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Unhealthy, Wealthy and Unwise: Private Equity's Anticompetitive Effects in Healthcare Markets

Introduction

A growing body of evidence demonstrates that private equity (PE) acquisitions in the healthcare industry are causing harm to patients and healthcare providers. PE acquisitions can lead to higher costs and higher rates of adverse outcomes such as infections, hospitalizations and deaths. PE growth strategies aimed toward rapid returns and financed by large amounts of debt can end up forcing bankruptcies or closures of necessary health providers such as hospitals. And PE acquisitions are on the rise across healthcare industries, from home health care to dialysis centers to private physician practices.

To address these harms, the Federal Trade Commission (FTC), which has assumed responsibility for antitrust oversight of the healthcare industry, should increase enforcement pursuant to Section 8 of the Clayton Act's prohibition on interlocking directorates. Additionally, the minimum value thresholds for mandatory pre-merger notification in the Hart Scott Rodino Antitrust Improvement Act (HSR Act) are currently too high to capture many concerning mergers in the healthcare industry, unduly hindering the FTC's enforcement capabilities under Section 7 of the Clayton Act. Relevant markets in healthcare can be highly localized, and accordingly the dollar amounts of mergers can be relatively small, frequently far below the current $110 million threshold to trigger HSR reporting, yet still cause significant competitive harm. This gap in reporting allows for stealth consolidation, or anticompetitive consolidation that escapes regulatory scrutiny. To address this issue, the HSR minimums should be lowered for local markets.

I. Growing Issues of Private Equity Acquisitions in the Healthcare Industry

PE activity is no new phenomenon. PE today was shaped by the advent of the leveraged buyout model that rose to prominence in the 1980's, taking advantage of the relatively lax U.S. regulatory regime.[1] Under this model, acquisitions are largely debt financed, and the acquired company takes most of the debt onto its own balance sheet.[2] As an industry, PE has grown rapidly, with an eightfold increase in global assets between 2000 and 2018.[3] As of 2021, PE deals constituted 60% of all deals (up from 10% in 2001).[4]

The trends in PE investment in the healthcare industry largely align with PE's general growth. Starting in the 1990s, PE firms bought up provider organizations, largely nursing homes and hospitals.[5] Between 2000 and 2020, PE firms acquired 2,500 clinics and other small healthcare services.[6] And 81% of PE acquisitions from 2000 to 2020 occurred after 2010, demonstrating the increase in PE activity in recent years.[7] Between 2000 and 2019, PE M&A buyouts increased at four times the rate of non-PE buyouts.[8] Recently, PE investment in healthcare has reached record highs. In 2018, PE investments in healthcare reached $100 billion in capital invested, representing a twentyfold increase from 2000.[9] In 2023, *announced* deal

[1] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 7.
[2] *Id.*
[3] Joseph Stiglitz, *Nobel Laureate Economist Joseph Stiglitz: It's Time for Congress to Do Something About the Economic Mess That Private-Equity Giants Have Created*, BUSINESS INSIDER (Dec. 7, 2019), https://www.businessinsider.com/joseph-stiglitz-private-equity-impact-us-economy-jobs-wages-2019-12. In 2000, the private equity industry had $700 billion in global assets. In 2018, the industry's global assets had grown to $5.8 trillion.
[4] Aslihan Asil, Johnathan Barrios, and Thomas Wollman, *Misaligned Measures Of Control: Private Equity's Antitrust Loophole*, VA. L. & BUS. REV. (forthcoming) at 5.
[5] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 4.
[6] *Id.* at 42.
[7] *Id.* at 42.
[8] *Id.* at 17 (Between 2000 and 2019, PE buyouts increased twelvefold, while non-PE buyouts only increased threefold).
[9] *Id.* at 3; Anaeze V. Offodile II et. Al, *Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts*, 40 HEALTH AFFAIRS 719, 719 (2021).

values in North America alone totaled $29 billion, despite fundraising challenges due to an inflationary economy and climbing interest rates and the majority of deals going unannounced.[10]

PE firms have invested in physician practices, nursing homes, hospices, home care, autism treatment, travel nursing, and many other sectors.[11] In recent years, PE firms have acquired numerous primary and physician specialties in outpatient healthcare and home healthcare.[12]

The healthcare industry is vulnerable to unique harms from PE in that it implicates concerns not present in every industry potentially affected by PE. Healthcare is, of course, intimately tied to health and, in turn, adverse outcomes such as sickness and death. PE acquisitions in the healthcare industry have cause not only economic downside, but also increases in adverse medical events. A 2023 Harvard Medical School study found that, after acquisition by PE firms, Medicare beneficiaries admitted to hospitals experienced a 27% increase in falls, a 38% increase in central line infections, and a 100% increase in surgical site infections compared to patients at non-PE hospitals.[13] PE owned nursing homes also have increased rates of mortality.[14]

Acquisitions frequently lead to increased consolidation, which tends to lead to adverse outcomes for both PE and non-PE acquisitions. A 2018 study on the kidney dialysis industry demonstrated that increased acquisitions correlated with increased doses of highly reimbursed drugs, fewer patients waitlisted for life-saving kidney transplants, increased replacements of highly skilled nurses with less-skilled technicians, and worse outcomes for hospitalizations and

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[10] Nirad Jain et. al, *Healthcare Private Equity Market 2023: Year in Review and Outlook*, Bain & Company (Jan. 3, 2024), https://www.bain.com/insights/year-in-review-global-healthcare-private-equity-report-2024/.
[11] The White House, *FACT SHEET: Biden-Harris Administration Announces New Actions to Lower Health Care and Prescription Drug Costs by Promoting Competition*, WhiteHouse.gov (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/.
[12] *Id.* at 4.
[13] Sneha Kannan et. al, Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition, 330 JAMA 2365 (2023).
[14] Atul Gupta et. al, *Owner Incentives And Performance In Healthcare: Private Equity Investment In Nursing Homes* (National Bureau of Economic Research, Working Paper 28474, 2023) at 30.

mortality.[15] Over the past three decades, the dialysis industry has become increasingly consolidated, with the share of independently owned and operated dialysis facilities dropping from 86% to 21%.[16] Similarly, a 2012 report on consolidation in hospital markets found that consolidation led to increased hospital care prices.[17] These higher prices, which hospitals generally charge directly to insurers or self-insured employers, were passed on to consumers through higher premiums, lower benefits, and lower wages.[18] When mergers occurred in already concentrated markets, prices rose more than 20%.[19] The report also found that when competition existed between hospitals, quality of care improved.[20] These reports are not isolated. Multiple other studies have demonstrated that PE acquisitions of healthcare facilities have led to increased charges and negotiated prices.[21]

Additionally, physicians have a negative view of PE acquisitions. In a recent JAMA Internal Medicine study led by the American College of Physicians, only 10% of physicians surveyed viewed PE involvement in healthcare positively or somewhat positively.[22] Physicians have expressed reservations about the impact of PE's profit focus on their ability to provide care for

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[15] Paul J. Eliason et. al, *How Acquisitions Affect Firm Behavior and Performance: Evidence from the Dialysis Industry*, 135 Q. J. OF ECON. 1, 221-67 (2018).
[16] *Id.* at 221.
[17] Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update*, ROBERT WOOD JOHNSON FOUNDATION, June 2012, at 1, https://www.researchgate.net/publication/283910115_The_Impact_of_Hospital_Consolidation_-_Update.
[18] *Id.* at 1.
[19] *Id.* at 2.
[20] *Id.* at 3.
[21] *The Growth of Private Equity in US Health Care: Impact and Outlook*, NIHM: EXPERT VOICES, https://nihcm.org/assets/articles/NIHCM-ExpertVoices-052023.pdf; Alexander Borsa et. al, *Evaluating Trends In Private Equity Ownership And Impacts On Health Outcomes, Costs, And Quality: Systematic Review*, 382 BMJ e075244 (2023); *see also* James Nie et. al, *Association Between Private Equity Acquisition of Urology Practices and Physician Medicare Payments*, 167 HEALTH SERVICES RESEARCH 121 (2022) (finding that after private equity acquisition, urologists had an 11% increase in Medicare payments); Yashaswini Singh et. al, *Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization*, 3 JAMA HEALTH FORUM e222886 (2022) (finding that physician practices acquired by PE had an average increase of $71 charged per claim).
[22] *ACP Survey Finds that Physicians are Concerned about Private Equity Investment in the Health Care Sector*, AMERICAN COLLEGE OF PHYSICIANS (Mar. 11, 2024), https://www.acponline.org/acp-newsroom/acp-survey-finds-that-physicians-are-concerned-about-private-equity-investment-in-the-health-care.

their patients. One issue is trust: patients almost always do not understand what treatment they need and must rely entirely on their belief that their medical providers have their best interests at heart.[23] But the PE focus on short term profits undermines this trust.

While there is a growing consensus that PE investments in healthcare are causing harm, PE remains largely unregulated.[24] The antitrust laws alone do not provide a comprehensive regime for regulating PE, but antitrust laws do cover anticompetitive PE behaviors and their resulting harms. To fully address the harms to consumers from PE acquisitions, a multi-pronged regulatory strategy is likely needed. But antitrust laws alone can address some of the most serious existing anticompetitive impacts from PE investment in healthcare.

II. The Private Equity Business Model

PE investments tend to follow a core model. PE funds usually consist of a general partner, which is a cohort of principals from the PE firm, and limited partner investors, which are large institutional investors and high-net worth individuals.[25] The general partner makes all management decisions, while limited partners share any gains or losses.[26] The PE firm provides 2 percent to up to 10 percent of equity in a fund, while the limited partners supply the rest.[27] Each fund has a preset time frame for liquidation, usually 5 years and almost always under 10 years.[28]

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[23] RICHARD M. SCHEFFLER ET. AL, AMERICAN ANTITRUST INSTITUTE, SOARING PRIVATE EQUITY INVESTMENT IN THE HEALTHCARE SECTOR: CONSOLIDATION ACCELERATED, COMPETITION UNDERMINED, AND PATIENTS AT RISK, 6 (2021), https://www.antitrustinstitute.org/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL-1.pdf.

[24] Under federal securities regulations, private equity firms are only required to submit “very minimal information.” Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 8.

[25] *Id.* at 6.

[26] *Id.* at 13.

[27] *Id.* at 6.

[28] Felix Barber & Michael Goold, *The Strategic Secret of Private Equity*, HARV. BUS. REV., Sept. 2007, https://hbr.org/2007/09/the-strategic-secret-of-private-equity.

Typically, a PE firm will appoint the board of directors for an acquired company.[29] Frequently, a PE firm will fill some of the seats with their own principals.[30] PE firms will also set performance goals for the acquired company and attempt to work with the existing CEO to meet these goals.[31] If the CEO is unwilling or incapable, the PE firm will replace them in short order.[32]

PE firms utilize leveraged buyouts ("LBOs"), or acquisitions characterized by high levels of leverage (a high ratio of debt to equity). The PE firm usually places this debt on the balance sheet of the portfolio company, which shifts nearly all exposure to risk of failure to the portfolio company rather than the firm.[33] If an acquisition is financed with 70 percent debt (which is not unusual), the PE firm stands to lose only .6 percent of the purchase price.[34] On the other hand, the PE firm stands to gain a portion of all fund profits, typically 20%, and usually charges investors a management fee of 1.5% to 2% of assets under management.[35] The moral hazard caused by this allocation of risk is significant.

In 2019, the total purchase price for LBOs averaged 11.5x the earnings before interest, taxes, depreciation and amortization, or EBITDA.[36] In comparison, after the 2008 financial crisis, the Federal Reserve Board, Federal Deposit Insurance Corporation, and Office of the Comptroller of

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[29] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 7.
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.* at 7.
[34] *Id.*
[35] Felix Barber & Michael Goold, *The Strategic Secret of Private Equity*, HARV. BUS. REV., Sept. 2007, https://hbr.org/2007/09/the-strategic-secret-of-private-equity.
[36] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 10.

the Currency advised banks that a leverage level over 6x Total Debt/EBITDA "raises concerns for most Industries."[37]

To maximize returns, PE firms frequently will utilize a "buy and build" strategy, where a firm initially acquires a target company, and then subsequently augments the size and market power of the initial acquisition, referred to as a platform company, through "bolt-on" or "tuck-in" acquisitions of smaller companies.[38] In the words of Bain & Company, "[t]he idea is to ensure that 1+1=3 by capturing the benefits of scale and scope."[39] As of 2019, 68% of PE buyouts were add-ons to previous acquisitions, up from 56.5% of buyouts in 2009.[40] A "buy and build" strategy is desirable because it facilitates more rapid growth than a strategy to grow a single portfolio company organically over time. [41] This meshes well with the 3 to 5 year horizon of most PE investments. While financially beneficial, increasing portfolio company value through "scale and scope" frequently means consolidation and aggregation of market power that can run afoul of the antitrust laws and harm consumers through reduced competition.

PE activity presents a unique difficulty for regulation in that it takes many forms. PE investors tend to be agile and willing to adopt diverse strategies to take advantage of

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[37] BD. GOVERNORS FED. RSRV. SYS., FED. DEPOSIT INS. CORP. & OFF. COMPTROLLER CURRENCY, INTERAGENCY GUIDANCE ON LEVERAGED LENDING (Mar. 21, 2013), https://www.federalreserve.gov/supervisionreg/srletters/sr1303a1.pdf.

[38] STATEMENT OF COMMISSIONER ROHIT CHOPRA, FEDERAL TRADE COMMISSION (July 8, 2020), https://www.ftc.gov/system/files/documents/public_statements/1577783/p110014hsrannualreportchoprastatement.pdf; *see also* Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 11-12.

[39] https://www.bain.com/insights/building-a-stronger-buy-and-build-global-private-equity-report-2024/

[40] STATEMENT OF COMMISSIONER ROHIT CHOPRA, FEDERAL TRADE COMMISSION (July 8, 2020), https://www.ftc.gov/system/files/documents/public_statements/1577783/p110014hsrannualreportchoprastatement.pdf; Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 12.

[41] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 12; *see also* Cox et. al, *Additive Dealmaking: Part II*, PITCHBOOK 2018, https://files.pitchbook.com/website/files/pdf/PitchBook_3Q_2018_Analyst_Note_Additive_Dealmaking_Part_II.pdf.

opportunities unique to each portfolio company. And PE firms do not focus on a single niche or submarket, but rather invest across industries according to various strategies.

III. Private Equity Strategies in Healthcare Markets

Healthcare is a broad term and encompasses many different sub-markets including physician practices for typical medical specialties (such as ophthalmology and dermatology), pharmaceuticals, medical staffing, and more. But trends across sub-markets show similar patterns. For example, hospitals and healthcare systems have increasingly consolidated in the past decades through merger and acquisition (M&A) activity.[42] Of course, consolidation can potentially yield benefits. Supporters argue that vertical integration of hospital systems and other health providers coupled with advances in health information technology systems allows for improved coordination between all medical professionals involved in a patient's care, which can improve the quality of care.[43] But in markets dominated by only one or two hospital systems, procedure prices are much higher than those with four or more hospitals.[44]

Local physician markets show similar trends. There are 384 metropolitan statistical areas (MSAs) in the United States, which approximate local physician markets.[45] In 2012, PE firms held more than 30% of the market share of one or more physician specialties in only a handful of MSAs.[46] But by 2021, PE firms had grown to hold more than 30% of the market share of one or more physician specialties in 108 MSAs, or 28% of the MSAs in the US. In 50 MSAs, PE firms

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[42] EILEEN APPELBAUM & ROSEMARY BATT, CENTER FOR ECONOMIC AND POLICY RESEARCH ORGANIZATIONAL RESTRUCTURING IN U.S. HEALTHCARE SYSTEMS: IMPLICATIONS FOR JOBS, WAGES AND INEQUALITY, 15 (2017), https://cepr.net/images/stories/reports/organizational-restructuring-healthcare-2017-09.pdf.
[43] *Id.* at 20.
[44] *Id.*
[45] RICHARD M. SCHEFFLER ET. AL, AMERICAN ANTITRUST INSTITUTE, MONETIZING MEDICINE: PRIVATE EQUITY AND COMPETITION IN PHYSICIAN PRACTICE MARKETS, 19 (2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.
[46] *Id.* at 20.

held more than 50% of the market share of one or more physician specialties, or 13% of MSAs.[47] Further, the average Herfindahl–Hirschman Index ("HHI", a proxy for market concentration) in MSAs where a PE firm holds more than 30% market share was 3516, 36% higher than the average HHI of MSAs where a non-PE firm held more than 30% market share (2576).[48] In MSAs where a single PE firm had 50% or more market share, the average HHI was 4675, an 85% increase in average HHI from MSAs where a non-PE firm had 50% or more market share.[49] And in MSAs where PE-firms had more than 30% market share in a physician specialty, most have experienced price increases, suggesting that PE firms are able to exercise market power in their favor.[50]

MSAs are not always an accurate proxy for healthcare markets. Depending on the segment of the industry, healthcare markets vary considerably in geographic reach. To define a market, courts will evaluate both products and geography. Major medical specialties, like cardiology or nephrology, usually constitute a defensible component of a well-defined market.[51] Segments such as pharmaceuticals, payor services, and healthcare information technology typically have a broad reach, and their markets can be statewide, national or even international. But segments such as physician practices, dialysis, nursing homes, and home healthcare can be very localized compared to other industries because patients need in-person care in their immediate geographic location. Kidney dialysis, for example, is a lifesaving procedure that patients require multiple times a week. Given the frequency of treatment, patients tend to utilize dialysis centers within 25 miles of their homes, yielding very localized geographic market

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[47] *Id.* at 20.
[48] *Id.* at 23.
[49] *Id.*
[50] *Id.* at 28-29.
[51] Cory Capps et. al, *Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools to Intervene*, 36 HEALTH AFFAIRS 1527, 1557 (2017), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0054.

definitions for dialysis centers.[52] Healthcare segments with localized markets are particularly vulnerable to consolidation, and declines in quality associated with consolidation have particularly dire consequences in the form of adverse outcomes like infections, hospitalizations and death due to the nature of the healthcare provided. And the dollar amounts tied to healthcare transactions in these markets are frequently small enough that they escape antitrust scrutiny.

There is a gap in the existing data regarding the size of many PE deals. Most deals are not announced, and accordingly little public information is available. Only deals above a certain threshold trigger SEC and FTC reporting requirements. According to Pitchbook, approximately 86% of deals are not public or reported in their data, which suggests that most PE deals are falling below the reporting thresholds.[53]

This paper will not attempt to chronicle every unique PE strategy employed in the healthcare sector as strategies are too diffuse and numerous. Rather, the following select case studies provide examples of PE strategies implemented in deals where data is available. These case studies contextualize PE action in healthcare and describe some of the potential risks of PE deals. In line with the focus of this paper, these case studies all focus on harms of PE acquisitions.

HCA Holdings

In 2006, Bain Capital, Kohlberg Kravis Roberts & Co. (KKR) and Merrill Lynch Global PE acquired HCA for $33 billion, the largest leveraged buyout in history according to

[52] Thomas G. Wollmann, *How to Get Away With Merger: Stealth Consolidation and Its Effects on US Healthcare*, 8 (National Bureau of Economic Research, Working Paper 27274) https://www.nber.org/system/files/working_papers/w27274/w27274.pdf.
[53] RICHARD M. SCHEFFLER ET. AL, AMERICAN ANTITRUST INSTITUTE, SOARING PRIVATE EQUITY INVESTMENT IN THE HEALTHCARE SECTOR: CONSOLIDATION ACCELERATED, COMPETITION UNDERMINED, AND PATIENTS AT RISK, 8 (2021), https://www.antitrustinstitute.org/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL-1.pdf.

Pitchbook.[54] After the deal, HCA had a considerable $26 billion in debt.[55] The PE firms took a majority of HCA's board seats, and steered their investment to major success financially.[56] In 2010 alone, HCA issued a massive $4.25 billion in dividend payments to the benefit of its PE owners.[57] Subsequently, Bain, KKR and Merrill Lynch took HCA public in March 2011 at a valuation of $15.5 billion.[58] Each of them raked in huge profits: Bain, for example, made $1.2 billion after its initial investment of $64 million.[59] While many hospitals were hit hard by the 2008-2009 financial crisis, HCA prospered. Other PE firms looked to the massive success of the HCA acquisition for inspiration, and many followed suit by acquiring their own hospital chains.

But the drivers for these profits drew public scrutiny. In 2008, HCA significantly increased its operating earnings by changing the billing codes it assigned to emergency room patients.[60] Billing codes are intended to reflect the care patients need but require subjective evaluation by medical staff to determine which codes to use and what treatment to provide for patients. The change in codes resulted in a near immediate shift in the number of patients that HCA reported needing higher levels of care. This in turn resulted in higher Medicare reimbursements.[61] After the change, 76% of HCA's Medicare payments stemmed from the two

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[54] *HCA Completes Merger With Private Investor Group*, HCA HEALTHCARE (Nov. 17, 2006), https://investor.hcahealthcare.com/news/news-details/2006/HCA-Completes-Merger-With-Private-Investor-Group/default.aspx; Kevin Dowd, *This Day in Buyout History: KKR, Bain Capital Complete the Biggest LBO Ever*, PITCHBOOK: NEWS & ANALYSIS (Nov. 16, 2017), https://pitchbook.com/news/articles/this-day-in-buyout-history-kkr-bain-capital-complete-the-biggest-lbo-ever.
[55] Julie Cresswell & Reed Abelson, *A Giant Hospital Chain is Blazing a Profit Trail*, N.Y. TIMES, Aug. 14, 2012, https://www.nytimes.com/2012/08/15/business/hca-giant-hospital-chain-creates-a-windfall-for-private-equity.html.
[56] *Id.*
[57] Kevin Dowd, *This Day in Buyout History: KKR, Bain Capital Complete the Biggest LBO Ever*, PITCHBOOK: NEWS & ANALYSIS (Nov. 16, 2017), https://pitchbook.com/news/articles/this-day-in-buyout-history-kkr-bain-capital-complete-the-biggest-lbo-ever.
[58] *Id.*
[59] *Id.*
[60] Julie Cresswell & Reed Abelson, *A Giant Hospital Chain is Blazing a Profit Trail*, N.Y. TIMES, Aug. 14, 2012, https://www.nytimes.com/2012/08/15/business/hca-giant-hospital-chain-creates-a-windfall-for-private-equity.html.
[61] *Id.*

most expensive classifications, compared to around 25% in 2006.[62] It's worth noting that the average among other hospitals was to bill 74% of procedures in the two most expensive classifications, meaning HCA was only showing a 2% increase from the mean. But the widespread practice of high billing does not prove that it is justified, and the explanation for how HCA's patients could supposedly become so much sicker almost overnight defies logic.

HCA also touted its success in reducing overcrowding in its emergency rooms, a problem plaguing hospitals across the country, where uninsured patients sought care in lieu of a typical doctor's office. To achieve this, HCA refused to treat patients who came in presenting nonurgent conditions unless they received advance payment.[63] This strategy was effective in reducing overcrowding, but at a cost. In 2012, the Office of the Inspector General fined an HCA hospital in Florida for refusing treatment and sending home a feverish patient that died 3 days later.[64] HCA also implemented a flexible staffing system where it would schedule nurses to align with the estimated number of patients received each day.[65] But nurses expressed concern about inadequate staffing, including in areas like critical care, and HCA struggled with a proxy measure for adequate staffing (prevalence of bedsores in bedridden patients), facing lawsuits.[66] After complaints by doctors, states investigated various HCA facilities, resulting in thousands of dollars of fines.[67]

Vanguard Health Care

[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*

In 2004, a group of PE firms led by Blackstone Group acquired two-thirds of Vanguard Health Care for $1.75 billion.[68] $1.05 billion of the purchase price was debt financed, with the remaining $700 million as equity.[69] In short order, Vanguard then took on significant additional debt to the benefit of its PE investors. First, in 2010, it took on an additional $950 million to retire debt and to pay a dividend.[70] Then, in 2011, Vanguard did a dividend recapitalization, raising $750 million dollars, which brought its debt to $2.73 billion.[71] Half of the proceeds from the recapitalization went to dividend payments to Vanguard's PE investors. In late 2011, Vanguard went public, but its PE investors held onto most of their shares. And in 2013, Tenet Healthcare acquired Vanguard for $1.8 billion. For Blackstone and its PE investors, Vanguard was a success, yielding significant returns.

But after acquiring Vanguard, Tenet has struggled to keep the acquired hospitals solvent. Tenet divested multiple hospitals to pay down debt, including Vanguard's significant debts.[72] One hospital it inherited from Vanguard, Detroit Medical Center (DMC) was federally investigated in 2016 after complaints of poor safety and cleanliness, and DMC was sued for wrongful death in 2014. While DMC likely had issues prior to acquisition by Vanguard, its PE owners failed to resolve these issues. Additionally, DMC's cardiology unit, which once was "stellar", faced new difficulties after acquisition by Tenet, including "difficult-to-meet production goals", "high profit expectations", "layoffs of key staff when profit margins dipped", an increase in risky procedures, and a decline in patient outcomes.[73] The Michigan Department

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[68] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 22.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses?*, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 23 (citing Jay Greene, *Detroit Medical Center's Cardiology Program Faces Problems*, MODERN HEALTHCARE, October 7 2018,

of Licensing and Regulatory Affairs and the Centers for Medicare and Medicaid Services also investigated and cited DMC for multiple violations of federal and state regulations.

This case study casts into sharp relief the differences between PE interests and patient interests: while a PE acquisition can be an unmitigated success for the PE firm, bringing in significant returns, it can simultaneously be harmful to consumers as a result of focus on profits over providing high quality care and the consequences of loading up companies with high amounts of debt that they then struggle to pay off.

Community Health Systems

Forstmann, Little & Co. took Community Health Systems (CHS) private in a leveraged buyout in 1996, one of the first PE acquisitions of a hospital chain.[74] CHS went public in June 2000, with Forstmann retaining a majority stake.[75] At the time of its IPO, CHS had a debt/equity ratio of 161.2%. In 2000, CHS held a secondary offering, where Forstmann sold about 7.6 million shares, bringing its stake down to just under 55%. In 2004, in another secondary offering, Forstmann unloaded its remaining stake with CHS purchasing just over half of its shares.[76] To finance this purchase, CHS took on an additional $260 million in debt.

CHS initiated a string of acquisitions, adding on 66 health care companies between 2000 and 2017 to temporarily become the largest for-profit chain in the U.S. by number of hospitals.[77] Many of CHS's acquisitions fell under the HSR threshold and thus did not face scrutiny by the FTC. But some did. CHS acquired Triad, a hospital system, for $5.1 billion plus $1.7 billion in

http://www.modernhealthcare.com/article/20181007/NEWS/181009921?utm_source=modernhealthcare&utm_medium=email&utm_content=20181007-NEWS-181009921&utm_campaign=am).

[74] Eileen Appelbaum & Rosemary Batt, Private Equity Buyouts in Healthcare: Who Wins, Who Loses?, (Institute for New Economic Thinking, Working Paper No. 118, 2020) at 28.

[75] *Id.*

[76] *Id.* at 29.

[77] *Id.* at 28-29.

debt in 2007, almost doubling the number of its hospitals.[78] The FTC apparently did not raise questions or require CHS to divest any hospitals for the merger. In 2013, CHS took Health Management Associates (HMA), the second-largest hospital chain, private in a leveraged buyout.[79] HMA had 71 hospitals, and CHA had 135. While valued at $7.5 billion, HMA had a significant debt burden of $3.7 billion and was struggling financially. The FTC required CHS to divest just 2 hospitals to approve the merger, despite CHS's astronomic growth over the past 8 years and heavy debt burden.[80] After the merger, CHS had 206 hospitals across 29 states.

Soon after, CHS began divesting hospitals as it struggled to meet the obligations of its debts, and its share price dropped from $65 post-merger to under $14 in February 2016.[81] It spun off 38 hospitals into a newly created public company, Quorum Health Corp. Many of Quorum's hospitals were in rural areas, and 84% of them were the only provider of acute-care hospital services in their market.[82] But while the Quorum spinoff gave CHS $1.2 billion to put towards its debt, Quorum retained about $1 billion in undesirable, speculative grade debt.[83] Quorum struggled from the start and sold or closed 11 rural hospitals in the three years after its creation. The proceeds from the sales went almost entirely to paying down debt, rather than to improvements in quality of care or investments in new technologies. By November 2019, Quorum's stock had fallen to $.85 after two years of significant losses.[84] In 2020, Quorum filed for Chapter 11 Bankruptcy.[85] By 2021, CHS had only 86 hospitals, down from a high of 206.[86]

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[78] *Id.*
[79] *Id.* at 29.
[80] *Id.* at 30.
[81] *Id.* at 30.
[82] *Id.* at 32.
[83] *Id.* at 31.
[84] *Id.* at 33.
[85] https://www.businesswire.com/news/home/20200407005274/en/Quorum-Health-Corporation-Reaches-Agreement-with-Majority-of-Lenders-and-Noteholders-on-Prepackaged-Recapitalization-Plan
[86] Sarah Kliff & Jessica Silver-Greenberg, *How Rich Hospitals Profit From Patients in Car Crashes*, N.Y. TIMES, Feb. 1. 2021, https://www.nytimes.com/2021/02/01/upshot/rich-hospitals-profit-poor.html.

IV. Proposed Solutions

A. Increased Federal Antitrust Enforcement

The Biden-Harris Administration is focused on PE harm to healthcare and has made it an enforcement priority. To that end, the administration recently announced the creation of a cross-government public inquiry into greed in health care.[87] The FTC has taken a more aggressive enforcement posture generally, bringing its first claim under Section 8 of the Clayton Act in 40 years against two natural gas businesses.[88] Regarding the healthcare sector, the FTC brought suit against U.S. Anesthesia Partners, Inc. and PE firm Welsh, Carson, Anderson & Stowe in September 2023 alleging an anticompetitive roll-up strategy resulting in monopoly pricing in Texas anesthesia markets.[89] Compared to the last few decades, the momentum for increased federal enforcement is at its peak. The largest remaining question remains the available means.

Many of the issues stemming from PE healthcare investments are outside the scope of the antitrust laws, and are better addressed by consumer protection laws, banking and lending regulations, or other regulatory frameworks. But the issue of increased consolidation to the detriment of competition and consumer welfare is squarely an antitrust issue and requires antitrust solutions.

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[87] The White House, *FACT SHEET: Biden-Harris Administration Announces New Actions to Lower Health Care and Prescription Drug Costs by Promoting Competition*, WhiteHouse.gov (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/.

[88] *The FTC Claims the Clayton Act's Ban on Interlocking Directorates Applies to a Non-Corporate Entity and Continues Its Efforts to Expand Section 5 of the FTC Act*, COVINGTON (Sep. 6, 2023), https://www.cov.com/en/news-and-insights/insights/2023/09/the-ftc-claims-the-clayton-acts-ban-on-interlocking-directorates-applies-to-a-non-corporate-entity-and-continues-its-efforts-to-expand-section-5-of-the-ftc-act.

[89] *FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas*, FED. TRADE COM. (Sep. 21, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across.

Various authors have proposed antitrust solutions, some requiring significant research and legislative overhauls by Congress.[90] This paper focuses on solutions that would either require relatively clear-cut changes to existing legislative structures (like changes to amounts in the existing HSR Act framework) and litigation strategies that would not require any legislative changes. Anticompetitive PE healthcare acquisitions have created an immediate problem, with lives at stack each year, and immediate solutions should be prioritized in the short term.

Section 8 of the Clayton Act

The prohibition of interlocking directorates in Section 8 of the Clayton Act is an underutilized tool to address anticompetitive PE behavior in healthcare. Section 8 of the Clayton Act provides that "[n]o person shall, at the same time, serve as a director or officer in any two corporations ... that are ... competitors such that the elimination of competition by agreement between them would constitute a violation of any of the antitrust laws."[91] Section 8 "was but one of a series of measures … intended to strengthen the Sherman Act[.]"[92] "[W]hat Congress intended by § 8 was to nip in the bud incipient violations of the antitrust laws by removing the opportunity or temptation to such violations through interlocking directorates. The legislation was essentially preventative."[93] Section 8 imposes strict liability such that violations are *per se* and do not require the plaintiff to prove harm to competition.[94]

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[90] RICHARD M. SCHEFFLER ET. AL, AMERICAN ANTITRUST INSTITUTE, MONETIZING MEDICINE: PRIVATE EQUITY AND COMPETITION IN PHYSICIAN PRACTICE MARKETS, 32-34 (2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.
[91] 15 U.S.C. § 19.
[92] *United States v. Sears, Roebuck & Co*, 111 F. Supp. 614, 616 (S.D.N.Y. 1953) (finding that an interlocking directorate between two companies violated Section 8 when the elimination of competition between the two corporations would violate any of the antitrust laws, not just when a merger or acquisition between the two corporations would create a monopoly).
[93] *Id.*
[94] Michael E. Blaisdell, *Interlocking Mindfulness*, FED. TRADE COM. (June 26, 2019), https://www.ftc.gov/enforcement/competition-matters/2019/06/interlocking-mindfulness.

Section 8 provides three safe harbors, allowing the same individual to serve on the board of two competing corporations if (i) either corporation's competitive sales are less than a *de minimis* amount adjusted yearly according to increase or decrease in gross national product; (ii) either corporation's competitive sale are less than 2% of its total sales; or (iii) both corporations' competitive sales are less than 4% of total sales.[95]

Some courts have adopted the "deputization" or "agency" theory of Section 8, which provides that a "person" under the statute denotes a legal person or entity, rather than solely a natural person.[96] Under this theory, the statute prohibits both direct interlocks, when a single natural person serves as director or officer in violation of the statute, and indirect interlocks, when a single firm appoints two different people to serve as its agents as directors or officers in violation of the statute.[97] Section 8 litigation has been rare, and only a handful of courts have opined on the deputization theory. In *Reading International, Inc. v. Oaktree Capital Management LLC*, the owner, operator and landlord of a cinema in Manhattan sued Loews Cineplex Entertainment Group ("Loews"), Regal Entertainment Group ("Regal"), Oaktree Capital Management ("Oaktree") and Onex Corporation ("Onex") alleging, among other claims, a violation of Section 8's prohibition on interlocking directorates under the deputization theory.[98] Loews and Regal declared bankruptcy in 2000 and 2001, respectively. Oaktree and Onex, asset management companies, swept in to acquire the claims of Loews' creditors, with Oaktree acquiring a 40% stake and Onex acquiring a 60% stake.[99] Oaktree and a non-party investment firm similarly acquired Regal's debts and, after some reorganization and consolidation with other

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[95] 15 U.S. Code § 19 (a)(2).
[96] Michael E. Blaisdell, *Interlocking Mindfulness*, FED. TRADE COM. (June 26, 2019), https://www.ftc.gov/enforcement/competition-matters/2019/06/interlocking-mindfulness.
[97] *Id.*
[98] 317 F. Supp. 2d 301, 308-09 (S.D.N.Y. 2003).
[99] *Id.* at 308.

theater chains, Oaktree owned 17% of Regal's equity.[100] Oaktree's President then served on Loews' Board of Directors while Oaktree's principal served on the board of Regal.[101]

Denying defendants' motion to dismiss, the court found that the language of Section 8 plausibly applied to corporations. The Clayton Act defines person to include corporations, and while a corporation cannot itself serve on a board of directors, the court reasoned that a corporation can *de facto* serve by appointing an agent to sit in its place on the board. The deputization theory, according to the court, "makes absolute sense."[102] To reject the deputization theory, according to the court, would be to "elevate form over substance." The claims against Oaktree and Onex were ultimately settled out of court.

Similarly, in *Square D Co. v. Schneider S.A.*, the court adopted a deputization theory.[103] There, the plaintiff sued under Section 8 in a defensive posture, attempting to stop the defendant from installing 11 individuals as board members, all of whom were officers or directors of the defendant's subsidiaries which competed with the plaintiff.[104] Denying defendant's motion to dismiss, the court "conclude[d] that a cause of action under § 8 is stated where a company attempts to place on the Board of a competitor individuals who are agents of, and have an employment or business relationship with, such company."[105] The case was ultimately resolved out of court when the defendant acquired the plaintiff. In the few other cases addressing the deputization theory, the courts either adopted the deputization theory or reserved judgment.[106] No court has rejected the theory.

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[100] *Id.*
[101] *Id.* at 309.
[102] *Id.* at 327.
[103] 760 F. Supp. 362 (S.D.N.Y. 1991).
[104] *Id.* at 366.
[105] *Id.* at 367.
[106] *United States v. Cleveland Tr. Co.*, 392 F. Supp. 699, 712 (N.D. Ohio 1974), aff'd, 513 F.2d 633 (6th Cir. 1975) (finding that "the issue of deputization is a question of fact to be settled case by case"); *Pocahontas Supreme Coal Co. v. Bethlehem Steel Corp.*, 828 F.2d 211, 216-17 (4th Cir. 1987) (granting a motion to dismiss because plaintiff

In the context of PE acquisitions in the healthcare industry, the deputization theory could prove a useful tool. PE firms typically control a portfolio firm through its board of directors, and frequently a single firm will focus on certain sectors, acquiring competitors in one sector across portfolios. Separation between portfolios provides no protection from anticompetitive behavior; as the same PE firm ultimately receives management fees and will benefit from any returns from each of its portfolios. Accordingly, that firm has the incentive to coordinate between various portfolio companies to maximize profits.

Section 8 also provides a less-invasive structural remedy than divestment under Section 7. After a completed merger or acquisition, disentangling and breaking up the firms post hoc is incredibly difficult. But restricting directors and officers under Section 8 can effectively prevent anticompetitive coordination between portfolio companies even after an acquisition is complete. Additionally, increased Section 8 enforcement would likely provide a deterrent effect, preventing PE firms from managing competitors and encouraging them to diversify, to the benefit of competition.

Section 7 of the Clayton Act

Section 7 of the Clayton Act allows the FTC and the DOJ to challenge mergers which "substantially [] lessen competition" or "tend to create a monopoly".[107] But the most effective merger challenges must occur prior to the merger. Post-merger, the government is hard-pressed to disentangle the merged firm. Colloquially, antitrust practitioners refer to post-merger enforcement as unscrambling eggs or trying to put the ketchup back in the bottle, referencing the inherent difficulty.

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only pled "conclusory allegations" that were insufficient to support a claim "even if the "deputization" theory be accepted, a matter we need not decide here.").

[107] 15 U.S.C. §18.

The Hart Scott Rodino Antitrust Improvements Act (HSR Act) defines a minimum transaction value threshold for mandatory pre-merger reporting.[108] In 2001, an amendment to the Hart Scott Rodino Act (HSR Act) raised the transaction value threshold for mandatory pre-merger reporting from about $10 million to about $50 million.[109] Immediately following the amendment, pre-merger notifications to the FTC and DOJ dropped by 70%.[110] Lowering the minimum threshold would allow the federal agencies to more efficiently police anticompetitive PE acquisitions practices, especially in local markets where transactions almost never meet the threshold amounts.

One might argue that lowering the HSR minimums is unnecessary as the agencies are currently legally capable of investigating all transactions, including those below the mandatory reporting threshold, pursuant to Section 7 of the Clayton Act.[111] But the agencies rarely investigate "below threshold mergers", or mergers whose size falls below the minimum threshold for reporting, and overwhelmingly focus investigations on "reportable mergers", or mergers that meet the minimum threshold for pre-merger reporting to the agencies.[112] This results in stealth consolidation, or the completion of anticompetitive deals that escape regulatory scrutiny due to their relatively small size, but have significant market effects.[113] In smaller localized markets, such as healthcare markets, merger size is often too low to trigger reporting, even if the merger is to a duopoly or monopoly.

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[108] 15 USC §18(a).
[109] Aslihan Asil, Johnathan Barrios, and Thomas Wollman, *Misaligned Measures Of Control: Private Equity's Antitrust Loophole*, VA. L. & BUS. REV. (forthcoming) at 17.
[110] *Id.*
[111] Aslihan Asil, Johnathan Barrios, and Thomas Wollman, *Misaligned Measures Of Control: Private Equity's Antitrust Loophole*, VA. L. & BUS. REV. (forthcoming) at 17. *See also* Thomas G. Wollmann, *How to Get Away With Merger: Stealth Consolidation and Its Effects on US Healthcare*, 6-7 (National Bureau of Economic Research, Working Paper 27274) https://www.nber.org/system/files/working_papers/w27274/w27274.pdf.
[112] *Id.*
[113] Thomas G. Wollmann, *Stealth Consolidation: Evidence From an Amendment to the Hart-Scott-Rodino Act*, 1 AER INSIGHTS 77, 77 (2019).

Professor Thomas Wollman, in a case study on dialysis mergers, examined the rates of agency enforcement through divestiture across reportable mergers and below threshold mergers. Wollman tracked rates of divestiture compared to changes in HHI, which serves as a proxy measure for the legal standard from Section 7 of the Clayton Act, which targets for enforcement mergers that "substantially [] lessen competition" or "tend to create a monopoly".[114] His study found that below threshold mergers almost entirely avoided antitrust enforcement across all HHI changes, from minimal HHI changes to increases nearing 5,000.[115] In contrast, reportable mergers had divestiture rates of almost 90% for mergers with an HHI increase to around 5,000.[116] For reportable mergers, divestiture rates tracked HHI changes regardless of the size of the merger, indicating that, amongst reportable mergers, the agencies are not choosing to enforce large mergers over small. Rather, the agencies are effectively enforcing Section 7 and taking action against mergers that would "substantially [] lessen competition" and "tend to create a monopoly", evidenced by the high change in HHI, for all mergers reported to them. Wollman concluded that the agencies are facing an information problem: when agencies are adequately informed of impending mergers through HSR reporting, they dutifully enforce Section 7. But for below threshold mergers, the agencies are without information provided by HSR reporting and are inadequately equipped to find timely information on impending mergers.[117] Without timely information, the agencies cannot take enforcement action.

Wollman also examined the efficacy of divestiture as an enforcement solution. The aim of divestitures is to prevent undue consolidation, thereby preserving competition and quality.

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[114] 15 U.S.C. §18.
[115] Thomas G. Wollmann, *How to Get Away With Merger: Stealth Consolidation and Its Effects on US Healthcare*, 16 (National Bureau of Economic Research, Working Paper 27274) https://www.nber.org/system/files/working_papers/w27274/w27274.pdf.
[116] *Id.*
[117] *Id.* at 17.

Wollman's analysis demonstrated that the data support this theory. For reportable mergers that were subject to divestiture, the actual HHI change 1, 3 and 5 years after divestiture was significantly lower than the predicted HHI change with no divestiture.[118] These results suggest that divestitures are an effective method of preventing consolidation. Analyzing rates of hospitalization and survival, Wollman found that pre-merger enforcement prevents harmful consolidation, or consolidation that yields higher rates of hospitalization and death.[119]

Following Wollman's study, lowering the HSR Act's mandatory minimum reporting threshold would help address the decline in quality attributable to PE acquisitions. Of course, lowering the threshold would result in a higher volume of pre-merger notifications received by the FTC and DOJ, and a resulting increase in costs for personnel to review those mergers. But Wollman estimates that removing the minimum threshold entirely would save life-years worth $1 billion and would be cost effective.[120] The costs of extending agency review to all mergers are partially ameliorated by the increased deterrent effects of full scope review: knowing that agency review will ultimately prevent many harmful mergers, PE firms and others may never attempt those mergers in the first place, and the agencies would not need to actually expend resources on their review.[121]

B. State Level Enforcement

Historically, the federal government has initiated nearly all merger challenges, with States Attorneys General joining the suits later.[122] But recently states have begun stepping up to

[118] *Id.* at 17-18.
[119] *Id.* at 19.
[120] Thomas G. Wollmann, *How to Get Away With Merger: Stealth Consolidation and Its Effects on US Healthcare*, 31 (National Bureau of Economic Research, Working Paper 27274) https://www.nber.org/system/files/working_papers/w27274/w27274.pdf.
[121] *Id.* at 31.
[122] Thomas G. Wollmann, *How to Get Away With Merger: Stealth Consolidation and Its Effects on US Healthcare*, 8 (National Bureau of Economic Research, Working Paper 27274) https://www.nber.org/system/files/working_papers/w27274/w27274.pdf.

supplement and gap-fill federal antitrust enforcement in the healthcare sector. States are arguably better positioned to review smaller scale regional healthcare mergers that pose significant risks of consolidation than the federal government, and 50 heads are undoubtedly better than one. But states' laws and politics vary widely. 4 states currently require pre-merger or pre-transaction notifications for all hospital and physician groups of a certain size, while 3 require pre-merger notice for all hospitals, and 26 require advance notification only for nonprofit hospitals.[123] Additionally, enforcement of these statutes varies considerably state by state. But momentum at the statewide level appears to be growing, as California, Minnesota, Illinois and Indiana have passed laws requiring pre-merger notification for healthcare entities in the past year.[124]

The Source on Healthcare, run by UC College of the Law San Francisco ("The Source"), evaluated different state approaches to preventing anticompetitive healthcare provider consolidation with the aim of identifying successful practices.[125] In line with Wollman's findings that pre-merger notice is key to enforcement, their report highlights advance notice of proposed transactions as a necessary state policy to enable effective enforcement.[126] While many states require healthcare providers to give notice to the Attorney General, states struggling to allocate resources can require notice to multiple entities, effectively spreading the burden of enforcement across entities rather than overburdening a single entity. The Source report also recommends broad notice requirements including not just mergers and acquisitions, but also transactions that

[123] https://sourceonhealthcare.org/market-consolidation/merger-review/. Some states require notification not just for mergers and acquisitions, but for transactions defined more broadly, usually in terms relating to material changes in control or operations.
[124] Danielle Kaye, *States Fill Gaps in FTC Health-Care Consolidation Crackdown (1),* BLOOMBERG L., Mar. 15, 2024, https://news.bloomberglaw.com/antitrust/states-fill-gaps-in-ftc-crackdown-on-health-care-consolidation.
[125] https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/06/PreventingAnticompetitiveHealthcareConsolidation.pdf
[126] https://sourceonhealth.wpenginepowered.com/wp-content/uploads/2020/06/PreventingAnticompetitiveHealthcareConsolidation.pdf at 11.

involve a material change in governance or operations.[127] While a broader notice system may prove more onerous for companies seeking to comply, it would be able to capture more transactions that potentially pose anticompetitive harm and would likely prove more difficult for entities to avoid by restructuring deals. In contrast, to avoid HSR reporting and subsequent scrutiny, entities need only avoid mergers and acquisitions, as management contracts, joint ventures, and other potentially anticompetitive arrangements are not covered by the scope of the Act.

The Source report also recommends a sufficient waiting period and substantive review criteria for transactions, which mirror the federal enforcement system.[128] But to alleviate resource constraints, states should consider employing independent consultants and requiring purchasers to pay for them[129] California, Massachusetts, Connecticut, Rhode Island, and Pennsylvania all employ some form of purchaser financed consultant review.[130] Instead of requiring state entities to go to the courts for injunctive relief, like federal enforcement requires, states can also directly empower AGs or an alternative agency to approve, conditionally approve, or block transactions.[131] To check this power, states can simultaneously implement procedures allowing potential purchasers to challenge blocked transactions or undesirable conditions, either via administrative processes or in the courts.

C. Private Plaintiff Enforcement

Section 4 of the Clayton Act allows private plaintiffs to receive treble damages for any violation of the antitrust laws.[132] Similarly, Section 16 of the Clayton Act empowers plaintiffs to

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[127] *Id.* at 12.
[128] *Id.* at 14-16.
[129] *Id.* at 18.
[130] *Id.*
[131] *Id.* at 21.
[132] Erin L. Fischer, *Private Merger Challenges Under Section 16 of the Clayton Act: Caution Post-Jeld-Wen*, 170 U. PENN. L. REV. 241, 248 (2021).

seek relief in equity for antitrust violations, subject to the affirmative defense of laches.[133] But, historically, plaintiffs have faced many challenges. PE and portfolio structures are complex and opaque, and plaintiffs are not always well positioned to acquire the necessary information to plead a Section 8 interlocking directorate claim or a Section 7 claim.[134]

As part of its initiative to prevent consolidation and anticompetitive behavior in healthcare, the Centers for Medicare and Medicaid Services (CMS), under the Health and Human Services (HHS), have released significant ownership data on hospitals, nursing homes, hospice providers, home health agencies, federal qualified health centers and rural health clinics.[135] This increased availability of data can help potential plaintiffs build a complaint that will survive a motion to dismiss.

Conclusion

Multiple recent studies have documented harms stemming from PE involvement in healthcare. While PE involvement is varied and takes many forms, this paper provides a basic model of PE strategies concerning to antitrust and select case studies demonstrating how those strategies have been implemented in the healthcare sector. While some PE activity and resulting harms are arguably outside the purview of the antitrust laws, it is exceedingly difficult to disentangle the harms from a PE firm's anticompetitive activities from the effects of its non-anticompetitive activities. Further, recent research has documented consumer harms from consolidation, the result of PE buy and build strategies.

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[133] *Id.*

[134] Alexander J. Sweatman, *Private Equity, The Clayton Act, And The Hurdles Of Private Plaintiff Enforcement Of Section 8*, 38 Antitrust ABA 82, 86 (2023).

[135] The White House, *FACT SHEET: Biden-Harris Administration Announces New Actions to Lower Health Care and Prescription Drug Costs by Promoting Competition*, WhiteHouse.gov (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/.

This paper aims to provide solutions on the federal, state and individual level to PE firm's anticompetitive practices in the healthcare industry. At the federal level, increased enforcement under Section 8 of the Clayton Act provides the FTC with enforcement options that are less drastic than post-merger divestments under Section 7. Section 7 enforcement is also effective at ensuring competition, but to adequately address the healthcare sector, the minimum reporting thresholds of the HSR Act must be lowered to bring more smaller scale acquisitions under the scope of the Act's reporting requirements. At the state level, states seeking to supplement federal enforcement can follow successful practices from existing statutory regimes, including requiring broad scope pre-transaction notice and independent consultant review financed by potential purchasers. And while private plaintiffs still continue to face an information handicap, new data sharing by the federal government could empower them to sue under existing antitrust laws.