, senior advisor to the hospital equity and accountability project at Community Catalyst. That's a national nonprofit health advocacy organization. We want to urge your agencies to give greater attention in your merger and acquisition review guidelines to examination of several negative effects of hospital and health system consolidation. These are first increasing burdens of medical debt caused by price increases related to hospital consolidation, but also by harmful billing and collection practices imposed at community hospitals when they are acquired by large systems, we're grateful to the Biden administration for your attention to medical debt issues. Second, we want to flag trends of large health systems using mergers and acquisitions to expand into white suburban areas with concentrations of commercially insured patients while abandoning hospitals and urban and rural communities of color.

The consequences of these actions have been starkly exposed by the COVID 19 pandemic, which found black, latinx and indigenous people were not only disproportionately affected, but also struggling to find care in their own communities. Third, we wanted to flag the loss of access to services and interruptions in the continuity of care. When systems take over committee hospitals, and then downsize or close them such as by closing the ER or the maternity unit. In some cases, systems are also imposing non-medical restriction on reproductive health services, emergency obstetric care, gender affirming care, and end of life options leading to refusals of needed care to patients. We want to recommend near agencies consider introducing into the review guidelines, a sort of health equity assessment-

Peter Kaplan:

Thank You. Thank you, Lois.

Lois Uttley:

Okay.

Peter Kaplan:

Thank you, Lois. Our next speaker is Nancy [Peoura 01:03:28].

Nancy Peoura:

Thank you. Good afternoon. I appreciate the opportunity to be heard by the FTC and the DOJ. Two competing hospitals were merged in 1997. An additional nonprofit was formed. All had separate accounting books. The pooling of interest was misrepresented as a merger and no HSR filings were found. Slowly systematically one hospital was dismantled. Charity care was an excuse to close the higher rate of hospital, despite the impending financial relief of Obamacare. There were no legally required community needs assessments or forensic financial audits. 13 municipalities from three New Jersey counties were impacted all supply resolutions against the closure. Public policy engineer to healthcare desert and a sacrifice zone. A hospital that was nationally respected, highly rated 80 compared to 58 low infection rates and a commitment to compassionate care where the disenfranchise was closed. There were three hospital nonprofits. One, the auxiliary was terminated in a timely matter, all assets appropriately distributed.

The other two nonprofits remain and appear to act as the funnel, directing assets out of the community. There is no public transparency. A hidden aspect of older hospital closures as the money grabbed the legacy, trust, endowments, generational medical practices, scholarships and real estate for redevelopment purposes, the hospital property was mortgaged for \$152.9 million to enhance the other hospital, before profit purchase the hospital for \$3 million with a medical non-compete agreement on the deed that restricts medical competition, which is egregious in an act of regulatory racism. First do no harm. Mergers do harm, especially when they restrict competition lead to hospital closures and ultimately create a medically underserved community. The effect of this hospital merger was a closed essential hospital with unregulated asset transfers, 131 years of philanthropy loss. There is a demonstrated lack of commitment to serve the diverse population. Medical services for a different demographic should not have been prioritized. Thank you.

Peter Kaplan:

Thank you. Thank you, Nancy.

Nancy Peoura:



Thank you.

Peter Kaplan:

Thanks a lot. Our next speaker is Lisa Goldstein.

Lisa Goldstein:

Thank you, Peter. And thank you to the FTC and department of justice for this opportunity. My name is Lisa Goldstein, senior vice president with Kaufman Hall and Associates. We are a national advisory firm for not for profit hospitals across the country. I think what's important today is that we look to history, but we don't need to go too far back. Scale proved to be essential during COVID, being part of a larger health system enabled small, rural, and even midsize hospitals to gain critical access to PPE, ventilators, staffing that could be reassigned within a system. And in some cases, other system hospitals to direct patient care. In many markets hospital became the central, if not the only organization providing the community with not only healthcare care like vaccinations, but also critical public services, such as housing and food banks, childcare, and even laundry services. Looking forward, it will be the US public healthcare system that addresses the healthcare disparities and access to care.

Something that everyone has talked about today to address all the social determinants of health and many smaller independent hospitals may not have the resources or expertise to address these persistent and pervasive challenges. Without a partner or being part of a larger system. Smaller hospitals will face closures. Bankruptcies, downsizing of services because of the inability to absorb very large and now permanent labor increases, recruit the future workforce and clinicians and treat an aging population. They simply will not be able to afford their future and the capital to maintain state of the art, or even up to date facilities. Finally, many hospitals, as we know are the largest employer in their service area and they bring in many support industries. They serve as the economic anchor and sometimes being part of a larger system will keep that economic anchor in place. If hospitals close or file for bankruptcy, there will be larger repercussions on the economy. Per data from the American hospital association. Everyone-

Peter Kaplan:

Thank you, Lisa.

Lisa Goldstein:

Oh, thank you.

Peter Kaplan:

Thanks Lisa.

Lisa Goldstein:

Thank you.

Peter Kaplan:

Our next speaker is Sean May, Sean.

Sean May:

Thank you. Thank you for the opportunity to speak with you today. My name is Sean May and I'm a healthcare economist with Charles River Associates in Boston. I spent more than two decades studying competition in healthcare markets. And I want to take the opportunity to briefly describe several studies of the effects of hospital mergers that my colleagues and I've conducted. These studies were funded by the American Hospitals Association, but CRA also works on behalf of government agencies to analyze competitive effects hospital mergers. As part of our studies, we interviewed hospital leaders to determine the primary objectives in pursuing acquisitions. They told us that acquisitions allowed them to expand their scale and scope in order to deliver cost effective value based care. They also identified several mechanisms through which hospital mergers benefit consumers. They believe that hospital mergers allow them to improve quality through the standardization of clinical practices.

They facilitate investment separate services and enhance hospital's ability to recruit specialized physicians. Hospital mergers were also motivated by a desire to become more efficient, to reduce the cost to access in capital markets to avoid unnecessary expenditures and to standardized clinical processes, which increase quality. In addition to these interviews, we've conducted a comprehensive empirical study of the cost and quality effects of hospital mergers, including an analysis of the effects of all acquisitions of community hospitals in the US between 2009 and 2019. Our empirical findings are consistent with the objectives voiced by hospital system leaders. There are three primary findings of these analysis. First, we found that hospital mergers were associated with reduction in operating expenses at acquired hospitals. Second, we found some evidence that measures of clinical quality improve the departed hospitals, including reductions in inpatient, readmission rates and decline in mortality. Third, revenue per admission and acquired hospitals declined suggesting the cost reductions were passed on at least in part to health plans and patients. We view these empirical findings providing evidence that hospital leaders were successful in achieving their intended goals. Thank you for your time today.

Peter Kaplan:

Thank you Sean. Our next speaker is Robert McNamara, Robert.

Robert McNamara:

Thank you for the opportunity to comment. I'm a physician whose practiced, emergency medicine 40 years. Past president of the American Academy of Emergency Medicine. Simply put private equity does not belong in our nation's emergency departments. ED's were the most vulnerable patients cared for, and it needs to be free of their profit seeking methods. Private equity's blown under the radar to now dominate emergency medicine. The majority of states prohibit laying ownership of medical practices specifically to keep the business influence out of the patient physician relationship, private equity flounders by setting up sham professional entities using the license of well-compensated corporate physicians. In an emergency, you may have the choice of where to go for care. When private equity owns the ED contract. The physician has no control over what you are charged. As seen with the surprise billing crisis. Profits are put over patients, hospitals have incentives to award ED contract to private equity.

This can be directly through joint ventures where collective fees are shared and other situations it's less needed to provide substitute. Despite having an emergency, you might not get to see a doctor because of a business decision that someone less experienced is better for the bottom line. Importantly, doctors who work for private equity have no protections when they speak up about the quality of care or patient safety. We saw ED physicians terminate that during the pandemic. Specialty emergency medicines in crisis, we lead in self-reported burnout at 60%. Physicians who choose emergency medicine

have a strong sense of social justice. They know they will care for the homeless, those struggling with substance use, the victims of violence... Weekends, holidays. Their moral code is incompatible with the profit motives of ED. They feel widely detest the role of corporations in our specialty. Then you're now choosing to leave emergency medicine, private reign day. Thank you for your time.

Peter Kaplan:

Thank you, Robert. Our next speaker is Carlo Passeri, Carlo.

Carlo Passeri :

Thank you. My name is Carlo Passeri and I'm here representing the Biotechnology Innovation Organization, which represents some 1000 biotech companies. Come here today not only as an advocate for the industry, but as a former investor venture fellow for several university as a biotech entrepreneur. M&A plays a significant role in driving biomedical innovation and the launching of new medicines in the United States and globally. In 2020, 55% of the \$34 billion invested in live scientist startups can from private capital, such as venture capital. M&A provides these investors with the exit opportunities required in order to recuperate invested capital, and then redeploy those funds into the next generation of companies, the other exit opportunities I feel add to that subject market group. It is remarkably difficult for a group of entrepreneurs, to exit the university and stand on their two feet without the presence of private capital. This is what has been dubbed the value of death and M&A is a key reason why that investment makes sense, particularly since there's a 10% chance that experimental drug will be approved by the FDA. That success rate falls to 3% for cancer drugs according to MIT.

Limiting exit opportunities for private capital by limiting M&A threatens the funding to the next generation of medicine. The unended consequence of erecting barriers to M&A in biomedical science is that DC's will be forced to consider more developed pipelines first. This begins a chicken and egg conundrum, because how do you create a more developed pipeline and if you don't have the cultivate to reach that point, a robust market for mergers and acquisitions and the live scientist is critical to our success. This is how we have developed therapies for HIV. This is how we develop a cure for HPV and how we created a gene therapy for treating inherited retinal disease that leaves childhood [inaudible 01:14:04]. The thing about medicine is that most don't care until the need arises with [inaudible 01:14:08]. The United States produces more new medicines every year than the rest of the world can buy. Our capital system will allow for that to happen given the probability success, current theories of harm and competition analysis should not be altered or arbitrarily widen when it comes to the biomedical finding. Thank you so much for the opportunity.

Peter Kaplan:

Thank you, Carlo. Our next public speaker is Sophia Tripoli, Sophia.

Sophia Tripoli:

Hi everyone. My name is Sophia Tripoli from Families USA, a national non partisan voice for healthcare consumers. Thank you for hosting this session. Nearly half of all Americans forego medical care due to cost. And a third say that the cost of care interferes with their ability to secure basic needs like food and housing. Healthcare spending in the US has increased more than fourfold over the last four decades, which is primarily driven by paying higher prices than anywhere else in the world for healthcare, including prescription drugs, hospital stays, MRIs and CT scans and births. These higher prices are driven by growing consolidation. Although these medical monopolies promise that mergers and acquisitions will bring efficiencies, economies of scale and improve quality data continue to prove the opposite. Our

nation's families are not healthier and care is unaffordable. Tomorrow Hamilton lives in Mancos Colorado, a rural town of about 1.000 people.

Across Colorado, hospital mergers have forced smaller rural hospitals to reduce hours, cut services or shut their doors all together. Meanwhile, larger hospitals are expanding their networks, covering larger areas of the state and leaving patients like tomorrow with few options for nearby healthcare and higher prices. Her insurance premiums are higher than anywhere else in the state. Every doctor in the county is on the same network and there's no competition. Medical appointments are so backlog taking up to four months to the scene. Tomorrow has literally told the receptionist, "That far from now I'll either be better or I'll be dead." Consolidation, often results in big health corporations buying up and moving doctors offices into expensive medical buildings, where they can charge higher prices for the same service. By taking over half the hospitals in a city, they can set prices so high that insurance companies deny bills, leaving hardworking Americans with billions of dollars of debt and medical debt every year that they can never pay off.

Just last week. A young man in Georgia needed life saving surgery, and no one told him he'd leave the hospital with a \$40,000 bill. Twice his annual income, even wall street speculators have gotten in on the action as firms whose only purposes to buy and sell companies to make a quick profit for their rich investors, buy hospitals, and then shut down less profitable units like maternity wards in rural hospitals, or they shut down rural hospitals altogether. Our health isn't a game and no one should be allowed to play monopoly with it. Thank you very much.

Peter Kaplan:

Thank you, Sophia. Our next speaker is Terry Serinsky.

Terry Serinsky:

Hi thank you. Can you hear me okay?

Peter Kaplan:

Yep.

Terry Serinsky:

Can you hear me? Oh, good.

Peter Kaplan:

Yes, we can.

Terry Serinsky:

Okay. I am a licensed clinical social worker and I have a personal experience in the field that I want to share, but I just want to put in my 2cents worth about the pharmacy industry. And I'll tell you that my insurance comes from Optum RX and the only way I can get a 90 day supply of my medicine is if I buy it right through them, if I try to buy it through Rite Aid, they're only allowed to give me a 30 day supply. I hear your point there. My next point is I so regret that the merger between CVS and Aetna occurred, it had a terrible effect on me as a worker. I worked as an EAP clinical counselor. I was hired by Aetna. It was a job I really loved. My job involved taking calls from people that were wanting to speak with a counselor for in the moment, support with things having to do with problems.

We all have grief, substance abuse, relationship problems, work problems, and many, many other types of issues. I really loved that job. A couple years in, after the merger became finalized with CVS, my conditions changed, my salary was modest from the beginning. My salary was \$68,000 a year, and I didn't mind it because I loved my work. I knew I could get a higher salary somewhere else, but it was worth it to me for the satisfaction. But after CVS took over that satisfaction went way downhill. And for me to do my personal best, I need a sort of amount of satisfaction. And when I think I reached my personal limit, the day that I saw on paper, that after four years with the company, a new hire that I was training was getting paid more money than me.

Peter Kaplan:

Thanks Terry. Thanks a lot, Terry. Our next speaker is JC Scott.

JC Scott:

Thank you. I'm JC Scott. And I'm here on behalf of PCMA, the national association representing America's Pharmacy Benefit Managers, and the commission has heard several things about PBMs that I would like to address to level set the role of PBMs in lowering consumer drug costs for the 266 million Americans with health insurance is well documented, including in several prior studies by the FTC specifically, PBM saved patients 40 to 50% on prescription drugs annually or nearly \$1,000 in savings per patient per year for every \$1 spent on PBM services, PBMs deliver \$10 in savings. And this includes negotiating rebates and discounts, which are used to benefit patients. PBMs pass along 99.6% of rebates to part D plans lowering part D cost by 7%. The commission has heard claim that the industry is overly concentrated, but in fact, there are currently 70 PBMs, including 10% growth in new entrants in the last three years. We've also heard claims that PBMs harm independent pharmacies, but pharmacies are key partners.

And there are more independent pharmacies today than there were just 10 years ago, instead of singling out the one industry that is time and again been proven to be the only actor in the drug supply chain that is lowering cost for consumers. I would respectfully encourage the commission to examine not just PBMs, but the broader marketplace dynamics, including the obvious sources of high drug prices, such as manufacturers who have raised their prices by 159% over the last 10 years and the numerous other stakeholders, such as large organizations that represent independent pharmacies interests. Most importantly, the commission should prioritize and focus on the impact that higher pharmacy costs would ultimately have on consumers. I believe any study of PBMs would once again, validate the value our companies provide through lower costs for consumers and that any study that seeks to focus on barriers to lower costs for consumers needs to use a broader lens. Thank you for the opportunity.

Peter Kaplan:

Thank you, JC. Our next speaker is Randy McDonough.

Randy McDonough:

Thank you. My name is Randy McDonough. I'm an independent community pharmacy owner in Iowa city, and also a board of trustee with the American Pharmacist Association. Today, I want to talk to you about out the consequences of vertical integration of pharmacy benefit managers on the loss of community pharmacy practices and the negative impact on patient care. Back in 2013, I wrote my legislators an urgent letter about the practices of PBMs and the impact it was having on my practice. And more importantly, my patients, I started a letter with a quote from Lord Acton in 1887 that said

power tends to corrupt. And absolute power corrupts absolutely. Nine years later here I am speaking to you just as urgently. PBMs, have a mass exorbitant profits, but at the expense of pharmacies and patients and their power continues to increase, especially because of this vertical integration, PBMs have little, no regulation, are non transparent and wield their tremendous power to dictate how pharmacies are paid.

It becomes an ethical decision for the pharmacist owner. Stopped accepting ridiculous contracts and lose my patients or accept the contract and hope that something happens to stop this craziness. Unfortunately, it seems that this craziness will continue. More pharmacies will close due to the business model being upside down from the PBM practices and patients will not only continue to pay more out of pocket, but they also will lose one of their trusted healthcare professionals. This in turn can lead to patients experiencing more and more problems as it relates to the drug therapies. Back in the 1990s, it was estimated that for every dollar spent on drug therapy, we spent another dollar to correct the problems associated with that drug therapy.

In 2016, this number increased to a \$1.51. I have estimated the cost today to be over \$2. There are countless studies that show when the patient has a relationship with their pharmacist, patient health outcomes are improved and overall healthcare costs are reduced. This type of care is being lost in the current PBM model. And this has impacted my own patients. Many of which are older on complex medications at risk of medication related problems. They want my services yet they feel trapped to move to a PBM owned pharmacy due to the threat of their own out of pocket cost increasing. Lastly, because so pharmacies business models are upside down-

Peter Kaplan:

Thanks, Randy.

Randy McDonough:

Are closing. Thank you.

Peter Kaplan:

All right. Thanks Randy. Our next speaker is Vicki Norton.

Dr. Vicki Norton:

Hello, thank you. Hi, my name is Dr. Vicki Norton and I'm an emergency physician and a board member of the American Academy of Emergency Medicine. The academy was founded in 1993 out of concern over the corporate influence in emergency departments, specifically about the quality of care and the treatment of physician employees. To this day, AAEM continues to advocate for the bedside physicians and against corporate control, which we view as putting profits over patients.

Dr. Vicki Norton:

Unfortunately, I've personally experienced the negative consequences of corporate ED consolidation. When I graduated residency, my first job was at an HCA hospital in Southeast Florida where the contract to staff the emergency department was owned by two physicians. I moved across the country with a newborn daughter and bought a home in the area. I found out a month before I was to start that the two physicians had sold the contract to a corporate group called Sheridan who in turn had a deal to staff both the radiology and the emergency departments. I was given an employment contract and told, take it or leave it. The contract had a restricted covenant and a non-interference clause. The other

emergency physicians working there attempted to talk to the hospital administration to take over the contract themselves as a group and were denied, likely due to this arrangement with the bundling of staffing contracts. The quality of care at the site and the treatment of the physicians working there became so bad over the next two years that the entire original group of physicians which staffed the ED for over 10 years ended up leaving including myself.

What I didn't know at the time was that HCA's entire Southeast division was under direction to contract with corporate groups. And specifically in many hospitals to staff the ED through a joint venture with Envision. Currently the ED and the hospital I left is staffed under this arrangement. And I've heard from colleagues that its worse than ever working there. I luckily ended up at my current position with a physician owned democratic group at a nonprofit hospital in my hometown. Given the lack of jobs like this in my area, I could safely say that if my group ever loses its contract I would either end up moving out of the state completely or leaving emergency medicine altogether, a profession I have always viewed as a calling. Thank you so much for the opportunity to speak about this.

Speaker 2:

Thanks. Thank you Vicki. Our next speaker is John Hopkins. John.

John Hopkins:

Hi, my name is Dr. John Hopkins. I'm a residency trained board certified emergency physician as well as a veteran of the United States Air Force. I'm deeply disturbed by the merger and acquisition activity within medicine by private equity backed corporations such as USACS, Envision and Team Health. I have seen firsthand how these consolidations can harm patients. As a result of these companies' commitment to their investors, profits are prioritized over patient care. Staffing of emergency departments is largely driven by the desire to maintain a significant profit margin and not on the needs of the medical staff. This directly puts patients at risk. I know this because I've worked in over 20 emergency departments throughout the United States. When I began my career in emergency medicine, I was enthusiastic and an energetic emergency physician ready to serve the public. I loved my specialty and the system in which I trained. What I experienced post-residency training was vastly different and caused me to almost abandon medicine altogether.

What I discovered is the practice of emergency medicine has become consolidated to the point that corporations were able to exhibit a large amount of control over physicians' medical decisions. These corporations pressure physicians to evaluate and treat more patients per shift regardless of their level of illness and admit them regardless of need. One very good illustration of some of these deceptive corporate practices is the Health Management Associate's massive Medicare fraud scheme as shown on 60 minutes. Over time, I began to despise practicing emergency medicine, a specialty I once loved. Not because of the patients but because money, not care have become the priority. Since several large contract management groups manage all the emergency departments in my region, I could either continue in this environment or leave the specialty altogether. I decided to leave emergency medicine in 2017 due to the effects of corporate control. I was only seven years out of residency. I miss it dearly but would never consider going back to a corporate rich consolidated landscape that cares little about the patients and mainly about the almighty dollar. Thank you for your time.

Speaker 2:

Thank you John. Our next speaker is Benjamin Jolly. Benjamin.

Benjamin Jolly:

Thank you. Chair con and deputy assistant [inaudible 01:28:12]. Thank you for hosting this session. My name is Benjamin Jolly. I'm a third generation independent pharmacist in Salt Lake City. I echo the sentiments of my colleagues, Doctors Belcher, Tenaren and McDonough. The vertical integration and the market power of the largest companies in healthcare perverts our entire care delivery system to benefit the needs of their shareholders over the health of our communities. From my perspective, the market access and reimbursement concerns of independent pharmacies and the workplace burnout concerns of employed physicians and employed pharmacists both stem from the same root cause, the tyrannical power of the largest corporations in America. I believe that a good remedy to our current plight is structural separation. No pharmacy benefit manager should own any pharmacy, whether that be mail, specialty or retail. No health insurance carrier should own any care delivery assets, hospitals, physician practices and others.

In other words, price setters should not be allowed to be price takers in their own controlled markets. I believe this doctrine applies across industries. Slaughterhouses should not own hog farms. Amazon marketplace should not be owned by Amazon retail. Similarly, most favored nation policies should be prohibited. Their effect is to raise prices for anyone outside of this most favored nation. For example, in my industry the most favored nation ask usual and customary price rules of pharmacy and benefit managers are the cause of the price dysfunction that empowers good RX and discount cards generally. Similarly, Amazon's best price rule imposes a minimum price and attacks on nearly all internet retail sales to the benefit of Amazon. I ask that you reimpose these doctrines that served our country well for decades following the New Deal. Please save my profession from the power of these tyrants.

Speaker 2:

Thank you Benjamin. Our next speaker is Sailesh Konda. Sailesh. Sailesh I think you're on mute.

Sailesh Konda:

I'm a dermatologist and [inaudible 01:30:15] at the University of Florida. I've lectured extensively on private equity in dermatology and researched as well. Dermatologists from all over share with me their disconcerting experiences with these groups. However, many of them are shackled by non-disparagement agreements and are afraid to speak publicly. Dermatology has experienced a tie with a consolidation over the last decade. Influential leaders in dermatology selectively recruited by these groups in order to minimize scrutiny. There have been at least 38 regional PA backed derm groups for which are now defunct. Furthermore, 10 of the largest have formed a trade coalition which controls approximately 70% of the PA backed dermatology space. We're now entering a phase of regional mega markers and in some metro areas consolidation is limited to both choice for patients and insurers. Publications have documented a largely negative impact in DOP ownership and [inaudible 01:31:01] physicians state these groups worsen quality of patient care and physician autonomy.

Our research found some PA firms that were not performing due diligence and were employing outliers an intralesional injections performed on nursing home patients where 70% had a diagnosis of Alzheimer's disease. Some have also acquired outliers in skin biopsies when consolidating practices. Additionally, research has shown these groups over leveraged non physician practitioners with varying degrees of supervision which generates larger corporate profits. The mainstream media has documented these issues including adequate or faulty supplies in these groups. Unfortunately, these groups are not legally obligated to disclose PA ownership to patients. Public health experts have asked legislatures for transparency and a moratorium on PA investment in dermatology.

Lastly, debt dilutions of these groups have decreased and many remain discounted and below pre pandemic levels which means some may cease to meet their debt obligations, it'll have to further



increase revenue and cut cost of service large debt loads, which could further impact patient care. Meanwhile, many of these large groups tend to be small businesses have secured over 26 million in forgivable SBA PPP loans. We hope the FTC and DOJ will also serve the best interest of patients first. The governments propose guard rules for PA backed nursing homes and we now need similar [inaudible 01:32:14] for all of medicine. Thank you for the opportunity to speak to all of you today.

Speaker 2:

Thank you Sailesh. Our next speaker is Beth McCracken. Beth.

Beth McCracken:

Good afternoon. I'm a patient living in Pennsylvania. In Western Pennsylvania we have two major integrated healthcare systems whereby they're both the insurer and the provider. They're UPMC and Highmark Allegheny Health Network. In the 1990s, UPMC began buying hospitals and specialty practices and by 2010 they had acquired the majority of specialty hospitals and doctors in the region. One of those hospitals and specialists practiced there was the Pittsburgh Inair Institute. In 2014, UPMC decided that they would no longer accept Highmark Insurance thereby barring patients access to those specialty services. At the time I had Highmark Insurance and I had begun experiencing severe pain in the left side of my face. Over the next five years I saw numerous ENT network, ear, nose and throat doctors. All of whom told me that it was a nerve condition and there wasn't much they can do for me. Finally, in 2019 I was diagnosed with a rare cancer and told that the only doctors that could help me were at the now UPMC Eye and Ear Institute.

Fortunately, the cancer diagnosis opened a loophole and I was finally able to see the doctors there. Unfortunately, the five year delay in my diagnosis had given the cancer time to progress to where it was not only in my face and my ear but it had metastasized to my lungs. Had I had access to the specialists at UPMC Eye and Ear Institute in 2014, I would've had an early diagnosis and my prognosis for survival would be much better. I am but one story that illustrates what effects hospital consolidation can have on patients' lives. Hospital consolidation robs patients of their ability seek treatment that is imperative to their successful health outcomes. As you can see, this is literally a matter of life and death. I highly urge you to go to [inhospitablefilm.com](http://inhospitablefilm.com) and look at the documentary *inhospitable*, which addresses these issues. *Inhospitable* recently won the best documentary award at the Phoenix Film Festival. For patients did not-

Speaker 2:

Thank you Beth.

Beth McCracken:

Thank you.

Speaker 2:

Thank you very much Beth. Our next speaker is Darren Patz. Darren.

Darren Patz:

Thank you. Hello. I'm Darren Patz, senior vice president of Pediatrix Medical Group. Pediatrix Medical Group is a national medical group comprised to the nation's leading providers of physician services to mothers and children. Our affiliated clinicians are committed to providing coordinated compassionate

and clinically excellent services to women, babies and children in hospital settings and office based settings. Our specialties include obstetrics, maternal fetal medicine and neonatology complimented by 18 pediatric subspecialties. Pediatrix was founded in 1979 as a single affiliated neonatology practice. And today via organic growth and acquisitions, provides it's highly focused and often critical care services through more than 4,700 affiliated physicians and other clinicians in 38 states in Puerto Rico. It is estimated that nearly 60% of the patients that our clinicians serves are Medicaid beneficiaries. Pediatrix affiliated clinicians care for or diagnose one in four babies in the United States, more infants than any other physician services organization in the nation. But our highly specialized care has been bolstered by company's investment in more than \$25 million of research and education, quality improvement and safety initiatives over the past five years alone.

Yes, we are an organization dedicated to quality improvement in patient safety. Our efforts contribute to better patient outcomes and reduced long term healthcare system costs. Not only for our patients and hospital partners, but for all patients and providers across all specialty areas. Certainly in this recent pandemic as a leader in clinical research, Pediatrix affiliated clinicians published many studies on the effect of COVID on women and children. We continue to monitor this impact in the NIC use and PIC uses around the country. Indeed, our work in the Center for Research Education Quality could only be possible due to the growth of Pediatrix into a national medical group. In addition to the benefits of research, quality improvement, patient safety and education, our coverage-

Speaker 2:

Thank Darren. Thanks Darren. Our next speaker is Jonathan Michael Eisenberg.

Jonathan Eisenberg:

Thank you. I am Jonathan Eisenberg. I am deputy general counsel for AIDS Healthcare Foundation which is a worldwide leader in providing cutting edge medicine and advocacy for people living with and HIV/AIDS. We have a chain of independent specialized pharmacies in the United States and also many healthcare centers and often the pharmacies and the healthcare centers are integrated. I want to speak briefly about the review of vertical integration mergers for PBMs and other participants in the pharmaceutical distribution system in the United States. I would ask the FTC when reviewing these mergers in the future to look beyond just the relationship between PBMs and the insurance companies that they're merging with and also PBMs and the pharmacies that they're merging with. It's not enough to just say, well are there still enough insurance companies left in the marketplace to appear competitive and same for pharmacies. It's more important to look at the end users, the patients.

These mergers in the healthcare industry cannot treat the end user like a widget where one is interchangeable with the other. I heard one of the previous speakers speak about providing standardized care but AHF and many other innovative healthcare providers serve specialized needs populations, niche populations and you cannot provide cookie cutter healthcare or cookie cutter pharmacy services to those populations and expect the good outcomes. The integrated care model that AHF innovated and that is also seen in the Ryan White CARE Act programs is superior and lifesaving. And we should not allow these mergers that fragment integrated care that is so important and life saving. So-

Speaker 2:

Thank you Jonathan. Thank you. Our next speaker is Mark Peters.

Mark Peters:

Hi, my name is Mark Peters. I'm a retired first generation physician assistant trained in the 1970s and who practiced long enough to see the negative effects of the fact that there is currently no billing code for caring for the patient. I was an allied health medical staff member of Mission Hospital in Asheville, North Carolina from 1995 until 2012. I want to point out the fact that the sale of not for profit organizations in North Carolina is not controlled by the North Carolina attorney general who has no authority to disapprove or approve of these sales. I heard of this through an article published by Asheville Watchdog, a free not for profit investigative news organization that obtained 6,000 documents from the AG's office regarding acquisition of Mission by HCA. It's my understanding that the FDC has the regulatory authority to reverse acquisitions like this. And I would strongly recommend these documents be reviewed and then reverse this acquisition.

The article stated that the North Carolina attorney general had, "Great concerns about how HCA was selected as the purchaser of Mission health systems," including that quote, "The deck had been stacked in HCA's favor from the beginning," by then CEO Ronald A. Paulus and his advisor, Philip D. Green. Who had, Philip D. Green, who had a previously undisclosed, "Prior business relationship with ACA." Mr. Paulus, "Coached HCA behind the scenes on how to best present its care to the mission board," of directors. The document stated that, "In the end an outside observer could conclude that HCA rose to the top among a limited number of bidders because the deck had been stacked in its favor from the beginning by Dr. Paulus and Mr. Green." The AG was sufficiently concerned that it required the mission board to take another vote.

Speaker 2:

Thanks. Thanks Mark. Thank you very much. Our next speaker is Mercy Hilton. Mercy.

Mercy Hilton:

Hello, I'm Dr. Mercy Hilton. For 20 years I've been a pediatric emergency physician in Indiana which is now the poster child state of the ills of the health system consolidation. I recently left the profession to burn out moral injury and the increasing corporatization of emergency medicine well illustrated when local physician owned group I worked for was replaced with the national group. I'm also the founder of a very active physicians social media group with participants from around the state and from all specialties. And I have become a patient advocate and grassroots physician advocate. I feel an obligation to speak up on behalf of the many physicians who cannot voice their own concerns due to fear of retaliation. I believe that the following are some of the direct consequences of health system consolidation in Indiana.

Reduced patient autonomy and consumer choice, unfair anti-competitive environment for private locally owned physician practices, among the highest healthcare prices for payers in the nation, among the highest average rate of profit in the nation for similar tax exempt hospitals, lower than average percentage of physician owned practices, physician workforce monopsony, lower than national average physician compensation and declining work conditions for healthcare workers with little to no leverage to make changes, ferociously applied and enforced physician non-compete clauses in employment contracts which may leave physicians with no option but to leave the state or profession in order to leave a health system, reduced physician autonomy, specifically undo corporate influence on medical judgment and medical education and graduate medical education. I'm inviting the FTC and DOJ to launch an investigation of healthcare consolidation in the state of Indiana and the resulting negative effects on prices, access to physician care, quality of care for Hoosiers, autonomy of the medical profession and the healthcare workforce.

Speaker 2:

Thank you Mercy. Thanks very much. And that concludes our comments from members of the public today. I note we've been joined by Assistant Attorney General Jonathan Kanter. So I'm going to turn it over to Jonathan for some additional remarks from him. Jonathan.

Jonathan Kanter:

Sure. Thank you so much and I'm truly sorry to be joining everybody late. I honestly would not miss this for anything less than a court appearance. And in fact that's exactly why I'm late. I just left a court appearance. But it's actually really useful to think about the issues that we're discussing today from the perspective of the courtroom. Our jobs as protectors of the public and competition is to make sure that we are not only reflecting the concerns that exist in our economy, in our healthcare system, but that we are dealing so with full visibility and full understanding and conversation with those who are most directly affected. And this listening session like the others is just going to be so important to help guide us as we develop in a trust framework and revised merger guidelines that allows us to really understand the effects of corporate concentration and consolidation.

The issues we're talking about here today literally save lives. We're talking about access to healthcare. We're talking about affordability of healthcare. This is so fundamental and foundational and it is so important that we hear from all of you and more. And so I thank all of you for joining, our colleagues at the FTC for joining us and doing this together. Certainly would also like to express my gratitude to my heroic and awesome principal deputy Doha Mackey for joining and representing the Department of Justice at the outset of this conversation. And for those who have spoken up today, it demonstrates extraordinary courage and commitment to our country. And I'm so grateful for that. And I assure you that we are listening. With that I'm going to hand it back over to chair con.

Chacon:

Thanks so much. Would just echo much of that and thank everybody who's participated today for taking the time and being brave in sharing the problems that you're seeing, especially in instances where we see threats of retaliation and we see our jobs as really ensuring that we're enforcing the law to the full extent to prevent illegal situations where we're seeing those types of market power dynamics. Because at the end of the day this is about access to lifesaving medicines but it's also about liberty and not living in fear in that way. So very, very grateful for everybody who participated. Did want to note again that we are still accepting comments in our merger docket. So folks should please feel free to submit comments. We'll be collecting them through next Thursday.

Very grateful for everybody who has already submitted comments, I believe we are now over 400. And we are already making our way through these comments and really want to make sure that ultimately our guidelines are informed by the experiences and the perspectives that we're hearing about. So thanks so much everybody. And thanks so much as well to the DOJ and FTC staff for heroically putting this together. Very grateful for all of your work as well and hope everybody has a good rest of your afternoon. Take care.