

Preliminary Report: Healthcare Affordability



This document is the report to the Washington State Legislature as directed by the 2023 Legislative Operating Budget codified in Engrossed Substitute Senate Bill 5187 Section 126 (33).

Executive Summary

Consolidation is prevalent in the healthcare industry, contributing to a significant increase in healthcare concentration.¹ Many healthcare providers² in Washington consolidated in recent years, as shown in Figure 1.³ This environment is linked to:

- Increased patient prices⁴ without improvements in the quality of care;⁵
- Impacts on healthcare labor markets, such as suppressed wage growth for hospital workers⁶ and degraded working conditions.⁷

Given the impacts of healthcare consolidations on cost, quality, access to healthcare, working conditions and wages, states are amplifying their efforts to scrutinize local healthcare markets. This preliminary report provides:

- Information about current law in Washington and other states regarding healthcare transaction notifications and reviews, restrictions on anticompetitive contract clauses and non-compete agreements; and
- A primer on enforcement of federal and state antitrust laws.

Transaction Notification and Review

In recent years, states enacted laws to require the parties to a healthcare transaction to report the transaction prior to closing. This notice provides a new avenue for antitrust enforcers—responsible for reviewing mergers and acquisitions for potential harm to competition—to learn about transactions before they close. In some states, the department of health and agencies specifically designed to control healthcare costs and develop affordability solutions assess the impact of proposed transactions on broader criteria, including affordability, access to services, and quality of care.⁸

Anticompetitive Contracts

States are also restricting or banning anticompetitive contract clauses between insurers and healthcare providers that can drive up prices for patients and their employers.⁹ This proactive

Key Findings

Washington’s transaction notification program enables more scrutiny of healthcare consolidations.

Washington lacks authority to review transactions for anything other than competition concerns, such as affordability.

Washington is unable to challenge or restrict transactions through an administrative process, but must go to court.

Most anticompetitive contract clauses are not restricted in Washington.

These contract clauses can result in increased costs for patients. Banning or restricting these clauses can be more efficient and effective than litigation, which is reactive and resource-intensive.

Non-competes agreements can impact provider-patient relationships.

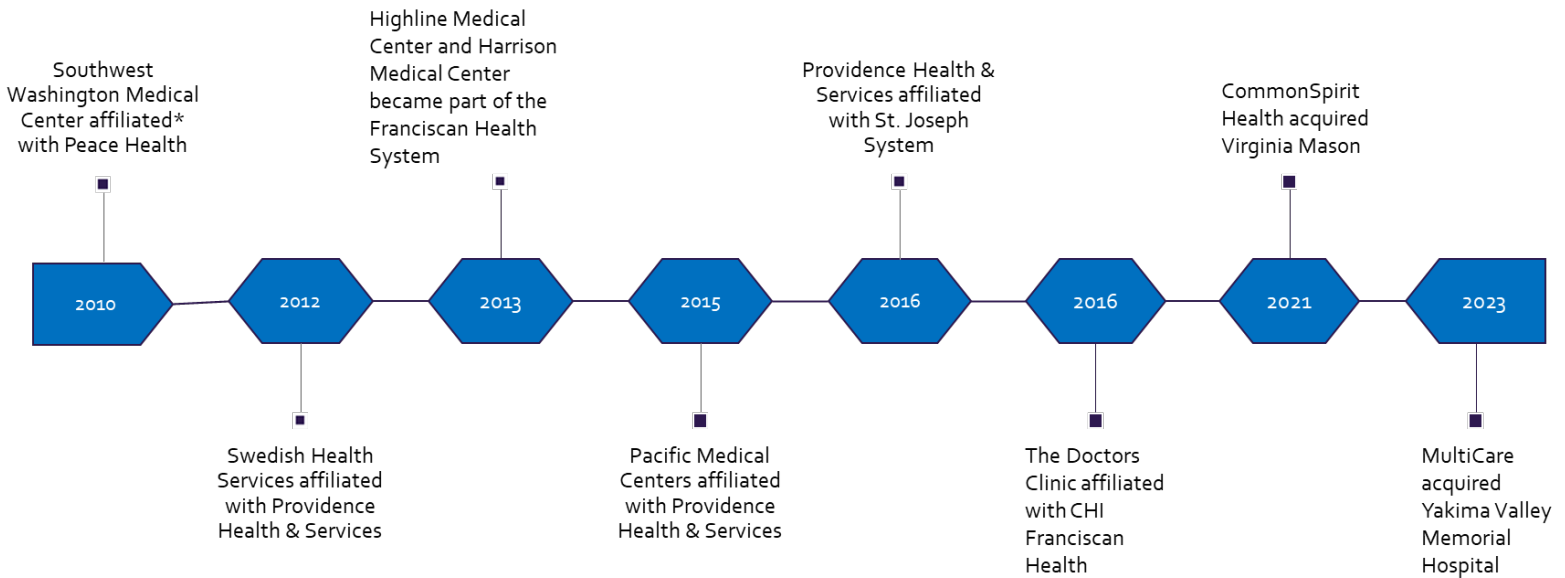
These agreements are unenforceable in Washington for those making below a certain amount, but this earnings threshold does not cover many healthcare workers.

approach can be more efficient and effective than litigation, which addresses the harms caused by these clauses after they have occurred and may not restrict the practice across-the-board.

Non-Compete Agreements

Finally, states are leading efforts on limiting the use of non-compete agreements, which restrict workers from seeking employment with a competitor, leading to decreased job mobility, lower wages, and increased prices. In healthcare settings, these agreements can limit providers' ability to continue patient relationships.

Figure 1: Examples of Recent Consolidation in Washington



*Affiliations describe a range of business arrangements that fall short of mergers or acquisitions. Healthcare providers that affiliate may share health records systems or jointly provide operational services.

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Glossary

- **All-or-Nothing Contract** - requires an insurer that wants to contract with a particular healthcare provider or affiliate in a healthcare system to contract with all the other providers in that system. Simply put, if the insurer wants its enrollees to have access to a hospital in an area, it needs to agree to provide access to all the other facilities, even if those facilities provide higher cost, lower quality services. Healthcare entities typically use all-or-nothing provisions to leverage the status of their *must-have healthcare providers* in a highly concentrated market to demand higher payment rates for the entire organization, including for providers in more competitive areas and specialties.¹⁰
 - **Must-Have Healthcare Provider** - a hospital or provider group which has monopoly-status in a particular area or a hospital or provider group that is required to meet state adequacy laws (i.e., an insurer cannot construct an adequate network without them).
- **Anti-Incentive Provisions** - require that an insurer place all physicians, hospitals, and other facilities associated with the dominant healthcare provider in the most favorable tier of providers (*anti-tiering*) or at the lowest cost-sharing rate to avoid steering patients away from that network (*anti-steering*), even if providers in that network are more expensive or are of lower quality than other providers in that area.¹¹ These clauses are often used by dominant health systems asking insurers to place these systems in the lowest cost tier for consumer cost sharing, regardless of their quality or cost performance.¹² These clauses can cripple insurers' abilities to direct patients to higher-value providers or require patients to pay a higher co-pay for higher-cost providers.
 - **Tiering** - occurs when an enrollee (patient) pays less out of their own pocket for care received from a provider in a more favorable group ("tier") and pays more if they see a provider in a less favorable tier. Insurers use tiering to incentivize enrollees to seek care at lower cost or higher quality providers.
 - **Steering** - a common cost containment practice used by insurers to steer patients from higher priced in-network providers to less expensive providers. Steering can take many forms. For example, "hard" steerage—authorizing a service or procedure *only* if it is performed in a particular setting, and "soft" steerage—providing a patient with economic incentives, such as reduced out-of-pocket expenses, for obtaining care from a particular provider. Accordingly, healthcare providers have been using their leverage to negotiate contractual provisions that limit (or even prohibit) an insurer, during the performance of a contract, from steering patients to alternative sites of care, typically a rival competing for similar services.
- **Cost Growth Benchmark** - limits how much a state's healthcare spending can grow each year. A benchmark does not cap price or spending growth. It is designed as a measurable goal to track the state's progress in moderating spending growth over time.

- **Cross-market Merger** - involves combinations among in-state healthcare providers that are in neighboring markets as well as providers that are far apart geographically. In geographical cross-market mergers, providers do not directly compete in the same local geographic market, but could sell the same, related, or complementary products or services to a common customer or set of customers.¹³ By contrast, product cross-market mergers include mergers between entities that offer different products and services, regardless of whether these entities are in the same or different geographic markets, such as the mergers of different specialties in a single physician market. These mergers can trigger price increases and result in the elimination of certain service lines, limiting access to care.¹⁴
- **Gag Clause** - provision in a contract that prevents insurers, employers who purchase insurance, and *self-funded health plans* from providing plan members with access to pricing, quality, and cost information, which can help patients make better care decisions.¹⁵ Gag clause provisions may hide any overall price difference from patients.
 - **Self-funded Health Plan** - one in which the employer assumes the financial risk for providing health benefits to its employees.
- **Horizontal Merger** - occurs between similarly situated market participants operating in the same product and geographical market. These mergers, such as mergers of two hospitals or two physician groups, eliminate close competitors performing similar levels of service, causing direct harm to competition. For example, consolidation among health systems is associated with higher premiums for plans sold on Affordable Care Act marketplaces,¹⁶ and reduced wage growth,¹⁷ without improvement in the quality of care.¹⁸ Antitrust enforcers and economists group mergers into horizontal and non-horizontal mergers (i.e., vertical and cross-market), but many recent healthcare mergers include both horizontal and non-horizontal elements.¹⁹
- **Most-Favored-Nations or Pricing-Parity Clause** - guarantees that a buyer of goods or services (an insurer in the healthcare markets) receives terms from the seller (i.e., a hospital or physician) that are at least as favorable as those provided to any other buyer. Health systems with a strong presence in an area can offer an MFN to an insurer in exchange for higher rates guarantying to the insurer the most favorable pricing (i.e., no other insurer will negotiate lower rates).²⁰ To keep their strong market position, dominant insurers often do not need to negotiate a “low” reimbursement rate from healthcare providers; they need to negotiate the lowest rate among their competitors. This protects the position of the most dominant insurer in the market.
- **Stealth Consolidation** - refers to anticompetitive mergers and acquisitions that escape antitrust scrutiny, usually because the transacting entities may be relatively small in size. However, the cumulative effect of these transactions on competition is large. Private equity

roll-ups and *buy-and-build* strategies are part of these serial acquisitions, where an individual transaction, such as an acquisition of an individual or small physician group practice, is too small to trigger scrutiny in isolation.²¹

- **Roll-up** - a serial acquisition strategy involving a series of often smaller transactions, appearing insignificant in isolation, but whose cumulative impact significantly harms competition.
- **Buy-and-build** - the bolting together of smaller entities into business empires.
- **Vertical Merger** - occurs between entities operating at different levels in the distribution chain, such as acquisitions of physicians' practices, laboratories or outpatient clinics by a hospital, or a health system, or acquisitions of healthcare providers by insurers. Since these groups do not directly compete, they may not initially appear to be anticompetitive. As noted in some studies, the combinations result in price increases in both the hospital and the acquired physician group, with reduced to no improvement in quality.²²

State Healthcare Notification & Review Laws Enable States to Assess the Impact of Transactions Before They Occur

States' efforts to curb anticompetitive healthcare consolidations, control costs and enhance access to affordable healthcare notification laws led to the enactment of state healthcare notification laws, which require healthcare providers to notify state entities before completing a merger, acquisition or other affiliation. These laws provide more visibility into healthcare consolidations and enable states to review—and in some cases, approve or restrict—transactions before closing. This authority may be housed within the State Attorney General's Office, another state agency, or a newly created entity.

Current Law in Washington

Since 2020, Washington has mandated at least 60 days' advance written notice to the Attorney General's Office (AGO) for certain healthcare providers before undergoing a "material change."²³ Transactions covered by the statute include mergers, acquisitions or contracting affiliations between two or more healthcare entities that did not have previous common ownership. There are no fees imposed on healthcare entities for the transaction review program. The Antitrust Division within the AGO receives no general fund support, funding its own actions through recoveries made in other cases.

- Healthcare entities must notify states before completing a merger, acquisition, or other affiliation.
- Washington receives notice of a wide range of transactions and reviews for harms to competition.
- Some states also review transactions for impacts to affordability, access to services, and quality of care.
- Some states have statutory authority to approve, reject or impose conditions on transactions without going to court. Washington lacks this authority.

Washington's law:

- ✓ Requires notice of transactions involving healthcare providers besides non-profit hospitals.
- ✓ Covers in-state transactions regardless of size and dollar thresholds (out-of-state entities are subject to the requirement if they generate at least \$10 million or more in healthcare service revenue from Washington patients).
- ✓ Mandates reporting of contract affiliations between hospitals and groups of seven or more affiliated providers.
- ✓ Focuses on capturing anticompetitive transactions.
- ✓ Provides discretion, enabling the AGO to focus on transactions that may cause the most harm, rather than requiring the agency to conduct a review or prepare a report for every transaction notice.
- ✓ Protects the confidentiality of information submitted to the AGO.
- ✗ Does not cover physician groups with fewer than seven providers.
- ✗ Does not direct the AGO to consider the impact of transactions on affordability, access to services, or quality of care.
- ✗ Does not authorize the AGO to administratively approve, reject or impose conditions on transactions without going to court.
- ✗ Does not provide for a public involvement process.

Comparing Washington to Other States

Washington's law provides visibility on a wide range of potentially harmful transactions. It is one of a small number of states that requires notification of transactions involving physician groups with at least seven providers and all hospitals.²⁴ In addition, Washington does not limit notice of most transactions to a particular revenue threshold.

In contrast, some states have broader authority than Washington, enabling reviews beyond antitrust concerns to capture the impact of transactions on affordability, access to services, and quality of care. These programs are often embedded in offices doing other health policy work, and in some cases, spearheading multiple programs to address healthcare affordability. The Washington State Legislature is considering bills, such as the Keep Our Care Act, that would expand the scope of the Attorney General's review to assess whether transactions will negatively impact accessible, affordable healthcare in the state.²⁵ This change, if enacted, would make Washington more similar to the three programs described in Table 1, though the state would be unique in housing an expanded review program within the Attorney General's Office. Recently

signed legislation in Minnesota requiring pre-closing notification for certain healthcare transactions authorizes the Attorney General to challenge transactions that impact the public interest.²⁶ Factors informing whether a transaction is contrary to the public interest include whether the transaction will reduce the community’s continued access to affordable and quality care, increase healthcare costs for patients, and impact total healthcare spending, among other factors. Appendix I provides additional information about states’ healthcare notification laws.

Table 1: Healthcare Transaction Review Programs in Select States			
	California	Massachusetts	Oregon
Agency	Office of Health Care Affordability	Health Policy Commission, an independent state government agency	Oregon Health Authority
Year of First Review	2024	2013	2022
Type of Review	Discretionary	Initial Review: Mandatory; Full Review: Discretionary	Mandatory
Factors for Review	<u>Issues under consideration (pending):</u> competition; costs to payers, purchasers, or consumers; affordability; availability or accessibility of healthcare services; quality of care	Impact to healthcare cost benchmark or competitive market ²⁷	Competition; costs to consumers; access to services; health equity and healthcare quality ²⁸
Approximate Program Staffing	26 now, expanding to 100	5	4*
Fees	No— funded through general fund appropriations	Hospitals pay agency’s entire budget; no additional fees	Yes**
Consultant Costs	Covered by healthcare entities involved in transaction; no cap; appeals process for “unreasonable” costs	Hospitals pay agency’s entire budget	<u>For comprehensive reviews only:</u> covered by healthcare entities involved in transaction; no cap
<p>*The program was established with 4 positions, but according to program officials, additional staffing is necessary to conduct required reviews.</p> <p>**The fees for preliminary reviews are \$2,000; fees for comprehensive reviews range from \$25,000 to \$100,000 depending on the revenues of the entities involved.</p>			

Table 2 provides information about the transparency of the transaction review programs in Massachusetts and Oregon. Certain information can be redacted for public posting. While the program in California’s Office of Health Care Affordability is new, the existing program in the Attorney General’s Office, requiring notice of nonprofit healthcare transactions, also provides for a public meeting and posts submissions on the website with redactions for confidential information.²⁹ Attempting to strike a balance, the New York Attorney General must post a summary of proposed transactions online for public comment, but the materials submitted to New York Department of Health and then transmitted to the Attorney General are not posted in full.³⁰

Table 2: Transparency Mechanisms: Transaction Review Information Posted Online		
	Massachusetts	Oregon
Transaction notice	✓	✓
One-page summary of proposed transaction		✓
Preliminary review report	✓	✓
Supplemental information from entities involved in transaction	✓	✓
Public comments	✓	✓
Comprehensive review report	✓	✓

After Massachusetts and Oregon complete their public processes, the states have different authorities. The Massachusetts Health Policy Commission has no authority to challenge or restrict proposed transactions. Rather, it refers certain cost and market impact review³¹ final reports to the Attorney General, which can use that analysis to determine whether to challenge a proposed transaction on anticompetitive grounds. Notably, the agency conducted nine cost and market impact reviews out of 162 transactions reviewed since 2013.³² According to an agency official, HPC uses the cost and market impact review process judiciously because it is intensive. Similarly, in Connecticut, the Office Health Strategy refers final cost and market impact review reports to the Attorney General if a healthcare entity has a dominant market share or charges prices that are materially higher than median prices. In Oregon, the Health Care Market Oversight Program is responsible for approving, approving with conditions, or disapproving proposed transactions. The agency approved with conditions about half of the transactions reviewed as of October 2023.³³ In some cases, healthcare entities approved with conditions are required to submit compliance reports for five or more years. Conditions placed on individual transactions include maintaining access to specific services for ten years, prohibiting facility fees, and banning restrictions on employment opportunities for former employees.

Legislation Banning Anticompetitive Contract Clauses May Be More Efficient Than Litigation in Protecting Patients

In the current concentrated healthcare landscape, states are pursuing alternatives to litigation to proactively address anticompetitive practices. Four contract clauses that raise the most concerns among antitrust enforcers and lawmakers are all-or-nothing contracts clauses, anti-incentive

- Certain anticompetitive contract clauses can result in increased costs for patients.
- Some states are restricting or banning these clauses.
- Washington has not banned most anticompetitive contract clauses.
- Legislation can be more efficient and effective than litigation, which is reactive and resource-intensive.

provisions (anti-tiering and anti-steering), nondisclosure requirements (gag clauses), and most-favored-nation (MFN) clauses. Legislation restricting or banning anticompetitive contract clauses can be more efficient and effective than litigation.³⁴ These contract clauses can harm patients, since insurers often pass increased costs onto patients and their employers through increased premiums.³⁵ Through litigation, states address the harms caused by contractual provisions that can stifle competition *after* they have occurred. Moreover, time- and resource-intensive litigation may not result in the elimination of these practices across the state.

Current Law in Washington

Washington prohibits most-favored-nations clauses in some healthcare provider contracts.³⁶

Washington does not prohibit other contractual provisions that limit patients' ability to obtain price information and prevent providers from incentivizing patients to seek care at a lower cost or from higher quality providers. The Washington State Legislature has considered bills, such as Senate Bill 5393 (2023) and House Bill 1160 (2021), that would restrict certain anticompetitive contractual provisions.³⁷ The former bill will remain active in the 2024 Legislative Session.

Comparing Washington to Other States

Massachusetts³⁸ (2010), Nevada³⁹ (2021), Connecticut⁴⁰ (effective July 1, 2024), and Texas⁴¹ (2023) enacted legislation banning anti-tiering and anti-steering clauses in some contracts. In addition, in 2023, legislatures in California,⁴² Maine,⁴³ New Jersey,⁴⁴ and New York⁴⁵ considered restrictions on anti-tiering or anti-steering contract provisions. Among the legislation that passed, Connecticut's law also bans gag-clauses, and all-or-nothing clauses.⁴⁶ In Texas, the statute prohibits MFNs, gag clauses, anti-steering and anti-tiering clauses in provider network contracts.⁴⁷ Massachusetts also bans all-or-nothing provisions, but these only apply to specific plans, not across all plans.

States that passed legislation in recent years aimed it at providers⁴⁸ or multiple entities. For example, Connecticut's law is the most comprehensive, subjecting providers, health insurance carriers, and health plan administrators to the restrictions. In contrast, when the restriction is aimed only at insurance carriers, such as in Massachusetts,⁴⁹ state enforcement may be limited. For example, state insurance regulators do not have authority over self-funded insurance plans. These are plans offered by larger companies where the employer collects premiums from enrollees and takes on the responsibility of paying employees' and families' medical claims. In Washington, more people are covered by self-funded insurance plans than those regulated by the Office of the Insurance Commissioner.

While prohibitions and restrictions on anticompetitive contractual provisions are promising,⁵⁰ legislation may not alleviate all risks. For example, legislation aimed at prohibiting certain terms in written contracts may not capture *de facto* leverage exercised by dominant firms at the negotiation stage, particularly through oral and other agreements.⁵¹ Additionally, these legislative prohibitions may fail to capture the potential cumulative effect of multiple contract terms used in combination.⁵² To address these shortcomings, some scholars propose creating an oversight entity or expanding existing state regulatory oversight.⁵³

Non-Compete Agreements in Healthcare Can Harm Both Workers and Patients

Non-compete agreements across all professions in the healthcare industry can restrict workers from seeking employment with a competitor or from starting a competing business. These agreements can lead to less job mobility, lower wages for workers, and increased healthcare prices.⁵⁴

Besides their implication for workers' mobility, non-competes further strain the provider-patient relationship,⁵⁵ which is critical to providing equitable care.⁵⁶ These clauses may prevent physicians from continuing to care for their patients should they leave a particular practice. Limiting the healthcare provider market can lead to inadequate provider networks and decreased access to care. For providers concerned about potential retaliation, non-competes can also pose a threat to advocacy efforts for better clinical standards and patient safety.⁵⁷

Earlier this year, the FTC proposed banning all non-compete agreements.⁵⁸ There is no timetable for finalizing the rule and it is unclear whether a final rule would apply to non-profit hospitals.⁵⁹

- **Non-compete agreements restrict workers' job mobility. In healthcare, they impact provider-patient relationships.**
- **Washington restricts non-compete agreements for employees and independent contractors making below a certain amount – physicians and other healthcare workers often earn more.**
- **Other states restrict non-compete agreements outright or have specific restrictions on non-competes involving physicians and other healthcare providers.**

Current Law in Washington

States are leading efforts to restrict the use of non-competes. Since 2020, non-competes agreements are unenforceable in Washington for employees and independent contractors if they make below a certain earnings threshold or if the terms of the non-compete violates certain statutory constraints.⁶⁰ The earnings thresholds are adjusted each year and are posted on the Department of Labor and Industries' website.⁶¹ The 2023 threshold for W-2 employees is \$116,593.18. The 2023 threshold for independent contractors is \$291,482.95. Although higher paid healthcare workers and physicians likely earn more than the statutory threshold, they may still argue that a non-compete is unenforceable for other reasons.

Comparing Washington to Other States

Many states have some level of restrictions on non-competes.⁶² Like Washington, at least seven states have enacted legislation to block enforcement of non-competes against low-wage or low-skilled workers since 2019.⁶³

Other states, including Minnesota, North Dakota, Oklahoma,⁶⁴ and California,⁶⁵ prohibit non-compete agreements outright. Expanding worker's protection and enforcement options, California's governor recently signed two bills banning any restraint of trade through contracting clauses like non-compete agreements, and making clear that a violation of California's non-compete ban constitutes unfair competition.⁶⁶ Notably, the bill reaches all employment contracts regardless of where the contract was signed or where the employment is maintained, even if outside of the state of California.

States Laws Pertaining to Non-Compete Agreements in Healthcare

Some states have specific restrictions on non-competes involving physicians and other healthcare professionals. For example, Rhode Island, Delaware, Massachusetts and New Hampshire ban physician non-compete agreements.⁶⁷

Other states prohibit only certain physician non-competes. For example:

- West Virginia declares physician non-competes void if they last longer than a year, extend more than 30 miles, or are applied against a fired employee.⁶⁸
- Similarly, Connecticut and Tennessee place statutory limits on the length of time and geographic restrictions in physician non-compete agreements.⁶⁹
- Colorado prohibits employers from collecting damages for breach of a non-compete if physicians are providing treatment of a rare disorder for a previously established patient.⁷⁰
- Florida prohibits non-competes between physicians and entities such as rural hospitals that have no real competition in their geographic area.⁷¹ Such non-compete agreements remain "void and unenforceable" for three years after a competitive entity enters the same county.
- Indiana prohibits a primary care physician and an employer from entering into a non-compete agreement.⁷² Under this law, non-compete agreements for other physicians are not enforceable under certain circumstances.⁷³
- Texas allows physician non-competes, but their law includes certain provisions to protect patients and ensure continuity of care. Accordingly, the agreements must (1) not deny the physician access to a list of patients they saw or treated in the year prior to the termination of the employment contract; (2) provide access to patient records upon authorization by the patient; (3) allow the physician to continue to provide care to

patients during the course of an acute illness; and (4) include a provision allowing the physician to buy out the agreement for a reasonable price.⁷⁴

Some states broadened their non-compete bans to include other healthcare professionals besides physicians. For example, New Mexico⁷⁵ banned contractual provisions that restrict any healthcare practitioner's right to provide clinical healthcare services after employment. South Dakota's near-total prohibition against non-compete provisions includes nurses and many other healthcare providers.⁷⁶ One of two pending bills in Iowa is also aimed at nurses, setting an income threshold, while the other seeks to ban all non-competes for everyone earning less than 150 percent of state or federal minimum wage. Alabama's ban on non-competes includes physical therapists.⁷⁷ A bill in Massachusetts would ban non-competes for physician assistants.⁷⁸ A more expansive bill in New York, if enacted, would cover "de facto" agreements that have the effect of prohibiting individuals from seeking or accepting employment.⁷⁹

Overview of Antitrust Oversight in Healthcare

The Role of Antitrust Agencies as Market Regulators and Enforcers of Antitrust Laws

Antitrust enforcers review mergers and acquisitions for potential harm to competition, challenging proposed transactions that may substantially lessen competition, imposing conditions on allowed transactions that offer benefits but pose some risks to competition, and enforcing laws prohibiting anticompetitive conduct. Two federal antitrust enforcers share responsibilities for antitrust enforcement in healthcare. The Federal Trade Commission (FTC) and the Antitrust Division of the U.S. Department of Justice (DOJ) jointly enforce the federal antitrust laws—the Sherman Act⁸⁰ and the Clayton Act;⁸¹ the FTC also enforces the FTC Act.⁸² The FTC Act⁸³ prohibits unfair methods of competition and unfair or deceptive acts or practices, anticompetitive transactions covered by the Sherman Act and the Clayton Act, and other anticompetitive practices. Unlike the Sherman Act and the Clayton Act, the FTC Act generally cannot be applied to nonprofit entities, but it can be applied to nonprofit and for-profit health insurance companies, as authorized by the Competitive Health Insurance Reform Act of 2020.⁸⁴ While their authority is joint, the agencies typically divide their reviews along business lines: the FTC oversees healthcare entity transactions, while the DOJ oversees health insurance transactions. Their transactional review and enforcement is subject to the notice and reporting limitations under the Hart-Scott-Rodino Act (“HSR Act”),⁸⁵ which mandates that merging entities report their plans before closing the deal if the transaction exceeds a specified value (\$111.4 million in 2023), giving the federal enforcers notice and time to investigate and intervene if needed.⁸⁶

The DOJ and FTC issue and revise merger guidelines (i.e., Horizontal Merger Guidelines and Vertical Merger Guidelines) setting forth how the agencies conduct an antitrust analysis for certain identified conduct. Since 1968, the DOJ and FTC have issued and revised merger guidelines several times, including in 1982, 1984, 1992, 1997, 2010 and 2020. While not binding on the courts, the guidelines help shape the evolution of both state and federal antitrust law, and serve as important enforcement tools. In July 2023, the agencies proposed new merger guidelines outlining greater scrutiny for transactions involving private equity sponsors and institutional investors and serial acquisitions, as well as more scrutiny for labor markets.⁸⁷ A group of Attorneys General, including Washington, submitted public comments with recommended revisions to nearly all of the Draft Guidelines, and several Attorneys General issued specific comments addressing labor market issues, which the guidelines did not previously address.⁸⁸

In addition to enforcing state antitrust laws, state attorneys general share authority with DOJ and FTC in enforcing federal antitrust laws. State attorneys general may bring federal actions for

damages and injunctive relief under Sections 4 and 16 of the Clayton Act, respectively, as either direct purchasers and as *parens patriae* on behalf of their state’s residents.⁸⁹ Most states have their own antitrust statutes that are typically read in harmony with federal antitrust laws, but some states have more expansive antitrust laws.⁹⁰ State antitrust enforcers bolster and supplement the efforts of their federal counterparts, and can also act independently of federal enforcers. States often collaborate with their federal counterparts, too, and the enforcers’ concerns can coincide.

Case Spotlight – Federal and State Collaboration

2018 - Massachusetts and the FTC

State and federal enforcers investigated the proposed hospital merger between Beth Israel Deaconess Medical Center and the Lahey Health System. The Attorney General entered into a negotiated consent decree, filed with the court, which imposed a set of conditions—including conditions to address potential access barriers—before the merger could proceed. Another condition included setting an “unprecedented” price cap by prohibiting post-merger price increases from exceeding 0.1% below the state’s Cost Growth Benchmark for seven years. As a result of the state settlement, the FTC voted to close its investigation. Because Massachusetts received pre-merger notice of this transaction, pursuant to their state statute, they were able to challenge it before closing.

Highly Concentrated Healthcare Market Conditions Require More Oversight, Particularly Vertical Mergers

Acting with limited resources, antitrust enforcers have prioritized challenging horizontal hospital mergers. These enforcement challenges ceased after a period of losses in the 1990s, which led to further hospital consolidations. Thereafter, the FTC conducted a series of retrospective analyses of mergers, which resulted in new legal analytical tools to evaluate the competitive effects of horizontal consolidation, and triggering a resurgence of enforcement actions. Following those retrospective studies of consummated hospital mergers, the FTC was able to obtain thirteen federal injunctions in hospital cases from 2008 to 2018, after getting only two from 1997 to 2007.⁹¹ The litigation reshaped the focus of the horizontal hospital merger analysis by employing new tests based on the economic understanding of hospital markets. Successful enforcement cases followed, with courts unanimously employing a multi-stage model of hospital competition, and concluding that price effects of the mergers depended on the response of insurers, not patients, who are generally insensitive to retail hospital prices.⁹² This economic framework for analyzing competition in healthcare markets, and the years of successful legal

precedent it has produced, has become a bedrock for enforcement actions to challenge horizontal or within-market transactions. However, this strategy is not replicable for vertical mergers.⁹³

For reasons beyond the scope of this report, lawsuits blocking vertical mergers can be very challenging.⁹⁴ After an outpouring of concern that vertical mergers can harm competition, the FTC held hearings on vertical integration in 2018, and jointly issued with the DOJ the long-awaited Vertical Merger Guidelines in 2020. But even these guidelines reflect the view that efficiencies created by vertical integration may justify consolidation. Due to criticism that these guidelines were not equipped to transform vertical merger enforcement, the FTC withdrew them in 2021. Some authors urged federal agencies to update the guidelines to set “workable,” “economically sound standards” to assist the courts, enforcers and market participants in evaluating vertical deals.⁹⁵ In 2020, the FTC also announced a new retrospective review to include an assessment of the competitive impact of vertical combinations, particularly hospital acquisitions of physician practice groups,⁹⁶ which will allow the FTC to study the effects of consummated physician group and healthcare facility mergers that occurred from 2015 through 2020.⁹⁷ The FTC anticipates that it will collect data over several years and there is no definitive date for completion of the project.

Without supportive economic data, legal precedent and updated standards in the merger guidelines, antitrust enforcers left vertical mergers unchallenged.⁹⁸ The lack of enforcement triggered more healthcare consolidations, inviting entities to test the boundaries of antitrust enforcement. In recent years, however, antitrust enforcers have signaled more willingness to litigate vertical merger cases, as opposed to settling, despite losing the last two merger challenges that raised vertical concerns. Last year, the DOJ and a few states lost their challenge to the UnitedHealth-Change Healthcare merger, which raised both horizontal and vertical concerns.⁹⁹ That case brings forward even more issues in antitrust enforcement—evaluation of a private equity firm as a divestiture buyer.

Conduct Remedies Provide an Avenue to Address Harms Associated with Consolidation, Especially Vertical Transactions

Federal and state antitrust laws typically confer trial courts with broad equitable authority to fashion remedies that address a transaction’s competitive harm. When reviewing the transactions, antitrust enforcers have the ability to use structural remedies—such as blocking or undoing a recent merger, or requiring a divestiture of assets to restore or maintain competition—or conduct remedies—promises by the merged entity as to future business conduct, to be monitored for compliance after closing. Horizontal mergers have traditionally been blocked or unwound. However, these structural remedies are harder to impose after a merger is executed. Specifically, for healthcare mergers, the merged entities claim that unwinding a consummated merger would negatively impact patient care, as the merged entities have become too financially

and clinically integrated. In contrast, conduct remedies allow the healthcare transaction to proceed with some set of conditions in place, monitored for a set time by antitrust enforcers. Antitrust enforcers historically disfavored conduct remedies, in part because they require resource-intensive monitoring to ensure that the merged entity is complying with conditions. When used effectively, however, conduct remedies can mitigate anticompetitive concerns and may provide an avenue to address vertical transactions.

Case Spotlight – Conduct Remedies

Washington (2018)

The Washington State Attorney General filed a lawsuit against Franciscan Health System seeking a structural remedy by asking the District Court to undo Franciscan’s acquisition of a physician group, WestSound Orthopedics in Silverdale, and affiliation with The Doctors Clinic, a multispecialty physician practice, because of violations of Section 1 of the Sherman Act, Section 7 of the Clayton Act,¹⁰⁰ and corresponding state law.¹⁰¹ The District Court dismissed the claim involving the acquisition of the physician group, but ruled that the State’s claim regarding the affiliation with The Doctors Clinic would go to trial.¹⁰² The state concluded its litigation with a consent decree imposing a set of conduct remedies¹⁰³ and monetary relief. For example, Franciscan is required to notify Attorney General’s Office of future deals that could decrease competition.

California (2021)

The California Department of Managed Health Care (DHMC) conducted a comprehensive review of Centene Corporation’s acquisition of Magellan Health Inc., to address both horizontal and vertical concerns raised by that transaction.¹⁰⁴ On December 30, 2021, DHMC announced that it had approved the merger with conditions to ensure that it does not adversely impact enrollees or the stability of California’s healthcare delivery system.¹⁰⁵ This was the first merger reviewed under the 2018 law that gave DHMC more authority to review health plan mergers, including a public involvement process to receive comments about the transaction, and an independent health system impact analysis.

Limited Enforcement Activity on Cross-Market Transactions Until Recently

There has been a widespread increase in the number of cross-market mergers, which account for more than half of all the hospital mergers in the last decade.¹⁰⁶ This triggered further research to assess the potential for these enlarged entities to charge higher prices.¹⁰⁷ Until recently, only a handful of economic analyses focused on cross-market mergers, limiting enforcers' ability to rely on empirical data to show the potential consequences of these transactions.¹⁰⁸ Some economists concluded that certain cross-market healthcare mergers result in significant post-merger price increases.¹⁰⁹ However, legal scholars, economists and antitrust enforcers need to do more analysis to determine the circumstances when these deals harm healthcare competition.¹¹⁰

There have been relatively few lawsuits challenging cross-market transactions due to the limited availability of empirical data proving that these deals harm competition.¹¹¹ One example of a cross-market deal between two large health systems was Colorado-based Catholic Health Initiatives' merger with San Francisco's Dignity Health in 2019, resulting in one of the largest health systems in the U.S. with 700 care sites and 139 hospitals across 28 states.¹¹² Other examples include the \$3.9 billion acquisition of Health Management (71 hospitals) by Community Health Systems (135 hospitals) in 2014, and the 2013 merger of Dallas-based Baylor Health Care System and Temple-based Scott & White Health, where post-merger the combined entity comprised 43 hospitals and more than 6,000 affiliated physicians.¹¹³

Cross-market deals recently received more interest from regulators and enforcers. While the DOJ and FTC have not yet released detailed guidelines for evaluating cross-market mergers, the 2023 proposed Merger Guidelines include language that could be used to challenge them.¹¹⁴ Importantly, in 2023, the DOJ¹¹⁵ and the FTC¹¹⁶ withdrew from their respective healthcare policy statements dating back to 1993, calling them outdated.¹¹⁷ These statements identified some types of transactions that were exempt from antitrust challenges, which has allowed large health systems to acquire small hospitals in other markets.¹¹⁸ Additionally, in September 2021, the FTC expressed interest in cross-market deals, reporting that their effects will be part of FTC's review of large merger deals.¹¹⁹

While federal antitrust enforcers have yet to test legal strategies for challenging cross-market mergers in courts, some state enforcers have scrutinized some mergers identified as cross-market mergers and have conditioned their approvals.

Case Spotlight – Cross-Market Transactions

California (2020-2022)

Despite being limited to reviewing only nonprofit hospital transaction, the California Attorney General has broad authority to review healthcare transactions for a variety of factors, including competition, access to care, and quality. The state Attorney General recently reviewed the cross-market effect of several transactions and imposed competitive impact conditions (i.e., a price freeze or caps on post-merger price increases for the merged entity) to address potential cross-market price effects, and quality and access impact conditions.¹²⁰

- Exercising its statutory approval power over nonprofit entities, the Attorney General recently imposed conditions on the affiliation between Cedar-Sinai Health System and Huntington Memorial Hospital, healthcare providers from different geographical markets in Southern California.¹²¹
- The final conditions outlined in a settlement agreement include a five-year price cap to prevent post-affiliation price increases, separate negotiation teams, and mandatory arbitration when negotiations with insurers.¹²²
- The settlement also banned certain terms in their contracts with insurers, including all-or-nothing clauses that would require insurers to contract with both Cedars-Sinai and Huntington Memorial, and anti-tiering and anti-steering clauses that would prevent insurers from steering patients away from these entities.¹²³
- Other cross-market transactions in California were required to comply with restrictions on price increases and to maintain certain services, such as by having a minimum number of emergency room, intensive care, and obstetrics beds.¹²⁴

Minnesota (2023)

The state Attorney General began to investigate whether to challenge a proposed merger between Fairview Health Services (based in Minnesota) and Sanford Health (based in South Dakota) before the two systems abandoned their plans in July 2023.¹²⁵

Stealth Consolidations and Private Equity Involvement in Healthcare

Antitrust enforcers have shown increased interest in addressing the risk serial acquisitions pose to competition in healthcare markets, especially in transactions involving private equity firms. In amending the Clayton Act in 1950, Congress explicitly stated that Section 7 reaches serial acquisitions.¹²⁶ Specifically, the House Report noted that “control of the market . . . may be achieved not in a single acquisition but as the result of a series of acquisitions.”¹²⁷ Even though federal law addresses serial acquisitions, until recently these transactions were left unchallenged. Recently, several studies demonstrated that private equity transactions in healthcare have grown exponentially, and have linked these deals to higher healthcare prices and lower quality of care, especially in markets where these firms have a strong presence.¹²⁸ Specifically, one study notes that from 2012 to 2021, private equity acquisitions of physician practices went from 75 deals in 2012 to 484 deals in 2021—more than a six-fold increase in only ten years.¹²⁹ While some private equity firms have obtained significant national market shares in areas such as emergency physician outsourcing and air ambulance, the primary strategy for most private equity firms has been to reach a strong presence in local or regional markets.¹³⁰ Examples of local markets dominated by a private equity firm abound.¹³¹

In their comments to the 2023 proposed Merger Guidelines, a group of state attorneys general highlighted their concerns with the recent trend of private equity firms engaging in stealth consolidation by acquiring multiple smaller companies that either compete against each other or are vertical in nature, and then combining the acquired companies for resale. Specifically, the state attorneys general noted that these roll-ups pose high risk for competition and often are below the reportable thresholds.¹³² Similarly, several authors call for more action from antitrust enforcers and policymakers.¹³³

Case Spotlight – Private Equity

FTC (2023)

In an unprecedented case, the FTC sued the private equity fund Welsh Carson, its affiliates, and its investment company, U.S. Anesthesia Partners in the Southern District of Texas challenging the so-called “roll up” strategy often employed by private equity firms investing in healthcare markets. The FTC’s complaint outlines an alleged scheme detailing a roll-up strategy with ongoing buy-outs in an effort to consolidate more than a dozen competing anesthesiology physicians groups in Texas.¹³⁴ This is an allegation of cross-market harm. The litigation is pending.

Legal Background: Plaintiffs Face an Enormous Burden to Demonstrate Anticompetitive Harms of Contract Clauses

Addressing the harms of anticompetitive contract clauses through litigation is challenging. Though anticompetitive contract clauses are actionable under federal and state antitrust laws, plaintiffs face difficulties proving these contractual practices are anticompetitive. This likely served as a deterrent to antitrust enforcement through private litigation. The plaintiff bears a hard burden to prevail in challenging anticompetitive contractual practices, which requires defining a market and showing market power for a violation of either Section 1 or 2 of the Sherman Act.¹³⁵ For example, the plaintiff has to prove that the contract between an insurer and a healthcare provider must have either collusive effects (enabling horizontal-direct competitors to raise prices) or exclusive effects (foreclosing rivals from entering the market or significantly raising their costs). As such, the plaintiff has to show either actual effects (such as price increases occurring after the contract term was adopted) or engage in a challenging exercise to show that the defendant possesses durable market power (i.e., maintain a strong presence in a market), which requires in-depth economic analysis to define the relevant product and geographic markets. Additionally, the defendants can rebut by showing substantial procompetitive benefits (anti-steering clauses may allow health systems to spread fixed operating costs across more services and reduce the cost of highly specialized services—for example, an orthopedic department may use anti-steering to reduce costs for specialized care and increase referrals).

Case Spotlight - Anticompetitive Contracts

Michigan Case Led to Legislation Banning MFN clauses (filed in 2010; settled in 2013)

The DOJ and the State of Michigan filed an antitrust lawsuit against Blue Cross Blue Shield of Michigan (BCBSM) alleging that BCBSM used MFN clauses to prevent other insurers from negotiating lower prices with hospitals.¹³⁶ The dominant insurer, BCBSM, prevented other insurers from entering and competing in local markets. The lawsuit was dismissed after the Insurance Commissioner in Michigan issued an order banning MFN clauses. Michigan later enacted laws banning MFNs in any healthcare provider contracts.

California's Sutter Litigation: *Sidibe v. Sutter Health* (first filed in 2012, on appeal); *UBET and State of California v. Sutter Health*¹³⁷ (filed in 2014, settled in 2021)

In 2012, class action plaintiffs sued Sutter, claiming that anticompetitive contracting practices inflated their premiums and co-pays.¹³⁸ The case is now pending on appeal to the Ninth Circuit.¹³⁹

The California Attorney General's lawsuit alleged that Sutter took advantage of its dominance when it used all-or-nothing provisions, anti-steering provisions and anti-tiering provisions, and gag clauses. The settlement¹⁴⁰ requires Sutter to: (1) pay \$575 million, (2) limit what it charges patients for out-of-network services, (3) increase transparency, (4) halt measures that deny patients access to lower-cost plans; (5) stop all-or-nothing deals, (6) cease anticompetitive bundling of services and products, (7) cooperate with a court order monitor, and (8) define integration to include patient quality of care.¹⁴¹

North Carolina Case Settlement Supports Notion that Anti-Steering Provisions Violate the Sherman Act (filed in 2016, settled in 2019)

The DOJ and the State of North Carolina filed a complaint against Carolinas Health System (CHS) (renamed Atrium Health)¹⁴² for including anti-steering provisions in its contracts with every major insurer in the Charlotte area. Since insurers need to include CHS in their networks, these provisions reduced competition, limited lower-cost options for employers purchasing health insurance, and restricted financial incentives for patients using less expensive healthcare services offered by the hospital's competitors. In the settlement reached in 2019, CHS agreed to not use or enforce any anti-steering provisions. CHS made no admission of liability.

Outcome in Pennsylvania's Litigation May Serve as a Deterrent to Others (2019)

In February 2019, Pennsylvania filed a petition to modify a consent decree with UPMC and Highmark, two vertically integrated healthcare systems. The consent decree entered in July 2014 required the Commonwealth to protect the public from UPMC's and Highmark's contract dispute. Pennsylvania alleged that UPMC, a nonprofit healthcare system, failed to fulfill its charitable responsibilities, violating various state laws. The Commonwealth's relief included a prohibition on UPMC from engaging in restrictive contracting practices (MFN, anti-tiering, anti-steering, gag clauses, all-or-nothing and exclusive contracting). UPMC and Highmark agreed to enter into a ten-year contract that ended their longstanding dispute, and Pennsylvania dismissed its litigation without prejudice.

Waves of Litigation in North Carolina Involving HCA Healthcare and Mission Health (filed in 2022 and 2023)

North Carolina filed a similar lawsuit accusing HCA Healthcare (HCA) of anticompetitive behavior similar to Sutter's contracting practices.¹⁴³ HCA is the nation's largest for-profit hospital system in both revenue and number of hospitals, with over 180 hospitals in twenty-one states. The litigation is pending. Two additional litigations are pending: a private class

action pending in North Carolina state court,¹⁴⁴ and a consolidation action of two municipalities and two counties in North Carolina.¹⁴⁵

APPENDIX: Healthcare Transaction Notification Laws in Select States

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
Washington RCW 19.390.030 (2019)	Attorney General	60 days' prior notice	Hospitals, hospital systems, and provider organizations	Merger, acquisition, contracting affiliations	Out-of-state entities: \$10M in revenue from WA patients	No
Rhode Island 23 RI General Laws §§ 23-17.14 (2022)	Attorney General and Department of Health	180 days-Transaction cannot proceed until approved.	Hospitals	Change of ownership or control of a hospital that results in one entity controlling 20% or more of the voting rights or assets of the hospital, or a new partner gaining or acquiring a controlling interest or vote in the hospital	None	Affordability and issues of market share especially as they affect quality, access, and affordability of services
Oregon OR Revised Statutes 415.500 (2021)	Health Authority	180 days pre-closing	Hospitals, health professionals, health insurance carriers and managed care organizations, other entities that provide healthcare or services	Merger, acquisition, corporate affiliations, transactions to form management services organizations, contracts or affiliations that impact access to essential services	One entity ≥\$25 million in revenue in prior 3 fiscal years, other entity ≥\$10 million in revenue in prior 3 fiscal years	Access to affordable healthcare

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
New York Public Health Law article 45-A (2023)	Department of Health	30 days pre-closing	Any healthcare facility, physician practices and groups, health insurance carriers, management services organizations	Merger, acquisition, affiliation, and many forms of change-in-control transactions Covers a single transaction or series of transactions within a 12-month period	Transaction must result in a healthcare entity increasing in-state revenues by \$25 million or more	No
Nevada NV Revised Statutes 598A.370 (2022)	Attorney General, Commissioner of Insurance	30 days pre-closing	Group practice or health carrier	Mergers, consolidations or affiliations; certain acquisitions	None	No
Minnesota MN Statutes, section 145D.01 (2023)	Attorney General and Department of Health	60 days pre-closing (≥\$80 million) 30 days pre-closing (\$10-80 million)	Hospitals, medical foundations, provider group practices, and captive professional entities	Merger, sale, or asset transfers of 40% or more Covers a single transaction, or a series of actions within a 5-year period	≥\$80 million subject to notice and waiting; \$10-80 million subject to notice only	Access to affordable and quality care

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
Massachusetts MA General Laws ch. 6D § 13 (2012)	Attorney General, Center for Health Information and Analysis, Health Policy Commission	60 days pre-closing	Hospitals, providers, health insurance carriers	Merger, acquisition, or affiliation of provider/provider organization and health insurance carrier; Merger or acquisition of a hospital/ hospital system; Acquisition of insolvent provider organizations; and Mergers or acquisitions of provider organizations resulting in the organization having a near-majority of market share in a given service or region	None	Impact to state's healthcare cost growth benchmark
Illinois 740 IL Compiled Statutes 10/7.2a (2023)	Attorney General	30 days pre-closing	Hospitals, outpatient surgery centers and provider organizations with 20 or more healthcare providers	Merger, acquisition, contracting affiliations	None for in-state entities; \$10 million or more in annual in-state patient revenue for transactions involving an out-of-state entity	No

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
Connecticut CT General Statutes § 19a-486i (2014, amended in 2018)	Attorney General and Office of Health Strategy	30 days pre-closing	Hospitals, hospital systems, group practices, captive professional entities, medical foundations or other entities affiliated with a hospital or hospital system	Merger, consolidation, certain acquisitions, change in employment of all/nearly all physicians, or other affiliation of a group practice with: 1) another group practice that results in a practice of 8 or more physicians, or 2) a hospital/hospital system or other entity controlled by a hospital/hospital system	None	Cost effectiveness of healthcare services (for hospital transactions) § 19a-639
California Knox-Keene Act § 1399.65 (2018)	Department of Managed Care	Transaction cannot proceed until approved	Health care service plan	Merger, consolidation, acquisition, change in control by another health care service plan or a health insurer	None	No
California <i>(rule-making underway - chart reflects proposed rules)</i>	Office of Health Care Affordability	90 days pre-closing	Payers, providers (with 25 or more physicians; smaller if the organizations are high-cost outliers), or fully integrated delivery systems	Mergers, acquisitions, corporate affiliations	\$25 million, or transactions that increase annual any healthcare entity not party to the transaction by either \$10 million or more	Impact on costs for payers, purchasers, or consumers

State	Entity Receiving Notice	Timing	Covered Entities	Covered Transactions	Revenue Thresholds	Review Includes Affordability/ Cost Criteria
California Cal. Corp. Code §§5914 and 5920 (1996)	Attorney General	20 days pre-closing	Non-profit hospitals and other non-profit healthcare entity	Transfer of material amount of assets or control to a non-profit or for-profit entity	None	No

Endnotes

¹ King, et al., *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States*, THE SOURCE ON HEALTHCARE PRICE & COMPETITION (June, 2020) (a report from the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley including an analysis of data from the American Hospital Association Annual Survey, SK&A Office Based Physicians Database from IQVIA, and Managed Market Surveyor File from Health Leaders Inter Study (accounting for approximately 800 healthcare transactions throughout the country over the last decade).

² In this report, the term “healthcare providers” includes hospitals, health systems, physicians, and other clinicians who provide healthcare services and care to patients. “Healthcare transactions” includes mergers, acquisitions, or other type of contractual affiliations involving healthcare providers. “Antitrust enforcers” encompasses both state attorneys general enforcing antitrust laws and their federal counterparts, the Department of Justice and the Federal Trade Commission.

³ Some examples include: Southwest Washington Medical Center affiliated with Peace Health (2010); Swedish Health Services become an affiliate of Providence Health & Services (2012); Highline Medical Center and Harrison Medical Center became part of the Franciscan Health System (2013); Pacific Medical Centers and Providence Health & Services affiliated (2015); Providence Health & Services and St. Joseph System affiliated to become Providence St. Joseph Health (2016); The Doctors Clinic and CHI Franciscan Health affiliated (2016); CHI Franciscan and Dignity Health became CommonSpirit Health (2019); CommonSpirit Health acquired Virginia Mason, to be known as Virginia Mason Franciscan Health (2021); MultiCare acquired Yakima Valley Memorial Hospital, which was renamed MultiCare Yakima Memorial Hospital (2023).

⁴ See e.g., Karyn Schwartz et al., *What We Know About Provider Consolidation*, KAISER FAMILY FOUND. (Sept. 2, 2020); see also, DAVID DRANOVE & LAWTON R. BURNS, *BID MED: MEGAPROVIDERS AND THE HIGH COST OF HEALTH CARE IN AMERICA* (2021); Nicholas C. Petris Center at the School of Public Health, University of California, Berkeley, *Consolidation in California’s Health Care Market 2010-2016: Impact on Prices and ACA Premiums* 44 (2018); Cory Capps & David Dranove, *Hospital Consolidation and Negotiated PPO Prices*, 23 HEALTH AFFAIRS 175 (2004).

⁵ Samuel M. Chang, et al., *Examining the Authority of California’s Attorney General in Health Care Merger*, California Healthcare Found., (Apr. 2020).

⁶ Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals* (Washington Ctr. for Equitable Growth, Working Paper, 2018) (finding evidence of negative wage growth among skilled workers following recent hospital mergers).

⁷ For example, after a merger, providers may see more patients per day without an increase in wages. See generally, Carley Thornell, *Physicians report that organizational and technology changes are among the biggest burnout factors*, athenahealth, (July 2, 2021) (reporting on findings from 799 physician respondents between October and December 2020).

⁸ Other state agencies are authorized to engage in merger review through laws governing charitable trusts, nonprofit corporations, health and safety, and certificate of need programs. Certificate of need programs regulate how certain healthcare providers get state approval before building facilities, or offering new or expanded services, such as increasing the number of licensed hospital beds. See e.g., National Conference of State Legislature, *Certificate of Need State Laws*, Jan. 1, 2023.

⁹ See generally, Issue Brief, Katherine L. Gudiksen, Alexandra D. Montague, and Jaime S. King., *Mitigating the Price Impacts of Health Care Provider Consolidation*, Milbank Memorial Fund 9 (Sept. 2021).

¹⁰ See e.g., *id.* at 3 (noting that these clauses allows a health system to “compound the negotiating leverage of one or more must-have providers, allowing the health system to demand supracompetitive rates” (“pricing above what can be sustain in a competitive market”).

¹¹ *Id.* (noting how these clauses may help health systems to “demand placement in the most favorable tier in a tiered network to contract with a health plan, even if some or all of their facilities do not meet the cost or quality metrics for inclusion in that tier. Additionally, health systems using anti-steering clauses may even limit the ability of insurers to give softer steering signals, like listing preferred providers on their websites.”).

¹² *Id.*

¹³ ANDREW C. SELDEN, *MERGERS AND ACQUISITIONS: UNDERSTANDING THE ANTITRUST ISSUES*, 405 (4th ed. 2015).

¹⁴ See generally, Jamie Godwin, et al., *Understanding Mergers Between Hospitals And Health Systems In Different Markets*, KAISER FAMILY FOUND. (Aug. 2, 2023) (listing cross-market mergers and other relevant articles); Jamie S. King & Erin V. Fuse Brown, *The Anti-Competitive Potential of Cross-Market Mergers in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL’Y 43, 45 (2018).

¹⁵ At the federal level, the Consolidated Appropriations Act prohibits insurers and group health plans from entering into agreements that include a gag clause. Insurers and health plans must annually submit an attestation of compliance with the requirement. See U.S. Dep’t of Labor, *Faqs About Affordable Care Act And Consolidated Appropriations Act, 2021 Implementation Part 57, EMP. BENEFITS SEC. ADMIN.* (2023) (discussing prohibition on gag clauses on price and quality information in healthcare provider agreements). Additional state oversight may still be helpful.

¹⁶ Andrew S. Boozary, et al., *The Association Between Hospital Concentration and Insurance Premiums in ACA Marketplaces*, 38 HEALTH AFF. 668, 672 (2019) (finding that areas with the highest levels of hospital market concentration had annual premiums that were, on average, five percent higher than those in the least concentrated areas).

¹⁷ See e.g., Prager & Schmitt, *supra* note 6; Martin Gaynor, et al., *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LIT. 235, 236 (2015); Brent D. Fulton, *Health Care Market Concentration Trends in the U.S.: Evidence and Policy Responses*, 36 HEALTH AFFS. 1530, 1531 (2017).

¹⁸ See generally, Nancy D. Beaulieu, et al., *Changes in Quality of Care After Hospital Mergers and Acquisitions*, 382 NEW ENG. J. MED. 51 (2020); Hannah Neprash & J. Michael McWilliams, *Provider Consolidation and Potential Efficiency Gains: A Review of Theory and Evidence*, 82 ANTITRUST L. J. 551 (2019).

¹⁹ Thomas L. Greaney & Richard M. Scheffler, *The Proposed Vertical Merger Guidelines and Health Care: Little Guidance and Dubious Economics*, HEALTH AFFS. FOREFRONT (Apr. 17, 2020); Leemore Dafny, Kate Ho & Robin S. Lee, *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286, 287 (2019).

²⁰ Gudiksen, et al., *Mitigating the Price Impacts*, *supra* note 9, at 4.

²¹ RICHARD M. SCHEFFLER, ET AL., *MONETIZING MEDICINE: PRIVATE EQUITY AND COMPETITION IN PHYSICIAN PRACTICE MARKET 15-16* (2023), (“SCHEFFLER I”) (evaluating market penetration across ten physician practice specialties within markets across the U.S., the impact on market shares and concentration, and on prices and expenditures).

²² Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, 77 MED. CARE RSCH. AND REV. 538 (2019) (The authors analyzed 29 quality measures reported to the Center for Medicare and Medicaid Services’ Hospital Compare database for 2008 to 2015 to test whether vertical integration between hospitals and physicians or increases in hospital market concentration influence patient outcomes. In their findings, they note that “increased market concentration is strongly associated with reduced quality across all 10 patient satisfaction measures”).

²³ RCW § 19.390.030.

²⁴ Colorado, Connecticut, Hawaii, Massachusetts, Rhode Island and Washington require pre-merger notification from all hospitals to the attorney general. Notice of transaction involving physicians group is required in Connecticut, Massachusetts, Nevada, Oregon, California and Washington.

²⁵ Senate Bill 5688 (2022); Senate Bill 5241 (2023-24) (pending bill in committee). In January 2023, Washington estimated that 14.5 staff would be needed to carry out the program.

²⁶ Minnesota Statutes, section 145D.01 (2023).

²⁷ When these impacts are likely triggered in the initial review process, the HPC may conduct a cost and market impact review (CMIR). When HPC conducts a CMIR, the agency needs to identify if healthcare providers have a dominant

market share, and charge prices and incur expenses that are materially higher. The comparison is made to the median prices charged by, and the median total medical expenses for all other providers, for the same services in the same market. See HEALTH POLICY COMMISSION, TECHNICAL BULLETIN FOR 958 CMR 7.00: NOTICES OF MATERIAL CHANGE AND COST AND MARKET IMPACT REVIEWS. (Setting forth the methodology for the calculation of Materially Higher Price). For some examples of CMIR see e.g., Massachusetts Health Policy Comm’n, *Massachusetts Health Policy Commission Review of The Proposed Merger of Lahey Health System; CareGroup and its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; and Each of their Corporate Subsidiaries into Beth Israel Lahey Health; AND The Acquisition of the Beth Israel Deaconess Care Organization by Beth Israel Lahey Health; AND The Contracting Affiliation Between Beth Israel Lahey Health and Mount Auburn Cambridge Independent Practice Association*, Sept. 27, 2018.

²⁸ Oregon has statutory requirements governing its reviews, see Oregon Revised Statutes 415.500. OHA also published an analytic framework, outlining the methods, performance measures, and sources of information it uses to review transactions. OREGON HEALTH AUTHORITY, HEALTH CARE MARKET OVERSIGHT ANALYTIC FRAMEWORK, Oct. 2022.

²⁹ See Nonprofit Health Facility Transaction Notices, Public Meeting On The Proposed Change In Control And Governance Of Good Samaritan Hospital, available at <https://oag.ca.gov/charities/nonprofitosp#sam-decision>.

³⁰ N.Y. Pub. Health Law §§ 4550 et seq.

³¹ MASSACHUSETTS HEALTH POLICY COMM’N REVIEW, *supra* note 27, at 1. A cost and market impact review prospectively assesses the impact of a proposed transaction. According to HPC, Massachusetts was the first state to conduct a policy-oriented, prospective review of the impact of healthcare changes, distinct from an administrative determination of need or law enforcement review of antitrust or consumer protection concerns.

³² As of November 27, 2023, HPC had not yet determined whether it will conduct a CMIR for six transactions. The agency received notice of these transactions from September 21, 2023 to November 3, 2023. The notice of material changes list is available at: <https://www.mass.gov/info-details/transaction-list-material-change-notices>; Final CMIR reports are available at: <https://www.mass.gov/lists/transaction-list-cost-and-market-impact-reviews#final-cmir-reports>.

³³ As of October 31, 2023, OHA approved four transactions, approved four transactions with conditions, and determined that one transaction was exempt from review. Two comprehensive reviews were in process. Of note, the information is available in several languages.

³⁴ Employee Retirement Income Security Act of 1974 29 U.S.C. § 1144(a) (2012). The Employee Retirement Income Security Act of 1974 (“ERISA”) restricts state health policy initiatives. Specifically, Section 514 of ERISA preempts state laws that “relate to any employee benefit plan.” *Id.* As a result, many states attempted to carefully craft legislation to avoid ERISA preemption. *Id.* States have less ability to regulate or oversee the practices of and coverage provided by self-insured employer plans. *Gobeille v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936 (2016) (holding that ERISA preempts Vermont’s healthcare reporting scheme because it “interferes with the uniformity of, plan administration.” (internal citations omitted)). See also RCW 48.43.005(31), which defines “health plan” and excludes several categories of health plans, such as plans governed by ERISA.

³⁵ See generally, Gudiksen, et al., *Mitigating the Price Impacts of Health Care Provider Consolidation*, *supra* note 9, at 4.

³⁶ At least twenty states, including Washington, ban most-favored-nations clauses. WASH. ADMIN. C.§ 246-25-045 (prohibiting MFN clauses in contracts between a healthcare provider or facility and a certified health plan). For example, in Washington, the Insurance Commissioner enforces this prohibition when reviewing the provider contracts and provider compensation agreements that health carriers that are required to file for his review. See RCW 48.43.730(2). “Health carriers” are defined in RCW 48.43.005(30). As another example, New York requires the Insurance Commissioner to review any contract between an insurer and a healthcare provider that includes a MFN provision for potential anticompetitive harm.

³⁷ Second Substitute Senate Bill 5393 (2023); Engrossed Second Substitute House Bill 1160 (2021).

³⁸ MASS. GEN. LAWS 1760, § 9A.

³⁹ NEV. REV. STAT. ANN. 598A.440.

⁴⁰ Connecticut Substitute House Bill No. 6669 § 19.

⁴¹ 8 Texas Insurance Code §§ 1458.001 and 1458.101 (2023).

⁴² AB-1091 (2023).

⁴³ LD 1708 (2023).

⁴⁴ Bill S1124 (2022-23).

⁴⁵ S6973 2023-2024. The bill is pending in committees (<https://www.nysenate.gov/legislation/bills/2023/S6973>). There is also a companion bill-A3148 2023-2024 (<https://www.nysenate.gov/legislation/bills/2023/A3148>).

⁴⁶ For the definition of health carrier, the statute references the same definition used in section 38a-591 of the Connecticut general statute. CONN. GEN. STAT. ANN. § 38a-591a, (25) (2023) (“Health carrier” means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health care center, a managed care organization, a hospital service corporation, a medical service corporation or any other entity providing a plan of health insurance, health benefits or health care services.”).

⁴⁷ See 8 Texas Insurance Code §§ 1458.001 and 1458.101 (2023). (“Provider network contract” means a contract between a contracting entity and a provider for the delivery of, and payment for, health care services to a covered individual.” The definition of providers includes: an advanced practice nurse; a physician; a physician assistant; a professional association composed solely of physicians; a single legal entity authorized to practice medicine owned by two or more physicians; a nonprofit health corporation certified by the Texas Medical Board; a partnership composed solely of physicians; and a physician-hospital organization that acts exclusively as an administrator for a provider to facilitate the provider’s participation in health care contracts.)

⁴⁸ NEV. REV. STAT. ANN. § 598A.440. (“Provider of health care” means: (1) A physician or other health care practitioner who is licensed or otherwise authorized in this State to furnish any health care service; or (2) An institution providing health care services or other setting in which health care services are provided, including, without limitation, a hospital, surgical center for ambulatory patients, facility for skilled nursing, residential facility for groups, laboratory and any other such licensed facility.”).

⁴⁹ The statute defines “Carrier” as “an insurer licensed or otherwise authorized to transact accident or health insurance . . . ; a nonprofit hospital service corporation . . . ; a nonprofit medical service corporation . . . ; a health maintenance organization . . . ; and an organization entering into a preferred provider arrangement.”

⁵⁰ See KATHERINE L. GUDIJKSEN, ET AL., *PREVENTING ANTICOMPETITIVE CONTRACTING PRACTICES IN HEALTHCARE MARKETS, THE SOURCE ON HEALTHCARE PRICE & COMPETITION 4*, Sept. 2020.

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

⁵⁴ See Letter from Rob Bonta, Cal. Att’y Gen., Brian L. Schwalb, D.C. Att’y Gen., and Matthew J. Platkin, N.J. Att’y Gen., to Lina Khan, F.T.C. Chair (Apr. 19, 2023) at 5-6 (“*AG Comments on Non-compete Ban*”) (discussing additional concerns with non-competes in healthcare).

⁵⁵ Mackenzie Bean, *How noncompete clauses can sever patient-provider relationships*, BECKERHOSPITALREVIEW.COM, Mar. 18, 2019.

⁵⁶ See generally, Emily McGrath and Tara Oakman, *Noncompete Agreements for the Health Care Workforce Put Profits over Patients*, THE CENTURY FOUNDATION, Jan. 19, 2023, <https://tcf.org/content/commentary/noncompete-agreements-for-the-health-care-workforce-put-profits-over-patients/>.

⁵⁷ Letter from Elizabeth Warren & Christopher Murphy, United States Senators, to Joseph Simons, Chairman, Federal Trade Commission (July 22, 2020).

⁵⁸ Federal Trade Commission (February 19, 2023). Proposed Rule: Non-Compete Clause Rule, available at <https://www.federalregister.gov/documents/2023/01/19/2023-00414/non-compete-clause-rule>.

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- ⁵⁹ The FTC relied on its powers under Sections 5 and 6(g) of the FTC Act (15 U.S.C. §§ 45, 46(g)), which prohibits “[u]nfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce” Criticism from many stakeholders abound regarding the proposed rule and its application. See e.g., Letter from Melinda Reid Hatton, Gen. Counsel and Secretary, Am. Hosp. Assoc., to Lina M. Khan, Chair, F.T.C., (Feb. 22, 2023).
- ⁶⁰ RCW § 49-62 (2019). While Washington’s statutory ban on certain non-compete agreements outlines situations in which non-competes are not enforceable, it preserves the common law reasonableness test, enabling workers to argue that their non-compete bans are unenforceable for other reasons.
- ⁶¹ Non-Compete Agreements (wa.gov).
- ⁶² Like Washington, Colorado, Illinois, and the District of Columbia banned non-competes for lower wage earners.
- ⁶³ ME. REV. STAT. tit. 26, § 599-A; MD. CODE ANN., Lab. & Empl. § 3-716; N.H. REV. STAT. ANN. § 275:70-a; R.I. GEN. LAWS § 28-59-3; VA. CODE § 40.1-28.7:8; WASH. REV. CODE ANN. § 49.62.020; Or. REV. STAT. ANN. § 653.295.
- ⁶⁴ S.B. 3035, 2023 Leg., 93rd Sess. (Minn. 2023); OKLA. STAT. tit. 15, § 217; N.D. Cent. Code § 9-08-06.
- ⁶⁵ California state law affords numerous protections to workers and competition through its antitrust law known as the Cartwright Act (CAL. BUS. & PROF. CODE §§ 16700-16770), the Unfair Practices Act (CAL. BUS. & PROF. CODE §§ 17000 et seq.), the Unfair Competition Law (CAL. BUS. & PROF. CODE §§ 17200 et seq.), Labor Code (Cal. Labor Code § 432.5) and non-compete restrictions (CAL. BUS. & PROF. CODE §§ 16600-16602), among others. SB 699 was signed on September 1, 2023, and AB1076 was signed on October 13, 2023.
- ⁶⁶ S.B. 699, 2023-2024 Reg. Sess., Gen. Ass. (Ca. 2023). A.B. 1076, 2023-2024 Reg. Sess., Gen. Ass. (Ca. 2023). Violations of California’s CAL. BUS. & PROF. CODE § 16600 are redressable under California’s Unfair Competition Law ((CAL. BUS. & PROF. CODE § 17200, et seq.)).
- ⁶⁷ R.I. GEN. LAWS ANN. § 5-37-33(2016); 6 Del. C. § 2707(1983); MA ST 149 § 24L (2021); N.H. RSA § 329:31-a (2016)(physicians); N.H. RSA § 326-B:45-a (2018) (nurses).
- ⁶⁸ West Virginia Physicians Freedom of Practice Act W. VA. CODE ANN. § 47-11E-2 (a)-(b) (2023).
- ⁶⁹ CONN. GEN. STAT. § 20-14p. (2023); TENN. CODE ANN. § 63-1-148 (2023).
- ⁷⁰ COLO. REV. STAT. § 8-2-113. For decades, Colorado has permitted liquidated damages but disallowed injunctive relief as a remedy for violations of physician non-compete provisions. See *Wojtowicz v. Greeley Anesthesia Servs., P.C.*, 961 P.2d 520, 522 (Colo. App. 1997).
- ⁷¹ FLA. STAT. ANN. § 542.336 (2023).
- ⁷² S.B. 7, 123rd Gen. Ass., Reg. Sess. (In. 2023).
- ⁷³ *Id.*
- ⁷⁴ TEX. BUS. & COM. CODE ANN. § 15.50 (2023).
- ⁷⁵ N.M. STAT. ANN. § 24-11-2 (2021).
- ⁷⁶ S.D. Codified Laws § 53-9-11.1(2021) (amended 2023).
- ⁷⁷ AL. ST. § 8-1-190 (a) (2016). Under Alabama statutory law, “professionals” are exempt from non-compete agreements, which serve to restrict competing activity within a defined geographic area and time period. The law does not define the term “professional.” Alabama courts have found that professionals include physicians and physical therapists. Other healthcare professionals who practice independently, have direct patient contact, and are separately licensed might also be found to fall under the professional exemption.
- ⁷⁸ H.B. 1950, 192nd Gen. Ct. (Ma. 2021).
- ⁷⁹ S.B. 6748, 2023-2024, Reg. Sess. (N.Y. 2023).
- ⁸⁰ Sherman Antitrust Act, 15 U.S.C. §§ 1-7. Enacted in 1890, the Sherman Act is used to challenge various anticompetitive practices, such as mergers, wage suppression, agreements among competing businesses to fix prices, and anticompetitive contracting clauses.

⁸¹ Clayton Antitrust Act, 15 U.S.C. §§ 12-27. Enacted in 1914, the Clayton Act reaches further by explicitly prohibiting anticompetitive mergers and other types of anticompetitive practices, not clearly addressed by the Sherman Act.

⁸² Another antitrust statute is Robinson-Patman Act of 1936 also known as Anti-Price Discrimination Act, Pub. L. No. 74-692, 49 Stat. 1526 (codified at 15 U.S.C. § 13). Seldom enforced, the Act addresses price discrimination by prohibiting sellers from treating their competing customers differently regarding prices, terms of sale, or marketing support.

⁸³ Federal Trade Commission Act, 15 U.S.C. §§ 41-58. The FTC Act created the FTC in 1914, and the Act grants to the FTC its regulatory authority.

⁸⁴ H.R. REP. No. 1418 (2020); Competitive Health Insurance Reform Act of 2020, 15 U.S.C. § 1011 (2020).

⁸⁵ Hart-Scott-Rodino Antitrust Improvements Act, Pub. L. No. 94-435, 90 Stat. 1383 (1976) (codified in 15 U.S.C § 18a (1976)).

⁸⁶ Premerger Notification Office Staff, *HSR threshold adjustments and reportability for 2023*, FTC.GOV (Feb. 1, 2023).

⁸⁷ DRAFT MERGER GUIDELINES, (U.S. DEP'T OF JUST. & F.T.C. 2023).

⁸⁸ See generally, Public Comments of Attorneys General of 15 States and Territories on Labor Market Issues in Response to the July 29, 2023 Request for Comments on the Draft Merger Guidelines; Public Comments of Attorneys General of 19 States and Territories in Response to the July 29, 2023 Request for Comments on the Draft Merger Guidelines, (September 18, 2023), (19 states signed onto the general comments, and 15 states signed onto the labor-specific comments) (“AG Comments”); Labor and Equity Comments from Attorneys General in Response to Request for Information on Merger Enforcement (Apr. 21, 2022).

⁸⁹ *Parens patriae* refers to the Attorney General’s authority to bring proceedings on behalf of the public. Pennsylvania used its *parens patriae* authority in *Commonwealth of Pennsylvania v. Geisinger Health System Foundation, Levinston Health Care Foundation*, (no.1:13 CV-02647-YK, Nov.1).

⁹⁰ See e.g., *State v. LG Elecs., Inc.*, 375 P.3d 636, 641 (Wash. 2016) (the Washington Supreme Court declined to follow federal law where the language and structure of the Washington’s Consumer Protection Act (CPA) departs from otherwise analogous federal provisions); see also *In re Cipro Cases I & II*, 61 Cal. 4th at 160-61 (“[T]he Cartwright Act is broader in range and deeper in reach than the Sherman Act.”).

⁹¹ F.T.C., OVERVIEW OF THE MERGER RETROSPECTIVE PROGRAM IN THE BUREAU OF ECONOMICS n.5.

⁹² See e.g., *St. Alphonsus Med. Ctr. Nampa, Inc. v. St. Luke’s Health Sys., Ltd.*, 778 F.3d 775, 784 n.10 (9th Cir. 2015) (stating that the “two-stage model” of healthcare is the “accepted model”); *FTC v. Penn State Hershey Med. Ctr.*, 838 F.3d 327, 342 (3d Cir. 2016) (stating that when using the hypothetical monopolist test the court must also look “through the lens of the insurers”); *FTC v. Advoc. Health Care Network*, 841 F.3d 460, 471 (7th Cir. 2016).

⁹³ See e.g., Cory Capps, David Dranove, and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, 59 J. OF HEALTH ECON. 139 (2018); Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending* 33 HEALTH AFFS.756 (2014).

⁹⁴ See *United States v. AT&T, Inc.*, 916 F.3d 1029, 1032 (D.C. Cir. 2019) (“unlike horizontal mergers, the government cannot use a short cut to establish a presumption of anticompetitive effect through statistics about the change in market concentration, because vertical mergers produce no immediate change in the relevant market share.”).

⁹⁵ Steven C. Salop, *Invigorating Vertical Merger Enforcement*, 7 YALE L. J. 1742 (2018).

⁹⁶ The FTC ordered six insurance companies to provide information and health claim data for fifteen states: Colorado, Florida, Georgia, Indiana, Illinois, Kentucky, Maine, Missouri, Montana, Nevada, New Hampshire, New Mexico, Ohio, Oklahoma, and Texas.

⁹⁷ Michael G. Vita, *Physician Group and Healthcare Facility Merger Study*, F.T.C. (2021).

⁹⁸ See generally, Greaney & Scheffler, Proposed Vertical Merger Guidelines, *supra* note 19. See also *In the Matter of Renown Health*, 111 F.T.C. 0101, No. C-4366 (2012). (The FTC challenged the acquisition of two cardiology physician groups by the largest health system in Reno, Nevada, on horizontal grounds because the combined entity

employed 88 percent of the active cardiologists in the area. The case resolved with a consent decree prohibited the merged entity from enforcing anticompetitive contractual provisions with cardiologists.).

⁹⁹ The antitrust enforcers claimed that the merger would combine two competitors in a market for the sale of first-pass claims editing solutions, resulting in UnitedHealth having more than a 90 percent share of the market. The enforcers also claimed that vertical harms would arise from UnitedHealth gaining control over Change’s EDI clearinghouse and using that control to disadvantage rival insurers. As such, the merger would give UnitedHealth the ability and incentive to use rivals’ claims data for its own benefit, which in turn would lessen competition in the markets for national accounts and large group commercial health insurance. Additionally, it would give UnitedHealth the ability and incentive to withhold innovations and raise rivals’ costs to compete in those same markets for national accounts and large group plans.

¹⁰⁰ Clayton Antitrust Act, 15 U.S.C. § 18 (2019).

¹⁰¹ *Washington v. Franciscan Health System*, No. C17-5690 BHS, 2018 WL 1256866 (W.D. Wash. Mar. 12, 2018).

¹⁰² *Id.*

¹⁰³ The consent decree, also includes other contract changes and notice requirements.

¹⁰⁴ See, e.g., Deborah Haas-Wilson, *Competitive Effects Analysis of Proposed Centene-Magellan Transaction*, Oct. 21, 2021, available at <https://www.dmhc.ca.gov/Portals/0/Docs/DO/CenteneMagellan/RedactedFinalHaas-WilsonReport-AccessibleUpdated.pdf?ver=2021-10-15-125037-443> (expert report).

¹⁰⁵ DMHC Approves Centene’s Acquisition of Magellan with Conditions to Protect Consumer, DMHC.CA.GOV, (Dec. 30, 2021).

¹⁰⁶ Brent D. Fulton, Daniel R. Arnold, Jaime S. King, Alexandra D. Montague, Thomas L. Greaney & Richard M. Scheffler, *The Rise of Cross-Market Hospital Systems and Their Market Power in the US*, 41 HEALTH AFFS. 1652-55 (2022) (sharing concerns with the increase in cross-market hospital systems, which warrants further scrutiny because of the anticompetitive impact of these system exert when negotiating with common customers). Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, supra note 19; See also Lawton Robert Burns and Mark V. Pauly, *Big Med’s Spread*, 101 MILBANK QUARTERLY 287 (2023) (discussing how different studies measure different types of cross-market activity but the results are fairly consistent).

¹⁰⁷ *Id.* See also Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, supra note 19; Burns, et al., and Mark V. Pauly, *Big Med’s Spread*, supra note 106.

¹⁰⁸ See e.g., Gregory S. Vistnes & Yianis Sarafidis, *Cross-Market Hospital Mergers: A Holistic Approach*, 79 ANTITRUST L. J. 253 (2013) (Engaging in a literature review on cross-market mergers, the authors recognize the need for further discussion about cross-market hospital mergers. The authors discuss, among others, a 2002 DOJ business review letter regarding a proposal by the Michigan Hospital Group (MHG) under which seven geographically dispersed hospitals in Michigan sought to engage in joint contract negotiations. In response, DOJ explicitly recognized the possibility that hospitals could increase their overall bargaining leverage by increasing the number of networks with which they could threatened a health plan, noting — “[A]lthough the [health] plans recognized that MHG’s hospital members serve distinctly different local geographic areas and thus are not substitutes to provide hospital services for those areas, a small number of plan representatives expressed the concern that the MHG hospitals might be able to increase their bargaining leverage with health plans by refusing to contract except through MHG.” The authors point out that DOJ’s conclusion that MHG’s proposal was unlikely to significantly reduce competition, was based in large part on the DOJ’s understanding that there would be efficiencies associated with the proposed joint contracting and that the hospitals would not be negotiating on an exclusive basis. *Id.* at 257-259); See, also, Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, supra note 19 (discussing previous studies addressing the impact of cross-market healthcare mergers).

¹⁰⁹ See, e.g., Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, supra note 10 (noting findings in prior research that combinations of nearby similar rivals leads to higher prices); Matt Schmitt, *Multimarket Contact in the Hospital Industry*, 10 AM. ECON. J.: ECON. POL’Y 361, 385 (2018); Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, 48 RAND J. ECON. 579, 580 (2017).

¹¹⁰ Fulton, et al., supra note 106 at 1659.

¹¹¹ See William J. Kolasky, Deputy Assistant Att’y Gen., Antitrust Div., U.S. Dep’t of Just., Address Before the George Mason University Symposium, *Conglomerate Mergers and Range Effects: It’s a Long Way from Chicago to Brussels* (Nov. 9, 2001) (distinguishing horizontal and vertical mergers from conglomerate mergers (which encompass cross-market deals), the Deputy Assistant remarked that the merging entity in “conglomerate mergers,” do not have the ability and incentive to raise prices and restrict output, but can generate significant efficiencies).

¹¹² Steve Dubb, “Record Merger Creates Nation’s Largest Nonprofit Catholic Healthcare Company,” NPQ, (Feb. 6, 2019).

¹¹³ See Dafny, Ho, and Lee, *Price Effects of Cross-Market Mergers*, *supra* note 19 n.3.

¹¹⁴ The guidelines include the language “tend to create a monopoly” suggesting more antitrust scrutiny if a proposed transaction appears to put an emerging party on the path towards becoming a monopoly, even if not directly competing.

¹¹⁵ Press Release, U.S. Dep’t of J., Office of Public Affairs, Justice Department Withdraws Outdated Enforcement Policy Statements, (Feb. 3, 2023).

¹¹⁶ Press Release, F.T.C., Federal Trade Commission Withdraws Health Care Enforcement Policy Statements (July 14, 2023).

¹¹⁷ Press Release, U.S. Dep’t of J., *supra* note 115.

¹¹⁸ Alexandra D. Montague, et al., *Considerations for state-imposed conditions on healthcare provider transactions*, 11 *Frontiers in Pub. Health* n. 45 (2023).

¹¹⁹ Holly Vedova, *Making the Second Request Process Both More Streamlined and More Rigorous During this Unprecedented Merger Wave*, FTC.GOV, (Sept. 28, 2021).

¹²⁰ See e.g., Press Release, California Office of the Att’y General, Attorney General Bonta Conditionally Approves of Sale of Adventist Health Vallejo (October 5, 2021) (listing as quality impact conditions— the appointment of an evaluation team to conduct a comprehensive survey of the quality of care at San Jose Behavioral to ensure past concerns have been resolved; and as access impact conditions— Adventist Vallejo must continue to serve patients under 18 years old for 10 years); Press Release, California Office of the Att’y General, Attorney General Bonta Conditionally Approves Affiliation Agreement Between Methodist Hospital and USC Health System (June 3, 2022); See also Amy Y. Gu, California AG considers Cross-Market Effects in Merger Review and Conditional Approval of USC Health System and Methodist Hospital Affiliation (July 14, 2022) (The author discusses the competitive impact analysis of the transaction, and summarizes some of the conditions imposed on transaction— 1) Prohibition of anticompetitive contracting practices (for 10 years with potential 3-year extension); 2) Price cap: Annual price increases for contract renewals not to exceed 4.8% per year (for 5 years with potential 3-year extension); 3) Monitor and Reporting. It further notes that other imposed conditions address access and quality.).

¹²¹ Press Release, California Office of the Att’y General, Attorney General Becerra Conditionally Approves Affiliation Agreement Between Cedars-Sinai and Huntington Memorial Hospital (Dec. 10, 2020).

¹²² *Id.*

¹²³ Jaime S. King, et al., *Antitrust’s Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power*, 74 *HASTINGS L. J.* 1057, 1068 (2022) (describing the anticompetitive contractual practices conditions in the Sinai case and other transactions, including the imposed conditions); see also, Fulton, et al., *supra* note 106 at 1059.

¹²⁴ See Nonprofit Health Facility Transaction Notices, Good Samaritan Hospital, *supra* note 29.

¹²⁵ The Office of Minnesota Att’y General Keith Ellison, Sanford Health and Fairview Health Services, (The parties announced their merger in 2022, with the intent of closing the deal in 2023. In January 2023, as part of reviewing the proposed transaction, the Attorney General hosted a series of community meetings to directly gather feedback. The community meetings were open to the press and the public and livestreamed on Attorney General Ellison’s Facebook Page. The parties set different proposed closing dates, which were further postponed with no specific dates, but they agreed to give the Attorney General a 90-day advanced notice.).

¹²⁶ Clayton Act, 15 U.S.C. § 18 (1914) prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly.

¹²⁷ H. R. REP. No. 1191, pt. 1, at 8 (1949); see also H. R. REP. No. 1775, part 2, at 4-5 (1950), (“that “[w]here several large enterprises are extending their power by successive small acquisitions, the cumulative effect of their purchases

may be to convert an industry from one of intense competition among many enterprises to one in which three or four large concerns produce the entire supply.”); FED. TRADE COMM’N, *THE MERGER MOVEMENT: A SUMMARY REPORT* (1948), at 6-7, 19 (“In appraising the over-all effect of mergers on economic concentration, it must be constantly borne in mind that they tend to become cumulative over a period of time. In other words, each year’s mergers are superimposed upon a structure of economic concentration which has been built up over many past years.”).

¹²⁸ See e.g., Laura M. Alexander, et al., *Private Equity’s Entry into Healthcare Reveals Gaps in Competition Policy*, CPI ANTITRUST CHRONICLE (2022); RICHARD M. SCHEFFLER, ET AL., *SOARING PE INVESTMENT IN THE HEALTHCARE SECTOR: CONSOLIDATION ACCELERATED, COMPETITION UNDERMINED, AND PATIENTS AT RISK*, THE AMERICAN ANTITRUST INSTITUTE & THE PETRIS CENTER AT THE SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA, BERKELEY (May 18, 2021) (“Scheffler II”); Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm*, THE N. Y. TIMES, July 10, 2023; ERIN FUSE BROWN, ET AL., *PRIVATE EQUITY INVESTMENT AS A DIVINING ROD FOR MARKET FAILURE: POLICY RESPONSES TO HARMFUL PHYSICIAN PRACTICE ACQUISITIONS* (2021); Ashvin Ghandi, YoungJun Song & Prabhava Upadrashta, *Private Equity, Consumers, and Competition: Evidence from the Nursing Home Industry* (Mar. 16, 2023) (unpublished manuscript), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3626558; Atul Gupta, et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* (Nat’l Bureau of Econ., Working Paper No. 28474, 2021), <https://www.nber.org/papers/w28474>; Diana Moss, *What Does Expanding Horizontal Control Mean for Antitrust Enforcement? A Look at Mergers, Partial Ownership, and Joint Ventures*, American Antitrust Institute (Nov. 4, 2020), https://www.antitrustinstitute.org/wp-content/uploads/2020/11/Moss_Horizontal-Control_11.4.20.pdf.

¹²⁹ SCHEFFLER I, *supra* note 21, at 4 (discussing concentration of physician services in local markets following private equity acquisitions below HSR Act reporting thresholds).

¹³⁰ See SCHEFFLER II, *supra* note 128, at 31-32; Alexander, *supra* note 128, at 5-6 (providing examples of private equity firms obtaining market power in healthcare specialties in local and regional markets).

¹³¹ See *AG Comments*, *supra* note 88, at 20 (citing to various sources).

¹³² *AG Comments*, *supra* note 88, at 19.

¹³³ See e.g., RICHARD M. SCHEFFLER, ET AL., *MONETIZING MEDICINE*, *supra* note 21 (setting policy steps that would strengthen antitrust competition enforcement and healthcare policy in physician practice markets). See also FUSE BROWN, ET AL., *PRIVATE EQUITY INVESTMENT* *supra* note 128, at 2, 16 (noting specifically that “policy responses could focus on antitrust enforcement, merger review, and prohibitions on anticompetitive physician contracting practices”).

¹³⁴ *Id.*

¹³⁵ 15 U.S.C. § 1. Section 1 of the Sherman Antitrust Act prohibits contracts, combinations, and conspiracies “in restraint of trade,” which in healthcare often occur in contracts between providers and insurers. 15 U.S.C. § 2. Section 2 of the Sherman Antitrust Act prohibits monopolization, attempted monopolization, or conspiracy to monopolize.

¹³⁶ *United States v. Blue Cross Blue Shield of Michigan*, 665 F. Supp. 2d, 809 (E.D. Mich. 2011).

¹³⁷ *UEBT v. Sutter Health* was a class-action lawsuit filed in 2014 in state court in San Francisco. *The People of California v. Sutter Health* was a lawsuit filed by then-Attorney General Xavier Becerra in 2018 in state court in San Francisco, and the case was promptly consolidated with the *UEBT* case. Sutter settled the consolidated state case in 2019 just before opening statements.

¹³⁸ *Sidibe v. Sutter Health* was a class-action lawsuit filed in 2012 in federal court in San Francisco, which is part of the Northern District of California. Before trying the case in early 2022, the district court dismissed it twice and had both dismissals reversed on appeal. In 2022, Sutter took the federal case to trial and won a unanimous jury verdict.

¹³⁹ Health insurance plan purchasers’ appealed multiple lower court rulings and a March 2022 verdict in Sutter’s favor. Specifically, the jury had rejected antitrust claims by a certified class of roughly 3 million premium insurance payers alleging that Sutter illegally forced insurers to agree to anticompetitive contract terms blocking plans that steered patients to lower-cost hospitals, or required them to contract for services at Sutter’s more expensive hospitals in order to get access to the medical care members needed.

¹⁴⁰ Final J., *UFCW & Employers Ben. Trust v. Sutter Health*, No. CGC-14-538451, 2021 WL 5027181 7, 18 (Cal. Super. Aug. 27, 2021).

¹⁴¹ Press Release, California Office of the Att’y General, Attorney General Bonta Announces Final Approval of \$575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices (Aug. 27, 2021).

¹⁴² *United States v. Charlotte-Mecklenburg Hosp. Auth.*, No. 316CV00311RJCDC, 2019 WL 2767005 (W.D.N.C. Apr. 24, 2019).

¹⁴³ Press Release, Att’y Gen. Josh Stein, Attorney General Josh Stein Demands Answers from HCA Over Cancer Services (Sept. 29, 2023).

¹⁴⁴ *Davis v. HCA Healthcare, Inc.*, No. 21 CVS 3276, 2023 WL 3120813 (N.C. Super. Apr. 27, 2023).

¹⁴⁵ *In re Mission Health Antitrust Litigation*, 2022 WL 20437003.