Private Equity Investment in Health Care and Ineffective Antitrust Regulations

Sofia Gracias[*]

The corporatization of health care in the United States has forced us to confront society's moral expectations of the industry, which serves uniquely vulnerable consumers. Health care has become increasingly more lucrative, attracting private equity ("PE") investment, specifically in private physicians' practices. Physicians find PE transactions appealing because physicians have difficulty competing with large hospital systems and complying with expansive regulatory requirements. The attention given by PE to health care has raised concerns regarding the tension between the expected priorities of PE firms and health care. Additionally, the nature of PE investments through roll-ups of smaller companies has regulators worried that they cannot control PE's involvement in the industry. The Federal Trade Commission ("FTC") is one regulatory agency that has explicitly addressed PE investments through revisions to its Merger Guidelines to ensure PE does not slip through its grasp.

As PE roll-ups are a type of health care consolidation, this Comment will compare the FTC's past efforts to regulate hospital mergers with its potential future efforts to regulate PE investment in health care under the 2023 Merger Guidelines. The Comment also states how the 2023 Merger Guidelines still fall short of effectively regulating PE investment in health care and how healthcare-specific guidelines could improve their effectiveness. It additionally argues that it may be best to let PE investment continue until the market self-corrects. The Comment provides supplementary methods to undermine the attractiveness of PE investment for physicians, which would decrease the frequency of these transactions and speed up the economic self-correcting process. The various paths forward further support the Comments overarching argument that, as it currently stands, the FTC's antitrust laws are not effective in regulating PE investment in health care.

[*] J.D. Candidate 2025, University of Chicago Law School; MPH 2021, Emory University, Rollins School of Public Health.

I. INTRODUCTION

As the United States (US) economy grew alongside industrialization in the 20th century each industry underwent an evolution. Health care emerged an economic giant. Hospitals became central social structures for medical learning and research and patient treatment.[1] Society reaped the benefits of a strong medical field which legitimatized it as an industry and funding and growth followed close behind; a natural byproduct of our capitalist structured society.[2] Historically, healthcare spending has been a large share of the US' Gross Domestic Product (GDP).[3] In 2022, healthcare spending grew by $4.5 trillion, accounting for 17.3% of the United States' GDP.[4] This trend of massive spending in the healthcare industry has created incentives for the corporatization of medicine, where privately owned institutions can access federal

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1 J. WARREN SALMON & STEPHEN L. THOMPSON, THE CORPORATIZATION OF AMERICAN HEALTH CARE 12–13 (Springer, 2021).

2 *Id.* at 14.

3 *Id.* at 29.

4 Historical Nat'l Health Expenditure Data, CENTERS FOR MEDICARE & MEDICAID SERVICES (Dec. 13, 2023), https://perma.cc/NHN2-3VNR.

funding through Medicare and Medicaid, thus decreasing their own spending and increasing their revenue.[5] The lucrative nature of the industry attracts those who want to make a profit.[6] Modern healthcare facilities are run like a business and, to stay operational, companies need to make money.[7] Research shows that increased healthcare costs decrease revenue, and burden the federal government, and do not necessarily lead to improved patient outcomes.[8] The growing recognition that large healthcare spending does not improve patient outcomes and the historic pattern of healthcare overspending has compelled both the healthcare industry and federal government to prioritize lowering costs.[9]

Mergers and acquisitions of healthcare entities have been a popular method of achieving greater efficiency to increase revenue, lower costs, and improve patient care.[10] This is reflected in the dramatic increase of hospital consolidations over the past three decades.[11] In 1990, 65% of Metropolitan Statistical Areas (MSAs) had highly concentrated hospital markets (those with HHIs greater than 2,500), and in 2006 that percentage increased to 77%.[12] These transactions operate under the assumption that large scale is needed for lower costs.

The federal government's Centers for Medicare & Medicaid Services (CMS) further incentivized this goal of improved patient care at a lower cost through the Affordable Care Act (ACA), enacted in 2010.[13] The ACA aimed to reward hospitals for improving patient outcomes and reducing costs.[14] This motivated hospital mergers because hospitals needed to share the expenses of the deliverables, among them dramatically improved quality of care,

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5 SALMON & THOMPSON, *supra* note 1, at 8–13.

6 *Id.*

7 *Id.* at 4.

8 *Id.*

9 Peter S. Hussey, Samuel Wertheimer & Ateev Mehrotra, *The Association Between Health Care Quality and Cost: A Systematic Review*, 158 ANN. INTERN. MED. 1, 6 (Jan. 1, 2013).

10 SALMON & THOMPSON, *supra* note 1, at 6.

11 Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, 36 HEALTH AFFAIRS 1530, 1530 (Sept. 2017).

12 *Id.*

13 Michelle Vu et al., *Hospital and Health Plan Partnerships: The Affordable Care Act's Impact on Promoting Health and Wellness*, 9 AM. HEALTH & DRUG BENEFITS 269, 269 (July 2016).

14 Sally Pipes, *Obamacare Drives Hospital Consolidation, Raising Prices for Patients*, FORBES (Sept. 16, 2019), https://perma.cc/S56K-Z42N ("Obamacare encouraged consolidation by incentivizing providers to coordinate care and adjusting Medicare payments to make mergers a smarter financial option.").

required by the ACA that accompanied.[15] It also incentivized hospital acquisitions of physicians' practices to increase overall revenue by shifting patient care to an outpatient setting thus increasing the hospitals' "outpatient revenues and secur[ing] referrals for hospital-based services."[16] Consolidation kept the revenue from patients' different hospital visits within the single hospital system. Between 2015 and 2016, over 5,000 physician practices were acquired by hospitals, illustrating the desirability of this tactic.[17] PE firms' investment in health care became one of the many ways the industry has corporatized in the last few decades.[18] Healthcare is a desirable industry for PE investment, given its potential for high revenue, which leads to significant returns on investment for the firms.[19] PE's growing interest in healthcare has been a concern for regulators who struggle to keep up with PE's impact on healthcare outcomes, overall spending, and industry competition.[20]

This Comment attempts to answer whether federal antitrust regulations under the 2023 Merger Guidelines effectively regulate PE investment in health care and whether PE's interest in health care should be controlled rather than terminated. Part II of this Comment provides background on how PE has influenced and been influenced by health care consolidation. Part III addresses attempts to regulate the health care industry through antitrust laws through the Merger Guidelines, old and revised, and potential outcomes for the suits the FTC will file against PE firms and physicians' practices. Part IV presents possible solutions to future PE-healthcare intersections through antitrust laws, the free-market effect, and other potential legal tools. Part V concludes that the 2023 Merger Guidelines improve the FTC's authority against PE investment in health care but still leave gaps that could be filled by healthcare-specific guidelines or through other regulatory avenues.

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15 Vu et al., *supra* note 13, at 270.

16 *The Impact of Hospital Consolidation on Medical Costs*, NCCI, July 18, 2018, https://perma.cc/PH66-GNJX.

17 *Id.*

18 Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, INST. FOR NEW ECON. THINKING WORKING PAPER SERIES NO. 118, 1, 4 (March 15, 2020).

19 Grace D. Mack & Michael F. Schaff, *A Guide to Private Equity Investment in Health Care*, N.J. LAW 44, 46 (August 2021).

20 Reed Abelson & Margot Sanger-Katz, *Who Employs Your Doctor? Increasingly, a Private Equity Firm*, N.Y. TIMES (July 10, 2023), https://perma.cc/4W3P-B3KH.

II. PRIVATE EQUITY AND HEALTH CARE CONSOLIDATION

A. The Influx of Private Equity Investment in Health Care

The corporatization of health care, along with an opportunity for large returns on investments, has motivated PE involvement in the $4 trillion healthcare economy.[21] PE investment in health care began with investments in nursing homes and hospital networks.[22] In the 1990s and 2000s, PE firms would purchase segments of the entities and roll them up into large for-profit chains.[23] PE firms have become important players in financing healthcare practices. In 28% of MSAs, a single PE firm employs more than 30% of the market of full-time physicians, or the equivalent, and in 13% of MSAs, a single PE firm has a 50% market share.[24] During the past five years, PE firms have moved toward investing in outpatient physician practices, such as primary care, dermatology, dentistry, and ophthalmology.[25] They use the roll-up method initially employed for nursing homes and hospital networks to expand horizontally by purchasing small physicians' practices of the same specialty and growing their power within the health care industry.[26] PE deals within the health care industry peaked in 2020 at 18% of total PE transactions, the largest portion of which, at 364, were with outpatient physicians' practices.[27] The physicians' practices that have remained independent after the consolidation enthusiasm, incentivized by the ACA, leave ample opportunity for further private equity investment.[28]

B. Impact of Private Equity Investment in Health Care

The major concerns surrounding PE investment in health care are the potential differences in the assumptions about the

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21 Historical Nat'l Health Expenditure Data, *supra* note 4.

22 Appelbaum & Batt, *supra* note 18, at 4.

23 *Id.*

24 Richard M. Scheffler et al., *Monetizing Medicine: Private Equity and Competition in Physician Markets*, AM. ANTITRUST INST. 1, 4 (July 10, 2023).

25 Appelbaum & Batt, *supra* note 18, at 4.; *see, e.g.*, Eloise May O'Donnell et al., *The Growth of PE Investment in Health Care: Perspectives from Ophthalmology*, 39 HEALTH AFFAIRS 1026 (June 2020).

26 *Id.*

27 Richard M. Scheffler, Laura M. Alexander & James R. Godwin, *Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*, AM. ANTITRUST INST. 1, 10 (June 4, 2021).

28 Abelson & Sanger-Katz, *supra* note 20.

business models of PE firms and healthcare practices.[29] The PE model solely focuses on profit and has a reputation for engaging in risky behavior. PE funds are pools of capital organized as partnerships and managed by PE managers who act as general partners.[30] They typically provide 2% of the fund capital.[31] Limited partners, normally pension funds or other institutional investors, provide 20-30% of the capital. The remaining percentage of the fund is in the form of bank-provided debt capital and secured assets of the companies in which the funds are invested. This feeds into the high-risk reputation of PE firms because the general partner or manager does not invest a lot of their own capital, so they do not have a lot to lose personally if the company fails.[32] PE's typical strategy for acquiring physicians' practices is through transactions between a physician-owned medical group and a PE-owned Management Services Organization (MSO) that provides space, equipment, non-clinical staffing, supplies, and management services.[33] The MSO potentially expands through the purchase of other physicians' practices and after three to seven years, the PE firm sells the expanded business to another investor with a minimum of a 20% expected annual return.[34] PE's high-risk reputation also stems from this expiration date accompanying their purchases and the desire to yield a high sales price for their portfolio companies.[35] This results in their prioritization of short-term profits and market consolidation.[36] For example, the PE general partner might take on more debt to keep the practice afloat, which creates a greater risk of practice failure and could result in a loss of providers in the market.[37]

While the PE and healthcare models could both prioritize revenue, healthcare practices differ significantly from other businesses. They serve less informed consumers who place a certain level of trust in the experts in the field, physicians, and that comes with additional scrutiny. Consumers, or patients, trust

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29 Scheffler, Alexander & Godwin, *supra* note 27, at 6.

30 *Id.*

31 *Id.*

32 *Id.* at 7.

33 Mack & Schaff, *supra* note 19, at 46 (stating that many states have CPOM laws "prohibit[ing] a business entity, such as a private equity investor, from practicing or employing a physician").

34 Jane M. Zhu, *Private Equity Investment in Physician Practices*, UNIV. OF PA. LEONARD DAVIS INST. OF HEALTH ECON., Feb. 15, 2020, https://perma.cc/KRT3-R7VR.

35 Scheffler, Alexander & Godwin, *supra* note 27, at 6–7.

36 *Id.* at 6.

37 *Id.* at 32.

physicians to prioritize their health and not maximize profits.[38] Health care is also different in that it operates under the assumption that insurance companies pay for services and consumers are not solely responsible for payments.[39] When used to determine the impact of price changes on consumers, healthcare consumers are assumed to have less price sensitivity to increased prices, especially if health services are needed in an emergency, and will use those services no matter the price. Although it should be noted that, as of 2023, 8.4% of all Americans are uninsured, they do not have health insurance, which means that are extremely price sensitive as they are paying out-of-pocket for services.[40] Additionally, in 2016, 28% of non-elderly adults were underinsured.[41] The underinsured population is people who have put off needed health care in the past year due to cost.[42] The large non-insurance dependent population in the US suggests that the assumption that healthcare consumers are not price sensitive is weak and that when the price of healthcare services rises, consumers are negatively impacted along with insurance companies.

PE firms also might apply their risky business strategy to physicians' practices by trying to pressure their physicians into increasing patient costs, such as unnecessary utilization of expensive healthcare technology. A studied method employed by PE firms in the past to increase their revenue is "surprise billing."[43] Surprise billing occurs when a patient unknowingly or involuntarily receives care from an out-of-network provider, which means they are billed out-of-pocket instead of being covered by insurance.[44] The use of surprise billing resulted in the passage of the No Surprises Act in 2020, which largely took effect in 2022, alongside numerous state laws to bolster healthcare consumer

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38 *Id.* at 6.

39 *Id.*

40 U.S. Uninsured Rate Dropped 18% During Pandemic, NAT'L CENTER FOR HEALTH STATISTICS (May 16, 2023), https://perma.cc/X3CY-WA6H.

41 Benjamin D. Sommers, *Health Insurance Coverage: What Comes After the ACA?*, 39 HEALTH AFFAIRS 502, 504 (March 2020) (stating other definitions of underinsured often used by researchers: people "spending more than 10 percent of income in the past year on health care costs (including premiums), or more than 5 percent for lower-income families; facing a deductible of more than 5 percent of household income").

42 *Id.*

43 Erin C. Fuse Brown & Mark A. Hall, *Private Equity and the Corporatization of Health Care*, 76 STAN. L. REV. 527, 540 (2024).

44 *Id.*

protection laws.[45] It also reinforced the impression that regulators could not trust PE firms as owners of physicians' practices.

PE firms' timeline for sale may also be detrimental to the healthcare market. PE firms consolidate their holdings in an area to make larger companies in the hope of generating more market power and more considerable financial gains from the sale of the business.[46] The quick turnover undermines the stability of the healthcare market, where independent practices usually compete to provide quality service at a fair price.[47] PE ownership of different practices would eliminate this competition aspect, meaning patients would likely suffer from poor care and high costs.

Researchers have sporadically studied the assumption that PE ownership of physicians' practices increases costs and leads to poor-quality patient care. One study, by Alexander Borsa and team, conducted a systemic review of existing studies and literature to synthesize the impact of PE firms purchasing healthcare practices.[48] The study reviewed 55 studies in the final sample and covered various healthcare facilities, such as hospitals, ambulatory surgical centers, dermatology practices, and nursing homes. It evaluated the studies' reporting of how PE ownership impacts at least one of the selected "health outcomes, costs to patients or payers, costs to operators, or quality" of care.[49] They found that there were no definitive conclusions regarding health outcomes. Some hospitals saw a decrease in the spread of viruses, such as COVID-19, while nursing homes had an increase in cases.[50] Eight studies showed increased costs to patients, while two showed a neutral impact on cost, and costs to operators were more neutral as well.[51]

The Borsa study showed that studies most frequently measured the impact of private equity ownership on quality of care.[52] Including changes in the quality of care repeatedly indicates the importance of maintaining high-quality care within the healthcare industry despite ownership changes. It is alarming

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45 *Id.* at 541.

46 Scheffler, Alexander & Godwin, *supra* note 27, at 7.

47 *Id.* at 2.

48 Alexander Borsa, Geronimo Bejarano, Moriah Ellen & Joseph Dov Bruch, *Evaluating Trends in Private Equity Ownership and Impacts on Health Outcomes, Costs, and Quality: Systematic Review*, BMJ, 1, 2 (June 11, 2023).

49 *Id.* at 5.

50 *Id.* at 7–10.

51 *Id.* at 10.

52 *Id.* at 11.

that 21 of the studies "identified at least some form of harmful impact, whereas 12 identified some form of beneficial impact."[53] Taken with the rest of the studies, that means that when private equity invests in health care, quality will likely decline while cost increases. There needs to be more data to determine if PE investment in health care leans more toward being a benefit or a burden on practitioners and patients. For now, the data shows that PE firms' purchase of physicians' practices has benefits and drawbacks. It can be concluded that PE investment in health care has a more negative impact on the system as it currently operates.

C. Why Do Physicians Continue to Engage with Private Equity Firms?

There are many concerns surrounding private equity investment in health care, specifically over increased expenditures and decreased quality of care for patients.[54] These concerns beg the question: why do physicians continue engaging with private equity firms if they know such transactions are potentially bad for patient care? The increasing expenses and regulatory matters that physicians have to manage continue to drive them toward transactions with PE firms. Recent years have shown a shift in health care where reimbursements from Medicare and other platforms are decreasing, creating an environment where physicians are providing the same services for less revenue.[55] The ACA and other legislation encouraged physicians "to institute value-based reimbursement programs, bundled payment initiatives, risk-based reimbursement, population health, and direct-to-employer programs."[56] The overhauled health care system created uncertainty and increased costs for the physicians implementing these programs. They made hospital mergers and vertical acquisitions more attractive for hospital systems, leaving independent physician practices particularly vulnerable to the new landscape. Private practices also face new competition from these larger health systems and non-traditional competitors, such as Optum or CVS clinics.[57] While physicians prioritize patient care, they also need

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[53] *Id.*

[54] Scheffler, Alexander & Godwin, *supra* note 27, at 6.

[55] Dana Jacoby & Gary Herschman, *Why so Many Physicians Are Partnering with Private Equity*, MEDICAL ECONOMICS (June 20, 2023), https://perma.cc/EP4J-2AM8.

[56] *Id.*

[57] *Id.*

to make a profit and administer regulatory and management requirements to keep a practice open.

PE transactions are attractive because the firms typically purchase 60 to 80% ownership of a practice to ensure the physicians still have decision-making power.[58] As a result, physicians do not feel like they are giving up their entire practice. They are also incentivized to maintain an interest in the practice's growth and success, which allows them to benefit from any potential sales, normally taking place about three to seven years after purchase.[59] PE firms provide private practices with the cash flow to implement many of the health programs proven to improve patient care and help them compete with the large health systems and other corporate entrants in the healthcare market. Physicians are more attracted to PE firms as buyers because of their managerial experience and the impression that this buyer will give them more independence and freedom than a hospital.[60] A study on private ophthalmology practices transacting with PE firms found that most physicians reported that clinical decision-making remained in the hands of the physicians after purchase.[61] With day-to-day patient care being a priority for most physicians, this would be one of the main measurements they would use to determine the value of private equity transactions. Costs to patients and quality of patient care remain inconsistently impacted by PE ownership, meaning it is reasonable that physicians would continue to transact with private equity firms while those factors are not definitively negatively impacted.[62]

III. ATTEMPTS TO REGULATE HEALTH CARE USING ANTITRUST LAWS

Consolidation within the healthcare market falls under the authority of antitrust laws because it generates fewer competitors in the industry and increases the risk of anti-competitive practices.[63] Between 1990 and 2017, around 1600 hospital mergers took place, many resulting in price increases of at least 20%.[64]

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58 O'Donnell et al., *supra* note 25, 1026–27.

59 *Id.* at 1026.

60 *Id.* at 1030.

61 *Id.*

62 Borsa et al., *supra* note 48, at 10–12.

63 Fulton, *supra* note 11.

64 Joseph T. Kannarkat & Farzad Mostashari, *Promoting Competition in the Health Care Marketplace*, JAMA HEALTH FORUM 1, 1 (April 9, 2021).

Antitrust laws, specifically the Sherman Antitrust Act, give authority to antitrust agencies to protect the market against anti-competitive practices that could lead to consumers, in the health care market patients, receiving lower quality care at a higher price.[65] The Clayton Act, specifically § 7, amended the Sherman Act, giving the agencies the authority to intervene in cases of mergers and acquisitions that run the risk of substantially lessening competition.[66] The Act was further amended in 1976 under the Hart-Scott-Rodino Act (HSR), requiring merging entities to report their plans to regulating agencies when the transaction exceeds $111.4 million, giving regulators time to investigate the transaction and intervene if it violates antitrust laws.[67]

The FTC & DOJ share federal antitrust authority. Within the healthcare market, the FTC focuses on the provider market, while the DOJ focuses on the insurance market.[68] The FTC was created and given its authority by the FTC Act, giving it regulatory authority over anti-competitive practices and the types of violations covered by the Sherman Act and Clayton Act.[69]

The FTC addresses the following mergers when the health care industry and antitrust concerns intersect. Horizontal mergers have been the main way the FTC has addressed health care consolidation. These mergers occur between entities that are in direct competition, specifically hospitals or providers in the same practice area, or when a health system acquires a hospital.[70] Vertical mergers occur between two entities in a buyer-seller relationship.[71] In the health care industry, vertical mergers are between hospitals and physician's practices.[72] Cross-market mergers, which occur between entities in different markets, have been largely underregulated due to difficulty reconciling their anti-competitive impact in a geographic market.[73] The FTC has been investigating the growing impact of mergers, specifically

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65 15 U.S.C. §§ 1–38.

66 Scott Hulver & Zachary Levinson, *Understanding the Role of the FTC, DOJ, and States in Challenging Anticompetitive Practices of Hospitals and Other Health Care Providers*, KFF (Aug. 7, 2023), https://perma.cc/2UA9-HFN5.

67 *Id.*

68 *The FTC's Health Care Work*, FTC, https://perma.cc/F9QR-QJUP (last visited Nov. 10, 2023); Hulver & Levinson, *supra* note 66.

69 Hulver & Levinson, *supra* note 66.

70 *Id.*

71 *Competitive Effects*, FTC: MERGERS, https://perma.cc/V3ZJ-2UZ5 (last visited Jan. 20, 2024).

72 Hulver & Levinson, *supra* note 66.

73 *Id.*

vertical and cross-market, and addresses their findings in the recently amended 2023 Merger Guidelines.[74] On the supply side, mergers could be anti-competitive when they create monopsonies in the relevant labor market, in this case healthcare professionals, and leave only one source of employment.[75]

A. Effectiveness of Antitrust Laws' Ability to Regulate Hospital Mergers

Since the late 2000s, after difficulty challenging hospital mergers in the 1990s, the FTC has successfully challenged multiple mergers.[76] An FTC's success consists of preventing an anti-competitive merger from taking place or easing the anti-competitive effects of a consummated merger. Their recognizable success started when they challenged a merger that had already taken place.[77] Although it is generally more difficult for the FTC to successfully challenge companies that have consummated a merger than to bring a pre-merger challenge. The remedy available to companies resulting from consummated mergers is divestiture, which involves a company selling some of its assets and is a harder case to win.[78] When the FTC challenges a pre-merger, it seeks an injunction, which is a significantly easier case to win.

Nevertheless, the consummated merger between Evanston Hospital and Highland Park Hospital in Chicago gave the FTC access to vital evidence of the anti-competitive effects of the hospitals' actions and reshaped how they challenged hospital pre-merger cases moving forward.[79] The FTC was able to redefine the geographic boundaries in which to assess the anti-competitive effects of a merger. The trial revealed that the methods used to define geographic boundaries for hospital mergers at the time resulted in geographic markets that were too large, and economists developed new models to define markets more narrowly.[80] The FTC was also able to introduce new economic models to assess

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74 *Id.*

75 ERIC POSNER, HOW ANTITRUST FAILED WORKERS, 14–18 (Oxford Univ. Press, 2021).

76 Hulver & Levinson, *supra* note 66.

77 *Id.*

78 David Ginensky, *Investigating Consummated Mergers: The Antitrust Agencies' Shift Toward a Retroactive Enforcement Policy*, 32 REV. BANKING & FIN. L. 88, 88–89 (2012).

79 Cory Capps, Laura Kmitch, Zenon Zabinski & Slava Zayats, *The Continuing Saga of Hospital Merger Enforcement*, 82 ANTITRUST L.J. 441, 446–47 (2019).

80 Hulver & Levinson, *supra* note 66.

hospital mergers, which are still used today, to determine price increases that occur from the mergers overtime.[81] The case also dispelled the long-held assumption that nonprofit hospitals behave in significantly different ways from for-profit hospitals.[82] Nonprofit hospitals' need for profit further supports the notion that businesses need to generate revenue to continue operating even with a differentiating moral standard. Building on this acquired information, the FTC successfully brought four hospital merger cases before appellate courts between 2014 and 2017.[83] The achievement demonstrates the continued influence of economic research on the FTC's success against mergers and their regained confidence in challenging hospital mergers.[84]

Additionally, in 2022, the FTC challenged three hospital mergers, and, in each case, the parties stopped their merger plans before the FTC could bring the case before a court.[85] The altered merger plans indicate that an FTC challenge to a merger may create a chilling effect on the companies seeking to merge. Merging companies either change their plans or settle with the FTC, where they are allowed to continue their transaction with specified reporting or other regulations put in place to avoid anti-competitive market effects.[86] While these cases are marked as FTC successes, an analysis documented that 53 hospital mergers were also announced in 2022.[87] The difference between the number of hospital merger cases brought by the FTC, three, and the number of mergers announced, 53, could represent a hole in the antitrust laws, or perhaps those mergers were not deemed anti-competitive. It does show that the FTC is not entirely successful at halting health care consolidation.

The following cases show the current strengths and weaknesses of the FTC's authority to contest health care consolidation. One 2022 FTC success story was its filing against Hackensack Meridian Health, which had filed its intent to merge with

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81 *Id.*

82 *Id.*; *see also* Cory S. Capps, Dennis W. Carlton & Guy David, *Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?*, 58 ECON. INQUIRY 1183, 1192 (July 2020).

83 Capps et. al., *supra* note 79, at 447–48. *See* ProMedica Health Sys., Inc., v. FTC, 749 F.3d 559 (6th Cir. 2014); FTC v. Penn State Hershey Med. Ctr., 838 F.3d 327, 343 (3d Cir. 2016; FTC v. Advocate Health Care, 841 F.3d 460 (7th Cir. 2016); Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775 (9th Cir. 2015).

84 Capps et. al., *supra* note 79, at 492.

85 Hulver & Levinson, *supra* note 66.

86 *Id.*

87 *Id.*

Englewood Healthcare Foundation in 2019.[88] The District Court and Third Circuit both held in favor of the FTC, finding that the merger would lead to anti-competitive effects, such as raising costs for patients, and that the merger justifications for increased efficiencies "with respect to upgrades and increased capacity limits, expansion of complex tertiary and quaternary care, cost-savings and quality improvements were insufficient to rebut presumption of anti-competitive effects due to merger."[89] When the Third Circuit was defining geographic area it followed the 2010 Merger Guidelines principle that courts must consider the commercial realities of a market and should not be boxed in by feasibility of price discrimination against consumers.[90] To complete the geographic market definition, the court applied the Hypothetical Monopolist Test, finding that insurer preferences and patient preferences would force them to deal with a healthcare monopolist.[91] After these trials, Hackensack terminated their merger plans. They did not reach a settlement with the FTC for conditions under which to continue the merger. Also, in 2022, RWJBarnabas Health had plans to acquire St. Peter's University Hospital of New Brunswick. The FTC filed to block the merger, and RWJ gave up its plans.[92] RWJ's changed plans reiterate that part of the FTC's power comes from threatening litigation against a proposed merger. The threat was likely more substantial so soon after the Hackensack success.

The FTC has had successes due to strong economic arguments and/or the cumbersome duties accompanying antitrust court cases, making continuing merger plans unattractive to hospitals. However, there are still marked ways in which the FTC has recently failed to succeed in the health care sector, such as through cross-market transactions. The FTC's lack of action against the merger between two Michigan systems, Beaumont

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88 FTC v. Hackensack Meridian Health, Inc., 30 F.4th 160 (3d Cir. 2022).

89 *Id.* at 162.

90 *Id.* at 169 (The Hospitals argued that a showing of price discrimination was required for the geographic market definition. Specifically, that patients living with the proposed market would pay more for inpatient general acute care services that patients outside the market).

91 *Id.* at 167; *see* U.S. Dep't of Justice & Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 4.1.1, at 8–9 (2010) (The Hypothetical Monopolist Test asks whether "a hypothetical monopolist who owns all the firms in the proposed market could profitably impose a small but significant non-transitory increase in price ('SSNIP') on buyers in that market.").

92 Allan Sloan & Carson Kessler, *How Effective Is the Government's Campaign Against Hospital Mergers?*, PROPUBLICA (Oct. 28, 2022), https://perma.cc/MC5L-W5FE.

Health and Spectrum Health, illustrates this weakness.[93] In February 2022, these health care systems "combined to create the largest health system and private employer in the state, with 22 hospitals and more than 300 outpatient locations."[94] The FTC dropped its challenge against the merger after it lost its case against the proposed merger between Thomas Jefferson University and the Albert Einstein Healthcare Network, and the Third Circuit denied the appeal.[95] In that case, the District Court found that the geographic market had a significant number of competitors and the merger would not substantially harm competition.[96] The defined geographic market plays a substantial role in antitrust analysis, making challenging cross-market deals difficult. The FTC also likely did not challenge the Michigan merger because the two systems did not compete in the same geographic area even though it did result in the consolidation of patient data.[97] The revised antitrust merger guidelines discussed below address the FTC's incapacity to bring cross-market cases.

B. 2023 Federal Merger Guidelines

The federal government has declared a renewed dedication to market regulation, given the rising consolidation in many of the major economic industries in the United States. President Biden released an executive order in 2021 to address economic consolidation and to reaffirm the current administration's public goals to promote competition and protect consumers from anti-competitive behavior.[98] One way the FTC and DOJ responded to this renewed dedication was to amend the Merger Guidelines, which provide insight into how the agencies will enforce the competition protection laws. [99] The Merger Guidelines are not binding law. They show how the agencies are likely to interpret antitrust laws to promote agency transparency for companies considering a

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93 Rebecca Pifer, *In Latest Merger Bid, Beaumont Seeks Union with Spectrum Health to Create $13B System*, HEALTHCARE DIVE (June 18, 2021), https://perma.cc/JML3-HJDS.

94 Sloan & Kessler, *supra* note 92.

95 Pifer, *supra* note 93.

96 FTC v. Thomas Jefferson Univ., 505 F. Supp. 3d 522, 545 (E.D. Pa. 2020).

97 Rebecca Pifer, *New Antitrust Merger Guidelines Could Have Significant Chilling Effect on Healthcare Deals*, HEALTHCARE DIVE (July 21, 2023), https://perma.cc/LCM5-SNTC.

98 Exec. Order No. 14036, 86 Fed. Reg. 36987 (July 9, 2021), https://perma.cc/F9FM-RCR7.

99 Pifer, *supra* note 97.

merger transaction.[100] Courts also use them as guidance to determine if proposed transactions are legal or cause anti-competitive effects and to bolster their reasoning for choosing one way or the other.[101] The Horizontal Merger Guidelines have not been amended in over a decade, although there has been an influx in mergers and acquisitions within health care over the last 15 years. The FTC and DOJ most recently amended the Vertical Merger Guidelines in 2020 but withdrew them shortly after in anticipation of revising all the Merger Guidelines.[102]

Congress has also taken legislative action to address health care consolidation. The Promoting Access to Treatments and Increasing Extremely Needed Transparency (PATIENT) Act was introduced in 2023 and requires antitrust reporting of certain health-related ownership information.[103] If passed, this could require reporting of acquisition smaller than those current required by the HSR Act, such as PE purchases of private physician practices. While this Comment does not analyze this Act in depth, it is important to note the other forces at work that influence PE involvement in the health care industry.

C. Application of the Merger Guidelines Revisions to Health Care

The FTC and DOJ released the 2023 Merger Guidelines on December 18, 2023.[104] The agencies engaged in an almost two-year revision process to ensure the updated guidelines would reflect modern market realities.[105]

The American Hospital Association (AHA) is notably against the merger guideline revisions and, it seems, regulation of consolidation generally. AHA general counsel says that "hospital mergers benefit patients and their communities in multiple ways" and the guidelines did not need to be so heavily revised.[106] The AHA submitted comments to the FTC and DOJ regarding the

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[100] Amy Y. Gu, Katherine L. Gudiksen & Jaime S. King, *How Will Draft Merger Guidelines Impact Health Care Markets?*, HEALTH AFFAIRS FOREFRONT: EDITOR'S NOTE (Dec. 13, 2023), https://perma.cc/LHR5-ZMQG.

[101] *See, e.g.*, FTC v. Penn State Hershey Med. Ctr., 838 F.3d at 350.

[102] Gu, Gudiksen & King, *supra* note 100.

[103] H.R. 3561, 118th Cong. (2023).

[104] *Federal Trade Commission and Justice Department Release 2023 Merger Guidelines*, FTC (Dec. 18, 2023), https://perma.cc/53CS-4D6X.

[105] *FTC and DOJ Seek Comment on Draft Merger Guidelines*, FTC (July 19, 2023), https://perma.cc/AM5F-RKEB.

[106] Pifer, *supra* note 97.

Draft Merger Guidelines, highlighting the agencies' inherent bias against mergers as a method of industry growth and their avoidance of modern economic principles.[107] The association states that the Merger Guidelines do not provide any guidance to hospitals and health systems.[108] This disagreement between the agencies and a major healthcare organization reveals a potential disconnect between antitrust regulations and the health care industry. The FTC's lack of success in stopping health care consolidation is also a reflection of this tension.[109]

The new Merger Guidelines increase guidance for vertical mergers, allowing the FTC to engage with hospitals and insurance companies purchasing private practices. Vertical mergers in health care have allowed the purchasers to keep more revenue in-house and switch to value-based payment systems.[110] The revised Guidelines could enable the FTC to succeed in challenges against acquisitions like the UnitedHealth Group's acquisition of Change Healthcare, in which the DC District Court found that the government did not sufficiently prove the merger would harm competition.[111] The new Merger Guidelines would advise the courts in new ways to analyze the evidence. They would also strengthen the FTC's authority over vertical transactions such as CVS' acquisition of Oak Street Health, which caters to seniors, at $10.6 billion.[112] This acquisition gives CVS full access to Oak Street Health patients' prescriptions and care, creating a barrier to entry for other organizations providing such services.

The Guidelines also strengthen the FTC's ability to challenge cross-market transactions, such as the one that took place last year in Michigan.[113] The FTC traditionally challenges a merger when two competitors in the same market merge, specifically in the same geographic market. A lack of cross-market guidance has

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[107] AHA Letter to the Attorney General and FTC on Draft Merger Guidelines, AHA (Sept. 13, 2023), https://perma.cc/N385-LJD2.

[108] *Id.*

[109] Hoag Levins, *Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality*, PENN LDI VIRTUAL SEMINAR (Jan. 19, 2023), https://perma.cc/FZ33-NXDZ.

[110] Pifer, *supra* note 97.

[111] *United States v. UnitedHealth Grp. Inc.*, 630 F. Supp. 3d 118 (D.D.C. 2022), *dismissed*, No. 22-5301, 2023 WL 2717667 (D.C. Cir. Mar. 27, 2023) (The Court found that the Government did not provide strong enough reasoning for why the merger would be horizontally or vertically anti-competitive and found that a divestiture of certain assets would maintain the post-merger level of competition).

[112] Pifer, *supra* note 97.

[113] *Id.*

made it difficult for the FTC to challenge mergers that may increase market power for the firms but are between entities in separate markets.[114] Guideline 11 outlines the FTC's authority to challenge mergers that augment an industry's trend toward concentration and will substantially lessen competition or tend to create a monopoly in that industry.[115] The FTC will be able to look at all the industry risks associated with a merger instead of being limited to a smaller market.

The Guidelines also target small transactions by allowing the FTC to examine the series of transactions when a firm engages in a pattern or strategy of anti-competitive acquisitions. This guideline will apply to PE roll-ups of physicians' practices, and the Comment will discuss it in detail later. This focus on combining smaller transactions and requiring reporting of previous transactions is a way to get around the HSR threshold for transactions. Concerning the HSR reporting threshold, the FTC has also recently proposed revisions to the pre-merger notification period and its requirements on the HSR form to require more detailed reports of merger plans and their impact on the market.[116] They would be particularly burdensome for PE firms because they will be required to provide detailed reports about all of their holdings, regardless of whether there are antitrust concerns about the proposed transaction.[117] The AHA is openly against these proposed requirements, stating they are unnecessary to determine whether horizontal or vertical mergers in health care violate antitrust laws.[118] The AHA is most notably against the provisions that require reporting of all prior acquisitions within ten years, regardless of size, where there is industry overlap and with a description of horizontal overlaps and potential vertical acquisition problems.[119] It also takes issue with the labor market information requirement and drafts of specific materials.[120] The AHA believes

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[114] *Federal Trade Commission and Justice Department Release 2023 Merger Guidelines*, *supra* note 104.

[115] *Merger Guidelines*, U.S. DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION (2023) [hereinafter 2023 Merger Guidelines].

[116] *FTC and DOJ Propose Changes to HSR Form for More Effective, Efficient Merger Review*, FTC (June 27, 2023), https://perma.cc/9LJ3-RXZG.

[117] Corey W. Roush et. al., *Antitrust Agencies' Proposed Changes to the HSR Form Will Dramatically Increase the Burden on Filers*, AKIN (July 11, 2023), https://perma.cc/BBH2-W5MT.

[118] Melinda Reid Hatton, *AHA Urges FTC to Withdraw Proposed Changes to Premerger Notification Rules*, AM. HOSP. ASS'N (Sept. 5, 2023), https://perma.cc/H3A3-C6Y6.

[119] *Id.*

[120] *Id.*

the agencies already have expertise in dealing with hospital mergers, and the cost of compliance would materially increase for hospitals.[121] While these proposed revisions to the HSR form are not guideline-specific, they will work with the Guidelines to impact healthcare mergers and acquisitions.

The Guidelines also reflect the agencies' desire to focus on how hospital mergers could create a monopsony rather than a monopoly that impacts consumers or patients. The Merger Guidelines achieve this through Guideline 10, which encompasses how a merger may substantially lessen competition for workers in a market.[122] To assess a merger's impact on the labor market, the Guidelines direct an examination of "the merging firms' power to cut or freeze wages, slow wage growth, exercise increased leverage in negotiations with workers, or generally degrade benefits and working conditions without prompting workers to quit."[123] Health care has been studied as a strong source of monopolistic labor markets because many hospitals operate in geographic areas with few competitors, and there are limitations to occupational mobility for healthcare professionals.[124] Health care consolidation shrinks the potential employers for healthcare workers. It could leave them with only one potential employer wage setting in an area.[125]

D. How Will the Revised Merger Guidelines Address the Gaps In the Antitrust Regulation of PE Purchase of Physician Practices?

The Merger Guidelines were revised to address growing consolidation within the major economic industries.[126] A primary concern was over PE's underregulated contribution to such consolidation in those industries, particularly health care.[127] The Guidelines guide the evaluation of the significant types of mergers: horizontal and vertical. They also provide a variety of ways to assess mergers that might not fit directly into one of the major categories but could still create anti-competitive effects. This

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121 *Id.*

122 2023 Merger Guidelines, *supra* note 115.

123 *Id.*

124 David Wasser, *Literature Review: Monopsony, Employer Consolidation, and Health Care Labor Markets*, CENTER FOR ECON. & POL'Y RSCH. (Jan. 28, 2022), https://perma.cc/563L-2EAC.

125 *Id.*

126 Exec. Order No. 14036, 86 Fed. Reg. 36987.

127 Abelson & Sanger-Katz, *supra* note 20.

section will analyze how the 2023 Merger Guidelines impact PE investment in private physicians' practices.

Applying the horizontal merger guidelines to PE firms acquiring physicians' practices is inappropriate. They apply to consolidation between providers of the same or similar services who are in direct competition with one another, such as when a health system acquires a hospital or two hospitals merge.[128] A PE firm's purchase of physicians' practices is a firm from one industry dealing with a firm in a different industry. The strengthened guidelines for vertical mergers are also unlikely to apply to PE involvement in health care because those transactions involve entities on the same supply chain which could withhold necessary supplies from a competitor along the chain, such as a health system acquiring a physician's practice that provides the same services as a group already owned by the system.[129] PE firms' investments in physicians' practices are not vertical mergers because the entities are in separate industries, and the merger does not result in anti-competitive constraints that foreclose a competitor's access to supplies.

The 2023 Merger Guidelines impact PE firms' purchase of physicians' practices in the later guidelines. The traditional guidelines were not successful in regulating the changing dynamics of the economy.[130] The revised Guidelines have additional guidance for how to apply the guidelines to nonstandard transactions.[131] While PE investment in health care and other industries is not a new concept, the Biden Administration's renewed dedication to reducing economic consolidation has prompted regulators to fill the gaps where, in the past, PE has been able to avoid antitrust scrutiny.[132]

One way PE firms have been able to do this in health care is through the utilization of PE roll-ups, where they engage in multiple small acquisitions of physicians' practices that go undetected by the HSR Act due to their small size.[133] The HSR Act sets forth reporting requirements for pre-mergers and acquisitions depending on the market share of the merger to give regulators time to

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128 Hulver & Levinson, *supra* note 66.

129 Gu, Gudiksen & King, *supra* note 100.

130 Heather Boushey & Helen Knudsen, *The Importance of Competition for the American Economy*, THE WHITE HOUSE: BLOG (July 9, 2021), https://perma.cc/38NT-6WVN.

131 Gu, Gudiksen & King, *supra* note 100.

132 Leah Nylen & Todd Shields, *Private Equity Regulation Becomes Biden Administration Focus*, BLOOMBERG LAW: NEWS FROM BLOOMBERG TERMINAL (Nov. 22, 2022).

133 Brown & Hall, *supra* note 43, at 549–552.

assess the merger for anti-competitive effects. PE roll-ups transform a PE firm's purchase of one practice into a form of horizontal merger, merging the practices under the firm's umbrella. It creates a potentially anti-competitive merger that does not fit neatly within the traditional horizontal and vertical merger categories. The new guidelines attempt to fill this size gap by requiring reporting of PE acquisitions where firms acquire and merge multiple smaller entities into one large business. Guideline 8 dictates: "when a merger is part of a series of multiple acquisitions, the agencies may examine the whole series."[134] The Guideline will specifically apply when PE firms purchase private physician practices of the same specialty and manage them together as one business.[135] The regulatory agencies will be able to focus on the pattern of acquisitions, including the smaller ones, rather than only one transaction that would not show the full effect. The downside of this updated reporting guideline is that many transactions must occur before they aggregate to a reportable status. There is potential that anti-competitive effects, such as increased service prices or lower wages for healthcare employees, would occur before regulatory agencies can intervene.

It has been established that health care as an industry is moving toward a more consolidated state.[136] Guideline 7 relays that an industry's consolidation trend will influence the determination of whether a merger is anti-competitive. [137] This builds on the argument that regulators are trying to catch everything that does not fall into the traditional horizontal and vertical buckets. Industry consolidation minimizes the requirement that merging firms must be either in direct competition or vertically integrated to be anti-competitive. It expands the scope of merger analysis to multiple geographic regions where firms may not have direct influence on one another. Still, a single firm controlling them would be anti-competitive from an industry perspective. A PE firm may drive an industry toward consolidation when purchasing many physicians' practices that have the same specialty but are not within a defined geographic market.[138] Perhaps they purchase multiple practices within a state that are not directly competing with one another. The large practice would potentially not be

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134 *FTC and DOJ Seek Comment on Draft Merger Guidelines, supra* note 105.

135 Pifer, *supra* note 97.

136 Hulver & Levinson, *supra* note 66.

137 2023 Merger Guidelines, *supra* note 115.

138 Scheffler, Alexander & Godwin, *supra* note 27, at 32–41.

considered anti-competitive under traditional analysis, but the PE firm's control over multiple practices would increase industry consolidation, which would push the transactions towards an anti-competitive identification.[139]

The Guidelines acknowledge that firms do not need complete ownership of an entity to have control.[140] Guideline 11 establishes that the agency can examine acquisitions involving partial control or minority interest that could substantially lessen competition. It addresses when PE firms become partial investors or owners of a physician's practices without owning it entirely. This formation of the transaction creates more of a partnership between the PE firm and the physician owning the practice, where the PE firm would still influence administrative decision-making.[141] Even partial ownership could reduce a PE-owned practice's incentives to compete with other practices owned by the firm or allow access to sensitive information within the firm that could negatively impact competition.[142] This Guideline also expands the scope of what entity characteristics the FTC includes when analyzing whether a merger is competitive. Instead of focusing on complete ownership, the analysis brings in potentially more numerous partial ownerships of practices, which likely have just as strong an influence on decision-making.[143]

The qualifying Guidelines discussed in this section are how the FTC will be able to address non-traditional mergers taking place in today's economy, specifically PE's purchase of physicians' practices. Since the Guidelines are guidance and not rules, courts can choose how much weight to give them and how to incorporate them into their anti-competitive analysis. This construal of the Guidelines, unraveling them from the traditional horizontal and vertical merger categories, allows for a broader application to abnormal mergers and acquisitions that potentially harm competition.

E. Predicting How FTC Filings Against Private Equity

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139 *Id.*

140 Diana L. Moss, *What Does Expanding Horizontal Control Mean for Antitrust Enforcement? A Look at Mergers, Partial Ownership, and Joint Ventures*, AM. ANTITRUST INST. 1, 1 (Nov. 4, 2020).

141 *Id.*

142 *2023 Merger Guidelines*, *supra* note 115.

143 Moss, *supra* note 140.

Acquisitions Will Emerge

The newness of the renewed Merger Guidelines means there is not a significant amount of existing case law regarding FTC filings against PE acquisitions of physicians' practices. Although, with the recent efforts toward stronger antitrust regulations in health care, the FTC has filed a case against a physician's practice, U.S Anesthesia Partners (USAP), and the acquiring PE company, Welsh Carson (Welsh).[144] The FTC is filing for an injunction against the parties to prevent violations of § 7 of the Clayton Act, 15 U.S.C. § 18, and Section 5(a) of the FTC Act, 15 U.S.C. § 45(a).[145]

FTC filings do not always result in a trial, as the parties either change their plans or reach a settlement with the FTC to continue their transaction in a way that does not violate antitrust laws. To predict the outcome of FTC filings against PE transactions in health care under the 2023 Merger Guidelines, such as the one involving USAP and Welsh, we could look to the previous consent agreement between the FTC, JAB Consumer Partners (JAB), a PE firm, and Ethos Veterinary Health in 2022.[146] The FTC conditionally approved the merger on the grounds that the merged entity would divest six veterinary clinics it already owned in the relevant markets, "obtain the FTC's prior approval for future acquisitions of specialty or emergency veterinary clinics within 25 miles of an existing JAB clinic anywhere in California or Texas for the next 10 years; and . . . provide 30-day advance written notice to the FTC before JAB attempts to acquire" a veterinary clinic under those same conditions.[147] The consent decree communicated that the FTC was taking a position against PE roll-ups in health care. The direction of the revised Merger Guidelines and the FTC's potential punitive decrees support that position. The FTC will likely continue down this path of asserting punitive measures against PE firms that create anti-competitive effects when purchasing physicians' practices.[148] Especially now

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144 Reed Abelson & Margot Sanger-Katz, *F.T.C. Sues Anesthesia Group Backed by Private-Equity Firm*, N.Y. TIMES (Sept. 21, 2023), https://perma.cc/G2AJ-SP53.

145 F.T.C. Decision and Order In the Matter of JAB Consumer Partners/National Veterinary Associates/SAGE Veterinary Partners, No. C–4766 (Aug. 2, 2022), https://perma.cc/6FTZ-5SRL [hereinafter JAB Decision and Order].

146 *Id.*

147 Michael F. Murray, Michael S. Wise & Noah Pinegar, *Considerations for Private Equity After FTC Vet Clinic Deal*, PAUL HASTINGS ATTORNEY AUTHORED (July 7, 2022), https://perma.cc/WG6M-TMGA.

148 *Id.*

that the FTC can use its authority to challenge those transactions under the 2023 Merger Guidelines.

The FTC's case against USAP provides a unique opportunity to measure the FTC's authority over PE firms purchasing specialized physician's practices under the 2023 Merger Guidelines. If the FTC and USAP settle, it could mean that the revised Guidelines are not as strong in action as their language intends.[149] To avoid a court case, USAP will likely work toward a settlement through divestiture or a system of requesting acquisition permission, similar to JAB's consent decree. Antitrust court cases are long and involve cumbersome and expensive discovery, which most companies would hope to avoid. It would be difficult for USAP and Welch to change their transaction plans because they have already consummated the merger, but they can still divest assets if required and change future transactional goals. In *Evanston*, the FTC's Final Order contained remedies other than divestiture adding more tools to help determine the outcome of future PE filings.[150] Although Evanston was the acquisition of a hospital by a health system, the same principles can apply. The FTC's Final Order stated that the entities were to negotiate contracts for managed care separately, payors were allowed to submit disputes for the prices obtained from the separate negotiations and they were to have separate negotiating teams and negotiate in competition with one another for managed care contracts. It also stated that the entities had to institute a firewall type of instrument to protect information and competition between the hospitals, payors could renegotiate existing contracts if they want a separate contract for Highland Park's inpatient services and they needed to give prior notice to the FTC of any potential acquisitions of hospitals within the Chicago MSA for the next ten years.[151]

In *Evanston*, the antitrust principles to protect competition and consumers from anti-competitive effects are present. Without divestiture, the FTC emphasizes maintaining competition between the two entities, giving payor insurance companies a choice of whose negotiated deal with managed care organizations they prefer, protecting consumer information, and controlling any

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149 *PE Must Pay Attention to Antitrust Actions, Says Baker Mackenzie*, PE INT'L. (May 2, 2023), https://perma.cc/3FJS-TMVW.

150 Final Order, Evanston Nw. Healthcare Corp., FTC Docket No. 9315 (Apr. 24, 2008) [hereinafter Evanston Final Order]; *see also* Capps et. al., *supra* note 79, at 447 n.27.

151 *Id.*

future acquisitions in the geographic market. The Final Order shows that the FTC does not want the newfound entity to use its market power to negotiate unfair deals and take advantage of payors. In this case, the FTC avoided divestiture because of how intertwined the two entities were after the merger. It should be noted that while divestiture did not happen in the *Evanston* case, the FTC ordered divestiture against JAB of six veterinary practices in the relevant market. The FTC may be more inclined to order divestiture of PE-owned private practices, given that it would be simpler to separate them and determine how many practices the firm would need to sell to restore a competitive environment. They could also impose the reporting requirement of future acquisitions and the specified negotiating terms and technology installments.

Given the FTC's publicized dedication to strong antitrust regulation, they will likely try to go to court to flex their restated power.[152] They will build on the 2023 Merger Guidelines and undergo the analysis of the series of acquisitions that make up private equity roll-up purchases in health care. Courts will likely apply the new Guidelines when making their decisions. However, since the Guidelines are not binding, court interpretations add unpredictability. Relying on court holdings could backfire against the FTC's goals if courts still do not find that their evidence reaches the necessary threshold to deem the merger anti-competitive. The FTC does have the *Evanston* case law and an emphasis on economic evidence on its side, which could sway the courts in their favor.[153]

Additionally, the FTC's filings against PE firms generally have been addressed toward two entities owned by the same PE firm attempting to merge. They target the entities rather than the PE firm because the entities are in control of any potential anti-competitive behavior, even if their mutual PE owner influences their decision-making.[154] They are more likely to avoid competition against one another and can potentially conspire to raise prices for insurance companies, in turn raising the price paid by patients or limiting the output of a specialized service, much like

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[152] Andrew Ross Sorkin et al., *Biden's Antitrust Team Isn't Backing Down from a Fight on Deals*, N.Y. TIMES (July 19, 2023), https://perma.cc/YAC2-4LJ7.

[153] Hulver & Levinson, *supra* note 66.

[154] James A. Keyte & Kenneth B. Schwartz, *Private Equity and Antitrust: A New Landscape*, 31 ANTITRUST 21, 23 (2016).

a monopoly.[155] There is less explored case law about case outcomes when a PE firm purchases a single entity without a monopoly problem, which could lead to anti-competitive effects or effects that are undesirable to other actors in the industry.[156] There are no apparent anti-competitive effects when a PE firm purchases a singular physician's practice. While Guideline 9 will strengthen the FTC's ability to regulate PE roll-ups, it will likely only challenge those mergers when they are in the same geographic area or aggregate to multiple purchases in that area, creating an opportunity for a monopoly. It is unclear how the FTC's authority could influence a PE firm's purchase of a singular physician's practice, or even a few, as it might not have anti-competitive effects. Given the potential differences between PE and health care as industries, antitrust laws, whose goal is to protect competition and consumers from anti-competitive effects, may not be best equipped to regulate this arena. The regulation of health care has other priorities outside of maintaining competition and protecting consumers from anti-competitive practices.[157] Although there is potential for their goals to overlap.

IV. RECOMMENDED WAYS TO REGULATE PRIVATE EQUITY INVESTMENT IN HEALTH CARE

While antitrust regulations appear to be the tool of choice to address health care consolidation, they may not be the most effective tool to address PE purchase of physicians' practices. Antitrust regulation enforcement against hospital consolidation has not been very effective either, given the 53 mergers that took place in 2022.[158] Although those mergers may not have presented anti-competitive violations and would not have required FTC intervention.

There is potential that the bias against the corporatization of health care generally, given the moral implications of the industry in providing care for society's health, has made regulators

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155 Scheffler, Alexander & Godwin, *supra* note 27, at 29.

156 Keyte & Schwartz, *supra* note 154.

157 Robert I. Field, *Why Is Health Care Regulation So Complex?*, 33 PHARMA. & THERAPEUTICS 607, 607 (Oct. 2008). *See also* Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers, AHA, https://perma.cc/U75X-9XJJ (last visited Jan. 23, 2024).

158 Hulver & Levinson, *supra* note 66.

especially harsh on PE involvement in health care.[159] Regulators should continuously assess their reasoning behind enforcing antitrust regulations. They need to determine if they are preventing a PE firm from purchasing a practice because it leads to anti-competitive outcomes or because it leads to poor patient outcomes and raised costs. The FTC might be straddling that line, which could create ineffectiveness in the application of the 2023 Merger Guidelines.[160] If PE transactions with health care entities do not create anti-competitive effects, the FTC should not regulate them. Although even if the transaction does not cause anti-competitive effects, PE investment in health care generally can lead to increased costs and poor patient outcomes. It would be difficult to separate whether these outcomes are due to PE's high-risk behavior or decreased competition, so the FTC can make an argument that such transactions fall within their authority no matter the cause of their interest.[161] If the FTC cannot properly regulate PE investment in health care, there are other ways for the law to intervene. The legal field could also provide a regulated opportunity for PE to invest in physicians' practices when necessary and supply them with much-needed capital to buoy them during this time of change in the industry.

A. Use of Antitrust Laws Versus Reliance on the Free-Market Effect

Recently, two economic schools of thought have competed for influence over antitrust analysis. One is the Chicago School, and the other is the Neo-Brandeisian School.[162] The Chicago School asserted the benefits of applying neutral economics to antitrust analysis largely based on the idea that the market is self-correcting.[163] They introduced the application of the "consumer welfare" principle to antitrust analysis, which concerns trading partners and sellers.[164] The idea is that consumers are best off when

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159 Grace Niewijk, *New Findings Show Private Equity Investments in Healthcare May Not Lower Costs or Improve Quality of Care*, UCHICAGO MEDICINE (July 25, 2023), https://perma.cc/F38V-UJBG.

160 Harris Meyer, *FTC Chief Gears Up for a Showdown With Private Equity*, KFF HEALTH NEWS (Nov. 30, 2023), https://perma.cc/YZ9U-MYZ2.

161 *Id.*

162 Leah Samuel & Fiona Scott Morton, *What Economists Mean When They Say "Consumer Welfare Standard"*, PROMARKET (Feb. 12, 2022), https://perma.cc/3QHG-SJTU.

163 *Id.*

164 Herbert Hovenkamp & Fiona Scott Morton, *The Life of Antitrust's Consumer Welfare Model*, PROMARKET (Apr. 10, 2023), https://perma.cc/W7RL-4SF9.

conditions are good for those parties to produce a high output, at high quality, with lower prices and free innovation.[165] It allows defendants in merger suits to argue for the efficiencies of their proposal so long as it supports these outcomes. The Chicago School of thought has recently been challenged by the Neo-Brandeisian School, of which FTC Chair Lina Khan is a member.[166] Neo-Brandeisians reject the notion of potential efficiencies in anti-competitive behavior and "consumer welfare" standards.[167] They reintroduce the idea that large firms in a concentrated industry can amass political power that could influence many aspects of daily life.[168] Regulators in this School argue that regulators should gear antitrust law toward protecting political power rather than protecting consumers and economic balance.[169] This section discusses the influence of both approaches on regulating private equity investment in health care.

i. Improvements to the Merger Guidelines for Private Equity Application

With the filing of the suit against USAP and Welsh, it seems antitrust laws will continue to be the method of choice for addressing PE involvement in health care. The suit is particularly interesting because FTC brought it against both the anesthesiology group and the PE firm.[170] When the FTC sues companies for antitrust violations, they rarely name the PE firm that owns the company because firms normally operate in the background of their portfolio companies.[171] In the case of USAP and Welsh, the FTC has found that despite Welsh's below 50% ownership of the company, they have been actively involved in USAP's strategy and decision-making.[172] The FTC's choice to file against Welsh supports the notion that the FTC is acting especially hostile

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165 *Id.*

166 Justin Lindeboom, *Two Challenges for Neo-Brandeisian Antitrust*, 68 THE ANTITRUST BULLETIN 392, 394 (2023).

167 *Id.*

168 James Keyte, *New Merger Guidelines: Are the Agencies on a Collision Course with Case Law?*, 36 ANTITRUST 49, 49 (2021).

169 *Id.*

170 Abelson & Sanger-Katz, *supra* note 144.

171 Gretchen Morgenson, *FTC Sues Private-equity Backed Anesthesia Staffing Firm, Saying It Tried to Corner the Market and Drive Up Prices*, NBC NEWS (Sept. 21, 2023), https://perma.cc/VXT5-4L7T.

172 *FTC Sues PE Fund and Its Portfolio Company, Signaling Continued and Growing Focus on PE Funds and Roll-up Acquisitions*, ALLEN & OVERY (Sept. 26, 2023), https://perma.cc/7Z9W-A73L.

toward PE firm investment in health care. They are lowering the bar for PE's control of their portfolio companies and suing firms that do not have full ownership of practices.

If the FTC continues down this pathway, one of its strongest tools will be the 2023 Merger Guideline 8, allowing regulators to assess a single transaction as part of a series of transactions. This will be most important in addressing PE's most well-known tool of roll-ups. As applied to health care, they buy multiple small physicians' practices but manage them as one large business.[173] However, this guideline is still limited by the geographic region requirement. PE firms may buy physicians' practices all over a state that are not directly competing with one another and, therefore, do not pose strong anti-competitive threats in specific geographic markets. It may also benefit the FTC to propose a lowered HSR threshold and the proposed amendments to current HSR reporting. However, PE's transactions with physicians' practices might be too small to require reporting. Additionally, altering HSR reporting could impact future PE investment in health care but not address past transactions. In these ways, antitrust law is limited in the efficiency of its regulation of PE firms purchasing physicians' practices.

To strengthen its authority, the FTC could create healthcare-specific guidelines requiring a PE firm to report all health care entities it owns when it purchases another health care entity. The FTC could place these specific guidelines with the existing appendixes of the Merger Guidelines and how to apply them.[174] The FTC and DOJ have never shaped the Merger Guidelines in their application to a specific industry. The rulemaking for application has been left up to the courts, with guidance from the Guidelines.[175] The specified guidelines would remain guidance, and the courts would continue to consider them. Specified guidelines would not be a way for the executive branch to capture power from the judicial branch.[176] Specialized guidelines are needed because health care consolidation is a rapid threat to market competition, and inefficient regulation impacts patients' health and the costs

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[173] *Id.*

[174] *2023 Merger Guidelines*, *supra* note 115.

[175] Hillary Greene, *Guideline Institutionalization: The Role of Merger Guidelines in Antitrust Discourse*, 48 WM. & MARY L. REV. 771, 809 (2006).

[176] Adam Liptak, *Conservative Justices Appear Skeptical of Agencies' Regulatory Power*, N.Y. TIMES (Jan. 17, 2024), https://perma.cc/PJA9-SCMC/.

they pay.[177] The stakes are much higher in health care than in other economic industries, and the FTC could argue that other industries do not need such specifications. This reasoning aligns with the Neo-Brandeisian School of thought in that health care is an influential market area and must be regulated accordingly. Specialized healthcare guidelines would help get around the HSR Act threshold by marking health care as a special industry for reporting and could help determine if PE firms are concentrating on an area. They could be a supplement to Guideline 8 to help determine if a PE firm was forming a monopoly of a specialized healthcare service instead of waiting for the practices to aggregate and anti-competitive effects to come into action.[178]

One recommendation for a health-care-specific guideline could be defining the geographic market. There needs to be a firmer determination of how far patients are willing to travel for healthcare services and how emergency services factor in when patients do not have a choice about where they receive their care.[179] A smaller geographic market could favor PE firms purchasing physicians' practices because they could invest all over the state instead of in a traditional geographic market. Such a method is counterintuitive to geographic market definitions in the case law since a smaller market normally means the court is more likely to find anti-competitive behavior.[180] The uniqueness of PE investment in health care requires the Merger Guidelines to guide how to assess the potential anti-competitive effects of a merger or acquisition.

ii. Applying the Free-Market Effect to Private Equity Investment in Health Care

There is space to acknowledge that PE firms' purchase of physicians' practices should be left to their own devices when it does not lead to anti-competitive effects or does not harm the quality of patient care. Although there is growing data that PE investment in health care leads to worsening healthcare outcomes,

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177 Sara R. Collins, Shreya Roy & Relebohile Masitha, *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer*, THE COMMONWEALTH FUND (Oct. 26, 2023), https://perma.cc/G4C3-UHH3 ("In 2021, there was an estimated $88 billion of medical debt on consumer credit records, accounting for 58 percent of all debt-collection entries on credit reports — by far the largest single source of debt.").

178 For the data behind this idea, see Keyte & Schwartz, *supra* note 154, at 24.

179 Hosp. Corp. of Am. v. F.T.C., 807 F.2d 1381, 1388 (7th Cir. 1986).

180 *Id.*

which could increase the incentives for intervention.[181] This aligns with the Chicago School approach to antitrust law, which argues the economy will self-correct in a way most beneficial for suppliers and consumers.[182]

PE invested in the healthcare market initially, in part, due to inflated health care spending in the United States that made it a lucrative industry.[183] They also entered the industry because they saw a need to be filled.[184] They entered the healthcare market as an alternative to hospital acquisition of practices, which many physicians thought would create a loss of their clinical decision-making independence.[185] Since transactions with PE firms within health care continue to grow, it can be assumed that many physicians still feel this way, even with commentators lamenting the horrors of the deals.[186]

Antitrust laws will not effectively combat PE's purchase of physicians' practices, especially when they continue to fall beneath the HSR Act reporting threshold and are not increasing the firm's market power in the same geographic area. PE firms will continue to engage with physicians' practices so long as it is a lucrative deal and conditions remain such that physicians want to make the transactions.[187] There is the stance that PE firms should be able to purchase physicians' practices. At the same time, the market enables it, and regulators should monitor the quality of patient care and outcomes to determine if their involvement is bad for patients. However, if regulators wish to cool PE investment in health care without allowing the market to correct itself, changing the economic circumstances that make their deals appealing would be most efficient.

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[181] Sneha Kannan, Joseph Dov Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, 330 JAMA 2365, 2368 (Dec. 26, 2023).

[182] Hovenkamp & Morton, *supra* note 164.

[183] Mack & Schaff, *supra* note 19, at 45.

[184] O'Donnell et al., *supra* note 25, at 1026–27.

[185] Jacoby & Herschman, *supra* note 55.

[186] Rebecca Pifer, *Private Equity Notched Second-Highest Year of Healthcare Dealmaking in 2022, Pitchbook Finds*, HEALTHCARE DIVE (Feb. 6, 2023), https://perma.cc/8ASY-R5SA.

[187] Mark Gilreath, Steven Morris, & Joel V. Brill, *Physician Practice Management and PE: Market Forces Drive Change*, 17 PRACTICE MANAGEMENT: THE ROAD AHEAD 1924, 1926 (May 9, 2019).

B. Stronger Enforcement of Hospital Merger Regulations

A major reason that physicians turn to PE firms is to combat hospital mergers that create large hospital systems in their geographic area. Hospitals and practices connected through these systems have the capital to implement the desirable patient-centered programs outlined in the ACA and other legislation.[188] They also engage in referral agreements that help increase their revenue and keep patients within the system. These competitors, along with the newer competitors discussed earlier, decrease patient count and lower revenue for private physicians' practices.[189] PE firms, and even their roll-ups, appeal to physician-owned practices because they give them a capital boost and provide them with their own network of potential patient referrals.

From this perspective, antitrust laws could be the right tool to chill PE investment in health care. The revised 2023 Merger Guidelines could be effective in addressing hospital mergers. The guidelines strengthen the FTC's position to bring vertical merger cases against hospitals acquiring physicians' practices or health care systems acquiring hospitals.[190] They also create space for the FTC to file cases against cross-market mergers, which create conglomerate health care systems that squeeze out smaller practices.[191] FTC case outcomes will likely reflect the strength of the 2023 Merger Guidelines as courts are likely to be heavily influenced by the Guidelines.[192] The FTC's reinforced stance against hospital mergers in the Guidelines, plus their improved case strategy obtained from the Evanston Hospital and Highland Park Hospital merger in Chicago,[193] will likely lead to more case outcomes in their favor. Antitrust regulators could fulfill their end goal of stopping PE investment in health care circuitously, through their more substantial authority against hospital consolidation.

C. Reimbursement Decline for Healthcare Services

Another driver for physician engagement with PE firms is the decreasing government, Medicare and Medicaid, and third-party

188 Jacoby & Herschman, *supra* note 55.
189 *Id.*
190 Gu, Gudiksen & King, *supra* note 100.
191 *Id.*
192 Greene, *supra* note 175, at 809–13.
193 Hulver & Levinson, *supra* note 66.

reimbursement for healthcare services.[194] In 2010, the ACA altered the existing reimbursement model by moving the system away from fee-for-service (FFS) reimbursement to value-based, bundled payments.[195] This change in payment models not only spurred hospital mergers but favored large hospital networks.[196] The change was supposed to incentivize value-based care and discourage increased volume of services for more payments. Over a decade after implementation, these policies have been successful in some geographic areas but have largely not achieved those goals.[197]

Physicians' practices being unable to make the switch swiftly and effectively is partly a reason for this stilted change. The quality and performance metrics required by the ACA to receive value-based reimbursements create a need for health care entities to invest in new technologies and reform their infrastructure.[198] It is a complex and expensive process. Most physicians who own their practice do not have the capital or enough administrative knowledge to make these changes. This is the main attraction of the PE buyout option. PE firms either buy the practice entirely or become partial investors, and in exchange for their return on capital, they provide much-needed managerial advice.[199] To undermine this rationale for the transaction, the Centers for Medicare and Medicaid Services (CMS) needs to make the transition administratively easier.[200] CMS could improve the administrative transition by prioritizing the identification and implementation of technical changes to the structure of payment models and applying regional benchmarking for the value of care provided. Hence, physicians know where they stand in the payment model.[201] Making this transition to value-based payments smoother could remove some financial pressure from private physicians' practices. They will not need to rely on PE firms. It could

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194 Appelbaum & Batt, *supra* note 18, at 52.

195 Rachel M. Werner, et al., *The Future of Value-Based Payment: A Road Map to 2030*, PENN LDI 1, 2 (February 2021).

196 Appelbaum & Batt, *supra* note 18, at 57.

197 Werner et al., *supra* note 195, at 6.

198 Mary Beth Nierengarten, *Adoption of Value-Based Reimbursement Among Private Insurers*, HMP GLOBAL LEARNING NETWORK: POPULATION HEALTH (Apr. 2019), https://perma.cc/62G7-E9W4.

199 Gilreath, Morris, & Brill, *supra* note 187.

200 Werner et al., *supra* note 195, at 12.

201 *Id.* at 13.

also lead to decreased healthcare spending overall, making it a less attractive industry for PE investment.

Removing one of the factors above would undermine either physicians' need to engage with PE firms or PE's desire to purchase physicians' practices. While market forces push physicians to deal with PE firms, it is reasonable that they would choose to do so. Altering market forces would be an effective way for regulators to achieve an end to PE investment in health care if that is the best way to ensure decreased spending and high-quality patient care.

V. CONCLUSION

At this stage, we are working within the confines of our existing system, which has embraced the corporatization of health care.[202] While some would prefer not to treat health care like a business and patients like customers, that is our reality unless policymakers find a way to reconfigure the United States' health care system. Health care as a business concerns us as a society because of the moral implications of health care. Patients are at an informational disadvantage, in a way they are not in other industries, which is why regulators are strict regarding health care mergers and acquisitions.[203] Larger companies have a greater chance of taking advantage of consumers. This is where antitrust laws come into play. The FTC has been at the forefront of combating health care consolidation through antitrust laws but there has been a steady increase in hospital mergers throughout the last decade, indicating they have yet to be very successful. Increasing health care consolidation led to a revision of the FTC and DOJ's Merger Guidelines, released in December 2023.

PE investment in health care is a by-product of the corporatization of health care. It is even more of a concern because of the predatory behavior associated with their profit-making strategy. The 2023 Merger Guidelines have revised methods for addressing PE investment in health care. PE firms use a roll-up technique when purchasing practices, making multiple small acquisitions that fall below the HSR Act and combining them to run them as one business. To better apply the Guidelines to these unique PE transactions, it is most effective to group them into categories. One category focuses on traditional private equity transactions,

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[202] Brown & Hall, *supra* note 43, at 578.

[203] Scheffler, Alexander & Godwin, *supra* note 27, at 6.

horizontal and vertical. The other category consists of specific lenses through which to view the mergers when they do not fit into the conventional categories.[204] The strategic application of the Guidelines will most effectively apply to PE investment in physicians' practices. The case law regarding this fact pattern will grow with the FTC's strengthened authority to file against PE investment in physicians' practices. The existing cases show that the merging entities will likely try to settle with the FTC, and a likely avenue for the settlement will be through the divestiture of some of their portfolio to avoid anti-competitive effects.

Other ways to mitigate PE investment in health care outside traditional antitrust law applications exist. As they exist now, the Merger Guidelines can potentially stop PE from gaining market power in a specific practice area but are generally ineffective in halting PE involvement in health care. Healthcare-specific guidelines could be effective in regulating PE purchasing new physicians' practices. Their portfolio could expand beyond traditional market definitions and still have anti-competitive effects. There is also an argument that PE's purchase of physicians' practices is a natural byproduct of the market and should be allowed to continue so long as physicians continue to deal with PE and those transactions do not produce anti-competitive effects.[205] Regulators could reduce PE investment in health care through other means. The revised Guidelines allow the FTC to take a stronger stance against hospital consolidation. Hospital consolidation is a significant reason why PE transactions are so attractive to physicians' practices. Regulators could decrease PE investment in health care by regulating hospital consolidation more effectively. If antitrust laws continue to leave space for PE to go underregulated, then other areas of law could fill the gaps. This could be achieved by increasing reimbursements for physicians' practices and developing guidance for technological improvements, undermining physicians' need for administrative guidance from PE firms.

The FTC and other regulators will likely attempt to address PE investment in health care using antitrust laws. This strategy will potentially be successful for the cases they bring, but there will continue to be PE transactions within health care outside the scope of antitrust laws. The FTC could bolster these laws with healthcare-specific guidelines or through other regulatory

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[204] Gu, Gudiksen & King, *supra* note 100.

[205] Gilreath, Morris, & Brill, *supra* note 187.

methods that make the health care industry more compatible with private physicians' practices and PE transactions less attractive to physicians.