International Center for Law & Economics

Comments of the International Center for Law & Economics

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

June 5, 2024

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I. Introduction/Summary

We appreciate the opportunity to respond to this request for information on consolidation in health-care markets, Docket No. ATR-102, issued by the U.S. Justice Department (DOJ), the U.S. Department of Health and Human Services (HHS), and the Federal Trade Commission (FTC) (collectively, "the agencies").[1] We agree wholeheartedly that robust competition in health-care markets is critical to consumer welfare and the U.S. economy. As an FTC staff policy paper summarized, "[c]ompetition in health care markets benefits consumers by helping to control costs and prices, improve quality of care, promote innovative products, services, and service delivery models, and expand access to health care services and goods."[2] Conversely, anticompetitive health-care acquisitions can harm competition and consumer welfare; there is a substantial economic literature to that effect.[3] The agencies, over decades, have done well to oppose such mergers and, as a related matter, attempts to insulate such mergers from federal antitrust scrutiny.[4] Hence, the agencies have important roles to play in protecting health-care competition, as they enforce key federal statutes relevant to it, including the general antitrust laws that are enforced by the FTC and the DOJ,[5] and that apply across health-care markets, among others. Effective and accurate antitrust enforcement is a key component of health-care policy, and one that tends to benefit patients and other health-care consumers, including both private and public payers.

We recognize that the FTC also has a distinctive research and reporting mission assigned by Congress under Section 6 of the FTC Act, and that it has decades of experience engaging in policy and economic research, both internally and in cooperation with DOJ and HHS.[6] Acknowledging express statutory limits—such as the restriction on studies and reports regarding the business of insurance

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[1] *Request for Information on Consolidation in Health Care Markets*, Docket No. ATR-102, DEP'T JUSTICE, DEP'T HEALTH & HUMAN SERVS., & FED. TRADE COMM'N (Mar. 5, 2024), https://www.regulations.gov/docket/FTC-2024-0022 [hereinafter "RFI"].

[2] Daniel J. Gilman & Tara Isa Koslov, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, FED. TRADE COMM'N, 1 (Mar. 2014), *available at* https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

[3] For an overview, *see*, *e.g.*, *Hearing on Antitrust Applied: Hospital Consolidation Concerns and Solutions*, Testimony before the SUBCOMM. ON COMPETITION POL'Y, ANTITRUST, AND CONSUMER RIGHTS, S. COMM. ON THE JUDICIARY, 117th Cong. (2021) (statement of Martin Gaynor, E.J. Barone University Professor of Economics and Public Policy Heinz College, Carnegie Mellon University), https://www.judiciary.senate.gov/download/martin-gaynor-testimony.

[4] For successful cases against provider mergers, s*ee, e.g.*, *Fed. Trade Comm'n v. Hackensack Meridian Health, Inc.*, 30 F.4th 160 (3d Cir. 2022); ProMedica Health Sys., Inc., FTC Docket No. 9346, 2012 WL 2450574 (Jun. 25, 2012), *aff'd*, *ProMedica Health Sys., Inc., v. FTC*, 749 F.3d 559 (6th Cir. 2014); *FTC v. Penn State Hershey Med. Ctr.*, 185 F. Supp. 3d 552 (M.D. Pa. 2016), *rev'd*, 838 F.3d 327, 343 (3d Cir. 2016); *Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd.*, No. 1:12-cv-00560, 2014 WL 407446 (D. Idaho Jan. 24, 2014), *aff'd*, 778 F.3d 775 (9th Cir. 2015). Regarding the authority to review provider mergers, *see Fed. Trade Comm'n v. Phoebe Putney Health Sys., Inc.*, 586 U.S. 216 (2013) (acquisition not immune from scrutiny under state-action doctrine).

[5] We refer to the Sherman and Clayton Acts and, by extension, the Federal Trade Commission Act, and recognize that other parties, including state attorneys general and private parties, may sue to enforce certain provisions of the antitrust laws, while recognizing that there is no private right of action under the FTC Act.

[6] 15 U.S.C. § 46. *See infra.*, text accompanying notes 23-31, for constructive examples.

under Section 6(l) of the FTC Act[7]—the fulfillment of that research mission across health-care markets has been wide-ranging; and, as described below, it has often found salutary application in antitrust enforcement.

Our response to the agencies' RFI comprises, at the highest level of generality, one observation and one recommendation. The observation is that, while health-care-provider acquisitions remain an extremely important domain of merger scrutiny, neither enforcement experience nor the economic literature support any fundamental changes in procedural or substantive antitrust law or regulation, whether for provider acquisitions generally or any of the categories of acquirers specified in the RFI. Competition policy is not, and should not be, static. At the same time, sound policy reform is a difficult, stepwise process, and one that requires a firm foundation in both research and enforcement experience, along with attention to established precedent. Information submitted in response to the RFI may well contribute to the agencies' aggregate knowledge base on provider transactions. But the present inquiry does not appear designed to move that body of knowledge much beyond the margin. Indeed, as explained below, FTC research and enforcement experience underscore not just the importance of health-care competition, but also how complex the tasks of merger scrutiny and reform are.

Correspondingly, our overarching recommendation is that the agencies build on the substantial body of research regarding mergers and acquisitions in the health-care sector that has been conducted over the course of several decades by agency staff and others. That body of research includes, notably, contributions made by the staff of the FTC Bureau of Economics (BE).[8] More specifically, to that end, we recommend that economic and policy staff at the agencies synthesize the extant body of research at their disposal. To be sure, market developments, and developments in research methods and available data, may suggest new avenues of research, as well as those in need of significant updates. But a serious, critical synthesis of the available literature will only help to sharpen the agencies' sense of new research demands, just as it will provide a basis on which to contemplate new enforcement initiatives. Such a synthesis can also ground more focused and productive requests for information on critically important issues in health-care competition going forward.

Our recommendation of such a research synthesis or review is consistent with the agencies' acknowledgement that they may require "additional proceedings, including workshops or other public engagement, to learn more about [concerns identified in response to the RFI]."[9] While such workshops and other engagements have been a useful component of the agencies' understanding of health-care-competition policy, we stress that they should be seen as complements to rigorous systematic research. And both should be seen as complements to building on case-specific agency enforcement

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[7] *Id.* at § 46(l).

[8] Links to economic research, including reports, working papers, issue papers, and articles in peer-reviewed journals can be found at Fed. Trade Comm'n, Bureau of Econ., Research in the Bureau of Economics, https://www.ftc.gov/about-ftc/bureaus-offices/bureau-economics/research-bureau-economics. *See also infra.* Section II.A.2.

[9] RFI at 11.

experience, which typically scrutinizes the specific facts and circumstances of transactions and other firm conduct.

For example, in many smaller markets, independent providers of hospital-based services, such as anesthesiology, may be highly concentrated on any standard for "highly concentrated" markets.[10] Further research might aid the agencies in examining highly concentrated provider markets to develop filters or screens for provider acquisitions below the Hart-Scott-Rodino filing threshold, so that the agencies might identify and investigate those sub-threshold filings that are the most likely candidates for investigations and, depending on the results of those investigations, enforcement actions. Efficient matter-selection tools will be critical to that effort, less the agencies commit scarce resources to small, unpromising investigations and impose undue costs on health-care providers.

In our comments below, we recognize that the agencies themselves have established models for building the sort of "policy R&D" contemplated by the RFI in a way that complements their enforcement mandates. Also, we understand that the RFI is but one of the tools the agencies use to further their understanding of provider consolidation.[11] And, indeed, the RFI may contribute to the larger health-care-competition R&D programs at the agencies, if only at the margin.

At the same time, we write to note certain concerns about the agencies' framing of their RFI, including, specifically, elements of the RFI that appear to be in tension with learning from agency-sponsored research and agency-enforcement experience.

Some of our concerns may be summarized as follows:

First, evidence and enforcement experience do not identify categories of health-care acquisitions that "always or almost always" impede competition and reduce output. That militates against *per se* prohibitions. Absent an express charge from Congress, new competition regulations regarding health-care acquisitions are not justified.

Second, agency experience—and, indeed, the FTC's landmark success in the 2nd U.S. Circuit Court of Appeals in the *American Medical Association* case[12]—suggests legitimate competition concerns about undue restraints on "the corporate practice of medicine." More broadly—and consistent with longstanding agency practice—the agencies should be cautious about drawing general conclusions

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[10] Sub-threshold acquisitions may well be 3-to-2 or merger-to-monopoly transactions for critical services. "Any standard" would include, for example, those described in any or all editions of the horizontal merger guidelines.

[11] We note that, *e.g.*, in January 2021, the FTC issued orders, under its FTC Act Section 6(b) authority to six health-insurance companies to provide information to facilitate the agency's study of the effects of physician group and health-care-facility consolidation from 2015 through 2020. *See* Press Release, *FTC to Study the Impact of Physician Group and Healthcare Facility Mergers*, Fed. Trade Comm'n (Jan. 14, 2021), https://www.ftc.gov/news-events/news/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers. While the information collected under such orders is limited partly by restrictions imposed under the Paperwork Reduction Act, and not merely available data and methodological concerns, it may nonetheless help advance understanding of provider consolidation. We assume that this project, initiated at the tail end of the last administration, is ongoing.

[12] *AMA v FTC*, 638 F.2d 443 (2d Cir. 1980).

about whole industries, business models, or methods of health-care delivery, and more cautious still in condemning them.

Third, while there is no doubt that provider consolidation can be anticompetitive, the relationship between concentration and competition is complex, both as a general matter and—on current understanding—across the various sectors and subsectors identified in the RFI. That general point has been illustrated by BE staff research, even as that research has helped to refine and strengthen appropriate antitrust scrutiny of health-care provider mergers and acquisitions.

Fourth, it is well-understood that vertical acquisitions can harm competition and consumers under certain conditions. At the same time, vertical mergers are not generally—or even typically—anticompetitive. Vertical mergers may entail certain efficiencies, and are commonly procompetitive or benign on net, as research by agency personnel and the larger academic community has demonstrated. Analogously, while conglomerate mergers may raise competition concerns, they are not generally anticompetitive.

Fifth, the RFI's framing seems problematic—both uncharacteristic of open inquiry and in tension with antitrust experience and its economic foundations. For example, we question a statement at the outset of the RFI: "Given recent trends, we are concerned that transactions may generate profits for those firms at the expense of patients' health, workers' safety, and affordable health care for patients and taxpayers."[13] To be sure, some provider transactions, under particular facts and circumstances, may harm competition and consumer welfare, in violation of the antitrust laws.[14] But the agencies understand that antitrust law and economics do not recognize any general or fundamental tension between firm profits on the one hand, and the consumer benefits typically associated with competition on the other. Indeed, FTC research and enforcement have specifically undermined the notion that not-for-profit provider mergers should be treated differently under the antitrust laws.[15]

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[13] *Id.* at 1.

[14] *See generally, e.g.*, *Fed. Trade Comm'n v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216 (2013). In its unanimous decision, the Court noted that the 11th U.S. Circuit Court of Appeals had, as an initial matter, "'agreed with the [FTC] that, on the facts alleged, the joint operation of Memorial and Palmyra would substantially lessen competition or tend to create, if not create, a monopoly'" 568 U.S. at 222-3 (quoting *Fed. Trade Comm'n v. Phoebe Putney Health Sys., Inc.*, 663 F.3d 1369, 1375 (2011). The Court's holding in *Phoebe Putney* upheld the FTC's jurisdiction over the hospital merger, notwithstanding the grant of certain powers to hospital authorities by the state of Georgia. 568 U.S. at 224. For a discussion of various FTC research, advocacy, and enforcement activities in health care, including scrutiny of provider mergers, *see*, *e.g.*, Maureen K. Ohlhausen, *The First Wealth is Health: Protecting Competition in Healthcare Markets*, Remarks at the 2017 ABA Fall Forum (Nov. 16, 2017), *available at* https://www.ftc.gov/system/files/documents/public_statements/1275573/mko_fall_forum_2017.pdf. Although the FTC and the DOJ have concurrent jurisdiction over mergers under Section 7 of the Clayton Act, health-care-provider mergers are typically assigned to the FTC under the FTC/DOJ clearance process. For a list of health-care-enforcement matters, *see* FTC, *The FTC's Health Care Work: Cases*, https://www.ftc.gov/news-events/topics/competition-enforcement/health-care-competition (*last accessed* May 1, 2024).

[15] *See infra.* Section II.D.

More generally, health-care acquisitions can prove anticompetitive, procompetitive, or benign, but the RFI pointedly does not request information on potential patient or payor benefits that may be associated with consolidation. More generally, the RFI does not seem to recognize that health-care acquisitions commonly entail tradeoffs of benefits and costs. Such tradeoffs are well-documented in the literature and are recognized in U.S. merger jurisprudence.

As a related matter, the FTC's recent workshop, "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care,"[16] seemed uncharacteristically lax and imbalanced. The workshop was announced and timed to make it appear a complement to the RFI.[17] While sponsored by the FTC, leadership from the DOJ and HHS also participated. But there were no participants from the industry in question or from insurers, large health plans, or other private payors. Instead, participants—including those providing largely anecdotal evidence—appear to have been chosen exclusively for the purpose of representing agency and third-party criticism of private equity in health care. That is, the workshop seems to have been conclusory by design.

II. Discussion

A. Economic Research and Other Forms of Policy R&D Provide a Critical Foundation for Enforcement Policy

A 2009 report by then-FTC Chairman William Kovacic defines "policy R&D" broadly in a way that comprises, but is not limited to, original, author-initiated academic research by BE staff.[18] It also

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[16] *Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care*, FED. TRADE COMM'N (May 5, 2024), https://www.ftc.gov/news-events/events/2024/03/private-capital-public-impact-ftc-workshop-private-equity-health-care. The workshop webpage includes a description, along with links to the agenda, participant biographies, and a transcript of the proceedings.

[17] Press Release, *Federal Trade Commission, the Department of Justice and the Department of Health and Human Services Launch Cross-Government Inquiry on Impact of Corporate Greed in Health Care*, FED. TRADE COMM'N (Mar. 5, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/03/federal-trade-commission-department-justice-department-health-human-services-launch-cross-government (noting that, "[i]n addition to the launch of the RFI, all three agencies will also be participating today in a virtual public workshop that will explore the impact of private equity in health care and will discuss what the government is doing to address any harmful effects."). The announcement of the FTC workshop was repeated verbatim in DOJ and HHS announcements of the RFI. Press Release, *Justice Department, Federal Trade Commission and Department of Health and Human Services Issue Request for Public Input as Part of Inquiry into Impacts of Corporate Ownership Trend in Health Care*, DEP'T JUSTICE (Mar. 5, 2024), https://www.justice.gov/opa/pr/justice-department-federal-trade-commission-and-department-health-and-human-services-issue; Press Release, *HHS, DOJ, and FTC Issue Request for Public Input as Part of Inquiry into Impacts of Corporate Ownership Trend in Health Care*, DEP'T HEALTH & HUMAN SERVS. (Mar. 5, 2024), https://www.hhs.gov/about/news/2024/03/05/issue-request-for-public-input-as-part-of-inquiry-into-impacts-of-corporate-ownership-trend-in-health-care.html.

[18] WILLIAM E. KOVACIC, THE FEDERAL TRADE COMMISSION AT 100: INTO OUR SECOND CENTURY, 91-92 (Jan. 2009), *available at* https://www.ftc.gov/sites/default/files/documents/public_statements/federal-trade-commission-100-our-second-century/ftc100rpt.pdf.

incorporates diverse forms of policy inquiries, including, *e.g.*, hearings,[19] workshops,[20] conferences,[21] and, indeed, requests for public information.[22] These can all be mutually reinforcing, providing expert input that range from issue-spotting to literature review, to the presentation of new data and studies, as well as diverse perspectives on agency interests and activities. They can, in turn, help to inform case selection and enforcement, just as enforcement experience can yield data and other inputs into subsequent policy R&D. But one need not gainsay concerns about health-care competition or specific types of acquisitions to appreciate the difficulty of grounded, systematic reform of enforcement policy in these areas. We appreciate the agencies' recent extension of the deadline for submissions in response to the RFI; that will likely increase the utility of the inquiry. Still, while the present RFI may be a useful endeavor, it is just one tool—in itself, a limited one—in the agencies' "policy R&D" toolbox.

Below, we sketch some of the long-running developments in the agencies' policy R&D pertinent to provider acquisitions and health-care consolidation. Our description of the many pertinent agency endeavors focuses on work by FTC staff and leadership, in large part because of the FTC's enforcement experience with provider mergers and its sustained health-care-competition research program. We recognize, of course, that DOJ and HHS have also made substantial contributions of their own and, in turn, that the empirical literature regarding health-care consolidation is considerable, if not vast. We recognize, too, that inquiries are ongoing, and not restricted to the RFI. Our sketch is an abridged one, partly because the agencies—and, certainly, the FTC Bureau of Economics—are well familiar with their own research programs, just as they are familiar with the challenges of building lasting enforcement reforms.

On the one hand, we mean to underscore the advances made in understanding the competitive effects of provider consolidation and its potential—both realized and residual—for application in rigorous enforcement. At the same time—and based in no small part on their own contributions to understanding health-care consolidation—the agencies should appreciate the complexity and

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[19] *Public Hearings: Health Care and Competition Law and Policy Hearings*, FED. TRADE COMM'N & DEP'T JUSTICE (2023), https://www.ftc.gov/news-events/events/2003/02/health-care-competition-law-policy-hearings (hearings page with links to agendas and transcripts); *Hearings on Competition and Consumer Protection in the 21st Century*, FED. TRADE COMM'N (2018-19), https://www.ftc.gov/enforcement-policy/hearings-competition-consumer-protection (hearings page with links to agendas, transcripts, and submissions).

[20] *See, e.g.*, *Now Hear This: Competition, Innovation, and Consumer Protection Issues in Hearing Health Care*, FED. TRADE COMM'N (Apr. 18, 2017), https://www.ftc.gov/news-events/events/2017/04/now-hear-competition-innovation-consumer-protection-issues-hearing-health-care (FTC Workshop); *Examining Health Care Competition*, FED. TRADE COMM'N (Mar. 2014), https://www.ftc.gov/news-events/events/2014/03/examining-health-care-competition (FTC Workshop); *Innovations in Health Care Delivery*, FED. TRADE COMM'N (Apr. 24, 2008), https://www.ftc.gov/news-events/events/2008/04/innovations-health-care-delivery (FTC Workshop).

[21] *See, e.g.*, *16th Annual Microeconomics Conf.*, FED. TRADE COMM'N (Nov. 2023), https://www.ftc.gov/news-events/events/2023/11/sixteenth-annual-microeconomics-conference (annual conference hosted by FTC Bureau of Economics; 2023 conference was cosponsored by FTC and Tobin Ctr., Yale Univ.).

[22] *See, e.g.*, RFI; *FTC Seeks Comment on Contact Lens Rule Review*, 16 CFR Part 315, FED. TRADE COMM'N (May 28, 2019), https://www.regulations.gov/document/FTC-2019-0041-0001.

challenge of the Policy R&D project, both across health-care sectors and within them. That complexity and challenge militate against hasty conclusions about, *e.g.*, specific sectors, business models, and competitive trends.

1. Policy investigations

Varied hearings, workshops, RFIs, and other agency policy tools have played a significant role in developing competition policy at the agencies, even if no single agency workshop or RFI is likely to generate a record adequate to justify a significant change in enforcement policy. For example, from February through October 2003, FTC and DOJ jointly conducted 27 days of hearings on health-care-competition issues, with testimony from diverse stakeholders from academia, industry, and, not incidentally, agency staff.[23] Although HHS did not cosponsor those hearings, representatives from various HHS agencies—including the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ)—provided testimony and otherwise consulted on the hearings.

Based on the record of those hearings, an FTC-sponsored workshop in September 2002, and independent research (including applied-industrial-organization research conducted within and without the agencies), FTC and DOJ jointly published a substantial policy report in 2004.[24] The report reviewed systematic research, diverse stakeholder perspectives, and numerous health-care-competition policy issues. It also presented concrete policy recommendations by FTC and DOJ, drawn from that review.[25]

Follow-up workshops conducted by FTC staff, such as the 2008 workshop "Innovations in Health Care Delivery,"[26] also included participation by HHS personnel, including that of the national coordinator for health information technology and the deputy director for health information privacy at the HHS Office for Civil Rights.[27] A 2014 FTC workshop[28] and 2015 joint FTC/DOJ workshop[29]

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[23] *Public Hearings: Health Care and Competition Law and Policy*, DEP'T JUSTICE (*last updated* Aug. 21, 2023), https://www.justice.gov/archives/atr/event/public-hearings-health-care-and-competition-law-and-policy (describing hearings jointly conducted by DOJ and FTC, and providing links to agendas and transcripts for individual hearings, submissions to the public record, and various supporting materials).

[24] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE ("DOJ"), IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), *available at* https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

[25] *Id.* at exec. summ., 20-29.

[26] *Innovations in Health Care Delivery (workshop)*, FED. TRADE COMM'N (Apr. 24, 2008), https://www.ftc.gov/news-events/events/2008/04/innovations-health-care-delivery.

[27] The workshop agenda is *available at* https://www.ftc.gov/sites/default/files/documents/public_events/innovations-health-care-delivery/agenda-5.pdf.

[28] *Examining Health Care Competition (workshop)*, FED. TRADE COMM'N (Mar. 2014), https://www.ftc.gov/news-events/events/2014/03/examining-health-care-competition.

[29] *Examining Health Care Competition*, FED. TRADE COMM'N & DEP'T JUSTICE (Feb. 2015), https://www.ftc.gov/news-events/events/2015/02/examining-health-care-competition.

on health-care-competition issues both similarly involved officials and other personnel from HHS, FTC, DOJ, and other agencies, as well as academics, practitioners, and diverse industry stakeholders.

More focused health-care-competition and policy workshops have also informed agency enforcement policy. For example, a 2010 workshop on accountable care organizations (ACOs) jointly conducted by the FTC, the DOJ, and HHS, together with a 2011 FTC workshop on ACOs (with participation from DOJ staff),[30] informed the joint FTC/DOJ enforcement-policy statement on ACOs,[31] which was developed in consultation with the HHS Centers for Medicare and Medicaid Services, and which applied to specific forms of provider collaborations (not mergers) under the Medicare Shared Savings program.

2. *Economic research on provider consolidation*

The wide-ranging policy inquiries described above were not conducted in a vacuum. Rather, they build on a larger body of economic research and enforcement experience, including, notably, research on health-care competition from within and without BE, coupled with enforcement by the FTC Bureau of Competition. Staff and management in BE have made substantial contributions to the study of competition in health-care markets, with a focus on the study of provider consolidation;[32] and the FTC's longstanding, multi-pronged investigation of provider consolidation represents a signal model of the application of applied-industrial-organization research to policy development and law enforcement.[33]

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[30] *Another Dose of Competition: Accountable Care Organizations and Antitrust*, FTC Workshop (May 2011), https://www.ftc.gov/news-events/events/2011/05/another-dose-competition-accountable-care-organizations-antitrust.

[31] *See, e.g.*, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, 76 FED. REG. 67026 (Oct. 28, 2011), (Final Policy Statement, Fed. Trade Comm'n and Dep't Justice Antitrust Div.).

[32] *See, e.g.*, Devesh Raval *et al.*, *Using Disaster Induced Closures to Evaluate Discrete Choice Models of Hospital Demand*, 53 RAND J. ECON. 561 (2022); Thomas Koch & Shawn W. Ulrick, *Price Effects of a Merger: Evidence from a Physicians' Market*, 59 ECON. INQUIRY 790 (2021); Keith Brand & Ted Rosenbaum, *A Review of the Economic Literature on Cross-Market Healthcare Mergers*, 82 ANTITRUST L.J. 533 (2019); Thomas Koch *et al.*, *Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries*, 53 HEALTH SERVS. RES. 3549 (2018); Thomas G. Koch, Brett W. Wendling, & Nathan E. Wilson, *How Vertical Integration Affects the Quantity and Cost of Care for Medicare Beneficiaries*, 52 J. HEALTH ECON. 19 (2017); Julie A. Carlson *et al.*, *Economics at the FTC: Physician Acquisitions, Standard Essential Patents, and Accuracy of Credit Reporting*, 43 REV. INDUS. ORG. 303 (2013); *See also, e.g.*, Martin Gaynor & Robert J. Town, *The Impact of Hospital Consolidation–Update*, Robert Wood Johnson Foundation, The Synthesis Project (2012) (Gaynor is a former director of the FTC's Bureau of Economics who serves presently as a special advisor to the assistant U.S. attorney general for antitrust); Martin Gaynor & William B. Vogt, *Competition Among Hospitals*, 34 RAND J. ECON. 764 (2003); Maximillian J. Pany, Michael E. Chernew, & Leemore S. Dafny, *Regulating Hospital Prices Based on Market Concentration Is Likely to Leave High-Price Hospitals Unaffected*, 40 HEALTH AFF. 1386 (Sept. 2021) (Dafny was deputy director for health care antitrust in the FTC's Bureau of Economics from 2012-13); Leemore S. Dafny, *Hospital Industry Consolidation–Still More to Come?*, 370 NEW ENG. J. MED. 198 (2014).

[33] We focus here on research associated with the FTC's Bureau of Economics, which comprises a significant body of pertinent research. We recognize, of course, that diverse empirical research from DOJ economists and, indeed, various HHS agencies, may be pertinent to provide antitrust scrutiny as well. Stepping back, the larger and still-developing body of academic literature regarding health-care competition is considerable and complex. We do not attempt to review it here.

Many—including current leadership at the antitrust agencies,[34] among others[35]—have recognized that BE research, specifically, has had a significant impact on the courts' treatment of provider mergers. Between 1993 and 2000, antitrust enforcers challenged eight hospital mergers, losing all eight challenges.[36] Hospital-merger challenges waned, and might have been abandoned, but the losing streak spurred renewed research efforts, both within the bureau and across the academy.[37] Critically, BE staff undertook a series of merger-retrospective studies, with then-FTC Chairman Timothy Muris initiating a program of merger-review studies that built on, for example, Vita & Sacher's 2001 study, "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study."[38]

Subsequent provider-merger-retrospective studies have ranged from individual case studies to reviews of dozens of consummated provider mergers.[39] These are, in essence, forensic investigations, aiming "to determine ex post how, if at all, a particular merger affected equilibrium behavior in one or more

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[34] *See, e.g.*, *Letter from Lina Khan, Chair, Fed. Trade Comm'n & Jonathan Kanter, Asst. Atty. General, Antitrust Div., Dept. Justice to the Hon. François-Philippe Champagne, Canada Ministry Innovation, Sci. & Indus.* (Mar. 31, 2023), https://www.justice.gov/atr/page/file/1578296/dl?inline. *See also id.* at 3, n. 11 and 9, n. 40 (highlighting specific hospital-merger retrospective studies and merger retrospectives more generally).

[35] *See, e.g.*, Michael A. Salinger, *The 2023 Merger Guidelines and the Role or Economics*, REV. INDUS. ORG. (May 3, 2024), https://doi.org/10.1007/s11151-024-09957-x; *see also*, *Prepared Opening Remarks of Chairman Joseph J. Simons*, Hearings on Competition and Consumer Protection in the 21st Century, Merger Retrospectives, FED. TRADE COMM'N (Apr. 12, 2019), *available at* https://www.ftc.gov/system/files/documents/public_statements/1513555/merger_retrospectives_hearing_opening_remarks_chairman.pdf. Numerous injunctions obtained by the FTC in provider matters since commencement of the hospital-merger retrospective study program can be found at https://www.ftc.gov/legal-library/browse/cases-proceedings?search=hospital+clinic&sort_by=search_api_relevance.

[36] *See, e.g.*, Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Law in Health Care*, 21 HEALTH AFFS. 185 (2002); Christopher Garmon, *Hospital Mergers–Retrospective Studies to Improve Prediction*, CPI ANTITRUST CHRONICLE (Jul. 2017).

[37] Orly Ashenfelter, Daniel Hosken, Michael Vita, & Matthew Wienberg, *Retrospective Analysis of Hospital Mergers*, 18 INT. J. ECON. & BUS. 5, 6 (2011).

[38] Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001).

[39] *See, e.g.*, Christopher Garmon & Laura Kmitch, *Hospital Mergers and Antitrust Immunity: The Acquisition of Palmyra Medical Center by Phoebe Putney Health*, 14 J. COMP. L. & ECON. 433 (2018); Christopher Garmon, *The Accuracy of Hospital Screening Methods*, 48 RAND J. ECON. 1068 (2017) (reviewing post-merger price changes for 28 hospital mergers, initially published as BE Working Paper); Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18 INT. J. ECON. BUS. 17 (2011); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction*, 18 INT. J. ECON. BUS. 65 (2011) (originally published as BE Working Paper); Aileen Thompson, *The Effect of Hospital Mergers on Inpatient Prices: A Case Study of the New Hanover-Cape Fear Transaction*, 18 INT. J. ECON. BUS. 91 (2011) (originally published as BE Working Paper); Ashenfelter *et al.*, *supra* note 37; Patrick S. Romano & David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 INT. J. ECON. BUS. 45 (2010); John Simpson, *Geographic Markets in Hospital Mergers: A Case Study*, 10 INT. J. ECON. BUS. 291 (2003); Vita & Sacher, *supra* note 38. A bibliography of merger-retrospective studies compiled by the Bureau of Economics comprises more than 30 provider-merger retrospectives, with contributors from within and without BE. Those, in turn, inform and are informed by the larger body of research regarding health-care merger retrospectives. FED. TRADE COMM'N, Merger Retrospectives Bibliography, https://www.ftc.gov/policy/studies/merger-retrospective-program/bibliography (*last visited* May 10, 2024).

markets."[40] The retrospectives have helped to refine merger-screening methods employed within the FTC; and they have been widely credited with reversing the way that hospital mergers are viewed in the courts.[41] As Michael Salinger observes in a recent article in the *Review of Industrial Organization*, the retrospective studies grounded testimony in, *e.g.*:

> the FTC's successful challenge to Evanston-Northwestern Healthcare's acquisition of the Highland Park Hospital . . . and the empirical methods the Bureau of Economics developed (in conjunction with noted academic health care economists) were essential to subsequent success of the Agencies in challenging hospital mergers.[42]

Especially important to litigation challenges were results on the price effects of not-for-profit hospital mergers (which some courts had supposed were generally benign) and on methods of geographic-market definition (where some courts had been inclined toward very broad geographic markets).[43] Subsequent provider retrospectives have extended the scope of the body of work, considering, *e.g.*, nonprice effects,[44] and merger-screening methods more broadly.[45] Indeed, subsequent studies have not been confined to hospital mergers, but have examined, for example, mergers of physician practice groups[46] and the acquisition of physician practices by hospitals.[47]

Of course, retrospective studies of provider mergers at the enforcement margin have limitations, as well as advantages.[48] Critically, the retrospective studies are not conducted or considered in isolation; rather, they complement methodologically diverse studies of hospital mergers and other forms of provider consolidation, including observational studies based on panel data and cross-sectional

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[40] Joseph Farrell, Paul Pautler, & Michael Vita, *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals*, 35 REV. INDUS. ORG. 369 (2009).

[41] *See*, *Overview of the Merger Retrospective Program in the Bureau of Economics*, FED. TRADE COMM'N (*last visited* Apr. 12, 2023), https://www.ftc.gov/policy/studies/merger-retrospective-program/overview; *see also*, Simons, *supra* note 35; Khan & Kanter, *supra* note 34.

[42] Salinger, *supra* note 35, at note 10.

[43] Ashenfelter *et al.*, *supra* note 37, at 6-7.

[44] *See, e.g.*, Romano & Balan, *supra* note 39 (regarding impact on clinical quality).

[45] *See, e.g.*, Hass-Wilson & Garmon, *supra* note 39.

[46] Koch & Ulrick, *supra* note 32.

[47] *See, e.g.*, Thomas G. Koch, Brett W. Wendling, & Nathan E. Wilson, *The Effects of Physician and Hospital Integration on Medicare Beneficiaries' Health Outcomes*, 103 REV. ECON. & STATS. 725 (2021) (initially published as BE Working Paper).

[48] *See, e.g.*, Dennis W. Carlton, *Why We Need to Measure the Effect of Merger Policy and How to Do It*, 5 COMP. POL'Y INT. 77 (2009); Ashenfelter *et al.*, *supra* note 37; Farrell, Pautler, & Vita, *supra* note 40.

data,[49] event studies,[50] and theoretical work.[51] Research has also examined the interaction between providers and third-party payors, as it shapes the nature of competition in health-care-provider markets,[52] as well as vertical[53] and cross-market acquisitions.[54]

Several of the annual review papers published by BE (first, by the FTC, and subsequently by the *Review of Industrial Organization*) provide brief reviews and, importantly, sketch the application of the academic research to provider merger reviews.[55] Learning from the body of research has, in turn, informed investigations of transactions involving, *e.g.*, outpatient kidney-dialysis centers and specialty surgical centers, as well as physician and hospital mergers.[56]

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[49] Matthew Panhans, Ted Rosenbaum, & Nathan E. Wilson, *Prices for Medical Services Vary Within Hospitals, But Vary More Across Them*, 78 MED. CARE RES. REV. 157 (2021, initially published as BE Working Paper); Koch, Wendling, & Wilson, *Medicare Beneficiaries' Health Outcomes*, *supra* note 47 (initially published as BE Working Paper); Asako S. Moriya, William B. Vogt, & Martin Gaynor, *Hospital Prices and Market Structure in the Hospital and Insurance Industry*, 5 HEALTH ECON, POL'Y & LAW 1 (2010) (Martin Gaynor is a former director of the FTC's Bureau of Economics presently serving as a special advisor to the assistant U.S. attorney general for antitrust); Martin Gaynor & William B. Vogt, *Competition Among Hospitals*, 34 RAND J. ECON. 764 (2003); Maximillian J. Pany, Michael E. Chernew, & Leemore S. Dafny, *Regulating Hospital Prices Based on Market Concentration Is Likely to Leave High-Price Hospitals Unaffected*, 40 HEALTH AFF. 1386 (September 2021) (Dafny was deputy director for health care antitrust in the FTC's Bureau of Economics from 2012-13); Leemore S. Dafny, *Hospital Industry Consolidation—Still More to Come?,* 370 NEW ENG. J. MED. 198 (2014); Devesh Raval *et al.*, *Using Disaster Induced Closures to Evaluate Discrete Choice Models of Hospital Demand*, 53 RAND J. ECON. 561 (2022) (initially published as BE Working Paper); Nathan E. Wilson, *Market Structure as a Determinant of Patient Care Quality*, 2 AMER. J. HEALTH ECON. 241 (2016) (studying hemodialysis care) (initially published as BE Working Paper).

[50] *See, e.g.*, Devesh Raval, Ted Rosenbaum, & Nathan E. Wilson, *Using Disaster-Induced Closures to Evaluate Discrete Choice Models of Hospital Demand*, 53 RAND J. ECON. 561 (2022). Event studies are, of course, also observational studies, even if they—and merger retrospectives—may be considered in some regards "quasi-experimental."

[51] David J. Balan & Keith Brand, *Simulating Hospital Merger Simulations*, 71 J. INDUS. ECON. 47 (2023) (initially published as BE Working Paper); *see also* Leemore Dafny, Katherine Ho, & Robin Lee, *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286 (2019) (theoretical analysis with empirical extension).

[52] *See, e.g.*, Carlson *et al.*, *supra* note 32 (citing Cory Capps, David Dranove, & Mark Satterthwaite, *Competition and Market Power in Option Demand Markets*, 34 RAND J. ECON. 737 (2003); Robert Town & Gregory Vistnes, *Hospital Competition in HMO Networks*, 20 J. HEALTH ECON. 753 (2001)).

[53] Koch, Wendling, & Wilson, *Quantity and Spending, supra* note 32; Koch, Wendling, & Wilson, *Health Outcomes, supra* note 47.

[54] Dafny, Ho, & Lee, *supra* note 51; *see also*, Keith Brand & Ted Rosenbaum, *A Review of the Economic Literature on Cross-Market Healthcare Mergers*, 82 ANTITRUST L.J. 533 (2019).

[55] Keith Brand, Martin Gaynor, Patrick McAlvanah, David Schmidt, & Elizabeth Scheirov, *Economics at the FTC: Office Supply Retailers Redux, Healthcare Quality Efficiencies Analysis, and Litigation of an Alleged Get-Rich-Quick Scheme*, 45 REV. INDUS. ORG. 325 (2014); Julie A. Carlson, Leemore S. Dafny, Beth A. Freeborn, Pauline M. Ippolito, & Brett W. Wendling, *Economics at the FTC: Physician Acquisitions, Standard Essential Patents, and Accuracy of Credit Reporting*, 43 REV. INDUS. ORG. 303 (2013); Joseph Farrell, David J. Balan, Keith Brand, & Brett W. Wendling, *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets*, 39 REV. INDUS. ORG. 271 (2011). *Cf.* Martin Gaynor, Kate Ho, & Robert J. Town, *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LIT. 235 (2015); Brand & Rosenbaum, *supra* note 54 (review of cross-market health-care mergers literature).

[56] *See* Carlson *et al.*, *supra* note 32.

B. There Is No Sound Basis for New Substantive Competition Regulations Regarding Health-Care Acquisitions, and the RFI Seems Unlikely to Provide One

The agencies state that the RFI will inform, *inter alia*, "new regulations aimed at promoting and protecting competition in health care markets."[57] Absent a notice of proposed rulemaking (NPRM), it is unclear what is being contemplated, and correspondingly unclear how the RFI might lead to an NPRM from any of the three agencies. Certainly, FTC and HHS already enforce consumer-protection regulations, issued under express congressional charges, that may have procompetitive effects.[58] These include, for example, the FTC's Contact Lens Rule (CLR),[59] implementing the Fairness to Contact Lens Consumers Act,[60] and FDA regulations regarding over-the-counter (OTC) hearing aids,[61] implementing certain provisions of the FDA Reauthorization Act of 2017 (FDARA).[62] We would welcome reporting from the FTC on the question of whether it has brought any cases to enforce the central prescription-release provision of the CLR, initially adopted in 2004. More broadly, study of the competitive effects of these regulations may be salutary, to the extent that it might inform proposals to amend the rules. Still, we recognize that enforcement of these regulations is a proper part of the congressional charges to the agencies, and we do not propose changes to either rule.

The prospect of new competition regulations seems, at best, premature. First, the agencies may lack the authority to promulgate such competition rules. The question of whether Congress has granted the FTC substantive or "legislative" competition-rulemaking authority is contentious;[63] and we are aware of no legal basis on which the DOJ could adopt substantive competition regulations. We also are unaware of any amenable statutory charge to HHS. Certainly, HHS can and should consider competitive effects when implementing health-care statutes, but statutory charges for health-care regulations to HHS tend to be specific ones—as was the charge to promulgate regulations for OTC hearing aids noted in the preceding paragraph—and not commonly related to merger scrutiny.

Cognizant of the agencies' substantial enforcement experience and a significant body of academic literature regarding health-care consolidation, it is difficult to imagine how submissions to the RFI

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[57] RFI at 4.

[58] *See, e.g.*, *FTC Staff Comment to the Food and Drug Administration in Docket No. FDA-2021-N-0555 Concerning Over-the-Counter Hearing Aids*, FED. TRADE COMM'N (Jan. 28, 2022), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-federal-drug-administration-docket-no-fda-2021-n-0555-concerning-over-counter/v220000staffcommentotchearingaids2.pdf (noting the likely procompetitive effect of rule).

[59] 16 C.F.R. § 315.

[60] 15 U.S.C. 7601-7610.

[61] 21 C.F.R. § 800.30.

[62] Pub. L. 115-52, 131 Stat. 1005, Aug. 18, 2017.

[63] *See, e.g.*, Thomas W. Merrill, *Antitrust Rulemaking: the FTC's Delegation Deficit*, 75 ADMIN LAW REV. 277 (2023) ("the FTC has no legal authority to engage in legislative rulemaking on competition matters." *Id.* at 278); *see also*, Thomas W. Merrill *et al.*, *Agency Rules with the Force of Law: The Original Convention*, 116 HARV. L. REV. 467 (2002).

could establish the prerequisites to competition rulemaking regarding health-care acquisitions, even if FTC were deemed to have the requisite rulemaking authority. At present, the agencies do not enforce any such health-care regulations and, to the best of our knowledge, none of the agencies has ever adopted a rule regarding health-care acquisitions under a general grant of legislative rulemaking authority. Specific health-care acquisitions, whether proposed or consummated, can, of course, be blocked, if found anticompetitive, under an administrative ruling, by the Federal Trade Commission, or a judicial ruling, by a federal court. To the best of our knowledge, such decisions have always been case-specific.

Contemporary antitrust law reserves broad rule-like prohibitions for a very limited number of "naked" restraints on trade, such as horizontal price-fixing. For more than 40 years, the U.S. Supreme Court has been clear that general, *per se*, prohibitions are reserved for the types of matters that "always or almost always tend to restrict competition and decrease output."[64] None of the types of acquisitions listed in the RFI can demonstrably meet that standard and, absent an express statutory charge from Congress, there is no evident ground for regulating categories of health-care acquisitions under a lesser standard.

Again, we do not—and cannot—impugn *ex ante* competition concerns that may be raised by specific health-care acquisitions. But, for example, a given study suggesting that certain private-equity acquisitions of hospitals are associated with poorer quality in-patient care, at least on certain measures (chiefly, falls and central-line infections for Medicare beneficiaries)[65] may indeed inform merger scrutiny, but such average effects from a single noncausal study,[66] driven by select effects in a select patient population, cannot suffice to establish that such acquisitions are anticompetitive on net, on average, much less that they "always or almost always tend to restrict competition and reduce output."

Of course, by noting the potential for new regulations, the agencies might contemplate not only—or even primarily—the promulgation of regulations *sui generis*, but research and advocacy reported to lawmakers that could inform subsequent and specific statutory charges for regulations.[67] Such

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[64] *Broadcast Music, Inc. v. Columbia Broad. Sys., Inc.*, 441 U.S. 1, 19-20 (1979) (citations omitted).

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

[66] As discussed below, other studies suggest mixed results. *See, e.g.*, *infra.* note 118, and accompanying text.

[67] Regarding competition advocacy generally, *see, e.g.*, James C. Cooper, Paul A. Pautler, & Todd J. Zywicki, *Theory and Practice of Competition Advocacy at the FTC*, 72 ANTITRUST L.J. 1091 (2005); Maureen K. Ohlhausen, *Identifying, Challenging, and Assigning Political Responsibility for State Regulation Restricting Competition,* 2 COMP. POL'Y INT. 151 (2006); Daniel J. Gilman, *Advocacy*, *in* SAGE ENCYCLOPEDIA OF POLITICAL BEHAVIOR 8 (Fathali M. Moghaddam ed., 2017). Links to numerous studies, reports, and advocacy documents by the FTC and its staff are at https://www.ftc.gov/advice-guidance/competition-guidance/industry-guidance/competition-health-care-marketplace. We note that FTC and DOJ jointly issued many such documents. *See, e.g.*, *Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice Regarding Certificate-of-Need (CON) Laws and Alaska Senate Bill 62, Which Would Repeal Alaska's CON Program* (Apr. 12, 2017), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006_ftc-doj_comment_on_alaska_senate_bill_re_state_con_law.pdf.

research and advocacy can indeed have a salutary effect on policy, although, again, we caution that the present RFI seems unlikely to lead to well-founded policy recommendations, even if it does advance agency learning at the margin.

C. Vertical Transactions Are Not Generally Anticompetitive

The RFI raises broad questions about vertical acquisitions, both in questioning the impact of "[t]ransactions conducted by private equity funds or other alternative asset managers,"[68] (some of which might be considered conglomerate mergers) and in questioning the impact of "[t]ransactions conducted by health systems."[69]

There is no doubt that vertical mergers *can* be anticompetitive under certain circumstances. For example, an integrated firm may have an incentive to exclude rivals,[70] and a vertical merger *can* have an anticompetitive effect if the upstream firm has market power and the ability, post-acquisition, to foreclose its competitors' access to a key input.[71] In that regard, raising rivals' costs can "represent[] a credible theory of economic harm" if other conditions of exclusionary conduct are met."[72] But the implications of vertical mergers are theoretically ambiguous: anticompetitive effects are possible, but they are neither necessary nor, for that matter, typical: "The circumstances… in which [raising rivals' costs] can occur are usually so limited that [it] almost always represents a minimal threat to competition."[73] Moreover:

> [a] major difficulty in relying principally on theory to guide vertical enforcement policy is that the conditions necessary for vertical restraints to harm welfare generally are the same conditions under which the practices increase consumer welfare.[74]

This structural ambiguity weighs against any presumption against vertical mergers, and it suggests the importance of empirical research in formulating standards to evaluate vertical transactions.

The economics literature is, to borrow a phrase from *Leegin*, "replete with procompetitive justifications" for vertical integration. Vertical integration typically confers benefits, such as eliminating

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[68] RFI at 5.

[69] RFI at 6.

[70] Steven C. Salop & David T. Scheffman, *Cost-Raising Strategies*, 36 J. INDUS. ECON. 19 (1985).

[71] Janusz A. Ordover, Garth Saloner, & Steven C. Salop, *Equilibrium Vertical Foreclosure*, 80 AM. ECON. REV. 127 (1990).

[72] Malcolm B. Coate & Andrew N. Kleit, *Exclusion, Collusion, and Confusion: The Limits of Raising Rivals' Costs* (FTC Bureau of Economics, Working Paper No. 179, 1990).

[73] *Id.* at 3.

[74] James C. Cooper *et al.*, *Vertical Antitrust Policy as a Problem of Inference*, 23 INT'L. J. INDUS. ORG. 639, 643 (2005).

double marginalization,[75] increasing R&D investment,[76] and creating operational and transactional efficiencies.[77]

Empirical evidence further supports the established legal distinctions between horizontal mergers and vertical mergers (as well as other forms of vertical integration), indicating that vertical integration tends to be procompetitive or benign. For example, a meta-analysis of more than 70 studies of vertical transactions analyzed groups of studies for their implications for various theories or models of vertical integration, and for the effects of vertical integration. From that analysis:

> a fairly clear empirical picture emerges. The data appear to be telling us that efficiency considerations overwhelm anticompetitive motives in most contexts. Furthermore, even when we limit attention to natural monopolies or tight oligopolies, the evidence of anticompetitive harm is not strong.[78]

On the contrary, "under most circumstances, profit-maximizing vertical integration decisions are efficient, not just from the firms' but also from the consumers' points of view."[79] And "[a]lthough there are isolated studies that contradict this claim, the vast majority support it...."[80] Lafontaine & Slade accordingly concluded that "faced with a vertical arrangement, the burden of evidence should be placed on competition authorities to demonstrate that that arrangement is harmful before the practice is attacked."[81] Another study of vertical restraints finds that, "[e]mpirically, vertical restraints appear to reduce price and/or increase output. Thus, absent a good natural experiment to evaluate a particular restraint's effect, an optimal policy places a heavy burden on plaintiffs to show that a restraint is anticompetitive."[82]

Subsequent research has reinforced these findings. Reviewing the more recent literature from 2009-18, John Yun concluded "the weight of the empirical evidence continues to support the proposition that vertical mergers are less likely to generate competitive concerns than horizontal ones."[83]

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[75] David Reiffen & Michael Vita, *Comment: Is There New Thinking on Vertical Mergers?* 63 ANTITRUST L. J. 917 (1995); *see also, e.g.*, Daniel O'Brien, *The Antitrust Treatment of Vertical Restraint: Beyond the Possibility Theorems*, *in* THE PROS AND CONS OF VERTICAL RESTRAINTS 22, 36 (Konkurrensverket ed., 2008); Michael A. Salinger, *Vertical Mergers and Market Foreclosure*, 103 Q. J. ECON. 345 (1988).

[76] Henry Ogden Armour & David Teece, *Vertical Integration and Technological Innovation*, 62 REV. ECON. & STAT. 470 (1980).

[77] Dennis W. Carlton, *Transaction Costs and Competition Policy*, 73 INT'L J. INDUS. ORG. 1 (2020).

[78] Francine Lafontaine & Margaret Slade, *Vertical Integration and Firm Boundaries: The Evidence*, 45 J. ECON. LIT. 629, 677 (2007).

[79] *Id.*

[80] *Id.*

[81] *Id.*

[82] Cooper *et al.*, *supra* note 74, at 639.

[83] John M. Yun, *Vertical Mergers and Integration in Digital Markets*, *in* THE GAI REPORT ON THE DIGITAL ECONOMY (Joshua D. Wright & Douglas H. Ginsburg eds., 2020) at 245.

Leading contributors to the empirical literature, reviewing both new studies and critiques of the established view of vertical mergers, maintain a consistent view. For example, testifying at a 2018 FTC hearing, former FTC Bureau of Economics Director Francine Lafontaine acknowledged that *some* of the early empirical evidence is less than ideal, in terms of data and methods, but reinforced the overall conclusions of her earlier research "that the empirical literature reveals consistent evidence of efficiencies associated with the use of vertical restraints (when chosen by market participants) and, similarly, with vertical integration decisions."[84]

The empirical literature regarding vertical acquisitions involving health-care providers, specifically, remains unclear.[85] One study of hospital acquisitions of large physician groups, employing Medicare claims data, finds significant changes at the physician level, with acquired physicians delivering substantially more care in the acquirers' hospitals post-acquisition (and less at other hospitals and via office-based care).[86] It also finds increased billing at the hospital level, although observed hospital-level effects are smaller, and estimates less precise, than those at the physician level.[87] Here, increased costs—at least for these acquisitions on these measures—appear to be "consistent with the hypothesis that acquired physicians are responding to CMS' location-based billing policy, which provides higher compensation for care delivered in hospital settings relative to doctors' offices."[88] Another study fails to find systematic clinical benefits to vertical integration across diverse quality-of-care metrics.[89]

Such studies may tend to impugn the notion that vertical acquisitions of physician practices by hospitals tend to provide efficiencies that offset cost or price increases, but they cannot be regarded as comprehensive. Further, they suggest the role that public health-care programs and regulations may play in distorting competitive dynamics for both utilization and costs. That raises the question of where policy reform might best be located, supposing that it is called for.

Finally, such studies do not resolve the larger question of why so many physicians—both individually and through their practice groups—are leaving independent practice for hospital- and system-based employment. While the extant literature can certainly inform provider-merger scrutiny in individual matters, it does not appear to implicate general policy reforms for vertical acquisitions of health-care

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[84] Francine Lafontaine, *Vertical Mergers (Presentation Slides)*, in FTC, Competition and Consumer Protection in the 21st Century; FTC Hearing #5: Vertical Merger Analysis and the Role of the Consumer Welfare Standard in U.S. Antitrust Law, Presentation Slides 93 (Nov. 1, 2018), *available at* https://www.ftc.gov/system/files/documents/public_events/1415284/ftc_hearings_5_georgetown_slides.pdf. *See also* Francine Lafontaine & Margaret E. Slade, *Presumptions in Vertical Mergers: The Role of Evidence*, 59 REV. INDUS. ORG. 255 (2021).

[85] *See* Koch, Wendling, & Wilson, *Outcomes*, *supra* note 47 (discussing research challenges and mixed results in the literature).

[86] Koch, Wendling, & Wilson, *Quantity and Cost of Care*, *supra* note 32

[87] *Id.* at 20.

[88] *Id.* at 20.

[89] Koch, Wendling, & Wilson, *Outcomes*, *supra* note 47.

providers and, indeed, suggests equal concern with the design of federal programs and regulations beyond antitrust.

In short, empirical research confirms that the law properly does not presume that vertical mergers have anticompetitive effects; rather, it requires specific evidence of both harms and efficiencies.

The preceding comments apply *a fortiori* to conglomerate mergers. Whereas vertical mergers combine firms in the same supply chain, conglomerate mergers combine firms that are neither engaged in head-to-head competition nor operating in the same supply chain. Such mergers thus do not inherently reduce competition in any market. The government has explained that conglomerate mergers can produce many of the same "procompetitive benefits" of vertical mergers if the combined firms' "production or distribution uses the same assets, inputs, or know-how."[90] That is so "even if the merged firm will become a more effective competitor or gain [market] share."[91] The resulting economies of scope can increase consumer welfare.

Conglomerate mergers between large, established firms and smaller innovators also play an important role in fostering innovation—and, thus, product competition—in, for example, the pharmaceutical industry. As the Congressional Budget Office (CBO) explains:

> The acquisition of a small company by a larger one can create efficiencies that might increase the combined value of the firms by allowing drug companies of different sizes…to specialize in activities in which they have a comparative advantage. Small companies—with relatively fewer administrative staff, less expertise in conducting clinical trials, and less physical and financial capital to manage—can concentrate primarily on research. For their part, large drug companies are much better capitalized and can more easily finance and manage clinical trials. They also have readier access to markets through established drug distribution networks and relationships with buyers.[92]

Conglomerate mergers in the pharmaceutical industry thus can realize the procompetitive effects of vertical combinations (creating efficiencies) while avoiding the anticompetitive effects of horizontal mergers (eliminating competition).

That is not to say conglomerate mergers can never lead to higher prices. Recent research on bargaining models indicates it is possible for cross-market acquisitions to facilitate a price increase. Such models do not, however, suggest that is a likely result. Instead, empirical research indicates that, generally, "cross-market acquisitions by larger companies do not have a significant effect on price."[93]

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[90] *Conglomerate Effects of Mergers – Note by the United States* 2, OECD (Jun. 10, 2020), *available at* https://www.ftc.gov/system/files/attachments/us-submissions-oecd-2010-present-other-international-competition-fora/oecd-conglomerate_mergers_us_submission.pdf ("Conglomerate Effects").

[91] *Id.* at 2-3.

[92] *Research and Development in the Pharmaceutical Industry*, CONG. BUDGET OFF. (April 2021), https://www.cbo.gov/publication/57126.

[93] Josh Feng *et al.*, *Mergers that Matter: The Impact of M&A Activity in Prescription Drug Markets* 6 (SSRN Working Paper, Jul. 25, 2023), https://ssrn.com/abstract=4523015.

Moreover, a common theory of competitive harm holds only "as long as" the parties' "products have common customers."[94] Hospital acquisitions may provide a special case, in that they may cross geographic markets even if they do not cross product markets. Moreover, geographic markets may have different boundaries from the perspectives of patients and third-party payors.[95] Put another way, certain provider mergers that may be deemed cross-market transactions from a patient perspective may also alter provider bargaining with health plans for whom the providers are substitutes (or complements); hence, from another perspective, they are within the same geographic market. In that regard, additional research[96] and additional enforcement experience may, in time, lead to further refinements in hospital-merger scrutiny.

Of course, none of this is to say that the agencies should not scrutinize vertical or conglomerate mergers involving health-care providers. Further research might sharpen the agencies' understanding of specific industries in which, or circumstances under which, provider acquisitions may be more or less likely to raise competitive concerns. Ongoing research by the agencies—including BE staff research[97]—will no doubt further that goal.

But, as we note above, a single study is not a body of literature, much less one that is mature or settled. Indeed, a single study suggesting that certain private-equity acquisitions of hospitals are associated with poorer quality in-patient care, at least on certain measures (chiefly, falls and central-line infections for Medicare beneficiaries)[98] may, indeed, inform merger scrutiny, but such average effects from a single noncausal study, driven by select effects in a select patient population, cannot suffice to establish that such acquisitions are anticompetitive on net, on average, much less that they "always or almost always tend to restrict competition and reduce output." More plausibly, it may be pertinent to questions of, *e.g.*, when to issue a second request or commence a formal investigation, at least at the margin.

Similarly, future research may sharpen the agencies' understanding of the conditions under which vertical (or conglomerate) acquisitions by third-party payors are more, or less, likely to raise

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[94] *Id.* at 5-6.

[95] Leemore Dafny, Katherine Ho, & Robin Lee, *The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry*, 50 RAND J. ECON. 286 (2019) (finding price effects for mergers across geographic markets, but within state boundaries); *see also* Keith Brand & Ted Rosenbaum, *A Review of the Economic Literature on Cross-Market Healthcare Mergers*, 82 ANTITRUST L.J. 533 (2019) (reviewing several studies and noting observed competitive effects and issues for further study).

[96] *See, e.g.*, Brand & Rosenbaum, *supra* note 95 (regarding possible application to hospital-merger cases, among others, as well as issues for further research).

[97] We note that, *e.g.*, in January 2021, the FTC issued orders under its FTC Act Section 6(b) authority to six health-insurance companies to furnish information in order to facilitate the agency's study of the effects of physician group and health-care-facility consolidation from 2015 through 2020. Press Release, *FTC to Study the Impact of Physician Group and Healthcare Facility Mergers*, FED. TRADE COMM'N (Jan.14, 2021), https://www.ftc.gov/news-events/news/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers. While the information collected under such orders is limited partly by restrictions imposed under the Paperwork Reduction Act, and not merely available data and methodological concerns, it may nonetheless help advance understanding of provider consolidation.

[98] Kannan *et al.*, *supra* note 65.

competition concerns. Such research might be bolstered by additional enforcement experience with such acquisitions, but we expect that the present RFI is not well-designed to further agency understanding much beyond that already available to agency staff.

D. A Provider's For-Profit or Not-for-Profit Status May Say Little About the Likely Competitive Effects of Mergers or Acquisitions Involving that Provider

As noted above, we were struck by a statement at the outset of the RFI: "Given recent trends, we are concerned that transactions may generate profits for those firms at the expense of patients' health, workers' safety, and affordable health care for patients and taxpayers."[99] To be sure, some transactions do just that. There is no doubt that the antitrust laws are broadly applicable to health-care transactions or that particular provider mergers, under particular facts and circumstances, may violate the antitrust laws, harming competition and consumer welfare.[100] And nonprice effects, such as quality of care, may factor in antitrust scrutiny of a provider merger.[101]

Nonetheless, the agencies understand that antitrust law and economics do not recognize any general or fundamental tension between firm profits, on the one hand, and the consumer benefits typically associated with price and nonprice competition in goods and services markets, on the other. Moreover, considerable research militates against the suggestion that for-profit and not-for-profit providers should be distinguished for the purposes of merger scrutiny. As Martin Gaynor—former director of the FTC Bureau of Economics and presently special advisor to the assistant U.S. attorney general for antitrust—summarized in testimony before the Senate Judiciary Committee: "Research evidence shows not-for-profit hospitals exploit market power just as much as for-profits."[102]

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[99] RFI at 1 (the second sentence of the summary).

[100] *See generally, e.g.*, *FTC v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216 (2013). In its unanimous decision, the Court noted that the 11th U.S. Circuit Court of Appeals had, as an initial matter, "'agreed with the [FTC] that, on the facts alleged, the joint operation of Memorial and Palmyra would substantially lessen competition or tend to create, if not create, a monopoly'" 568 U.S. at 222-3 (quoting *FTC v. Phoebe Putney Health Sys., Inc.*, 663 F.3d 1369, 1375 (2011). The Court's holding in *Phoebe Putney* upheld the FTC's jurisdiction over the hospital merger, notwithstanding the grant of certain powers to hospital authorities by the State of Georgia. 568 U.S. at 224. For a discussion of various FTC research, advocacy, and enforcement activities in health care, including scrutiny of provider mergers, *see*, *e.g.*, Maureen K. Ohlhausen, *The First Wealth is Health: Protecting Competition in Healthcare Markets*, Remarks at the 2017 ABA Fall Forum (Nov. 16, 2017), *available at* https://www.ftc.gov/system/files/documents/public_statements/1275573/mko_fall_forum_2017.pdf. While the FTC and the DOJ have concurrent jurisdiction over mergers under Section 7 of the Clayton Act, health-care-provider mergers are typically assigned to the FTC under the FTC/DOJ clearance process. For a list of health-care-enforcement matters, see FTC, *The FTC's Health Care Work: Cases*, https://www.ftc.gov/news-events/topics/competition-enforcement/health-care-competition (*last visited* May 1, 2024).

[101] *See, e.g.*, David J. Balan & Patrick S. Romano, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 INT. J. ECON. BUS. 45 (2011) (initially published as a BE Working Paper, *available at* https://www.ftc.gov/sites/default/files/documents/reports/retrospective-analysis-clinical-quality-effects-acquisition-highland-park-hospital-evanston/wp307.pdf).

[102] Gaynor testimony, *supra* note 3.

In fact, as noted above, two early foci for the FTC's hospital-merger retrospective studies were, one, the question of how best to approach geographic-market definition (not least, because some courts were inclined toward very broadly drawn hospital markets, at odds with established methods) and, two, the question of whether not-for-profit hospitals were less likely than for-profit hospitals to exploit market power, when they had it, within the relevant geographic boundaries (not least, because some courts were accepting what amounted to a "not-for-profit defense" to hospital-merger challenges).[103] The merger retrospectives consistently demonstrated that not-for-profit status did not make a difference.[104]

Our point is not that the extant literature is definitive or that it is easily generalized across different types of providers. Rather, there are good reasons to think that not-for-profit providers are not special from a competition standpoint, and substantial evidence on that point in a well-investigated provider domain.

Further research and enforcement experience might suggest a different perspective on one or more specific subcategories of provider acquisitions. Still, the agencies should be mindful of the hospital findings as a background matter. And as the agencies' research staff are likely aware, research regarding the question of whether for-profit provider status in, *e.g.*, hemodialysis treatment is associated with different treatment quality has provided mixed results, with some agency research failing to find any statistically significant indication that it is.[105] Results also are observed to vary across empirical specifications and available datasets.[106] In addition, given the large number of hemodialysis acquisitions nationwide associated with two acquiring firms, there is an open question, even with regard to kidney dialysis, how best to parse for-profit status from the management practices of two very large for-profit acquirers.[107]

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[103] Ashenfelter *et al.*, *supra* note 37, at 12.

[104] *Id.*

[105] *See, e.g.*, Wilson, *supra* note 49 (studying hemodialysis care and finding no statistically significant indication that for-profit status is associated with a different quality of care; and comparing, *e.g.*, Paul Grieco, & Ryan C. McDevitt, *Productivity and Quality in Health Care: Evidence from the Dialysis Industry*, 84 REV. ECON. STUDS. 1071 (2006) *with* John M. Brooks *et al.*, *Effect of Dialysis Center Profit-Status on Patient Survival: A Comparison of Risk-Adjustment and Instrumental Variable Approaches*, 41 HEALTH SERVS. RES. (2006)). As we note below, it may be difficult to generalize observations from the U.S. dialysis industry because of both variation in the quality of care and the degree to which two firms account for for-profit acquisitions of independent facilities.

[106] *See* Wilson, *supra* note 49.

[107] For example, in a 2020 paper, Eliason *et al.* observed that only 21% of dialysis facilities were independently owned, and that two large, publicly traded companies owned 60% of the facilities and 90% of the revenue in the space. Paul J. Eliason *et al.*, *How Acquisitions Affect Firm Behavior and Performance: Evidence from the Dialysis Industry*, 135 Q. J. ECON. 221, 222 (220). We note, too, that the FTC already has consent orders in place with both of those firms. Under one such order, DaVita, Inc. was required to divest certain facilities and limit its use of noncompete agreements; it must also get prior approval for future acquisitions from the FTC. *See, In the Matter of DaVita, Inc., and Total Renal Care*, FTC File No. 211-0013 (Oct. 25, 2021), (agreement containing consent orders).

E. Various Models of Health-Care Delivery May Be Associated with Complex Tradeoffs

Whereas some of the interests or concerns in the RFI focus on transactions' structural features—*e.g.*, on the competitive effects of horizontal, vertical, or conglomerate mergers—an overlapping set of questions focuses on the type of acquiring firm. For example, the RFI notes "concerning trends" in, *e.g.*, "transactions in the health care market conducted by private equity funds or other alternative asset managers, health systems, and private payers ."[108] The RFI suggests that there is "recent research indicating these categories of transactions may harm health care quality, access, and/or costs."[109]

But the suggestion about "recent research" has no attached citation. An earlier footnote substantiates the claim that "[a]cademic research and agency experience in enforcement actions has shown that patients, health care workers, and others may suffer negative consequences as a result of horizontal and vertical consolidation of a range of different types of providers—including not-for-profit providers."[110] While the agencies cite only two primary research articles and one policy review for that general proposition—and while one of the articles suggests limited results[111]—we take it that the far more general claim is (or should be) uncontroversial. The dozens of papers cited above in Section II.A.2. of these comments tend to substantiate those broad claims. That is, diverse provider acquisitions *can* raise competitive concerns; and, moreover, competitive concerns can be raised equally by transactions (or other conduct) involving not-for-profit and for-profit providers.

Not incidentally, many provider markets are highly concentrated, pre-acquisition, on any notion of "highly concentrated."[112] For example, the FTC's defense of its authority in the *Phoebe-Putney* matter concerned what was, in effect, a merger to monopoly;[113] and several surrounding counties—like many outside metropolitan areas across the country—had no general hospital at all.[114] No policy reform is needed to provide that two-to-one hospital mergers will be carefully scrutinized by antitrust

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[108] RFI at 3.

[109] RFI at 5.

[110] RFI at 4-5.

[111] Elena Praeger & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, 111 AM. ECON. REV. 397–427 (2021). Praeger & Schmitt examine whether hospital employees' wage growth slows following consolidation. While they observe some slowing wage growth under limited conditions (large increases in concentration, plus industry-specific skills), they fail to reject zero wage effects in most cases.

[112] *See supra* note 10.

[113] *FTC v. Phoebe Putney Health Sys., Inc.*, 568 U.S. 216 (2013).

[114] *See, e.g.*, *FTC Staff Comment Before the Georgia Department of Community Health Regarding the Certificate of Need Application Filed by Lee County Medical Center*, FED. TRADE COMM'N (2017), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-georgia-department-community-health-regarding-certificate-need-application-filed/v180001gaconleecounty_and_attachments.pdf (discussing ongoing dearth of competition for hospital services in surrounding five-county area).

authorities. Similarly high provider concentration can be observed across diverse specialty practices in many rural and other small markets.[115]

But the research base and enforcement experience regarding specific types of acquiring (or target) firms is considerably less well-developed. We do not mean to impugn specific studies, so much as to place available results in context. For example, as we also discuss above, there are studies suggesting negative health-care-quality effects—cognizable harms—associated with certain for-profit acquisitions of hemodialysis-treatment facilities.[116] But as we note there, results in that space are somewhat mixed, varying across empirical specifications and available data, and there is some research that fails to find any statistically significant indication that acquisitions by for-profit firms are associated with different treatment quality.[117]

Turning to private-equity acquisitions, the RFI cites a single study suggesting that certain private-equity acquisitions of hospitals are associated with poorer quality in-patient care, at least on certain measures (chiefly, falls and central-line infections for Medicare beneficiaries).[118] We cannot gainsay competition concerns about such acquisitions, and the study may, indeed, inform merger scrutiny going forward. Such average effects from a single non-causal study, driven by select effects in a select patient population, cannot, however, suffice to establish that such acquisitions are anticompetitive on net, on average, much less ground a fundamentally different approach to private-equity acquisitions of health-care providers. We note, too, that another study (with two of the same coauthors) found more mixed results, including some suggesting improved quality of care:

> In our main analysis, we observed greater improvements in process quality measures among private equity–acquired hospitals relative to controls, which may reflect better care for patients. However, it could also be consistent with better adherence to compliance standards or efforts to maximize opportunities for quality bonuses under pay-for-performance contracts.[119]

Positive income and profitability were also observed. Both studies evidence some heterogeneity of findings across the private-equity and control hospitals. Our point is not that the agencies should be unconcerned about nonprice effects, such as quality of care. Rather, it is that the understanding of this class of transactions is incomplete, and unlikely to be resolved by submissions in response to

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[115] For example, in a 2019 letter to the Texas Medical Board, FTC staff noted that most of the critical-access hospitals in Texas were located in counties where there were no practicing anesthesiologists, with 37 of those hospitals located in counties where certified-registered-nurse anesthetists were the only licensed, specialized providers of anesthesia and anesthesia-related services. *FTC Comment to Texas Medical Board on Its Proposed Rule 193.13 to Add Supervision Requirements for Texas-Certified Nurse Anesthetists*, 2, FED. TRADE COMM'N (2019), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-comment-texas-medical-board-its-proposed-rule-19313-add-supervision-requirements-texas-certified/v200004_texas_nurse_anesthetists_advocacy_letter.pdf.

[116] *See supra* text accompanying notes 105-107.

[117] *Id.* (citing Wilson, *supra* note 49).

[118] Kannan *et al.*, *supra* note 65.

[119] Joseph D. Bruch, Suhas Gondi, & Zirui Song, *Changes in Hospital Income, Use, and Quality Associated with Private Equity Acquisition*, 180 JAMA INTERN. MED. 1 (2020).

this RFI. Also, the research does not resolve the fundamental question of when or under what conditions hospitals may be targets for private-equity acquisitions. And to the extent it suggests new management practices, it may suggest not just concerns but tradeoffs in the management capacity associated with different acquirers.[120]

Given mixed results and a lacunae in the literature, further research is warranted, as well as case-specific investigation using established methods. To the extent that specific findings on specific categories of provider mergers are mixed, unclear, or conspicuously limited, more general economic learning and precedent regarding, *e.g.*, horizontal, vertical, and conglomerate mergers may be especially informative. So, too, may be agency experience with undue restraints on the "corporate practice of medicine" or other undue restraints on new models of distribution for health care, dating at least to the FTC's landmark 1980 case against the American Medical Association, which addressed various restraints on physician and nonphysician contracting.[121] Analogously, in 1992, based on its research regarding the eye-care industry, FTC staff advocated for the repeal of "prohibitions against practicing in retail settings and against corporate affiliations."[122]

Finally, given results suggesting the confounding effects of health-care programs and regulations, from Medicare reimbursement policies to state-based certificate-of-public-advantage and certificate-of-need regulations, the agencies should be ever alert to the question of the best locus for policy reform.

F. The Framing of a Request for Information Can Influence the Quality of the Response

As we explain above, we appreciate the importance of the agencies' efforts to protect and foster competition in diverse health-care markets; and we appreciate the mutually reinforcing roles that policy studies and enforcement experience can play in health-care and antitrust policy. Still, one

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[120] Agency staff have no doubt also noticed that the studies regard limited numbers of private-equity acquirers. For example, the Bruch, Gondi, & Song study, *id.*, incorporates numerous acquisitions by the Hospital Corporation of America (HCA), which may provide a sharper picture of HCA acquisitions, but may or may not generalize across the industry.

[121] *American Medical Assn. v. FTC*, 638 F.2d 443 (2d Cir. 1980) (aff'd *per curiam American Medical Assn. v. FTC*, 455 U.S. 676 (1982)); *cf.*, *e.g.*, Matthew Mandelberg *et al.*, *Reconsidering the Ban on Physician-Owned Hospitals to Combat Consolidation*, and Matthew Mandelberg, Michael Smith, Jesse Ehrenfeld, & Brian Miller, *Reconsidering the Ban on Physician-Owned Hospitals to Combat Consolidation* (Feb. 5, 2023). Forthcoming in N.Y.U. J. LEG. & PUB. POL'Y, *available at* SSRN: https://ssrn.com/abstract=4350105.

[122] *Statement on L.D. 1866 to the Committee on Bus. Leg.*, MAINE HOUSE OF REPRESENTATIVES (Jan. 8, 1992), *available at* https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-maine-house-representatives-committee-business-legislation-concerning-l.d.1866-repeal-prohibitions-against-optometry-practice-retail-settings-and-corporate-affiliations/af-21.pdf; *see also*, *FTC Staff Comment Before the North Carolina State Board of Opticians Concerning Proposed Regulations for Optical Goods and Optical Goods Businesses*, FED. TRADE COMM'N (2011), https://www.ftc.gov/legal-library/browse/advocacy-filings/ftc-staff-comment-north-carolina-state-board-opticians-concerning-proposed-regulations-optical-goods. *Cf. FTC Staff Comment to the Food & Drug Admin. in Docket No. FDA-2021-N-055 Concerning Over-the-Counter Hearing Aids*, FED. TRADE COMM'N (Jan. 8, 2022), *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-federal-drug-administration-docket-no-fda-2021-n-0555-concerning-over-counter/v220000staffcommentotchearingaids2.pdf.

need not gainsay concerns about health-care competition or specific types of acquisitions to appreciate the difficulty of grounded, systematic reform of enforcement policy in these areas. The agencies' extension of the deadline for submissions in response to the RFI will, no doubt, increase the utility of the inquiry. But while recognizing that the present RFI may be a useful endeavor, it is just one tool—in itself, a limited one—in the agencies "policy R&D"[123] toolbox. Moreover, the RFI's framing seems, in many ways, unfortunate: not conducive to the most constructive use of agency resources or third-party contributions.

First, the scope of the RFI is unclear. The agencies note that they are:

> particularly interested in information on transactions in the health care market conducted by private equity funds or other alternative asset managers, health systems, and private payers, especially those transactions that would not be noticed to the Department of Justice and the Federal Trade Commission under the Hart-Scott-Rodino Antitrust Improvements Act, 15 USC 18(a).[124]

Such transactions may be both numerous and diverse, with or without a restriction on HSR-reportable transactions. The scope and heterogeneity of agency interests is only underscored by the RFI's elaboration on the transactions of interest:

> These transactions could involve dialysis clinics, nursing homes, hospice providers, primary care providers, hospitals, home health agencies, home- and community-based services providers, behavioral health providers, billing and collections services, revenue cycle management services, support for value-based care, data/analytics services, and other types of health care payers, providers, facilities, Pharmacy Benefit Managers (PBMs), Group Purchasing Organizations (GPOs), or ancillary products or services.[125]

If the RFI is meant to be but one inquiry in a much larger project—say, for example, something akin to the 2003 FTC/DOJ health-care hearings that led to the 2024 Dose of Competition report—some sense of the scope of the larger project would be helpful to the public. On its own, the reference to acquisitions across such diverse health-care entities seems extremely broad, and not well-suited to the production of usefully focused submissions.

Whatever the scope of the RFI, its framing is critical to its utility. Given the agencies' considerable contributions to health-care competition over the course of several decades,[126] we regret to comment on a conspicuous deficit in the RFI's framing. As we note in our introductory summary, the agencies'

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[123] A 2009 report by then-FTC Chair William Kovacic defines "policy R&D" broadly in a way that comprises, but is not limited to, original, author-initiated academic research by BE staff. It also includes various review, issue-spotting, and synthetic endeavors, such as policy workshops and, indeed, requests for public information. WILLIAM E. KOVACIC, THE FEDERAL TRADE COMMISSION AT 100: INTO OUR SECOND CENTURY, 91-92 (Jan. 2009), *available at* https://www.ftc.gov/sites/default/files/documents/public_statements/federal-trade-commission-100-our-second-century/ftc100rpt.pdf.

[124] RFI at 3.

[125] *Id.* at 3-4.

[126] For a review of diverse endeavors, *see, e.g.*, Ohlhausen, *supra* note 3.

RFI seems, at times, to prejudge the answers to its own questions. That may be unproductive for research purposes and, specifically, may bias submissions to the public record.

The most egregious example of this may be the FTC's press release announcing the RFI, which informed both the press and stakeholders that the FTC, DOJ, and HHS "Launch Cross-Government Inquiry on Impact of Corporate Greed in Health Care."[127] That framing would seem overly dramatic if it announced allegations of antitrust violations; it seems an especially poor way to announce a request for information from the diverse stakeholders constituting "the public."

Of course, a press release is just that, but the language is repeated in the FTC's May 1 announcement that the agencies had extended the RFI comment period;[128] and at least some readers may have noticed that the language in the FTC's press release mirrors that of a White House "fact sheet" noting that the administration was "[l]aunching a cross-government public inquiry into corporate greed in health care."[129] Some individuals may be "greedy," in a colloquial sense, whether in their personal capacities or acting as corporate agents. But "corporate greed" has no clear meaning in antitrust law or industrial-organization economics. It is hardly a subject for systematic investigation by expert agencies; it seems, at best, an atmospheric distraction.

Announcements of the RFI from DOJ and HHS seem similarly, if less steeply, slanted, describing a "cross-government public inquiry into private-equity and other corporations' increasing control over health care."[130] Identifying legitimate competition concerns is not, in itself, problematic. But suggesting such concerns about broad categories of transactions, without any acknowledgment of potential merger benefits, and without any acknowledgment that most provider mergers and acquisitions are not challenged, much less blocked, and should be presumed lawful until established otherwise, seems to suggest a general hostility to provider acquisitions with no basis in legal precedent, economic research, or agency practice. Similarly, any suggestion that profits in highly differentiated product and service markets are inconsistent with the fruits of vigorous health-care competition—

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[127] Press Release, *Federal Trade Commission, Department of Justice, and Department of Health and Human Services Launch Cross-Government Inquiry on Impact of Corporate Greed in Health Care*, FED. TRADE COMM'N (Mar. 5, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/03/federal-trade-commission-department-justice-department-health-human-services-launch-cross-government.

[128] Press Release, *FTC, DOJ, and HHS Extend Comment Period on Cross-Government Inquiry on Impact of Corporate Greed in Health Care*, FED. TRADE COMM'N (May 1, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/05/ftc-doj-hhs-extend-comment-period-cross-government-inquiry-impact-corporate-greed-health-care?utm_source=govdelivery.

[129] Press Release, *Fact Sheet: Biden-Harris Administration Announces New Actions to Lower Health Care and Prescription Drug Costs by Promoting Competition*, THE WHITE HOUSE (Dec. 7, 2023), https://www.whitehouse.gov/briefing-room/statements-releases/2023/12/07/fact-sheet-biden-harris-administration-announces-new-actions-to-lower-health-care-and-prescription-drug-costs-by-promoting-competition.

[130] *See, e.g.*, Press Release, *Justice Department, Federal Trade Commission and Department of Health and Human Services Issue Request for Public Input as Part of Inquiry into Impacts of Corporate Ownership Trend in Health Care*, DEP'T JUSTICE, (Mar. 5, 2024), https://www.justice.gov/opa/pr/justice-department-federal-trade-commission-and-department-health-and-human-services-issue.

lower prices, higher quality, and greater availability of health care—would appear fundamentally at odds with both established antitrust law and economic learning.

Similarly, as we note above, we were struck by a statement at the outset of the RFI itself: "Given recent trends, we are concerned that transactions may generate profits for those firms at the expense of patients' health, workers' safety, and affordable health care for patients and taxpayers."[131] To be sure, some transactions do just that. But, as we discuss at some length above,[132] antitrust law and economics do not recognize any general or fundamental tension between firm profits, on the one hand, and the consumer benefits typically associated with price and nonprice competition in goods and services markets, on the other.

And while there is some research suggesting that some categories of for-profit provider acquisitions may be associated with competitive harms, at least in some circumstances, a considerable body of research, reinforced by agency-enforcement experience, militates against the suggestion that for-profit and not-for-profit providers should be distinguished for the purposes of merger scrutiny. As Martin Gaynor—former director of the FTC Bureau of Economics and presently special advisor to the assistant U.S. attorney general for antitrust—summarized in testimony before the Senate Judiciary Committee: "Research evidence shows not-for-profit hospitals exploit market power just as much as for-profits."[133]

We wonder, too, about the design of a March 5, 2024, workshop titled "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care,"[134] which was hosted by the FTC with leadership from the DOJ and HHS also participating. The workshop was timed to coincide with the RFI and, not incidentally, was noted identically by all three agencies in their press releases for the RFI.[135] The posted agenda specifies a brief event—less than half a day—at which roughly half of the participants represented the agencies themselves, and none obviously worked in or for the

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[131] RFI at 3.

[132] *See supra* Section II.D.

[133] Gaynor statement, *supra* note 3.

[134] *Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care*, FED. TRADE COMM'N (May 5, 2024), https://www.ftc.gov/news-events/events/2024/03/private-capital-public-impact-ftc-workshop-private-equity-health-care. The workshop webpage includes a description, along with links to the agenda, participant biographies, and a transcript of the proceedings.

[135] *Id.*; Press Release, *Justice Department, Federal Trade Commission and Department of Health and Human Services Issue Request for Public Input as Part of Inquiry into Impacts of Corporate Ownership Trend in Health Care*, DEP'T JUSTICE (Mar. 5, 2024), https://www.justice.gov/opa/pr/justice-department-federal-trade-commission-and-department-health-and-human-services-issue; Press Release, *HHS, DOJ, and FTC Issue Request for Public Input as Part of Inquiry into Impacts of Corporate Ownership Trend in Health Care*, DEP'T HEALTH & HUMAN SERVS. (Mar. 5, 2024), https://www.hhs.gov/about/news/2024/03/05/issue-request-for-public-input-as-part-of-inquiry-into-impacts-of-corporate-ownership-trend-in-health-care.html.

industry in question or, *e.g.*, for large health plans or other private payors. Several participants were individual practitioners relating their own perceptions of specific acquisitions.[136]

To be sure, providers and other stakeholders might well be interested in the perspectives of agency officials. At the same time, the airing of agency views and concerns seems ill-timed, given the timing of the RFI itself, as submissions in response to the RFI were initially due just one day after the workshop.

Moreover, the FTC's announcement of its workshop echoes the apparent imbalance of the RFI itself:

> In recent years, the Commission has become increasingly concerned about the effects of private equity investment in this sector. We are convening a workshop bringing together experts and affected individuals to discuss their insights. The workshop will consist of several panels and feature remarks from government officials, academics, economists, and practitioners, as well as members of the public who have experienced, first-hand, the effects of private equity investment in the health care system.[137]

Again, we do not take any issue with the identification of legitimate competition concerns. Merger scrutiny is the proper purview and, indeed, obligation of the antitrust agencies; and we do not write to opine on open matters or potential acquisitions. But the workshop design, description, and timing suggest an information-gathering exercise distinct from an open-minded public inquiry, if not the prejudgment of myriad fact-dependent potential enforcement matters.

III. Conclusion

Health-care-provider consolidation is an important area of concern for antitrust enforcers, and there is no doubt that specific provider acquisitions can prove anticompetitive. For those reasons, the RFI may indeed prompt the submission of useful materials to the antitrust agencies and, perhaps, to HHS. To the extent that the RFI is considered but one more step in the agencies' ongoing competition R&D program, it may be salutary. At the same time, the RFI does not seem designed to move agency learning much beyond the margin—certainly not across the broad swath of issues it raises; and the RFI's framing seems likely to skew, rather than focus, the information submitted.

Further, while competition concerns may be important to *how* the agencies implement various congressional charges to promulgate specific regulations (and, by statute, are implicated in any FTC

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[136] Their testimony is confined to their own perceptions of, as the agencies themselves put it in the RFI, "how their experiences . . . changed after a facility or other provider where they work or receive treatment or services was acquired or underwent a merger." Such perceptions may help make certain policy concerns vivid or accessible, but there is no credible argument that they were either randomly selected or representative of practitioner experience, much less that they represent legal or economic analyses of the acquisitions under discussion. That they may be considered as part of a larger policy inquiry is uncontroversial. That three such participants were selected for such a brief workshop—absent industry participants, and given the dearth of economic evidence and legal perspectives beyond those of enforcers—strains credulity.

[137] *See supra* note 135.

rulemaking regarding unfair or deceptive acts or practices), neither enforcement experience nor economic literature militate in favor of new competition regulations regarding provider mergers and acquisitions.

While there may be ample reasons for diverse competitive concerns, such concerns do not establish categories of acquisitions that warrant *per se* condemnation, via regulation or otherwise. To the contrary, agency experience and expertise with, *e.g.*, restraints on the "corporate practice of medicine" and with other regulatory restraints on diverse methods or models of health-care delivery illustrate the competitive (and welfare) tradeoffs implicated by many types of provider acquisitions and, indeed, by specific transactions. Such tradeoffs can have—and have had—directionally different competition implications on a case-by-case basis.

More specifically, while extant research and enforcement experience may identify or heighten competitive concerns about certain transactions, they militate *against*, rather than for, new policies regarding for-profit providers, overly simple structural approaches to health-care-merger screening, and the conflation of considerations for horizontal, vertical, and conglomerate acquisitions.

Emerging concerns may prompt reallocation of screening resources and priorities within the agencies, although the importance of building experience cumulatively may suggest caution there, too.

As a related matter, concerns about provider acquisitions—single transactions or clusters of them—below the HSR reporting threshold may be justified in many markets, especially in rural or other underserved areas. That suggests a complex of inquiries, however, and not new rules or general policies. Given the myriad factors driving consolidation—especially in small (and, often, shrinking) markets—and given the fact that the large majority of mergers, above or below the threshold, are not anticompetitive, how can further research and enforcement experience identify filters by which the agencies might identify and screen those sub-threshold acquisitions most likely to raise competitive concerns?

Finally, as we suggest in the introduction to these comments, further policy inquiries—from RFIs to workshops to systematic research—might best be served by agency economists conducting a serious critical synthesis of the extant body of research regarding health-care-provider acquisitions. That is a nontrivial project, but it should be prologue to consideration of or recommendations regarding policy reforms in the area.