A Finger in the Dike: Mobilizing State Health Care Transaction Notification and Corporate Practice of Medicine Laws to Scrutinize Private Equity Investment in Health Care

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This Article explores the impact of private equity investments in the health care sector, highlighting how private equity's profit-driven model often conflicts with the ethical obligations of health care. The Article posits that federal antitrust laws and the False Claims Act are insufficient to curb private equity's negative impact on health care; rather, state laws, including corporate practice of medicine laws and state health care transaction notification laws, are more effective tools in scrutinizing and regulating private equity investment in health care. The authors suggest that consolidating these state laws into a unified regime would enhance scrutiny and accountability, protecting health care from the detrimental effects of private equity ownership.

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INTRODUCTION

On September 21, 2023, the Federal Trade Commission ("FTC") filed a lawsuit against U.S. Anesthesia Partners, Inc. ("USAP") and a number of entities associated with the private equity firm Welsh, Carson, Anderson & Stowe ("Welsh Carson") for alleged violations of Section 2 of the Sherman Act, Section 7 of the Clayton Act, and Section 5(a) of the FTC Act.[1] The allegations in the complaint paint a disturbing picture. The complaint avers that USAP and Welsh Carson "engaged in a three-part strategy to consolidate and monopolize the anesthesiology market in Texas."[2] Over a period of over ten years, backed by Welsh Carson, USAP aggressively bought up anesthesiology practices in the key urban markets in Texas in what has been labelled a "roll-up" scheme.[3] Through the aggressive consolidation strategy, Welsh Carson's objective was to snatch up anesthesiology practices with high market share in a few key markets in Texas, eliminating competitors and giving "the power to raise prices, raking in tens of millions of extra dollars for USAP, Welsh Carson, and their executives."[4] Other anti-competitive conduct allegedly engaged in by USAP included entering or maintaining price-setting arrangements with other anesthesiology groups[5] and engaging in a market allocation agreement with another provider.[6] Heralded as a "significant synergy opportunity" by Welsh Carson, it is alleged that USAP wielded its dominant market position to net tens of millions of dollars in additional profits at the expense of patients, their employers, and insurers.[7] As a result of the roll-up strategy, USAP became the dominant provider of anesthesiology services in the major markets in Texas by many multiples, including Houston and Dallas.[8] Using its dominant position obtained by the aggressive consolidation strategy, anesthesia service prices skyrocketed across Texas, resulting in tens of millions of dollars in additional costs for

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1. Complaint, Fed. Trade Comm'n v. U.S. Anesthesia Partners, Inc., No. 4:23-cv-03560, 2024 WL 2137649, (S.D. Tex. Sept. 21, 2023).
2. Press Release, Fed. Trade Comm'n, FTC Challenges Private Equity Firm's Scheme to Suppress Competition in Anesthesiology Practices Across Texas (Sept. 21, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/09/ftc-challenges-private-equity-firms-scheme-suppress-competition-anesthesiology-practices-across [https://perma.cc/CHX5-C7KP].
3. Complaint, *supra* note 1, at ¶ 4.
4. *Id.* ¶ 3.
5. *Id.* ¶ 6.
6. *Id.* ¶ 7.
7. *Id.* ¶¶ 5–6.
8. *Id.* ¶ 8.

patients, employers, and insurers without a corresponding improvement in services.[9]

The USAP case and other private equity abuses in health care have brought discussion about private equity-related health care transactions to the forefront. On March 5, 2024, the FTC hosted a public workshop called "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care," which examined the role of private equity investment in health care markets.[10] Concurrently, on March 5, 2024, the FTC and the U.S. Department of Justice ("DOJ"), joined by the Department of Health and Human Services ("HHS"), released a press statement publicizing a request for information seeking public comments from stakeholders and the public on consolidation in health care markets.[11] The RFI invited comments regarding the effects of transactions involving health care providers, facilities, or ancillary products or services, conducted by private equity funds or other alternative asset managers, health systems, or private payers.[12] On

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9. Complaint, *supra* note 1, ¶¶ 319–327. The FTC is not the only governmental authority scrutinizing Welsh Carson's involvement and activities with USAP. Targeting the same scheme in the Denver, Colorado market, in February 2024, the Colorado Attorney General filed a complaint charging USAP with unlawful, anticompetitive conduct in snapping up most of the surgical anesthesia practices in the Denver area, in violation of the newly enacted Colorado State Antitrust Act of 2023, COLO. REV. STAT. §§ 6-4-101 to 6-4-122 (2024). *See* Complaint, Colorado v. U.S. Anesthesia Partners of Colorado, Inc., No. 2024CV30595 (D.C. Denver Feb. 26, 2024), https://coag.gov/app/uploads/2024/02/2024-02-26-13-57-23-FINAL-USAP-COMPLAINT-1.pdf [https://perma.cc/X6YK-DZC9]. A settlement was reached and announced shortly afterward under which USAP agreed to certain divestitures and changes to certain of its business practices, as well as a monetary fine of $200,000. *See* Press Release, Phil Weiser, Colo. Att'y Gen., Private Equity-Run U.S. Anesthesia Partners to End Colorado Health Care Monopoly Under Agreement with Attorney General Phil Weiser (Feb. 27, 2024), https://coag.gov/press-releases/usap-health-care-monopoly-attorney-general-phil-weiser-2-27-2024 [https://perma.cc/MN4X-NLWV].

10. *Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care,* FEDERAL TRADE COMM'N (Mar. 5, 2024), https://www.ftc.gov/news-events/events/2024/03/private-capital-public-impact-ftc-workshop-private-equity-health-care [https://perma.cc/4KLW-YBV3].

11. Press Release, U.S. Dep't of Just., 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 (Mar. 5, 2024), https://www.justice.gov/opa/pr/justice-department-federal-trade-commission-and-department-health-and-human-services-issue [https://perma.cc/5RL3-EV9L].

12. *Request for Information on Consolidation in Health Care Markets* at 2, U.S. DEP'T OF JUSTICE, FED. TRADE COMM'N & DEP'T OF HEALTH & HUM. SERVS. (Feb. 29, 2024), https://content.govdelivery.com/attachments/USDOJOPA/2024/03/05/file_attachments/2803589/DOJ-FTC-HHS%20HCC%20RFI%20-%2003.04.24%20-%20FINAL.pdf [https://perma.cc/RF9D-H9PF]. The RFI invited comments regarding the effects of transactions

April 18, 2024, on its newly created "Healthy Competition" portal, the DOJ invited consumers to submit complaints about health care competition.[13] The DOJ's website provides a robust discussion of healthy competition, including giving examples of harmful, anti-competitive conduct, including "Consolidation, Joint Ventures, and 'Roll-ups' of Healthcare Providers or Companies."[14] Bearing down on private equity and its roll-up strategy, as targeted in the USAP case, on May 23, 2024, the FTC and DOJ jointly launched another, more targeted request for information "to identify serial acquisitions and roll-up strategies throughout the economy that have led to consolidation that has harmed competition."[15] And on June 11, 2024, U.S. Senators Ed Markey and Elizabeth Warren introduced the Corporate Crimes Against Health Care Act, which seeks to impose civil and criminal penalties

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involving health care providers, facilities, or ancillary products or services, conducted by private equity funds or other alternative asset managers, health systems, or private payers. In their press release announcing the RFI, the three agencies noted:

> "Private equity firms and other corporate owners are increasingly involved in health care system transactions, and, at times, those transactions may lead to a maximizing of profits at the expense of quality care. The cross-government inquiry seeks to understand how certain health care market transactions may increase consolidation and generate profits for firms while threatening patients' health, workers' safety, quality of care, and affordable health care for patients and taxpayers."

Press Release, U.S. Dep't of Justice, 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 (Mar. 5, 2023), https://www.justice.gov/opa/pr/justice-department-federal-trade-commission-and-department-health-and-human-services-issue [https://perma.cc/KXH6-LLVU]. While the comment period for the RFI was initially slated to close on May 6, 2024, the deadline to submit comments was subsequently extended to June 5, 2024. Press Release, Fed. Trade Comm'n, FTC, DOJ, and HHS Extend Comment Period on Cross-Government Inquiry on Impact of Corporate Greed in Health Care (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 [https://perma.cc/8VE3-NAMH].

13. Antitrust Division, *Help Us Ensure Access to Fair and Competitive Healthcare Markets for You and Your Family*, U.S. DEP'T OF JUSTICE, https://www.justice.gov/atr/HealthyCompetition [https://perma.cc/Y2CZ-GWFL].

14. *Id.* In the example, "roll-ups" (also called serial acquisitions) is defined as: "When a firm buys multiple small but similar businesses in the same area. Such conduct reduces the number of competitors over time." *Id.*

15. Press Release, Fed. Trade Comm'n, FTC and DOJ Seek Info on Serial Acquisitions, Roll-Up Strategies Across U.S. Economy (May 23, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/05/ftc-doj-seek-info-serial-acquisitions-roll-strategies-across-us-economy [https://perma.cc/YCR4-V8VD]. The RFI is not limited to the health care sector but seeks input about serial acquisitions in all sectors. *Id.*

upon health care investors for certain "triggering events" resulting in patient injuries. [16]

There has been an abundance of literature already examining the policy arguments against and tools for fighting private equity investment in health care. For example, with particular focus on nursing homes, one article undertakes a critical examination of the impact of private equity's aggressive investment strategies.[17] In it, the authors argue for a number of regulatory reforms, including adopting federal requirements for greater transparency of ownership structures,[18] tying Medicaid reimbursement more directly to direct care costs,[19] imposing minimum staffing levels,[20] and even imposing a federal ban altogether on private equity ownership of nursing homes.[21] Another article focuses on the False Claims Act (the "FCA") and private equity's role in health care fraud.[22] The author calls for reforms to the FCA to extend liability to private equity firms actively involved in fraudulent health care schemes. [23] Still another article examines private equity's penetration of the health care sector and its resulting erosion of quality of care and increased prices.[24] This author also advocates for FCA liability for the private equity owners of health care entities,[25] as well as for federal legislation for increased transparency and oversight of private equity transactions in health care.[26] Finally, in the most sweeping analysis to date, Fuse Brown and Hall examine the issues surrounding private equity investment in health care.[27] The authors contend that current legal enforcement tools, including federal and state antitrust laws,[28] the FCA,[29]the federal Stark Law,[30] state corporate practice of

16. S. 4503, 118th Cong. (2024).

17. Robert I. Field et al., *Private Equity in Health Care: Barbarians at the Gate?*, 15 DREXEL L. REV. 821 (2023).

18. *Id.* at 886–87.

19. *Id.* at 888.

20. *Id.* at 889.

21. *Id.* at 889–90.

22. Gregory F. Maczko, Note, *Make Hay While the Sun Shines: Private Equity and the False Claims Act*, 74 VAND. L. REV. 797 (2021).

23. *Id.* at 818–23.

24. Emma Goodman-Fish, *Capitalizing Health: The Impact of Private Equity on Health Equity*, 33 ANNALS HEALTH L. & LIFE SCIS.: ADVANCED DIRECTIVE 145 (2024).

25. *Id.* at 152–53.

26. *Id.* at 149–52.

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

28. *Id.* at 547–52.

29. *Id.* at 552–56.

30. *Id.* at 557–58.

medicine laws and fee-splitting laws,[31] and federal and state laws limiting enforcement of non-competition covenants in physician employment contracts,[32] if sharpened, remain effective tools at combatting private equity investment in health care.

In this Article, we argue that the concerted mobilization of a combination of older state corporate practice of medicine laws and newer state health care transactions notifications laws offer the best hope for combatting the negative outcomes associated with private equity investment in health care. Part I of this article looks at how private equity has stormed the U.S. health care sector, including characteristics of the private equity model, the conditions that have led to private equity's foray into health care, trends of private equity health care investment, and concerns about effects on care and other outcomes. For illustrative purposes of how physician practice acquisition strategies are structured, Part I concludes by looking more closely at the allegations in the FTC's case against USAP and Welsh Carson. Part II demonstrates that, despite the FTC's vigorous focus on private equity activity, especially in health care, the federal antitrust laws are deficient in stemming the tide of these transactions. Part II also shows that the while the False Claims Act remains a fairly potent tool for combatting questionable billing practices by private equity affiliated firms, it does nothing to deter the other ills of private equity health care investment. Part III shows how a combination of state laws, specifically laws embodying the corporate practice of medicine doctrine and state health care transactions notifications laws, hold greater promise for subjecting health care transactions, including those involving private equity, to scrutiny. Part IV concludes with the assertion that these state laws are potent tools for protecting us from the evils of corporatization of health care in general, and private equity investment in health care in particular, if they were consolidated into a comprehensive, unified regime enforced by a single state office or agency. Such approach represents the best hope of ensuring that health care transactions involving private equity are brought fully into the light for scrutiny, so that the pillagers may not continue their practice of escalating the costs and diminishing the quality and availability of health care.

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31. *Id.* at 561–73.
32. *Id.* at 573–75.

I. PRIVATE EQUITY HAS INVADED HEALTH CARE

A. The Private Equity Model Is Inherently Incompatible with Health Care

Private equity is a type of private fund that is managed by a private equity firm.[33] Private equity funds are generally not subject to the extensive regulation imposed on investment companies under the Investment Company Act of 1940 ("ICA").[34] In order to be exempt under the ICA, private equity funds are normally restricted to investors that are "qualified purchasers" and meet the criteria outlined in Section 3(c)(7) of the ICA, including not making a public offering of securities.[35]

On purely financial metrics, some literature finds the effects of private equity buyouts to be positive: increasing productivity, operational efficiency, and governance.[36] Another group finds that, compared to other non-public firms, private equity firms have better management practices that are on par with publicly listed firms.[37] Even in the health care sector, there are some who seem to champion private equity investment.[38] Acquiring a number of physician practices in the same specialty, it is argued, creates economies of scale, provides managerial expertise, and increases bargaining power with payers.[39] But a seemingly more compelling part of the literature paints an entirely different picture of private equity investment, especially in health care.

Alarm bells about private equity investment in general, and in health care in particular, have been going off for a while. Mainstream books have explored the rise of private equity investment in many sectors and the

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33. *Glossary: Private Equity Fund*, U.S. SEC. & EXCH. COMM'N, https://www.sec.gov/resources-small-businesses/cutting-through-jargon-z#PEF [https://perma.cc/W3LY-Z94C].

34. Investment Company Act of 1940, ch. 686, 54 Stat. 789 (codified at 15 U.S.C. §§ 80a-1 to -64). Although the private equity fund itself is not subject to registration requirements, private equity advisers themselves are generally required to register as investments advisers under federal or state securities laws. *See Private Funds*, U.S. SEC. & EXCH. COMM'N, https://www.sec.gov/resources-small-businesses/capital-raising-building-blocks/private-funds [https://perma.cc/6WJQ-F2RS].

35. 15 U.S.C. § 80a-3(c)(7). Qualified purchasers are individuals, companies, or trusts that meet certain minimum investment dollar thresholds. 15 U.S.C. § 80a-2(a)(51)(A).

36. *See, e.g.*, Steven N. Kaplan & Per Stromberg, *Leveraged Buyouts and Private Equity*, 23 J. ECON. PERSP. 121 (2009).

37. Nicholas Bloom et al., *Do Private Equity Owned Firms Have Better Management Practices?*, 105 AM. ECON. REV. 442, 444–45 (2015).

38. *See, e.g.*, Susan Birk, *The Question of Private Equity*, 38 HEALTHCARE EXEC. 16 (2023).

39. *Id.* at 20–21.

devastating consequences that flow from such investment.[40] More recent books have amplified the volume of the alarms, attributing to private equity the growing wealth inequality, as well as other consequential ills, such as job losses and business failures.[41] At least one author has ventured specifically into discussing how private equity has stormed health care.[42] In their best-selling book, Pulitzer Prize winning author Gretchen Morgenson and Joshua Rosner provide an in-depth examination of the private equity industry and the profound impact it has had on American businesses.[43] They delve into the private equity business model, under which private equity firms acquire companies, leverage the acquisition with burdensome debt taken on by the acquired company, cut costs of the company in order to pay that debt, extract cash along the way, then sell the company within a few short years at a profit—it is a model which the authors characterize as "capitalism on steroids."[44] The authors illustrate how private equity firms in every sector maximize short-term profitability "while slashing workers, cutting necessary costs, and harming local, state, and federal taxpayers when their companies fail."[45]

Morgenson and Rosner's observations are not novel. When private equity firms buy companies and financially reorganize them with a view to selling them off within a few short years, they "vastly increase the pay of the underlying company's top management and extract extraordinary sums for themselves," while generating above market returns for their investors.[46] The money must come from somewhere. This layer of managers aims at extracting the maximum short-term value from the underlying corporation

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40. *See, e.g.*, JOSH KOSMAN, THE BUYOUT OF AMERICA: HOW PRIVATE EQUITY IS DESTROYING JOBS AND KILLING THE AMERICAN ECONOMY (2010) (exploring the explosive growth of private equity and its business model of wringing profits at the expense of long-term health, arguing that private equity's debt-financed acquisitions and mismanagement will lead to another economic crisis); EILEEN APPELBAUM & ROSEMARY BATT, PRIVATE EQUITY AT WORK: WHEN WALL STREET MANAGES MAIN STREET (2014) (demonstrating how private equity investment often leads to significant negative consequences for businesses and workers).

41. *See* GRETCHEN MORGENSON & JOSHUA ROSNER, THESE ARE THE PLUNDERERS: HOW PRIVATE EQUITY RUNS AND WRECKS AMERICA (2023) (taking an investigative look at the outsized role private equity has played in the growing wealth inequality in America); *see also* BRENDAN BALLOU, PLUNDER: PRIVATE EQUITY'S PLAN TO PILLAGE AMERICA (2023) (looking at private equity, how it kills businesses and jobs, and how it can be stopped).

42. *See* LAURA KATZ OLSON, ETHICALLY CHALLENGED: PRIVATE EQUITY STORMS US HEALTH CARE (2022).

43. MORGENSON & ROSNER, *supra* note 41.

44. *Id.* at 26–27.

45. *Id.* at 13–16.

46. Daniel J.H. Greenwood, *Looting: The Puzzle of Private Equity*, 3 BROOK. J. CORP. FIN. & COM. L. 89, 110 (2008).

with little regard for even the appearance of long-run proceeds or the interests of other corporate participants.[47] In contrast to the structures of public corporations, private equity firms add an extra layer of managers, private equity fund managers, in addition to the operating company managers.[48] The operating company managers answer to the private equity managers, who effectively run the company in a manner that ignores any sort of fiduciary obligations to the company.[49] To extract monies to pay themselves, the private equity managers squeeze employees and other non-shareholder participants harder.[50] This is usually accomplished by reducing headcount or pay, increasing workloads, or reneging on promised future benefits.[51] Most troubling is that, unlike public companies who are required to report a wealth of information, including executive compensation and related party transactions, private equity is "shrouded in secrecy."[52] Olson put it succinctly as follows:

> It is an uncanny ability of the [private equity] industry to infiltrate every aspect of our daily lives while simultaneously remaining unknown. Secrecy is a hallmark of the private equity industry, and it sticks to its code of silence with pride . . . . Such confidentiality, along with lax regulatory control, translates into a lack of accountability, scrutiny, and transparency; [private equity]-owned firms are far less transparent than publicly traded businesses.[53]

The classic private equity business model of extracting value in a short time frame in order to service the typically high levels of debt associated with private equity buyouts and to pay "'outsized returns' to investors" simply is not consistent with building a sustainable health care system for high quality patient care.[54] Referred to as robber-barons,[55] modern-day pirates and plunderers,[56] a cloud of locusts,[57] and barbarians at the gate,[58] private equity

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47. *Id.* at 114.
48. *Id.* at 111.
49. *Id.* at 111–12.
50. Greenwood, *supra* note 46, at 110.
51. *Id.* at 113.
52. MORGENSON & ROSNER, *supra* note 41, at 27.
53. OLSON, *supra* note 42, at 8.
54. Eileen Appelbaum & Rosemary Batt, *Private Equity Buyouts in Healthcare: Who Wins, Who Loses*?, INST. NEW ECON. THINKING (Mar. 25, 2020), https://www.ineteconomics.org/perspectives/blog/private-equity-buyouts-in-healthcare-who-wins-who-loses [https://perma.cc/YR9D-JN4T].
55. *See* Greenwood, *supra* note 46, at 114.
56. *See* MORGENSON & ROSNER, *supra* note 41.
57. *See* Fuse Brown & Hall, *supra* note 27, at 527.
58. *See* Field et al., *supra* note 17.

firms are depicted as heartless pillagers. One author concluded that we are suffering from a new culture of private corruption, of which private equity is the most extreme manifestation.[59]

Private equity's furious investment in the health care sector, including buying up physician practices, has especially raised alarms.[60] While the FTC's suit against USAP and Welsh Carson focuses on surgical anesthesiology, anesthesiology is no outlier—private equity's takeover of provider specialties includes dermatology, optometry and ophthalmology, orthopedics, gastroenterology, urology, kidney disease and dialysis, fertility and women's reproductive health, and urgent care centers.[61] Especially in transactions involving larger health care entities such as hospitals, private equity investments often use leveraged buyouts, under which the private equity firm pledges the assets of the health care entity acquired to secure the debt funding the acquisition.[62] This leads to high debt-burdens for private equity-acquired health care firms, because it is typically the acquired firm, not the private equity fund or firm, which is responsible for servicing the debt.[63]

The Carlyle Group's acquisition of HCR ManorCare in 2007 has become the poster child for abusive private equity practices in the health care segment. After the 1998 merger of ManorCare, one of the largest nursing home operators in the country, with Health Care and Retirement Corp., the combined company had a market valuation of $3.7 billion in March 2000, vast real estate holdings, and positive cash flow.[64] Then, in December 2007, HCR ManorCare was taken private in a $7 billion leveraged buyout ("LBO") by the Carlyle Group.[65] Carlyle borrowed against the real estate assets of the

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59. *See* Greenwood, *supra* note 46, at 90–111 (positing that under the private equity structure, high level managers view themselves not as fiduciaries with an appreciation of some level of public or ethical responsibilities to the organization, but as self-interested contractors free to use and exploit the firm's resources for their own personal gain); *see also id.* at 110 ("Private equity funds are primarily devoted to transferring corporate wealth to private pockets. In the economic jargon, they are in the business of extracting rents, transferring wealth from employees, citizens, the government, and future innovation to a handful of highly paid managers. In the grittier language of politics, they are engaged in legalized theft.").

60. *See, e.g.*, Ashish K. Jha, Opinion, *Private Equity Firms Are Gnawing Away at U.S. Healthcare*, WASH. POST (Jan. 10, 2024), https://www.washingtonpost.com/opinions/2024/01/10/private-equity-health-care-costs-acquisitions.

61. *See* OLSON, *supra* note 42, at 78–122.

62. *See* ERIN FUSE BROWN ET AL., PRIVATE EQUITY INVESTMENT AS A DIVINING ROD FOR MARKET FAILURE: POLICY RESPONSES TO HARMFUL PHYSICIAN PRACTICE ACQUISITIONS 6 (2021).

63. *See id.*

64. OLSON, *supra* note 42, at 184.

65. *Id.*

company to finance over $5 billion of the purchase price.[66] Carlyle also split the real estate holdings off from the operating company, selling the assets for $6.1 billion to a REIT, and making a tidy profit for itself and its investors.[67] HCR ManorCare was then in the position of having to lease what used to be its own facilities from the REIT, making rent payments to spinoff that now owned the real estate.[68] Weighed down by the debt of the LBO and further burdened with crushing rent payments, HCR ManorCare's one lucrative chain of nursing facilities was forced into filing a pre-packaged Chapter 11 bankruptcy in March 2018.[69] To keep the chain afloat for as long as it did, Carlyle cut the number of nurses and other front line employees, and implemented other drastic cost-cutting measures that resulted in deplorable levels of resident care.[70] Carlyle and its managers profited heavily from the HCR ManorCare transaction, while residents, employees, and providers suffered.[71]

The unique business model of private equity investment found a perfect target in health care entities because of the conditions existing in the health care sector, as we will demonstrate in the next part.

B. Conditions Are Ripe for Private Equity Investment in Health Care

In the past several years, the health care sector has been a prime target for private equity investments. Spending on health care in the U.S. as a percentage of the GDP has risen every year from 1960, when health care spending was just 5% of the GDP, until 2020, when health care spending was

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66. *See id.*
67. *Id.*
68. *Id.* at 184–85.
69. *Id.* at 184–86.
70. *See* Peter Whoriskey & Dan Keating, *Overdoses, Bedsores, Broken Bones: What Happened When a Private-Equity Firm Sought to Care for Society's Most Vulnerable*, WASH. POST (Nov. 25, 2018), https://www.washingtonpost.com/business/economy/opioid-overdoses-bedsores-and-broken-bones-what-happened-when-a-private-equity-firm-sought-profits-in-caring-for-societys-most-vulnerable/2018/11/25/09089a4a-ed14-11e8-baac-2a674e91502b_story.html. In this article, the authors chronicle a parade of cases of patient abuse and neglect at HCR ManorCare's facilities in the aftermath of its purchase by private equity. *See id.* The authors observed that the number of health-code violations at HCR ManorCare's facilities increased by twenty-six percent in the four years after the real estate was spun off, including "neither preventing nor treating bedsores; medication errors; not providing proper care for people who need special services such as injections, colostomies and prostheses; and not assisting patients with eating and personal hygiene." *Id.*
71. Goodman-Fish, *supra* note 24, at 147.

a staggering 17.6% of the GDP.[72] The sheer size of the health care segment has made it attractive for private equity investment simply because "[t]hat is where the money is."[73] Other reasons health care is an attractive target include a non-cyclical, permanent demand for health care services, a disease burdened aging population, and fragmented health care subsectors.[74] Inefficiency in health care delivery and prevalent third-party payment systems have also been cited as factors.[75] In addition, in contrast to most other investment sectors, health care is growing at a quicker rate than the GDP, and is relatively recession-proof, with continued demand during economic downturns.[76]

Besides hospitals, physician practices—especially those of certain specialties—have been a target. Targeted specialties include those that provide an opportunity for "increased revenue[] from ancillary services," like "oncology, ophthalmology, dermatology, orthopedic, urology, gastroenterology, and radiology."[77] "The days of a physician 'hanging out a shingle'" and simply treating patients have long passed.[78] Fuse Brown and Hall acknowledge the complexity of the landscape in which the corporatization of medicine has arisen, rightly positing that "[s]ome balance must be maintained between core professional values in medical practice and the market economy in which medical care is practiced."[79] With respect to buyouts of physician and other provider practices, there is ample appeal to the providers—an initial lucrative payout followed by a salary for services in

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72. *National Health Expenditure Data: Historical*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 18, 2024), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical [https://perma.cc/RA33-V32W].

73. Olson, *supra* note 42, at 9.

74. *See* MARY BUGBY ET AL., PRIVATE EQUITY IN U.S. HEALTHCARE: TRENDS IN 2023 DEAL ACTIVITY 1, https://pestakeholder.org/wp-content/uploads/2024/03/PESP_report_2023-Healthcare-Acquisitions_March-2024.pdf [https://perma.cc/42R5-ZMXQ]; *see also* Field et al., *supra* note 17, at 825–27.

75. Sajith Matthews & Renato Roxas, *Private Equity and Its Effect on Patients: A Window into the Future*, 23 INT'L J. HEALTH ECON. & MGMT. 673, 673 (2023).

76. Patrick D. Souter & Andrew N. Meyercord, *Private Equity Investment in the Physician Practice: Has Its Time Finally Come or Will the Mistakes of the Past Be Repeated?*, 13 J. HEALTH & LIFE SCIS. L. 84, 88 (2020).

77. *Id.* at 88–89.

78. *Id.* at 87 (noting that consolidation has been driven by a number of factors, including "the desire for health care concerns to gain negotiating power," the need to "offset the ever-increasing fixed costs" associated with the practice, and the "ability to address and react to the uncertainties of the future of health care." Also noting that consolidation has affected every part of the health care industry, including hospitals, health systems, physician groups, "pharmacies, medical laboratories, imaging providers, device and medical supply concerns," and even insurers).

79. Fuse Brown & Hall, *supra* note 27, at 593–94.

practicing medicine, untethered from the administrative and managerial demands of handling the business aspects of the practice.[80] In that respect, the motivations for physicians in selling their professional practices to private equity concerns really is no different than those that have caused physicians in droves to choose the path of employment with a health system or hospital-affiliated entity. They are exchanging their autonomy for better practice resources, including in many cases with reimbursement rates higher than the independent practice was able to obtain.[81] Providers have been waging an "ever-increasing fight for economic dominance" with insurers.[82] A complex regulatory regime that dictates billing practices, the keeping of medical records, and the preservation of patient privacy, has in the words of one author "grown into a Byzantine maze that private practice physicians find progressively more difficult to manage."[83]

In recent testimony before the House Ways and Means Subcommittee on Health, Ashish Jha, Dean of the Brown University School of Public Health, made observations on the rapid change of health care delivery in the past years that have led to the collapse of the private practice.[84] Noting that Optum Health, part of UnitedHealth, "announced at the end of 2023 that it employs 90,000 doctors after adding 20,000 physicians in 2023 alone," Jha put it into perspective: "[o]ne in ten doctors in America is now employed by UnitedHealth Group."[85] Jha cited a number of interrelated factors driving the trend of small physician groups selling their practices, not just to private equity, but to hospitals and other private corporations.[86] These include a payment policy that pays more "when a patient receives the same care at a 'hospital' than if they receive that care in an independent practice," and the consolidation of insurers into "behemoths who have little incentive to reimburse physicians adequately or make issues such as administrative burdens simpler," to name a few.[87]

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80. *See* Maczko, *supra* note 22, at 803–04.

81. *See* Souter et al., *supra* note 76, at 88.

82. Erin E. Dine & MaryKathryn Hurd, *Health Insurer Merger Frenzy: How the Continued Arms Race Will Disrupt Traditional Market Roles*, 25 ANNALS HEALTH L. 98, 99 (2016).

83. Steven L. Hendler, *Serving Two Masters: Conflicts Between Physician Employment Contracts and the Physician's Duty of Care*, 32 ANNALS HEALTH L. & LIFE SCIS. 133, 135–36 (2023).

84. *See* Ashish K. Jha, Testimony to the House Committee on Ways and Means, Subcommittee on Health (May 23, 2024), https://waysandmeans.house.gov/wp-content/uploads/2024/05/Jha-Testimony-1.pdf [https://perma.cc/2QAQ-D424].

85. *Id.* at 4.

86. *See id.* at 3–8.

87. *Id.* at 5.

C. Trends of Decline in Private Equity Investment in Health Care Is Likely Short-Lived

As discussed above, the appropriateness of private equity acquisitions in the health care sector is increasingly being called into question. Incentive structures created by private equity takeovers may favor investors but are often misaligned with interests of other stakeholder groups, such as patients and employers.[88] Perhaps as a result of this increased scrutiny, health care sector private equity deals have declined in recent years—"2023 was the second year in decline [in] private equity dealmaking in [the health care sector]."[89] The analysis presented below confirms this observation. It notes that while there has been an overall decline in the total number of private equity deals recently, health care sector private equity deals have not just declined in numbers but also as a proportion of total private equity deals.[90]

Table 1 presents the number of private equity deals in the health care sector along with average deal value in each examined quarter. For comparison purposes, number of private equity deals and average deal value for all deals (all sectors combined) is also presented. Whereas the average deal value has a considerable degree of fluctuation quarter by quarter, the number of deals remains relatively stable over considerable periods of time, both for the health care sector and overall.[91] There does appear to be a spike in health care sector private equity acquisitions towards the end of 2020 which lasts through the second quarter of 2023.[92] However, this is not a unique phenomenon, because we can see a similar spike in the number of private equity acquisitions for the overall U.S. economy.[93] Moreover, health care sector private equity acquisitions have also fallen relative to the overall

88. *See* discussion *supra* Section I.A.

89. BUGBY ET AL., *supra* note 74, at 1.

90. We obtained health care sector acquisitions by private equity firms from the London Stock Exchange Group's ("LSEG") Eikon trading platform. Using the private equity screener ("PESCREENER") in an Eikon terminal, we obtained data for all private equity and venture capital investments in the United States where the investee company's primary industry major group was listed as "Medical/Health/Life Sciences," and the industry subgroup was listed as "Medical/Health." For purposes of comparison, we also obtained data for all private equity deals, representing all industry groups, over a similar sample period. We obtained quarterly data covering a sample period of January 1, 2014, until March 31, 2014, representing a sample of forty-one calendar quarters. Additionally, we also collected data on an annual frequency over the ten-year span covering the period 2021 to 2023.

91. *See infra* Table 1.

92. *See infra* Table 1.

93. *See infra* Table 1.

private equity deal activity, which itself has been in a decline.[94] This latter point is further underscored when we examine Figure 1.

Table 1: Private Equity Deals in Health Care vs. All Sectors Combined in the United States, 2014–2024

	Health Care Sector Private Equity		All Private Equity	
Year Quarter	No. Deals	Avg Deal Value ($mil)	No. Deals	Avg Deal Value ($mil)
2014 Q1	188	8.55	1,926	10.60
2014 Q2	187	26.49	2,051	17.09
2014 Q3	203	16.65	2,012	14.83
2014 Q4	201	5.25	2,106	17.65
2015 Q1	187	9.19	2,049	24.22
2015 Q2	180	6.28	2,159	12.83
2015 Q3	238	4.32	2,088	28.18
2015 Q4	224	1.11	1,954	24.31
2016 Q1	194	22.33	2,025	27.45
2016 Q2	206	3.31	2,046	14.25
2016 Q3	210	12.18	1,950	49.95
2016 Q4	221	8.04	2,001	24.10
2017 Q1	231	27.31	2,028	13.00
2017 Q2	205	1.13	2,076	17.09
2017 Q3	209	29.35	2,061	26.76
2017 Q4	203	8.54	1,990	14.46
2018 Q1	219	3.38	2,255	13.64
2018 Q2	228	16.56	2,263	18.56
2018 Q3	225	29.99	2,176	31.69
2018 Q4	220	66.54	2,258	33.33
2019 Q1	230	37.01	2,408	24.93
2019 Q2	267	0.39	2,667	23.21
2019 Q3	223	3.68	2,644	13.72
2019 Q4	270	4.70	2,692	18.07
2020 Q1	259	3.34	2,699	24.33
2020 Q2	211	1.35	2,190	13.92
2020 Q3	231	3.14	2,613	10.75
2020 Q4	291	24.37	3,026	24.26
2021 Q1	315	7.59	3,404	30.62
2021 Q2	307	18.78	3,569	27.52
2021 Q3	417	7.64	3,814	37.01

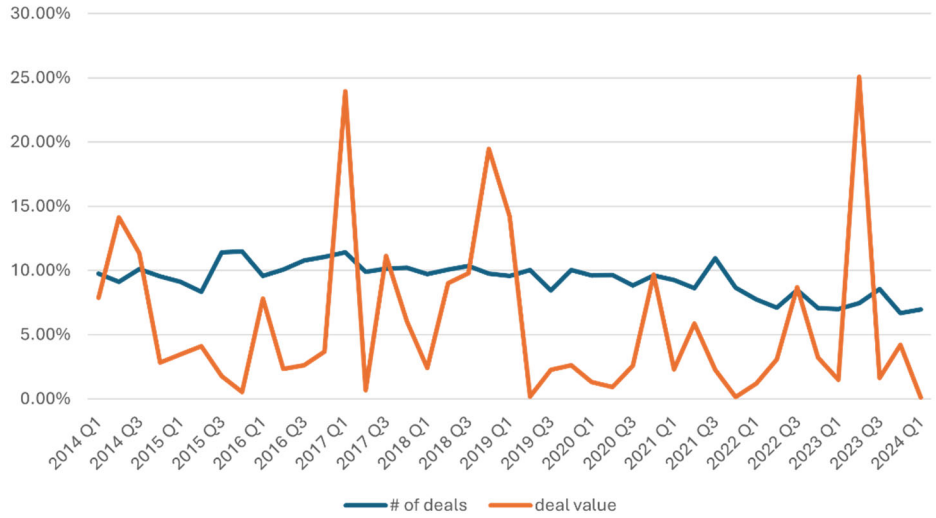
94. *See infra* Table 1.

	Health Care Sector Private Equity		All Private Equity	
2021 Q4	338	0.50	3,908	27.75
2022 Q1	279	4.85	3,602	31.00
2022 Q2	225	9.20	3,164	21.30
2022 Q3	331	27.83	3,903	27.14
2022 Q4	262	14.28	3,712	31.24
2023 Q1	251	3.36	3,590	15.91
2023 Q2	280	28.70	3,751	8.54
2023 Q3	251	3.12	2,941	16.55
2023 Q4	178	7.17	2,661	11.42
2024 Q1	179	0.15	2,569	11.54

Figure 1 charts the proportion of health care sector deals as a percentage of overall deals in each quarter. It also shows the proportion of average deal value in each quarter. Just like the average deal value, the proportional deal value also displays a considerable amount of fluctuation quarter by quarter, with no visible trends.[95] On the other hand, it is evident that the overall number of deals in the health care sector has fallen in recent years.[96] Whereas, between 2014 and 2021, the average proportion of private equity deals in the health care sector had hovered around ten percent of overall private equity deals, health care sector private equity deals have experienced a proportional decline in recent years and has averaged around seven percent over the last couple of years.[97]

95. *See infra* Figure 1.
96. *See infra* Figure 1.
97. *See infra* Figure 1.

Figure 1. Proportion of Private Equity Deals in the U.S. Healthcare Sector Versus All Sectors Combined



Note: This data was obtained from LSEG's Eikon server. Sample period includes quarterly data from January 1, 2014, until March 31, 2024.

Next, this Article examines annual data for all acquisitions, broken down by sectors.[98] Figure 2 presents the annual number of acquisitions for the four largest sectors and all other sectors combined. The health care sector is second only to the technology sector with the most private equity acquisitions over the 2014–2023 sample period.[99] There was an overall decline in private equity acquisitions in almost all sectors over the last couple of years, especially in 2023, suggesting that the decline in acquisitions activity is not limited to the health care sector.[100] However, as noted earlier during our discussion of Figure 1, health care sector private equity acquisitions activity seems to have fallen more than overall acquisitions activity in recent years.[101]

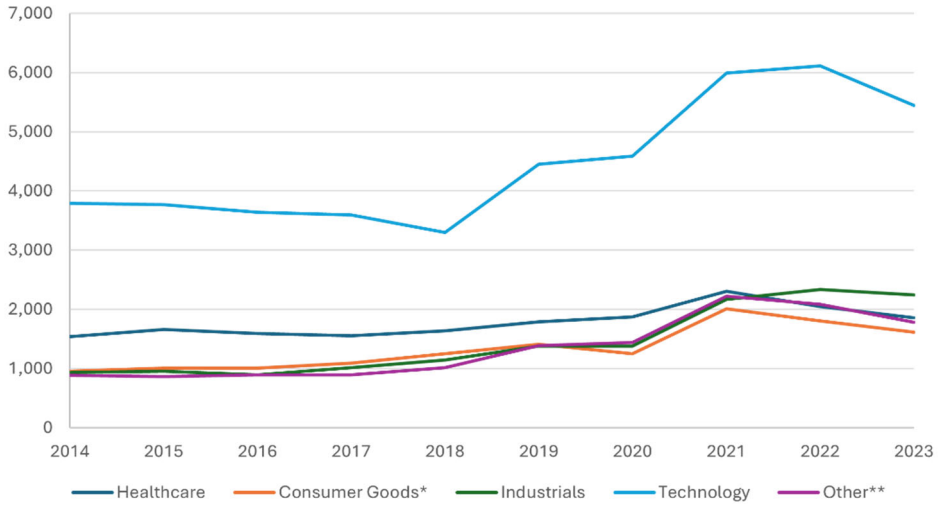
98. As identified by the LSEG Eikon server, using the Thomson Reuters Business Classification ("TRBC") schema. The TRBC schema uses thirteen industry sectors.

99. *See infra* Figure 2.

100. *See infra* Figure 2.

101. *See infra* Figure 2; *supra* Figure 1.

Figure 2. Private Equity Deals in the U.S. for the Top Four Sectors (in Terms of Number of Deals) and All Other Sectors Combined



Note: This data was obtained from LSEG's Eikon server. Economic sectors are identified using the Thomson Reuters Business Classification (TRBC) schema. Sample period includes annual data from January 1, 2014, until December 31, 2023.

An analysis of the data presented in Figure 2 shows an overall decline in number of private equity deals over the last couple of years. This trend could partly be driven by higher interest rates in recent years, which have adversely impacted the cost of financing private equity deals.[102] In the case of the health care sector, in addition to interest rate increases, labor shortages may have also played a role in this declining interest in private equity deals.[103] This Article's analysis finds that the decline in private equity deals in the health care sector has been more pronounced than in the overall U.S. economy. This observation aligns with the decreasing lure of profitability in the health care sector noted in recent literature.

The decline in health care deal volume is likely short lived. If the Federal Reserve follows through on its plan to start reducing interest rates by the end of 2024, it may very well unleash private equity's pent-up demand for acquisition of physician practices and other health care entities.[104]

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102. BUGBY ET AL., *supra* note 74, at 1, 7–8, 25.

103. *Id.*

104. Lola Butcher, *Private Equity Investing Showing Signs of Rebound*, 78 HEALTHCARE FIN. MGMT. 24, 24 (2024).

D. Private Equity Ownership Adversely Affects Availability, Quality, and Costs of Health Care

The returns private equity firms have promised to their investors are based on aggressive business strategies that include cutting staffing, directly impacting patient care, increasing payments from payers, resulting in higher health care costs, and shuttering unprofitable facilities, making health care less accessible for many.[105] While there are ample voices crying out in alarm at private equity's involvement in health care, the impacts on patient care of private equity investment are only beginning to be chronicled, and there is no consensus on the impact.

A recent study of changes in hospital-acquired adverse events and hospitalization outcomes associated with private equity acquisitions of U.S. hospitals found that Medicare beneficiaries admitted to private equity hospitals experienced a 25.4% increase in hospital-acquired conditions (such as falls and infections) compared with those treated at control hospitals.[106] One group examined the effects of private equity ownership in the context of nursing homes and found significant adverse effects on resident mortality for a subset of residents that are wrought with information frictions and/or are reliant on government subsidies.[107] Alarmingly, these researchers found that the mortality rate of these residents at nursing homes acquired by private equity increased by eleven percent.[108] While these studies are important, there is still a dearth of meaningful data to definitively support the postulate that private equity investment in health care worsens patient outcomes or results in higher costs for patients.

In their seminal work, Erin C. Fuse Brown and Mark A. Hall explore the concerning trend of private equity's incursion into health care.[109] Besides making observations like we have made above about the private equity model, specifically the heavy use of debt in leveraged buyouts and the focus on short-term profitability, the authors note a third unique characteristic of private equity investment in health care as distinguished from, say a non-profit hospital's purchase of a physician practice—that "the investment comes from lay entities or individuals, meaning that investors lack professional and institutional obligations to promote the higher ethical goals

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105. *See* Field et al., *supra* note 17, at 890.

106. *See* Sneha Kannan et al., *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, 330 JAMA 2365, 2367–68 (2023).

107. *See* Atul Gupta et al., *Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes*, 37 REV. FIN. STUD. 1029, 1033–34 (2024).

108. *Id.* at 1032.

109. *See generally* Fuse Brown & Hall, *supra* note 27.

of medical care."[110] Private equity's "push for rapid growth and quick exits," devoid of any ethical or professional grounding, means that the investment vehicles "us[e] health care entities as a means to extract wealth for investors, thereby prioritizing quick profits at the expense of patient care."[111]

Financial insolvency of the health care entity is another consequence of private equity investment. When you combine the challenge the private equity-acquired health care entity faces in servicing its debt load with the diminishing Medicare and private pay reimbursement rates, it spells insolvency for private equity-affiliated facilities. A recent article in the Pittsburgh Post-Gazette, noting that there had been over twenty bankruptcy filings in Pittsburgh area nursing facilities in just a few weeks' time, concluded that "long-term mismanagement of nursing homes by private equity firms has reached a tipping point."[112]

E. Current Legal Structures Allow Private Equity Schemes to Fly Under the Radar

The antitrust suit by the FTC against USAP and Welsh Carson details how USAP came to control the surgical anesthesia practice in key markets, especially in Texas, allowing it to raise its prices incrementally with each acquisition and negotiate more favorable rates with insurers and other payers for anesthesiology services.[113] Welsh Carson was able to accomplish this by flying under the radar of existing laws, including the premerger notification requirements of the Hart-Scott-Rodino Antitrust Improvements Act of 1976 ("HSR")[114] and the Premerger Notification Rules.[115] This is due in part to there being no single one of the serial transactions that met the size of transaction thresholds for premerger notification.[116]

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110. *Id.* at 530–31.

111. *Id.* at 531.

112. Editorial, *Private Equity and Nursing Homes Are a Match Made in Hell*, PITTSBURGH POST-GAZETTE (June 14, 2024), https://www.post-gazette.com/opinion/editorials/2024/06/14/private-equity-nursing-homes-bankruptcy-carlyle-group/stories/202406140027.

113. *See* Complaint, *supra* note 1, at 86.

114. 15 U.S.C. § 18(a).

115. 16 C.F.R. §§ 801–803 (2024).

116. *See* Premerger Notification; Reporting and Waiting Period Requirements, 89 Fed. Reg. 89216, 89234 (Nov. 12, 2024) (to be codified at 16 C.F.R. pts. 801, 803) (explaining how serial transactions went undetected under the previous Premerger Notification Rules, using Anesthesia Partners as an example).

The complaint details the control Welsh Carson exerted over USAP even after its ownership stake dipped below 50%.[117] Notwithstanding its continued ownership of a significant stake in the venture and de facto control, ruling on motions to dismiss filed by both USAP and the Welsh Carson group of defendants, on May 13, 2024, the District Court granted Welsh Carson's motion to dismiss and let it out of the case.[118] The District Court concluded that FTC had not sufficiently stated a claim against Welsh Carson for continuing antitrust violations simply because Welsh Carson continued to hold stock and receive profits from USAP.[119] The District Court's dismissal of Welsh Carson was a serious setback for the FTC and for others desiring to hold private equity firms accountable for anti-competitive roll-ups of physician practices.

Executing its acquisition plan incrementally enabled Welsh Carson to go unnoticed for over a decade, effectively flying under the radar, while consolidating the market for hospital anesthesiology in the major cities in Texas. It was as if we awoke one day to find that suddenly almost all of the anesthesiologists now worked for a single enterprise controlled by a private equity firm. Fuse Brown and Hall suggest that existing legal and policy tools, if sharpened, may be enough to address the key risks and harms posed by private equity investment in health care.[120] With this we disagree, as will be discussed below. The proof in the pudding is the court's dismissal of all of the Welsh Carson entities from the USAP litigation. As we will argue in the next section, federal legal tools, including antitrust and false claims laws, have been inadequate stem the tide of private equity transactions destroying competition in the health care sectors and leading to diminished accessibility, affordability, and quality of care.

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117. *See* Complaint, *supra* note 1, at 14–17. Welsh Carson controlled USAP's board of directors, initially having the right to appoint the majority of the board but at all times having at least two seats on the board. *See id.* at 16. Welsh Carson hired many of USAP's original executive management team, "[each] of whom had previously served in similar capacities at other Welsh Carson portfolio companies." *Id.* at 17. From its inception, Welsh Carson "provided USAP with strategic, operational, and financial support." *Id.*

118. *See* Memorandum Op. & Ord. at *1, FTC v. U.S. Anesthesia Partners, Inc., No. 4:23-CV-03560, 2024 U.S. Dist. LEXIS 85714 (S.D. Tex. May 13, 2024).

119. *Id.* at *9–*13. The court observed that "[s]ince 2017, only one of the Welsh Carson entities . . . has owned stock in USAP," a minority stake of 23%, and was entitled to appoint only "two of the fourteen directors to the USAP board." *Id.* at *11. Ownership of a minority stake in a company that reduces competition does not satisfy § 13(b) of the FTC Act. *See id.*

120. *See* Fuse Brown & Hall, *supra* note 27, at 533–34.

II. FEDERAL TOOLS FAIL TO ADEQUATELY SCRUTINIZE PRIVATE EQUITY INVESTMENT IN HEALTH CARE

Two of the most important tools the federal government has to fight against roll-ups and other private equity schemes that impact the costs, quality, and availability of health care are the federal antitrust regime[121] and the False Claims Act.[122] While these tools are important, they have their limitations.

A. Federal Antitrust Laws Fall Short in Addressing Private Equity Investment in Health Care

1. A Reinvigorated FTC Laudably Targets Antitrust in Health Care

The FTC's filing of the complaint in the USAP case really came as no surprise. President Biden selected Lina M. Khan, an Associate Professor at Columbia Law School specializing in antitrust law, for a term on the FTC as its Chair, which she assumed on June 15, 2021.[123] Since taking the reins of

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121. The principal federal antitrust laws are the Sherman Antitrust Act, 15 U.S.C. §§ 1–7, the Clayton Antitrust Act, 15 U.S.C. §§ 12–27, and the Federal Trade Commission Act, 15 U.S.C. §§ 41–58.

122. 31 U.S.C. §§ 3729–3733.

123. Press Release, Fed. Trade Comm'n, Lina M. Khan Sworn in as Chair of the FTC (June 15, 2021), https://www.ftc.gov/news-events/news/press-releases/2021/06/lina-m-khan-sworn-chair-ftc [https://perma.cc/NC2S-QM4W]. Khan burst onto the antitrust scene in 2017 with the publication of her note "Amazon's Antitrust Paradox" in the *Yale Law Journal*, while she was still a law student at Yale. *See generally* Lina M. Khan, *Amazon's Antitrust Paradox*, 126 YALE L.J. 710 (2017). The article was awarded the 2018 Antitrust Writing Award for "Best Academic Unilateral Conduct Article," Yale Law School's Israel H. Peres Prize, and the Yale Law Journal's Michael Egger Prize. *See Lina Khan*, ASPEN IDEAS, https://www.aspenideas.org/speakers/lina-khan [https://perma.cc/G7Z8-SEMS]. In her note, Khan surveyed the U.S. antitrust framework beginning in the mid-twentieth century, observing a shift away from a structure-based view of competition toward the so-called Chicago School, or price theory, approach. *Id.* at 717–19. Economic structuralism theorizes that concentrated market structures inherently promote anticompetitive conduct, because monopolistic and oligopolistic market structures allow dominant actors to coordinate pricing and block new entrants to the market, giving them greater bargaining power against consumers, enabling to raise prices while lowering quality, thereby maximizing profits. *Id.* at 718. In contrast, the price theory approach is based on a simple and flawed theoretical premise, that the market will inherently cause rational economic actors to "seek to maximize profits by combining inputs in the most efficient manner." *Id.* at 719. One of the ramifications of this shift from structuralism to price theory was that "consumer prices became the dominant metric for assessing competition." *Id.* at 720. By gauging consumer welfare solely with reference to short-term price effects, ignoring other forms of anti-competitive harm, antitrust law is ill equipped to address the complexities of market structures and the anticompetitive effects

the FTC, Khan has signaled that antitrust oversight will be a huge area of focus for the FTC, and indeed it has been.[124] A stated policy priority for the FTC is "to address rampant consolidation and the dominance that it has enabled across markets."[125] Right behind it is addressing dominant intermediaries and extractive business models, including "the growing role of private equity and other investment vehicles" that distort ordinary incentives in ways that strip productive capacity and may facilitate unfair methods of competition and consumer protection violations.[126] The FTC has private equity in its crosshairs.

Even though the FTC's enforcement principles for Section 5 unfair methods of competition claims had just been adopted in 2015,[127] in light of its renewed focus on antitrust, on July 1, 2021, the FTC repealed the enforcement principles.[128] The majority of the Commission noted that in the over five years since 2015, the FTC had pleaded a standalone § 5 violation only once, and concluded that, by tethering § 5 of the FTC Act to the Sherman and Clayton Acts, the 2015 UMC Statement had negated the FTC's core legislative mandate to reach beyond the Sherman Act and to provide an

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they breed. *See id.* at 716–17. While the paper looked specifically at the digital marketplace sector, and specifically predatory pricing and vertical integration strategies employed by Amazon, it is easy to theorize that Khan's criticisms might span a number of complex market structures today, including health care. *See id.* at 712–17. Khan would continue her criticism of the Chicago School, or price theory, approach to competition law even beyond the technology sector in a follow up paper. *See generally* Lina M. Khan, *The Ideological Roots of America's Market Power Problem*, 127 YALE L.J. 960 (2017).

124. *See* Memorandum from Lina M. Khan, Chair, Fed. Trade Comm'n, to Comm'n Staff and Comm'rs (Sept. 22, 2021), https://www.ftc.gov/system/files/documents/public_statements/1596664/agency_priorities_memo_from_chair_lina_m_khan_9-22-21.pdf [https://perma.cc/C97R-MNBL].

125. *Id.* at 2.

126. *Id.* at 3.

127. *See* Public Statement, Fed. Trade Comm'n, Statement of Enforcement Principles Regarding "Unfair Methods of Competition" Under Section 5 of the FTC Act (Aug. 13, 2015), https://www.ftc.gov/system/files/documents/public_statements/735201/150813section5enforcement.pdf [https://perma.cc/6RVA-J2ET]. Under the 2015 UMC Statement, the FTC announced that in deciding whether to challenge an act or practice on a standalone basis under § 5, the act or practice would be evaluated under "a framework similar to the rule of reason" by only challenging those that cause or are likely to cause harm to competition, "taking into account any associated cognizable efficiencies and business justifications." *Id.*

128. Public Statement, Fed. Trade Comm'n, Statement on the Withdrawal of the Statement of Enforcement Principles Regarding "Unfair Methods of Competition" Under Section 5 of the FTC Act 3 (July 1, 2021), https://www.ftc.gov/system/files/documents/public_statements/1591706/p210100commnstmtwithdrawalsec5enforcement.pdf [https://perma.cc/CW2V-LBPP] ("By proscribing conduct using this new term [of *unfair methods of competition*], . . . the plain language of the statute makes clear that Congress intended for Section 5 of the FTC Act to reach beyond existing antitrust law.").

alternative institutional framework for enforcing the antitrust laws.[129] It would take the FTC over a year to replace the repealed policy statement, which it did on November 10, 2022.[130] Not all of the Commissioners were on board with the repeal,[131] and it was one of the areas of dissension from Khan's stamp on the FTC that ultimately led to the resignations of Commissioners Phillips[132] and Wilson.[133]

Under his new FTC commissioner, President Biden issued his "Executive Order on Promoting Competition in the American Economy," taking aim at the anti-competitive impact of consolidation in many economic sectors.[134] On November 12, 2021, the FTC released a preliminary draft of its strategic plan for fiscal years 2022–2026, and invited public comments on the draft.[135] The FTC received an earful from the business community, including criticism of the subtle deletion in its mission statement of language that had been in prior plans for decades, language that required the FTC to take a balanced approach

129. *See id.* at 1–2.

130. *See* FED. TRADE COMM'N, COMM'N FILE NO. P221202, POLICY STATEMENT REGARDING THE SCOPE OF UNFAIR METHODS OF COMPETITION UNDER SECTION 5 OF THE FEDERAL TRADE COMMISSION ACT (2022).

131. *See* Public Statement, Noah Joshua Phillips & Christine S. Wilson, Comm'rs, Fed. Trade Comm'n, Dissenting Statement of Commissioners Noah Joshua Phillips and Christine S. Wilson on the "Statement of the Commission on the Withdrawal of the Statement of Enforcement Principles Regarding 'Unfair Methods of Competition' Under Section 5 of the FTC Act" (July 9, 2021), https://www.ftc.gov/system/files/documents/public_statements/1591710/p210100phillipswilsondissentsec5enforcementprinciples.pdf [https://perma.cc/XSQ6-7UMQ].

132. *See* Public Statement, Noah Joshua Phillips, Comm'r, Fed. Trade Comm'n, Note from Commissioner Noah Joshua Phillips to FTC Employees (Oct. 14, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/phillips-resignation-statement.pdf [https://perma.cc/4JB7-J8FQ].

133. *See* Letter from Christine S. Wilson, Comm'r, Fed. Trade Comm'n, to Joseph R. Biden, Jr., President of the U.S. (Mar. 2, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/p180200wilsonresignationletter.pdf [https://perma.cc/D52Q-SW8U].

134. *See* Exec. Order No. 14036, 3 C.F.R. § 609 (2021).

135. Press Release, Fed. Trade Comm'n, FTC Invites Public Comment on Draft Strategic Plan (Nov. 12, 2021), https://www.ftc.gov/news-events/news/press-releases/2021/11/ftc-invites-public-comment-draft-strategic-plan [https://perma.cc/G94G-S9T5].

in going about its consumer protection mission.[136] The concerns of the business community were largely ignored.[137]

The FTC, in conjunction with the DOJ's Antitrust Division, has taken a number of other steps to strengthen enforcement of the federal antitrust laws, including in health care. As part of a contemplated major overhaul of the HSR process, on June 29, 2023, the FTC and the DOJ proposed dramatic changes to the premerger notification rules and form.[138] The new rules were finalized on October 10, 2024.[139] The new rules and form, which are designed to provide the government with significantly more information with the initial filing, are expected to increase burdens on HSR filers anywhere from four to ten-fold.[140]

On December 18, 2023, the FTC and DOJ jointly issued new Merger Guidelines ("2023 Merger Guidelines"),[141] which replaced the guidelines from 2010 for horizontal mergers[142] and from 2020 for vertical mergers.[143] The 2023 Merger Guidelines "describe factors and frameworks the agencies

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136. *See, e.g.*, Andy Jung, *FTC Proposes Astounding Change to the Agency's Mission Statement*, WASH. LEGAL FOUND. (Dec. 7, 2021), https://www.wlf.org/2021/12/07/wlf-legal-pulse/ftc-proposes-astounding-change-to-the-agencys-mission-statement [https://perma.cc/3N6K-3DLW]. The deleted language from prior mission statements of the FTC is shown in the remaining text: "Protecting consumers and competition by preventing anticompetitive, deceptive, and unfair business practices through law enforcement, advocacy, and education." *Id.*

137. *See About the FTC*, FED. TRADE COMM'N, https://www.ftc.gov/about-ftc [https://perma.cc/9VUE-9DLG] (keeping the change in the FTC's mission statement).

138. *See* Premerger Notification; Reporting and Waiting Period Requirements, 16 C.F.R. § 801, 03 (2023); *see also* Press Release, Fed. Trade Comm'n, FTC and DOJ Propose Changes to HSR Form for More Effective, Efficient Merger Review (June 27, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/06/ftc-doj-propose-changes-hsr-form-more-effective-efficient-merger-review [https://perma.cc/MQ53-4SUB].

139. Press Release, Fed. Trade Comm'n, FTC Finalizes Changes to the Premerger Notification Form (Oct. 10, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/10/ftc-finalizes-changes-premerger-notification-form [https://perma.cc/C4UU-F6PY].

140. Bryan Koenig, *'Shocking' Merger Filing Overhaul Could Increase Costs 10x*, LAW360 (June 28, 2023), https://www.law360.com/articles/1693983/-shocking-merger-filing-overhaul-could-increase-costs-10x.

141. Press Release, U.S. Dep't of Just., Justice Department and Federal Trade Commission Release 2023 Merger Guidelines (Dec. 18, 2023), https://www.justice.gov/opa/pr/justice-department-and-federal-trade-commission-release-2023-merger-guidelines [https://perma.cc/Y3S5-ZKC8]; U.S. DEP'T OF JUST. & FED. TRADE COMM'N, MERGER GUIDELINES (2023).

142. *See* U.S. DEP'T OF JUST. & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (2010).

143. *See* U.S. DEP'T OF JUST. & FED. TRADE COMM'N, VERTICAL MERGER GUIDELINES (2020).

utilize when reviewing mergers and acquisitions."[144] Shifting the focus specifically to health care, on March 5, 2024, the FTC hosted a public workshop called "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care," which "examin[ed] the role of private equity investment in health care markets."[145] Concurrently, on March 5, 2024, the FTC and DOJ, joined by the Department of Health and Human Services, published a request for information seeking public comments from stakeholders and the public on consolidation in health care markets.[146] The RFI invited comments regarding the "effects of transactions involving health care providers, facilities, or ancillary products or services," conducted by private equity funds or other alternative asset managers, health systems, or private payers.[147] In the release, the three agencies noted:

> Private equity firms and other corporate owners are increasingly involved in health care system transactions, and, at times, those transactions may lead to a maximizing of profits at the expense of quality care. The cross-government inquiry seeks to understand how certain health care market transactions may increase consolidation and generate profits for firms while threatening patients' health, workers' safety, quality of care, and affordable health care for patients and taxpayers. [148]

While the comment period for the RFI was initially slated to close on May 6, 2024, the deadline to submit comments was subsequently extended to June 5, 2024.[149]

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144. Press Release, U.S. Dep't of Just., *supra* note 141.

145. *See Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care*, FED. TRADE COMM'N, https://www.ftc.gov/news-events/events/2024/03/private-capital-public-impact-ftc-workshop-private-equity-health-care [https://perma.cc/8KAP-N7DX].

146. *See* Press Release, U.S. Dep't of Justice, 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 (Mar. 5, 2024), https://www.justice.gov/opa/pr/justice-department-federal-trade-commission-and-department-health-and-human-services-issue [https://perma.cc/D9K3-RWS9].

147. U.S. DEP'T OF JUSTICE, ET AL., DOCKET NO. ATR 102, REQUEST FOR INFORMATION ON CONSOLIDATION IN HEALTH CARE MARKETS 5–7 (2024).

148. Press Release, Fed. Trade Comm'n, 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 (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 [https://perma.cc/C4YY-KNF8].

149. Press Release, Fed. Trade Comm'n, FTC, DOJ, and HHS Extend Comment Period on Cross-Government Inquiry on Impact of Corporate Greed in Health Care (May 1, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/05/ftc-doj-hhs-extend-comment-

Then on April 18, 2024, on its newly created "Healthy Competition" portal, the DOJ invited consumers to submit complaints about health care competition.[150] Although the FTC's case against USAP is a long way from being finally decided, the DOJ's Healthy Competition page provides a robust discussion of healthy competition, including "Examples of Conduct That Can Harm Competition in Healthcare."[151] The harmful, anti-competitive conduct targeted expressly includes "'roll-ups' of health care providers."[152] Bearing down on private equity and its roll-up strategy, as carried out by Carson Welsh and USAP, on May 23, 2024, the FTC and DOJ jointly launched another, more targeted request for information "to identify serial acquisitions and roll-up strategies throughout the economy that have led to consolidation that has harmed competition."[153]

While the focus may be more heightened now, FTC review of health care transactions is nothing new. The Health Care Division of the Bureau of Competition was formed in the mid-1970's "to investigate potential antitrust violations involving health care."[154] But the FTC Chair has signaled it will be an area of heightened scrutiny, including particularly private equity acquisitions of health care service providers.[155] The FTC wants to put their money where their mouth is—in the FTC's budget request for FY 2024, the FTC requested an increase in budget dollars for "promoting competition" from $211,488,000 in 2023 to $301,128,000 in 2024, an increase of 42%.[156]

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period-cross-government-inquiry-impact-corporate-greed-health-care [https://perma.cc/3AHE-AXJ8].

150. *See Help Us Ensure Access to Fair and Competitive Healthcare Markets for You and Your Family*, U.S. DEP'T OF JUSTICE, https://www.justice.gov/atr/HealthyCompetition [https://perma.cc/YWV2-GQ7G].

151. *See id.*

152. *Id.* In the example, "roll-ups" (also called serial acquisitions) is defined as: "When a firm buys multiple small but similar businesses in the same area. Such conduct reduces the number of competitors over time." *Id.*

153. Press Release, Fed. Trade Comm'n, FTC and DOJ Seek Info on Serial Acquisitions, Roll-Up Strategies Across U.S. Economy (May 23, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/05/ftc-doj-seek-info-serial-acquisitions-roll-strategies-across-us-economy [https://perma.cc/T6QV-AYXG]. The RFI is not limited to the health care sector but seeks input about serial acquisitions in all sectors. *See id.*

154. FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS 1 (2022).

155. Lina M. Khan, Chair, Fed. Trade Comm'n, Private Capital, Public Impact Workshop on Private Equity in Healthcare (Mar. 5, 2024), https://www.ftc.gov/system/files/ftc_gov/pdf/2024.03.05-chair-khan-remarks-at-the-private-capital-public-impact-workshop-on-private-equity-in-healthcare.pdf [https://perma.cc/D65R-CHPH].

156. *See* FED. TRADE COMM'N, CONGRESSIONAL BUDGET JUSTIFICATION: FISCAL YEAR 2024, at 8, 55 (2023).

2. Enforcement of Current Antitrust Laws in Private Equity Transactions Is Often Too Little, Too Late

Section 7 of the Clayton Antitrust Act of 1914 ("Clayton Act") prohibits mergers or acquisitions where the effect of such acquisition may be substantially to lessen competition or to tend to create a monopoly in interstate commerce.[157] A § 7 violation is established by showing that a pending acquisition is reasonably likely to cause anticompetitive effects.[158] While purely civil in nature, the Clayton Act gives the FTC[159] and the DOJ[160] concurrent power to bring actions for injunctive relief to prevent and restrain any prospective violation of the Clayton Act. The injunctive power was "a keystone in the erection of a barrier to . . . the rising tide of economic concentration," providing "authority for arresting mergers at a time when the trend to a lessening of competition in a line of commerce was still in its incipiency," giving the FTC and the courts "the power to brake this force at its outset and before it gathered momentum."[161]

Because the enforcement agencies could not very well seek to enjoin a transaction that they did not learn about until after it closed, it soon became apparent that they needed to be given an advance opportunity to review the proposed transaction for impacts on competition. HSR requires the parties to a merger or acquisition in interstate commerce and meeting certain other requirements to give notice of and certain information relating to the transaction to the FTC and DOJ at least 30 days before the transaction is closed.[162] The premerger notification program under HSR was established because of the difficulties and expense involved in challenging anticompetitive acquisitions after the fact, and because it is often impossible

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157. *See* Clayton Antitrust Act, ch. 7, 38 Stat. 730, 731–32 (1914) (codified at 15 U.S.C. § 18). The antitrust laws most likely to affect the legality of mergers or acquisitions are § 7 of the Clayton Act, 15 U.S.C. § 18; § 1 of the Sherman Act, 15 U.S.C. § 1; and § 5 of the Federal Trade Commission Act, 15 U.S.C. § 45. Mergers are prohibited under Section 7 of Clayton Act if their effect "may be substantially to lessen competition, or to tend to create a monopoly." Antitrust Act §7. When determining the lawfulness of a merger or acquisition under § 1 of the Sherman Act, which prohibits transactions that constitute contracts, combinations, or conspiracies in restraint of trade, or under § 5 of the Federal Trade Commission Act, which prohibits unfair methods of competition, the criteria of Section 7 of the Clayton Act are generally applied. *See* 15 U.S.C. §§ 1, 45.

158. *See* United States v. Penn-Olin Chem. Co., 378 U.S. 158, 171 (1964) (noting that a § 7 violation is established upon showing a "'reasonable likelihood' of a substantial lessening of competition in the relevant market").

159. *See* 15 U.S.C. § 53(b).

160. *See* 15 U.S.C. § 25.

161. Brown Shoe Co. v. United States, 370 U.S. 294, 317–18 (1962).

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

to restore competition fully once a merger takes place.[163] Trying to undo a completed merger has been likened to trying to "unscramble an egg."[164] HSR subjects transactions to review if they meet certain minimum dollar jurisdictional thresholds relating to size of the transaction and size of the person, which thresholds are to be revised annually based on the gross national product.[165] At $51,744 per day, penalties for noncompliance with the premerger notification requirements can be severe.[166] As of this writing, the HSR's size of the transaction threshold for reportability is $119.5 million.[167] As we contend in the next part, this high threshold diminishes the ability for federal antitrust enforcers to preemptively stave off anti-competitive health care mergers and transactions.

The large dollar threshold under HSR and the fact that HSR's scheme does not aggregate serial transactions like roll-ups limits HSR's effectiveness in combatting most private equity-backed health care transactions (other than perhaps larger hospital purchases). The federal antitrust laws unnecessarily put the FTC and DOJ at a disadvantage in reining in harmful mergers and acquisitions in the health care sector, including those involving private equity. The HSR framework, which subjects only larger transactions to review and without any mechanism of aggregation of transactions over a period of time, allows too many mergers and acquisitions to fall through the cracks. This reality is borne out by the fact that it took the FTC more than ten years after Welsh Carson hatched its scheme with USAP to take action.[168] In addition, the short notice period of thirty days (compared with periods from sixty to 180 days under the more rigorous of the state notification laws) ignores the increasing complexity of health care transactions and simply does

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163. *See* FED. TRADE COMM'N, WHAT IS THE PREMERGER NOTIFICATION PROGRAM?: AN OVERVIEW (2024).

164. Earl W. Kintner et al., *The Hart-Scott-Rodino Antitrust Improvements Act of 1976: An Analysis*, 46 GEO. WASH. L. REV. 1, 12 (1977).

165. *See* 15 U.S.C. § 18(a)(2).

166. Press Release, Fed. Trade Comm'n, FTC Publishes Inflation-Adjusted Civil Penalty Amounts for 2024 (Jan. 11, 2024), https://www.ftc.gov/news-events/news/press-releases/2024/01/ftc-publishes-inflation-adjusted-civil-penalty-amounts-2024 [https://perma.cc/9F5X-FEV6].

167. Revised Jurisdictional Thresholds for Section 7A of the Clayton Act, 89 Fed. Reg. 7708 (Feb. 5, 2024). If the transaction is greater than $119.5 million but less than $478 million, it is reportable only if the size of person threshold is met. *See id.*; 15 U.S.C. § 18a(a)(2)(B)(i). The current size of person threshold is met if one party has annual net sales or total assets of at least $239 million and the other party has annual net sales or total assets of at least $23.9 million. *See* Revised Jurisdictional Thresholds for Section 7A of the Clayton Act, 89 Fed. Reg. 7708; 15 U.S.C. § 18a(a)(2)(B)(ii).

168. *See* FTC v. U.S. Anesthesia Partners, Inc., 4:23-CV-03560, 2024 WL 2137649, at *1–2 (S.D. Tex. May 13, 2024) (noting that Welsh Carson began its scheme in 2012).

not allow enough time for review.[169] Furthermore, review of transactions under a conventional federal antitrust focus almost exclusively on price effects while ignoring other equally important harms. One of the inherent weaknesses of antitrust law is that it makes no differentiation between non-essential and essential items, or necessities, to which "the core pillars of antitrust's framework make little sense when applied."[170] Diminished quality of health outcomes and reduced availability of care are effects which our current federal scheme for competition review of mergers and acquisitions is ill-equipped to address. With transactions involving the health care sector, the inquiry should begin with the anticipated competitive effects of the transaction but not end there. Such transactions should be scrutinized for the impacts they might have on health care and its quality and availability. To that end, in addition to an overlapping review by the FTC and DOJ that is focused solely on concerns over market concentration, health care transactions should be subjected to a painstaking review by an independent health commission empowered by statute to review and approve or disapprove the transaction. As it is, a flurry of health care transactions has closed quickly without the right set of eyes looking at their potential effects.

Antitrust analysis paints in gray shades, with no bright lines between wrongful anticompetitive conduct and "socially acceptable and economically justifiable business conduct."[171] This inherent ambiguity is illustrated by the FTC's recent abandonment of its existing framework for examination of vertical and horizontal mergers in favor of a radically different framework, even though there has been no change at all in the statutory language.[172] Defining the relevant market for a particular type or class of health care service in a particular geographic area, essential for merger claims under § 7 of the Clayton Act, is an inherently complex task. Neither the antitrust regulators nor the parties to a transaction in health care should have to theorize about what a court might ultimately conclude as the "relevant market" for health care services.

Antitrust law is built upon a simple premise, that if consumers have a choice between two providers of the same product or service, they will

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169. For further discussion on state regulations, see *infra* Section III.B.3.

170. Gregory Day, *The Necessity in Antitrust Law*, 78 WASH. & LEE L. REV. 1289, 1294 (2021).

171. United States v. U.S. Gypsum Co., 438 U.S. 422, 441 (1978); *see also* W. Penn Allegheny Health Sys., Inc. v. UPMC, 627 F.3d 85, 108 (3d Cir. 2010) ("The line between anticompetitive conduct and vigorous competition is sometimes blurry.").

172. *See supra* Section II.A.1. Metamorphosis of the basic economic and legal framework for examining M&A activity is nothing new. *See* Luke Billman & Steven C. Salop, *Merger Enforcement Statistics: 2001–2020*, 85 ANTITRUST L.J. 1, 1–16 (2023).

choose the lesser priced provider. That premise has been challenged in a criticism of the current antitrust approach as ignoring other anti-competitive harms besides mere price,[173] and certainly does not hold true in the area of health care, either in consumers' choices of providers or health plans. The meaningful reform of federal antitrust law would be a step in the right direction, but is a step that, given the current disfunction of Congress is not likely to happen in time. The horse is well out of the barn.

B. The False Claims Act Does Nothing to Address Quality and Accessibility of Care Concerns

The False Claims Act ("FCA") imposes liability on anyone who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" to the United States.[174] According to the National Health Care Anti-Fraud Association, some law enforcement and government agencies estimate that up to 10% of total health care expenditures are fraudulent, which could be over $300 billion a year.[175] Additional losses accrue at the state level and in federal non-Medicare programs such as defense, education, environmental protection, homeland security, and research grants.[176] In February of 2024, Deputy Assistant Attorney General Brian M. Boynton reported that $1.9 billion of the nearly $2.7 billion in False Claims Act recoveries were "related to health care fraud schemes" in 2023.[177] He also noted their increased focus on private equity firms, stating that "entities may influence patient care by providing express direction for how a provider should conduct their business, or more indirectly by providing revenue targets or other indirect benchmarks intended to prioritize

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173. *See supra* Section II.A.2.

174. 31 U.S.C. § 3729(a)(1)(A).

175. *The Challenge of Health Care Fraud*, NAT'L HEALTH CARE ANTI-FRAUD ASS'N, https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud [https://perma.cc/PL9S-SXG8].

176. *See* Scott B. McBride & Rasmeet Chahil, *False Claims Act Trends and Expected Enforcement Priorities for 2024*, REUTERS (May 13, 2024), https://www.reuters.com/legal/litigation/false-claims-act-trends-expected-enforcement-priorities-2024-2024-05-13 [https://perma.cc/HH7V-4DR7].

177. Brian M. Boynton, Principal Deputy Assistant Att'y Gen., U.S. Dep't of Just., Remarks at the 2024 Federal Bar Association's Qui Tam Conference (Feb. 22, 2024), https://www.justice.gov/opa/speech/principal-deputy-assistant-attorney-general-brian-m-boynton-delivers-remarks-2024 [https://perma.cc/TX5C-NH7W].

reimbursement."[178] His remarks concluded by stating the department would not hesitate to pursue actors who endeavor to defraud the government.[179]

In their 2023 article, Field et al. note that there have been five cases involving FCA complaints and private equity defendants, although only two litigated the issue of private equity liability under the FCA.[180] In those cases, there was evidence that the private equity firms knew or had reason to know that the billing practices used were fraudulent.[181] It stands to reason that if the private equity owner has control of the company and knowledge of fraudulent activity, it can be liable under the FCA as a third-party defendant.[182]

The knowledge requirement for the FCA does not include specific proof of intent to defraud but instead can be established through actual knowledge of false information, deliberate ignorance, or reckless disregard of the truth or falsity of the information.[183] Even so, courts have increasingly looked to the materiality requirement in the FCA after the Supreme Court's ruling in *Universal Health Services v. United States ex rel Escobar*.[184] This means government enforcers and plaintiffs must prove that the decision to submit payments in non-compliance with government requirements are material to the payor's payment decisions.[185] Nonetheless, a third party defendant, such as a private equity owner, can be liable if it had knowledge and control to cause the submission of false claims.[186]

This becomes relevant in cases involving the issue of whether a private equity company is sufficiently involved with operations to be liable under the FCA. Private equity owners of health care entities argue that they are passive third-party investors and cannot be liable for the actions of medical professionals and are not authorized to practice medicine. While it is true that private equity firms may not practice medicine, there are two potential

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178. *Id.*

179. *Id.* The Civil Fraud division of the Justice Department has also taken the position that issues that arise during the due diligence phase of a potential investment which are not immediately corrected are enough to hold private equity investors liable under the FCA. McBride & Chahil, *supra* note 176.

180. Field et al., *supra* note 17, at 868. For a table of cases, see *id.* at 869–70.

181. *See* United States *ex rel*. Martino-Fleming v. S. Bay Mental Health Ctrs., Inc., 540 F. Supp. 3d 103, 128–33 (D. Mass. 2021); *see also* United States *ex rel.* Carmen Medrano v. Diabetic Care RX, LLC, No. 15-CV-62617, 2018 U.S. Dist. LEXIS 204225, at *31–37 (S.D. Fla. Nov. 30, 2018).

182. Fuse Brown & Hall, *supra* note 27, at 554.

183. *Id.*; Field et al., *supra* note 58, at 867.

184. Field et al., *supra* note 58, at 867–68 (quoting Universal Health Servs. v. United States *ex rel.* Escobar, 579 U.S. 193, 194 (2016)) (noting the standard "look[s] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation.").

185. Field et al., *supra* note 58, at 868.

186. Fuse Brown & Hall, *supra* note 27, at 554.

avenues to hold a private equity owned company liable under the FCA. First, courts can pierce the veil between a parent company and subsidiary, but only where the parent "so dominated the subsidiary corporation as to negate its separate personality."[187] In the *Hockett* case, the court considered factors such as identity of ownership, commonality of officers and directors, financial relationship between parent and subsidiary, whether the two maintained separate books and records, and whether property of one is used by the other as its own.[188] The second avenue for liability under the FCA is to be directly involved in submitting false claims or causing them to be submitted to the government.[189] In the *Hockett* case, there was enough evidence that an agent and employee of Columbia/HCA was involved in finalizing cost reports and billing to the government.[190] The frequency of communication between corporate officials at the parent company and clinic staff supported an inference that the corporation was aware of the fraudulent activity.[191] This argument has already been extended to private equity owners of health care firms. "Due to the administrative control exerted by [private equity] over acquired medical practices, this direct-involvement theory of parent liability seems more viable than veil piercing."[192]

In the *Medrano* case, the private equity company, Riordan, Lewis & Haden, Inc. ("RLH"), had a controlling interest in Diabetic Care Rx, LLC d/b/a Patient Care American ("PCA"), a compounding pharmacy.[193] The plaintiffs claimed that RLH and PCA engaged in schemes to generate referrals for topical creams, which resulted in kickbacks to a marketing firm.[194] RLH alleged that it could not be liable under the FCA because it did not know about the scheme and did not cause the claims to be submitted to the government.[195] The magistrate judge disagreed, because RLH had

187. AGS Int'l. Servs. S.A. v. Newmont USA Ltd., 346 F. Supp. 2d 64, 89 (D.D.C. 2004) (quoting Hart v. Dep't of Agric., 112 F.3d 1228, 1231 (D.C. Cir. 1997)).

188. United States *ex rel*. Hockett v. Columbia/HCA Healthcare Corp., 498 F. Supp. 2d 25, 60 (D.D.C. 2007).

189. *Id.* at 62.

190. *See id.* at 62.

191. *See id.* at 63.

192. Fuse Brown & Hall, *supra* note 27, at 555.

193. United States *ex rel.* Carmen Medrano v. Diabetic Care RX, L.L.C., No. 15-CV-62617, 2018 WL 6978633, at *4 (S.D. Fla. 2018).

194. *Id.* at *9–10.

195. *Id.* at *31–32.

actually approved the agreement between PCA and the marketing firm and funded the $2 million in commissions to the marketing firm.[196]

A private whistleblower brought a claim in the *Martino-Fleming* case against her mental health facility employer, South Bay Mental Health Center, and its private equity firm investor H.I.G. Capital, LLC and its affiliates.[197] Massachusetts Medicaid regulations required unlicensed staff to be supervised by licensed professionals, but unlicensed and unsupervised staff were allowed to provide care and those claims were submitted to the government for payment.[198] Plaintiff alleged that H.I.G. was aware of the violations through meetings and an internal initiative to address employee turnover.[199] The court found that "knowing ratification of the prior policy of submitting false claims by rejecting recommendations to bring South Bay into regulatory compliance constitutes sufficient participation in the claims process to trigger [FCA] liability."[200]

Curo Health Services Holdings, Inc. was a private equity-backed company which purchased Avalon Hospice and other hospice agencies in Tennessee.[201] Avalon was alleged to have submitted false claims for patients who were not eligible for hospice, and Curo allegedly assessed patient eligibility for hospice care, scrutinized decisions not to admit patients, gave financial incentives for increased admissions, and failed to take any action to correct issues with Avalon.[202] The court denied a motion to dismiss, finding that the government had pleaded the elements necessary to establish liability on behalf of Avalon's corporate parents, including Curo, based on the government's argument that Curo's policies resulted in the false claims.[203]

These cases show that the extent to which private equity companies exert control over acquired medical companies can in fact expose them to liability

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196. *Id.* at *39–40. Ultimately, the case was dismissed because the plaintiffs had not met the heightened pleading requirements of Rule 9(b) for fraud cases, and the parties later reached a settlement for $21.36 million. Field et al., *supra* note 58, at 873.

197. *See* United States *ex rel*. Martino-Fleming v. S. Bay Mental Health Ctrs., 540 F. Supp. 3d 103, 110 (D. Mass. 2021).

198. *Id.* at 118–19.

199. *Id.* at 129.

200. *Id.* at 130 (internal quotation marks omitted).

201. United States *ex rel.* Anderson v. Curo Health Servs. Holdings, Inc., No. 3:13-cv-00672, 2022 WL 842937 at *4 (M.D. Tenn. Mar. 21, 2022).

202. *Id.* at *14–15.

203. *Id.* at *15. Incidentally, Curo Health Services was acquired in 2018 (prior to this case) by Humana and its private equity partners TPG and Welsh, Carson, Anderson & Stowe, the latter being the same defendant in the USAP case discussed in Section II.E of this article. Eileen Appelbaum et al., *Preying on the Dying: Private Equity gets Rich in Hospice Care,* CTR. FOR ECON. & POL'Y RSCH. (Apr. 25, 2023), https://cepr.net/publications/preying-on-the-dying-private-equity-gets-rich-in-hospice-care [https://perma.cc/CSD5-Z37Z].

under the FCA. As Field et al. suggest, perhaps it is the business model which pushes companies over the edge into noncompliance with government regulations.[204] As stated earlier, we are likely to see additional government scrutiny and enforcement actions.

While the FCA is a potent weapon against fraudulent claims that lead to increased costs, it does nothing to address other cost factors or concerns about the accessibility and quality of care. As we will show below, a combination of state law tools, including renewed enforcement of older corporate practice of medicine laws and robust enforcement of newer health care transactions notification laws, hold greater promise at stemming the tide of problematic private equity transactions in the health care sector.

III. STATE TOOLS HOLD GREATER POTENTIAL FOR COMBATTING PRIVATE EQUITY ABUSES

A. The Corporate Practice of Medicine Doctrine Should Be Applied to Dubious Private Equity Health Care Structure

1. Private Equity Investment Is Contrary to the Ethical and Legal Underpinnings of CPOM

Doctors practice medicine—corporations do not.[205] Thus, many states have corporate practice of medicine ("CPOM") laws which limit the role of entities in clinical decision making of physicians.[206] State CPOM laws regulate the ownership and operation of medical practices by entities or individuals who are not licensed physicians.[207] The purpose of these laws is to ensure that independent medical decisions are made by qualified medical professionals rather than by business interests.[208] Their purposes are to allow physicians to exercise the practice of medicine independently and protect patients from conflicts between a physician's duty to patients and the physician's duty to a corporate employer.[209]

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204. Field et al., *supra* note 58, at 878.

205. *But see* Michele Gustavson & Nick Taylor, *At Death's Door—Idaho's Corporate Practice of Medicine Doctrine*, 47 IDAHO L. REV. 479, 481 (2011) (noting the "simple fact today is that corporations do practice medicine").

206. *See* Kathrine Marous, *The Corporate Practice of Medicine Doctrine: An Anchor Holding America Back in the Modern and Evolving Healthcare Marketplace*, 70 DEPAUL L. REV. 157, 159–60, 160 n.19 (2020).

207. *See id.* at 159–60.

208. *Id.* at 158.

209. *See id.* at 158–60.

CPOM rules and regulations date back to the American Medical Association ("AMA"), which adopted an official statement in 1890 and included condemnation for corporate medicine in its Principles of Medical Ethics in 1912.[210] The subsequent AMA Principles of Medical Ethics of 1934 and AMA lobby efforts with state legislatures resulted in the expansion of state CPOM legislation.[211]

CPOM laws vary significantly from state to state, but there are some common themes. Many state laws prohibit corporations or non-physicians from owning or controlling medical practices.[212] This prohibition is designed to ensure that patient care and not commercial interests remain the primary focus.[213] Some states require physicians to form professional corporations ("PCs") or professional limited liability companies ("PLLCs") to operate their practices.[214] Other states allow for management service organizations ("MSOs") to provide administrative and support services to medical practices as part of a contractual relationship.[215] Common exceptions to CPOM regulation include hospitals, health maintenance organizations ("HMOs"), and professional medical corporations where all shareholders are licensed physicians.[216]

It is important to understand how the corporate practice of medicine doctrine applies to different professions in each state. For example, a Minnesota court held that the corporate practice of medicine doctrine prohibited corporate employment of chiropractors but allowed the corporate employment of physical therapists and massage therapists pursuant to the Minnesota State statute.[217] A California case, applying its fairly strict CPOM law, acknowledged that there were "chinks in the armor of the corporate practice doctrine" since some institutions are allowed to enter into contracts for employment of physicians.[218]

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210. Gustavson & Taylor, *supra* note 205, at 491.

211. *Id.* at 493.

212. California CPOM law states that "corporations and other artificial legal entities shall have no professional rights, privileges, or powers." CAL. BUS. & PROF. CODE § 2400 (West 2024). Texas law limits the practice of medicine a person holding a medical license and prohibits an unlicensed entity from representing that it is authorized to practice medicine. TEX. OCC. CODE ANN. §§ 155.001 & 165.156 (West 2023).

213. Marous, *supra* note 206, at 159–60.

214. *See, e.g.*, *Guide for Determining Permissible Entity Types for Licensed Professions,* TEX. SEC'Y STATE, https://www.sos.state.tx.us/corp/forms/entitychart.pdf [https://perma.cc/2XYB-2SUF].

215. Marous, *supra* note 206, at 170–71.

216. *E.g.*, IND. CODE § 25-22.5-1-2; COLO. REV. STAT. § 25-3-103.7. (2024).

217. Isles Wellness, Inc. v. Progressive N. Ins. Co., 703 N.W.2d 513, 524 (Minn. 2005).

218. Conrad v. Med. Bd. of Cal., 55 Cal. Rptr. 2d 901, 904 (Cal. Ct. App. 1996).

Even though a number of states have CPOM laws, enforcement mechanisms vary widely. Some states use licensing boards, some have enforcement power in the attorney general's office,[219] and others depend on court rulings.[220] Violations can result in fines, revocation of medical licenses, and invalidation of contracts.[221] Because the delivery of health care and integrated systems of health care have become increasingly complex, many states have trended toward more flexible interpretation of CPOM laws.[222] Even so, there are some lessons to be learned from cases.

2. CPOM Cases Suggest Greater Enforcement Effort is Needed

In 2015, the New York attorney general announced a settlement with Aspen Dental Management, Inc., which required payment of a $450,000 civil penalty and an independent monitor for violating New York's CPOM law.[223] The attorney general's investigation found that although the dental practices were technically owned by individual dentists, Aspen Dental routinely made decisions that directly impacted patient care. These included pressuring staff to sell dental services and products, using revenue-oriented scheduling systems, and hiring clinical staff.[224]

In some cases, CPOM laws have been used to absolve health care entities of liability since the entities were not authorized to practice medicine. In

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219. ARI J. MARKENSON & ANGELA HUMPHREYS, WHAT IS . . . THE CORPORATE PRACTICE OF MEDICINE AND FEE-SPLITTING? 21–22 (2021) (noting Nevada, North Dakota, and Arkansas regulate CPOM through attorneys general).

220. *Id.* at 18–20 (listing Mississippi and South Carolina as examples of states that regulate CPOM through common law).

221. *See The Corporate Practice of Medicine 50-State Guide*, PERMIT HEALTH (Jan. 16, 2025), https://www.permithealth.com/post/the-corporate-practice-of-medicine-50-state-guide [https://perma.cc/X5HJ-PP4H].

222. *See id.*

223. *In the Matter of Aspen Dental Management, Inc.*, N.Y. ATT'Y GEN. (June 15, 2015), https://ur.ag.ny.gov/sites/default/files/settlements-agreements/ADMI_AOD.pdf [https://perma.cc/JH39-8SJP]; *A.G. Schneiderman Announces Settlement with Aspen Dental Management that Bars Company from Making Decisions About Patient Care in New York Clinics*, U.S. DEP'T HEALTH & HUMAN SERVS. (June 18, 2015), https://oig.hhs.gov/fraud/enforcement/ag-schneiderman-announces-settlement-with-aspen-dental-management-that-bars-company-from-making-decisions-about-patient-care-in-new-york-clinics [https://perma.cc/HE9F-8WK2].

224. *Id.* Interestingly, the Indiana attorney general filed an action against Aspen Dental around the same time. Indiana did not have a CPOM law however, so its action was based on state deceptive advertising law. As part of its settlement with Indiana, Aspen Dental paid a $95,000 penalty to the state. Matt Adams, *Attorney General's Office Settles Deceptive Advertising Case with Aspen Dental Management*, FOX 59 (Oct. 22, 2015), https://fox59.com/news/attorney-generals-office-settles-deceptive-advertising-case-with-aspen-dental-management/ [https://perma.cc/AP2X-8V6L].

considering a case of a hospital's direct liability in a medical malpractice case, a Texas court recently found that "a hospital cannot practice medicine and cannot be held liable for acts or omissions that are medical functions."[225] A California court dismissed a plaintiff's claim for vicarious liability against a hospital, finding merit in the hospital's argument that the California CPOM ban prohibited it from obtaining informed consent, performing surgeries, and implementing medical devices.[226] In such cases, the CPOM laws are used as a sword instead of the shield of protection for patients.

In a recent Texas case, a jury rendered a $10 million verdict in favor of a physician hospitalist group against its management company for exercising improper control over patient care.[227] The case was based on a breach of contract claim between the management company and the physician group in a unique application of CPOM laws. Hospital Internists of Texas and Hospital Internists of Austin alleged that Quantum Plus and Lonestar Hospital Medical Associates (an affiliate of TeamHealth Holdings, Inc., which is backed by the Blackstone Group private equity firm) breached its contract to comply with all state laws, including the corporate practice of medicine law, for provision of hospitalist services to the system's local hospitals.[228] Court testimony showed that the physicians were pressured to discharge patients early, to round on patients in a particular order, to accept patient transfers unnecessarily, and to discipline physicians who did not respond to hospital billing queries.[229] The $10.2 million jury verdict for breach of the medical services agreement took over four years of litigation and is currently under appeal.[230]

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225. Colum. Med. Ctr. of Arlington Subsidiary, L.P. v. Bush, 692 S.W.3d 606, 612–13 (Tex. Ct. App. 2023).

226. Brown v. Capen*,* No. 20STCV45208, 2023 Cal. Super. LEXIS 9136, at *11–12, (Cal. Super. Ct. Feb. 28, 2023).

227. Sean Price, *Judgment Call: Court Victory Highlights Importance of Corporate Practice of Medicine Laws*, TEX. MED. ASS'N (June 7, 2023), https://www.texmed.org/TexasMedicineDetail.aspx?id=62193 [https://perma.cc/YHB7-Q94D].

228. *Id.*

229. Lorinda Holloway, et al., *Texas Jury Renders $10 Million Verdict in Novel Corporate Practice of Medicine Case*, HEALTHCARE L. INSIGHTS (June 8, 2023), https://www.healthcarelawinsights.com/2023/06/texas-jury-renders-10-million-verdict-in-novel-corporate-practice-of-medicine-case [https://perma.cc/HK2E-FX4V]. The jury found in favor of the plaintiff doctor group on all causes of action, awarding actual damages and attorney fees. Hosp. Internists of Austin, P.A. v. Lonestar Hosp. Med. Assocs., No. D-1-GN-19-007224, 2023 WL 3134376, at *1 (Tex. Dist. Ct. Jan. 31, 2023), *aff'd in part, rev'd in part sub nom*. Quantum Plus, LLC v. Hosp. Internists of Austin, P.A, No. 03-23-00263-CV, WL 420213 (Tex. Ct. App. Feb. 7, 2025).

230. Price, *supra* note 227.

AAEMPG v. Envision is another pending case in California involving state CPOM laws.[231] The American Academy of Emergency Medicine Physician Group ("AAEMPG") alleged that Envision Healthcare, owned by private equity firm Kravis, Kohlberg and Roberts, violated California CPOM laws.[232] The two companies are competitors, and AAEMPG had an exclusive contract with Placentia Linda Hospital until the contract was awarded to an affiliate of Envision.[233] The primary allegations are that Envision uses a "friendly PC" model to exert control over physicians through MSOs.[234] AAEMPG alleges that Envision is allowed to influence critical aspects of medical practice, such as billing, hiring, and clinical guidelines, which should be under the sole purview of licensed physicians.[235] Moreover, the lawsuit alleges that the physician owners do not have actual control because the bylaws prohibit them from removing Envision officers and restrict their ability to issue dividends or create additional stock.[236] On May 15, 2023, Envision filed for Chapter 11 bankruptcy, pausing judicial proceedings while it pursued $41 million settlements with objecting creditors.[237]

3. Fee-Splitting Laws Work in Tandem With CPOM Laws

Fee-splitting laws often coordinate with state CPOM laws, so a brief discussion is relevant here. Fee-splitting restrictions "impose restrictions on physicians, prohibiting them from dividing fees with individuals for referrals made or for professional services rendered."[238] They are designed to ensure that physicians are not distracted from providing adequate care to patients by considering other outside financial influences.[239] These prohibitions are usually legislative or regulatory in nature and can "be found in insurance

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231. Am. Acad. of Emergency Med. Physician Grp., Inc. v. Envision Healthcare Corp., No. 22-CV-00421, 2022 WL 2037950, at *12 (N.D. Cal. May 27, 2022) (denying Envision's Motion to Dismiss).

232. *Id.* at *1.

233. *Id.* at *3.

234. *See* Kenneth Jonathan Yood et al., *Federal Bankruptcy Court Stays Envision Healthcare Litigation in California*, HOLLAND & KNIGHT (Aug. 3, 2023), https://www.hklaw.com/en/insights/publications/2023/08/federal-bankruptcy-court-stays-envision-healthcare-litigation [https://perma.cc/NC2Y-NWWS].

235. *Envision*, 2022 WL 2037950, at *4–5.

236. *Id.* at *3.

237. Rick Archer, *Envision Healthcare Gets OK for Ch. 11 Reorganization Plans*, LAW360 (Oct. 11, 2023), https://www.law360.com/articles/1731545/envision-healthcare-gets-ok-for-ch-11-reorganization-plans [https://perma.cc/45AL-VBCM].

238. MARKENSON & HUMPHREYS, *supra* note 219, at 33.

239. *See id.*

laws, fraud and abuse laws, and [] criminal laws."[240] The two broad categories of fee-splitting prohibitions cover "the referral of patients to specific providers for health care services or items, or the receipt of a referral of a patient for health care services or items, in exchange for remuneration";[241] and "fee splitting among individuals for health care services that are not personally performed by each person sharing in the revenue."[242] But just like CPOM laws, there are variations in fee-splitting laws and their exceptions that allow private equity firms to operate.[243]

4. Private Equity Acquisition of Medical Practices Threatens CPOM

In states with CPOM laws, a private equity sponsor is not allowed to acquire the entire practice or the equity of the practice.[244] Instead, the private equity company will invest in an MSO.[245] The MSO enters into an agreement with the physician practice to manage administrative and non-clinical business operations.[246] Physicians own and practice medicine through their physician practice entity.[247] The revenue for medical services is paid to the practice while a management fee is paid by the practice to the MSO, pursuant to an agreement that complies with the state CPOM laws and fee splitting laws.[248] In exchange, the MSO typically provides space, equipment, non-physician staff, administrative staff, billing services, and other administrative services.[249] Some argue that this structure allows physicians to take advantage of operational efficiencies, while others contend that MSO agreements allow an appearance of control by physicians.[250] Critics of CPOM laws bemoan the difficulties in business integrations because of the differences in CPOM

240. *Id.* at 33–34.
241. *Id.* at 37.
242. *Id.*
243. Fuse Brown & Hall, *supra* note 27, at 571.
244. Banee Pachuca et al., *A "Friendly" Guide to Private Equity Acquisitions of Physician Practices*, 35 HEALTH L. HANDBOOK 255, 258 (2023).
245. *Id.*
246. *Id.*
247. *See id.*
248. *Id.* at 258–59.
249. *Id.* at 259.
250. Fuse Brown & Hall, *supra* note 27, at 583.

regulations and exceptions.[251] Those critics further contend that this has negatively impacted medical innovation, quality, and efficiency.[252]

There is an inherent tension between the ethical underpinnings of health care and the ethics of business which must be addressed when considering private equity acquisition and control of health care entities. Ethical standards in health care rely largely on the four principles approach of autonomy, non-maleficence, beneficence, and justice.[253] In short, the principles are as follows: autonomy is the obligation to respect the decision making capacities of autonomous persons; non-maleficence is the obligation to avoid causing harm; beneficence is the obligation to provide benefits and to balance benefits against risks; and justice is the obligation of fairness in the distribution of benefits and risks.[254] They have been regarded as part of the DNA of health care ethics.[255]

In contrast, there is no universal approach to business ethics, but instead many different philosophies to consider. A complete discussion of the various theories and approaches is beyond the scope of this article; however, a brief overview follows. The modern view of the corporation or firm is often one of a nexus of contractual relationships among various constituencies.[256] Under this approach, shareholder wealth is the primary objective.[257] The Rational Actor model assumes that corporations act as a unitary, rational, profit-maximizing entrepreneur.[258] Other business ethics standards focus on principles of corporate governance. Dan Ostas writes that

> when law is underenforced from an economic perspective, it becomes the ethical responsibility of corporate executives and others in power to exercise self-restraint from their positions of advantage. This means that in many circumstances an executive

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251. Marous, *supra* note 206, at 158.

252. *Id.* at 182. The hurdle is notable in the area of telemedicine, where a properly licensed medical provider can inadvertently violate CPOM laws in another state through a telemedicine visit.

253. Richard Huxtable, *For and Against the Four Principles of Biomedical Ethics*, 8 CLINICAL ETHICS 39, 39 (2013) (noting that the approach originated in the 1979 book, PRINCIPLES OF BIOMEDICAL ETHICS, by Beauchamp and Childress).

254. *Id.*

255. R. Gillon, *Ethics Needs Principles—Four Can Encompass the Rest—and Respect for Autonomy Should Be "First Among Equals*," 29 J. MED. ETHICS 307, 308 (2003).

256. *See* John R. Boatright, *Business Ethics and the Theory of the Firm*, 34 AM. BUS. L.J. 217, 217 (1996).

257. *Id.* at 218.

258. Michael B. Metzger, *Organizations and the Law*, 25 AM. BUS. L.J. 407, 420 (1987).

> should refrain from using a strategy of expense and delay even when it is cost effective to do so.[259]

Don Mayer responds to this issue discussing Integrative Social Contract Theory in noting that corporations have "a duty to support the system of democratic capitalism by engaging in discourse that strengthens the system; by not seeking special exemptions or subsidies; and by not imposing externalities, hiding information, or subverting reasonable laws and regulations intended to enhance the overall public good."[260]

A review of these approaches to ethical conduct shows little overlap. One is focused on balancing benefits and harms to patients, as well as distribution of health care resources, while the other focuses on the transactional nature of relationships. Business stakeholders include investors, employees, customers, and suppliers, while health care stakeholders primarily include patients, health care providers, and society at large. Both industries are governed by various laws and are heavily regulated; but medical licensing boards have the ability to enforce medical standards, and physicians swear to uphold the ethics of their profession.[261] Finally, the two are distinguishable because of their potential impact in cases of malfeasance. The impact of unethical business practices includes loss of consumer trust, employee turnover, legal penalties, and loss of reputation.[262] Consequentially, unethical health care practices can harm patient health, public trust in the health care system, and wider public health outcomes.[263] Management of the two should not be conflated given such different standards and approaches.

The CPOM doctrine and fee-splitting laws in the states that have them are founded on the highest ethical principles that put patient care above

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259. Daniel T. Ostas, *Legal Loopholes and Underenforced Laws: Examining the Ethical Dimensions of Corporate Legal Strategy*, 46 AM. BUS. L.J. 487, 507 (2009).

260. Don Mayer, *Legal Loopholes, Business Ethics, and Corporate Legal Strategy: A Reply to Professor Ostas*, 48 AM. BUS. L.J. 713, 749 (2011).

261. Many recognize the Hippocratic Oath as the source of many of the ethical standards governing health care professionals today. *See generally Ancient Greek Medicine*, NAT'L LIBR. MED., https://www.nlm.nih.gov/hmd/topics/greek-medicine/index.html [https://perma.cc/9FED-QP7L] ("Over the centuries, [the Hippocratic Oath] has been rewritten often in order to suit the values of different cultures influenced by Greek medicine. Contrary to popular belief, the Hippocratic Oath is not required by most modern medical schools, although some have adopted modern versions that suit many in the profession in the 21st century. It also does not explicitly contain the phrase, 'First, do no harm,' which is commonly attributed to it.").

262. *See* Daniel Horowitz, *Ethical & Legal Challenges in Medicine*, L. IN LAFAYETTE (Apr. 28, 2024), https://www.lawyersinlafayette.com/blog/2024/april/ethical-legal-challenges-in-medicine [https://perma.cc/TAJ3-Q6E5].

263. *Id.*

commercial interests.[264] As such, these laws should be strengthened and enforced, and used in tandem with relatively new health care transactions notifications laws to scrutinize and stave off transactions that the federal regime have missed.

B. State Health Care Transactions Notification Laws Are More than a Gap-Filler for Federal Antitrust Laws

1. Introduction to State Health Care Transactions Laws

The high thresholds under HSR have prompted a growing number of states in the past few years to enact what some have termed "mini-HSR" or "baby HSR" laws.[265] Under these laws, states have imposed their own pre-merger notification requirements for health care transactions, enabling the state's attorney general or other agency to conduct a pre-closing review of health care transactions.[266] While the FTC's and DOJ's recent focus on merger activity in the health care sector is notable, states and their legislatures appear to be more nimble than Congress in overcoming the limitations of HSR to address smaller health care acquisitions.[267] However, despite the adoption by the National Academy for State Health Policy ("NASHP") of its Model Act for State Oversight of Proposed Health Care Mergers ("Model Act") in November, 2021,[268] the number of states that have adopted health care transactions laws is still quite small, and there is nothing anywhere close to

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264. Pachuca et al., *supra* note 244, at 257.

265. Nathaniel Weiner et al., *Behavioral Health M&A 2024 Legal Trends*, POLSINELLI (Mar. 19, 2024), https://www.polsinelli.com/publications/behavioral-health-ma-2024-legal-trends [https://perma.cc/448F-UZS4].

266. *See* Lauren Norris Donahue et al., *State Pre-Merger Notification Requirements for Healthcare Transactions: Increased Regulatory Scrutiny for Small, Sub-HSR Transactions*, 36 HEALTH L. 23, 23–25 (2023).

267. *See State Legislatures Target Private Equity Investments and Corporate Structures in Health Care with New Bills*, BASS BERRY & SIMS (Jan. 31, 2025), https://www.bassberry.com/news/state-legislatures-target-private-equity-investments-and-corporate-structures-in-health-care-with-new-bills [https://perma.cc/MQ37-F5EB].

268. *Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, NAT'L ACAD. FOR STATE HEALTH POL'Y (July 26, 2024), https://nashp.org/a-model-act-for-state-oversight-of-proposed-health-care-mergers [https://perma.cc/2DM8-LRDK]. NASHP is a "nonpartisan organization committed to developing and advancing state health policy innovations and solutions." *Mission, Vision, and Values*, NAT'L ACAD. FOR STATE HEALTH POL'Y, https://nashp.org/mission-vision-and-values [https://perma.cc/7G96-RB3B]. It aims to provide support for the development of policies that promote and sustain healthy people and communities, advance high quality and affordable health care, and address health equity. *Id.*

uniformity in how the states approach this issue.[269] We will not survey each of the state health care transactions notification laws now on the books—that effort has been made elsewhere.[270] The goal of this Section of the Article is to give a general understanding of the common ways these laws are structured and the wide variance in approaches taken to transaction notification.

2. NASHP Model Act Provides Framework for State Health Care Transactions Notification Laws

The Model Act was adopted by NASHP to provide guidance to states interested in enacting pre-merger notification laws to address the growing number of health care transactions, such as physician practice acquisitions by hospitals, health plans, and private equity investors, that evade antitrust scrutiny because they are too small to require federal antitrust reporting under HSR.[271] Recognizing that states have an important role in filling the gap left by HSR's high dollar thresholds, the Model Act grants states the authority to review, place conditions upon, and block potentially harmful consolidation of health care providers in their state.[272] The Model Act's notification provisions trigger a review and approval process by the state's attorney general and empower the attorney general to block or place conditions on problematic transactions without going to court, allowing the attorney general "to be more effective at overseeing cumulative, smaller transactions that may amass market power over time."[273]

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269. *See Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, *supra* note 268. Almost all states have laws and schemes regulating health care facility licensure, provider licensure, insurance, and other aspects of the provision of health care. To date, the states which have health care transaction laws beyond those restricted to hospital mergers are California, Connecticut, Illinois, Indiana, Massachusetts, Minnesota, Nevada, New York, Oregon, and Washington.

270. *See, e.g.*, Donahue et al., *supra* note 266, at 24–51; Cody Keetch & Pamela Polevoy, *A Patchwork Framework: A Range of State Health Care Transaction Review Laws Emerges*, 29 HEALTH L.J. 30 (2024).

271. *See Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, *supra* note 268.

272. *Id.*

273. *Id.*

The NASHP Model Act applies broadly to any "health care entity"[274] that undergoes a "material change transaction."[275] The term material change transaction is broad enough to encompass private equity roll-ups.[276] The heart of the Model Act is the notification requirement under which a health care entity, before consummating a material change transaction, must notify the state attorney general and health department some period of time before the date of the proposed transaction.[277] The information required to be included in the notice is not spelled out in the Model Act;[278] however, the act imposes upon the attorney general the obligation after receipt of a notice of a material change transaction to post on the attorney general's website certain information, most of which could only be known by the attorney general because it was supplied by the health care entity in or with the notice.[279]

Once notice is given, the proposed transaction undergoes a preliminary review.[280] Upon conclusion of the preliminary review period, the attorney general has three options: (1) approve the transaction without further review;

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274. *See id.* "Health care entity" is defined under the Model Act to mean a health care provider, health care facility, or provider organization. *Id.* "Health care facility" includes a "licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient facilities, . . . ambulatory surgical or treatment centers, skilled nursing facilities, residential treatment centers, diagnostic, laboratory and imaging centers, imaging centers, free-standing emergency facilities, outpatient clinics, and rehabilitation and other therapeutic health settings." *Id.* "Health care provider" is defined as "any person, corporation, partnership, governmental unit, state institution, medical practice, or any other entity qualified or licensed under state law to perform or provide health care services." *Id.* "'Provider organization' means any [entity] or organized group of persons that is in the business of health care delivery or management, . . . and that represents one or more health care providers in contracting with carriers for the payments of heath care services." *Id.* Finally, "health care services" include supplies, care, and services of medical, behavioral health, substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature. *See id.*

275. *Id.* "Material change transaction" includes a range of mergers, acquisitions, joint ventures, and affiliations. *See id.*

276. *A Tool for States to Address Health Care Consolidation: Improved Oversight of Health Care Provider Mergers*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Nov. 12, 2021), https://nashp.org/a-tool-for-states-to-address-health-care-consolidation-improved-oversight-of-health-care-provider-mergers [https://perma.cc/V7P9-8JXZ].

277. *See Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, *supra* note 268, § 4(B).

278. *Id.* § 2(B) ("[W]ritten notice shall include and contain the information the Attorney General [or the Department of Health or state cost commission] determines is required.").

279. The information to be posted includes a summary of the proposed transaction; an explanation of the groups or individuals likely to be impacted by the transaction; and information about services currently provided by the health care entity, commitments by the health care entity to continue such services, and any services that will be reduced or eliminated. *Id.* § 2(c).

280. *Id.* § 3(A) (noting the placeholder review period in the Model Act is 30 days).

(2) approve the transaction subject to conditions set by the attorney general; or (3) notify the health care entity that the transaction is subject to a comprehensive review.[281] A comprehensive review is mandated in various circumstances involving a change to market power or a potential material impact on cost, quality, or access to health care services.[282] The comprehensive review process has two components: a public hearing and a cost and market impact review ("CMIR").[283] There are a multitude of factors that the CMIR may examine relating to the proposed transaction and its parties, including their relative market position.[284] The Model Act empowers the attorney general to request from the transacting parties additional information or documents necessary to conduct the CMIR.[285] The CMIR is to be prepared and submitted by the state cost commission or third-party consultant retained by the attorney general.[286] The Model Act allows the attorney general to charge the transacting parties for the cost of the review, regardless of whether a state agency or third-party consultant performs it.[287] At the end of the day, the attorney general is empowered to either approve,

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281. *Id.*

282. Section 3(B) of the Model Act provides:

> A comprehensive review is required when any of the following apply to the material change transaction:
>
> 1. Will result in the transfer of assets valued above [$2 million];
>
> 2. Occurs in a highly consolidated market for any line of services offered by any party to the material change transaction;
>
> 3. Will cause a significant change in market share, such that any resulting health care entity possesses market power upon completion;
>
> 4. If either party to the material change transaction possesses market power prior to the transaction; and
>
> 5. If the Attorney General, at the Attorney General's sole discretion, determines that the material change transaction is likely to have a material impact on the cost, quality, or access to health care services in any region in the state.

Id. § 3(B).

283. *Id.* § 4(A); *see also A Tool for States to Address Health Care Consolidation: Improved Oversight of Health Care Provider Mergers*, *supra* note 276.

284. *See Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, *supra* note 268, § 4(B).

285. *Id.* § 4(C).

286. *Id.* § 4(E).

287. *See A Tool for States to Address Health Care Consolidation: Improved Oversight of Health Care Provider Mergers*, *supra* note 276.

conditionally approve, or disapprove the transaction.[288] The model law includes a non-exhaustive list of factors the attorney general may consider in making the determination, including effects on patient care and costs, effects on competition, and the public interest.[289] The model law also allows the attorney general to monitor post-transaction any conditions imposed by the attorney general.[290]

The Model Act itself was patterned after Massachusetts' statute, one of the first comprehensive health care transactions notice laws.[291] The Massachusetts Health Care Cost Containment Law requires every provider or provider organization to provide at least 60 days prior notice to the state Health Policy Commission ("HPC") and the attorney general before making any material change to its operations or governance structure.[292] The materiality threshold under the Massachusetts law is substantially lower than that under HSR, subjecting providers and provider organizations with $25 million or more in "net patient service revenue" to the notice requirements.[293] Massachusetts' scheme, like the Model Act, provides for a two-tiered system of review. The preliminary review, to be conducted by the HPC within 30 days after receipt of the notice, is to determine whether the material change is likely to result in a significant impact on either health care costs or the competitive market.[294] If the HPC makes that determination, then the HPC is authorized to conduct a comprehensive CMIR,[295] under which the HPC may request information and documents from the provider or provider organizations. The CMIR, which is ordinarily to be conducted within 185 days from the HRC's receipt of a complete notice,[296] may delve into a

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288. *Comprehensive Consolidation Model Addressing Transaction Oversight, Corporate Practice of Medicine and Transparency*, *supra* note 268, § 5(A).

289. *Id.* § 5(C).

290. *Id.* § 5(B)–(D). The health care entity is required to submit reports after one year, two years, and five years after the completion of the transaction. *Id.* § 5(D).

291. Act of Aug. 6, 2012, 2012 Mass. Acts ch. 224, § 15 (codified as amended at MASS. GEN. LAWS ch. 6D, § 13 (2024)). Even before Massachusetts' comprehensive statute, Rhode Island enacted its Hospital Conversions Act in 1997, under which certain transfers in ownership, assets, membership interest, authority, or control of a hospital in Rhode Island require approval by both the Department of Health and the Attorney General. *See* 23 R.I. GEN. LAWS §§ 23-17.14-1–23-17.14-20 (2025).

292. MASS. GEN. LAWS ch. 6D, § 13(a) (2024).

293. *See id.* §§ 10(a)–(b), 13(a).

294. *Id.*

295. *Id.* §§ 13(b)–(f).

296. *Id.* § 13(f); 958 MASS. CODE REGS. § 7.12 (2025).

multitude of factors relating to the provider or provider organization's business and its relative market position.[297]

3. A Comparison of the Approaches Taken by Three West Coast States Demonstrates the Nuances of State Health Care Transactions Notification Laws

A comparison of the health care transactions laws enacted by the three West Coast states—California, Oregon, and Washington—illustrates the wide disparity between these laws, notwithstanding that they were all enacted within a span of three years. The approaches taken by these states will be compared and contrasted below on some or all of the following: (a) subject health care entities; (b) covered transactions, including materiality thresholds; (c) initial notice period and notice recipient(s); (d) any secondary review process required or allowed; (e) whether a cost and market impact review ("CMIR") is mandated; (f) whether public notice is required; (g) whether approval by the attorney general or health agency is required; and (h) whether any post-closing reporting is required.

a. Washington

Washington's Substitute House Bill 1607, its health care transactions law designed to supplement HSR, was signed into law on May 7, 2019, with an effective date of July 28, 2019.[298] There are no administrative regulations issued or authorized under the Washington statute. The Washington statute requires the parties to a "transaction that results in a material change," meaning a merger, acquisition, or contracting affiliation between hospitals, hospital systems, and provider organizations, to provide written notice of the transaction to the attorney general at least 60 days before the effective date of the transaction.[299] There is a materiality revenue threshold of $10,000,000 from Washington patients before an out-of-state entity will be subject to the law, but there is no such threshold if both parties are Washington entities.[300]

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297. *Id.* § 13(d). Factors to be examined may include those relating to size and market share; prices for services, including relative to other providers; quality of services, including patient experience; impact on competing options for the delivery of health care services; methods used to attract patient volume and to recruit or acquire health care professionals or facilities; consumer concerns, including complaints of unfair method of competition or unfair or deceptive acts or practices; and other factors determined to be in the public interest.

298. H.B. 1607, 66th Leg., Reg. Sess. (Wash. 2019) (codified at WASH. REV. CODE § 19.390.030 (2024)).

299. WASH. REV. CODE § 19.390.040 (2024).

300. *See id.*

There is no mechanism for public notice or comments. The notice required to be given in connection with a health care merger or acquisition provides only perfunctory information of little value for the attorney general to assess the potential impact of the material transaction upon competition, the costs of health care, and quality of care.[301] The statute simply authorizes the attorney general to make requests for additional information from the parties within 30 days from receipt of the notice.[302] There is no CMIR authorized and no secondary review. The Washington statute does not require that the subject entities receive approval from the attorney general or any state health official before closing the transaction. No post-closing reporting is required. The penalty for noncompliance with the statute is a seemingly paltry civil penalty of not more than two hundred dollars per day,[303] compared to HSR's current penalty amount of $53,088 per day.[304]

b. Oregon

Oregon was the first of the West Coast states to enact a health care transactions law after adoption of the NASHP Model Act, but the Oregon statute was patterned only loosely after it.[305] Oregon's requirements are substantially more robust than those of Washington, with a review process that goes beyond just a pure competitive focus to an inquiry into the effects of the transaction on the availability, quality, and costs of care. The Oregon statute, creating Oregon's Health Care Market Oversight program ("HCMO"), requires that notice of a "material change transaction" (other than those involving domestic health insurers) be given, not just to the attorney general, but to the Oregon Health Authority ("OHA") as well, at least 180 days prior to the date of the transaction.[306] Oregon's initial notice period is the longest not just of the West Coast states, but of all states that have health care transactions notification laws. The health care entities covered by the Oregon statute include types of entities not covered under

301. The written notice, while inviting parties to voluntarily provide additional information, only requires the parties to the transaction to provide the names and business addresses of the parties, all locations where health care services are provided, a "brief description of the nature and purpose of the proposed material change," and the anticipated effective date. *Id.*

302. *Id.* § 19.390.050. The statute also makes clear that the Attorney General is not precluded from conducting an investigation or enforcing state or federal antitrust laws at a later date. *Id.*

303. *Id.* § 19.390.080.

304. Rebecca Farrington et al., *FTC Announces Annual Changes to U.S. HSR Thresholds with Highest Filing Fees Now $2.39 Million*, WHITE & CASE (Jan. 21, 2025), https://www.whitecase.com/insight-alert/ftc-announces-annual-changes-us-hsr-thresholds-highest-filing-fees-now [https://perma.cc/L4W5-LR2H]; *see* 15 U.S.C. § 25.

305. *See* H.B. 2362, 2021 Leg., 81st Sess. (Or. 2021).

306. OR. REV. STAT. § 415.501(4) (2023).

either the Washington statute or the Model Act, including, notably, parents and affiliates of subject organizations.[307] Like the model rule, Oregon's statute creates a two-tiered system of review—a preliminary review, which is to be conducted within 30 days after receipt by the OHA of the transaction notice,[308] and a comprehensive review, which is to be conducted within 180 days of the notice if the OHA determines the transaction does not meet the criteria for approval upon preliminary review.[309] The OHA is given regulatory authority to prescribe the contents and manner of giving the notice,[310] and is given additional authority to prescribe rules for, among other things, criteria for the consideration of requests by health care entities to engage in a material change transaction and procedures for the review of material change transactions,[311] criteria for approval of a transaction upon a preliminary review,[312] criteria for determining when to conduct a comprehensive review and appoint a review board,[313] and fees to be paid by the parties.[314] The OHA's comprehensive regulations implementing the HCMO program are set forth in Chapter 409, Division 70 of the Oregon Administrative Rules.[315] There are no post-closing obligations imposed on health care entities. Oregon's HCMO scheme is enforceable through a civil penalty of up to $10,000 for each offense.[316]

One of the significant points of departure of Oregon's HCMO scheme from Washington's statute and the Model Act is the approval requirement—material change transactions are not permitted to go forward in Oregon without approval by the OHA. Approval at the preliminary review stage is conditioned upon the OHA's determination that the transaction meets the criteria prescribed by the OHA by rule, including (i) the transaction is in the interest of consumers and is urgently necessary to maintain the solvency of

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307. The health care entities covered by the statute include not only hospitals, hospital systems, and individual licensed or certified health professionals, but also health benefit plan carriers, Medicare Advantage plans, coordinated care organizations or prepaid managed care organizations, and "[a]ny other entity that has as a primary function the provision of health care items or services or that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services." *Id.* § 415.500(4)(a).

308. *Id.* § 415.501(5). By rule, the 30-day period can be tolled if the OHA deems the notice to be incomplete or if it needs additional information. *See* OR. ADMIN. R. 409-070-0045(6) (2025).

309. OR. REV. STAT. § 415.501(7) (2023).

310. *Id.* § 415.501(4). The OHA rules prescribing the form and contents of the notice of material transaction are found in OR. ADMIN. R. 409-070-0045 (2025).

311. OR. REV. STAT. § 415.501(2) (2023).

312. *Id.* § 415.501(6).

313. *Id.* § 415.501(8)(c).

314. *Id.* § 415.512.

315. OR. ADMIN. R. 409-070-0000 to -0085 (2025).

316. OR. REV. STAT. § 415.900 (2023).

an entity involved in the transaction;[317] or (ii) the transaction does not have the potential to have a negative impact on access to affordable health care in Oregon;[318] or (iii) the transaction meets the ultimate criteria set forth in ORS 415.501(9),[319] discussed infra. These statutory guidelines were incorporated into the rules, which specify the criteria for OHA approval of a transaction at the conclusion of the preliminary review.[320] Approval after a comprehensive review appears to require satisfaction of the ultimate criteria for approval. The ultimate criteria spelled out in subsection (9) includes: (i) a determination by the OHA that the transaction meets the criteria adopted by the OHA by rule under subsection (2);[321] (ii) the parties to the transaction demonstrate that the transaction will benefit the public good and communities in the manner more fully specified in the statute;[322] (iii) the transaction will improve health outcomes for residents of Oregon;[323] and (iv) there is no substantial likelihood of anticompetitive effects from the transaction that outweigh the benefits of

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317. *Id.* § 415.501(6)(a).

318. OR. REV. STAT. § 415.501(5), (6)(b) (2023).

319. OR. REV. STAT. § 415.501(6)(b) (2023).

320. The material change transaction is to be approved, with or without conditions, if "the transaction meets one or more of the following criteria:

> (a) The material change transaction is in the interest of consumers and is urgently necessary to maintain the solvency of an entity involved in the transaction;
>
> (b) The material change transaction is unlikely to substantially reduce access to affordable health care in Oregon;
>
> (c) The material change transaction is likely to meet the criteria set forth in OAR 409-070-0060 [the ultimate criteria for approval after a comprehensive review];
>
> "(d) The material change transaction is not likely to substantially alter the delivery of health care in Oregon; or
>
> (e) Comprehensive review of the material change transaction is not warranted given the size and effects of the transaction."

OR. ADMIN. R. 409-070-0055(2) (2025).

321. OR. REV. STAT. § 415.501(2), (9) (2023).

322. *Id.* § 415.501(9)(a)(A). Benefitting the public good and communities includes: (i) reducing the growth in patient costs in accordance with certain health care cost growth targets, or maintaining a rate of cost growth that exceeds the target that the entity demonstrates is the best interest of the public; (ii) increasing access to services in medically underserved areas; or (iii) rectifying historical and contemporary factors contributing to a lack of health equities or access to services. *Id.*

323. *Id.* § 415.501(9)(a)(B).

the transaction in increasing or maintaining services to underserved populations.[324]

The approval criteria came under attack in a case brought by the Oregon Association of Hospitals and Health Systems against the State of Oregon and its OHA.[325] The association contended that the statute creating Oregon's HCMO scheme was facially invalid because (i) it is unconstitutionally vague in violation of the 14th Amendment's due process clause; and (ii) the statute impermissibly delegates legislative powers to the OHA, in violation of Oregon's nondelegation principles.[326] The State of Oregon moved for summary judgment on both counts,[327] and the plaintiff filed its own motion for summary judgment.[328] The district court rejected the plaintiff's Fourteenth Amendment challenge, holding that the plaintiff failed to show that the statute was unconstitutionally vague on its face, and granted summary judgment for the State of Oregon on that issue.[329] Absent the promulgation of fairly robust regulations under the authority of the statute to spell out review criteria, the district court may have decided differently on the constitutional vagueness challenge. The district court also dismissed the plaintiff's non-delegation doctrine claim under the Oregon Constitution, declining to exercise supplemental jurisdiction over the state law claim.[330]

c. California

The California Health Care Quality and Affordability Act ("HCQAA"), signed into law as Senate Bill 184 on June 30, 2022, like Oregon's health care transactions law, goes beyond the Model Act.[331] The law applies to transactions closing on or after April 1, 2024.[332] The legislative findings supporting the California act are lengthy, but flow from the central premise that "all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal."[333] The findings recognize the role that the anti-competitive effects of mergers, consolidations, and venture capital

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324. *Id.* § 415.501(9)(b).

325. *See* Or. Ass'n of Hosps. & Health Sys. v. Oregon, 734 F.Supp.3d 1139 (D. Or. 2024).

326. *Id.* at 1143–44.

327. Defendant's Motion for Summary Judgment at 1, *Or. Ass'n of Hosps.*, 734 F.Supp.3d 1139 (2023) (No. 3:22-cv-1486).

328. Plaintiff's Cross-Motion for Summary Judgment, *Or. Ass'n of Hosps.*, 734 F.Supp.3d 1139 (2023) (No. 3:22-cv-1486).

329. *Or. Ass'n of Hosps.*, 734 F. Supp. 3d at 1168.

330. *Id.* at 1168–69.

331. *See* CAL. HEALTH & SAFETY CODE §§ 127500–127507.6 (West 2024).

332. *Id.* § 127507(c)(1).

333. *Id.* § 127500.5(a)(1).

activity have had on health care costs.[334] Implementing regulations were adopted by the California Office of Health Care Affordability under the statute's interim emergency authority on December 18, 2023, and became effective January 1, 2024.[335]

Under the California regime,[336] "health care entities" that are subject to the law include a broad range of providers,[337] payers,[338] and fully integrated delivery systems.[339] Notably, pharmacy benefit managers are included.[340] Physician organizations with less than 25 physicians are excluded,[341] which may render the California scheme ill-equipped to scrutinize roll-ups of physician practices or similar serial transactions. The materiality standards of the California scheme require the entity to have $25 million in California revenue or assets, or $10 million in California revenue or assets and be party to a transaction with another entity with $25 million in California revenue or assets.[342] The "material change transactions" that trigger the notice provisions of the statute include mergers, acquisitions, corporate affiliations, and other transactions resulting in a material change to the ownership or governance structure of the entity or group.[343] There are a series of materiality thresholds for transactions subject to the reporting requirement, including a $25 million

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334. *Id.* § 127500.5(a)(4) ("Escalating health care costs are being driven primarily by high prices and the underlying factors or market conditions that drive prices, particularly in geographic areas and sectors where there is a lack of competition due to consolidation, market power, venture capital activity, the role of profit margins, and other market failures. Consolidation through acquisitions, mergers, or corporate affiliations is pervasive across the industry and involves health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities. Further, market consolidation occurs in various forms, including horizontal, vertical, and cross industry mergers, transitions from nonprofit to for-profit status or vice versa, and any combination involving for-profit and nonprofit entities, such as a nonprofit entity merging with, acquiring, or entering into a corporate affiliation with a for-profit entity or vice versa.").

335. CAL. OFF. OF STATEWIDE HEALTH PLAN. & DEV., REGULATIONS FOR THE COLLECTION AND REPORTING OF CERTAIN HEALTH CARE INFORMATION (Nov. 2023), https://hcai.ca.gov/wp-content/uploads/2023/11/CMIR-Regulation-Text-Posting.pdf [https://perma.cc/BHE2-KRPK].

336. CAL. HEALTH & SAFETY CODE § 127507 (West 2024).

337. "Providers" include physician organizations, health facilities, clinics, ambulatory surgical centers, clinical laboratories, and imaging facilities. *Id.* § 127500.2(q).

338. "Payers" include health insurers, third-party administrators, and pharmacy benefit managers. *Id.* § 127500.2(o).

339. A "fully integrated delivery system" means a system that includes a physician organization, health facility or health system, and certain nonprofit health care service plans. *Id.* § 127500.2(h).

340. *Id.* § 127507(a); CAL. CODE REGS. tit. 22, § 97431(g)(2) (2025).

341. CAL. CODE REGS. tit. 22, § 97431(g)(4).

342. *Id.* § 97435(b)(1).

343. CAL. HEALTH & SAFETY CODE § 127507(c)(1) (West 2024); CAL. CODE REGS. tit. 22, § 97435(c) (2025).

fair market value of the transaction; $10 million or 20% increase in annual California-derived revenue; sale, transfer, or lease of 25% or more of the entity's total California assets; and transfer of control, responsibility, or governance, i.e. generally 25% or more of the voting power, or possibly even less; among others.[344] Importantly, the materiality standard includes a ten-year look back period for serial, related transactions involving the same health care entities or their affiliates, treating the proposed transaction and prior transactions as a single transaction.[345] The default classification of the information submitted is that it is a public record, although the submitter may request that confidential treatment be afforded to it.[346]

The initial notice required under the California law is 90 days and is to be given to the Office of Health Care Affordability ("OHCA").[347] The information required to be supplied with the notice is extensive and includes an assessment of the post-transaction impacts on health care services.[348] Once the notice and submission is complete, the OHCA has from forty-five to sixty days to determine whether or not it will conduct a CMIR.[349] The factors to be considered by the OHCA on whether to conduct a CMIR are outlined in the regulations,[350] as are the factors which are to be reviewed in the CMIR.[351] Besides customary inquiry into effects on competition, the CMIR's scope includes an assessment of the impact of the transaction upon availability, quality, and cost of health care services.[352] The California regime contemplates a public comment period.[353] Although the OHCA's power to conduct a CMIR for a transaction is broad, there is nothing in the statute or regulations that require approval by the OHCA for the transaction to go forward. No post-closing reporting is required under the California scheme.

A comparison of the three West Coast statutes illustrates the significant divergence between laws enacted by states who share geographical and political similarities. Washington's law is significantly less burdensome than

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344. CAL. CODE REGS. tit. 22, § 97435(c)–(e) (2025).

345. *Id.* § 97435(c)(7), (8).

346. *Id.* §§ 97438(d), 97439(b).

347. *Id.* § 97435(a).

348. *Id.* § 97438(b).

349. *Id.* § 97440. Curiously, the regulations provide that the OHCA has forty-five days from the notice date to notify the subject entity that it will not conduct a CMIR, but sixty days to notify the entity that it will conduct a CMIR. The inconsistency potentially creates a fifteen-day window during which the OHCA may change its mind about not conducting a CMIR. These periods are subject to tolling or restarting under certain circumstances. *See id.* § 97440(a)(3), (b).

350. *Id.* § 97441(a).

351. *Id.* § 97442(b).

352. *Id.*

353. *Id.* § 97442(c)(2).

California's and Oregon's, has a shorter notice and review period, has only a single tier of review, and does not subject transactions to state approval. The notification laws of California and Oregon look more like Massachusetts' scheme and share many similarities, including longer notice periods (90 days to 180 days), the involvement of a health official, and a two-tiered review process that includes an examination of impacts on health care delivery. Oregon's law requires approval by the state health agency before a transaction may proceed, while those of California and Washington do not.

4. Indiana's New Health Care Transactions Law Specifically Targets Private Equity

While the states that have adopted health care transactions notification laws largely have been in so-called "blue states" in the Northeast, West Coast, and Illinois, Indiana, a decidedly "red state,"[354] has recently enacted such a law. Indiana's health care transactions reporting law was enacted on March 13, 2024, and became effective on July 1, 2024.[355] Indiana's law requires preclosing notice from any "Indiana health care entity that is involved in a merger or acquisition with another health care entity" as long as the combined entities' assets are at least $10 million.[356] The Indiana law is remarkable in its simplicity and brevity. Regrettably, the Indiana law appears to have been hastily drafted and ample criticism could be levied at its draftsmanship.[357]

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354. In 2024, Republicans held supermajorities in Indiana in both the Senate and the House, and Indiana's governor is a Republican. *2024 State & Legislative Partisan Composition*, NAT'L CONF. ST. LEGISLATURES (Feb. 24, 2024), https://documents.ncsl.org/wwwncsl/About-State-Legislatures/Legis-Control-2024-3-1-24.pdf [https://perma.cc/8WUC-TAX4].

355. IND. CODE §§ 25-1-8.5-1 to -4 (West 2024).

356. *Id.* § 25-1-8.5-4.

357. The term "acquisition" is defined inartfully to mean "any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person." *Id.* § 25-1-8.5-1. In defining the term "acquisition" using the word "acquire," the statute unnecessarily interjects a confusing circularity to the term. In addition, while acquisition has historically been understood to mean obtaining or holding assets, see, for example, United States v. ITT Continental Baking Co., 420 U.S. 223, 240–41 (1975) (holding that "acquisition" under Section 7 of the Clayton Act means holding as well as obtaining assets, so that the defendant's continuing violation of the FTC's consent order supported the imposition of penalties for each day the defendant held the stock), the Indiana statute's definition of "acquisition" is obtaining of control. Similarly, the term "merger" is confusingly defined as "any change of ownership, including: (1) an acquisition or transfer of assets; or (2) the purchase of stock effectuated by a merger agreement." IND. CODE § 25-1-8.5-1 (West 2024). While the statute rightfully uses the terms "merger" and "acquisition" in the disjunctive, with definitions for each, the inclusion of the term "acquisition" in the definition of merger, but interference to assets

Concerns over draftsmanship aside, the Indiana law is noteworthy for a couple of reasons. First, the Indiana law very explicitly includes within the definition of health care entities subject to the law "a private equity partnership," regardless of where it is located, seeking to enter into a merger or acquisition with any other health care entity.[358] The inclusion signals an intent on the part of the Indiana legislature to bring private equity into the purview of the law.[359] Second, the Indiana law has been characterized as one of the broadest enacted health care transaction review laws to date, applying "to a comparatively higher volume of transactions" than any other state statute so far enacted.[360] Third, as noted already, it may signal a growing bipartisan appetite for subjecting health care mergers and acquisitions, including those involving private equity, to regulatory scrutiny.

The state health care transactions notification laws which hold the most power to be able to curb anti-competitive private equity forays into health care are those with these features: (a) the health care entities subject to the law is broadly defined; (b) the subject transactions are broadly defined; (c) the threshold for reportability include low revenue or asset thresholds and/or low market concentration tests; (d) notice of the transaction must be given to a designated health authority, and not merely the attorney general; (e) notice is at least 90 days before the transaction close date; (f) the health authority has the opportunity to request a secondary review and require a cost and market impact review; (g) there is a mechanism for public notice and comment; and (h) there is meaningful post-closing reporting required.

While state laws indeed have augmented federal enforcement of antitrust laws in the health care segment, allowing state attorneys general to review and challenge smaller acquisitions of physician practices that come in under the radar for HSR,[361] only a handful of states have adopted the laws. As shown above, the states that have enacted such laws have taken widely divergent approaches to the issue, leaving what is indeed a "patchwork framework" to

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instead of control, only compounds the confusion wrought by the author's unfortunate drafting. *See id.* Unlike the Oregon statute—which with clarifying regulations survive a vagueness challenge, *see supra* notes 325–29 and accompanying text—it is hard to see how Indiana's statute might survive such a challenge.

358. IND. CODE § 25-1-8.5-2(a)(6) (West 2024).

359. Once again, drafting deficiencies may deprive the statute of its desired effect, as the term "private equity partnership" is undefined, and the structure of many health care deals, including Welsh Carson's USAP roll-ups, may not be true partnerships. *See id.*

360. Rachel Ludwig et al., *Indiana Passes Law Requiring Prior Notice of Healthcare Transactions*, DLA PIPER (Apr. 11, 2024), https://www.dlapiper.com/en/insights/publications/2024/04/indiana-passes-law-requiring-prior-notice-of-healthcare-transactions [https://perma.cc/5AAS-SUAF].

361. Fuse Brown & Hall, *supra* note 27, at 581.

the problem. Some of the states' approaches limit the inquiry to effects on market power, rather than a broader inquiry into the impacts of the transaction upon the availability, quality, and cost of care.

IV. CONCLUSION

The public policy implications of private equity investment in health care cannot be understated. Indeed, all mergers, acquisitions, and consolidations of health care entities are concerning, whether the acquirers are for-profit or not-for-profit hospitals or hospital systems, public university systems, or private equity funded ventures. But the exponential influx of private equity investment in health care is particularly alarming, especially given private equity's debt-burdening, cost-slashing formula to extracting profits, private equity's being unmoored to any standards of medical ethics, and importantly, the utter lack of transparency and visibility of private equity's business dealings.

Is private equity investment in health care generally, and physicians practices in particular, a positive or negative development? The proof is in the pudding. Negative impacts on accessibility, quality, and cost of care have been and will continue to be documented. Physicians have historically been at the higher end of the compensation scale, enjoying a very comfortable middle to upper middle class living from fees earned from their practices. It is counter-intuitive to believe that somehow those same fees can suddenly be stretched enough to not only provide physicians with that same standard of living, but to also compensate professional practice managers, line the pockets of private equity managers, and spill out profits to investors. "Efficiencies" and "synergies" are no sleight of hand. A pie cannot be divided into more slices without shrinking the size of the slices, that is unless you grow the size of the pie itself. Patients inevitably are the stakeholders that lose, because there are only two ways to grow the pie to enrich all the additional layers: either dramatically raise rates or dramatically reduce costs. Each by itself adversely impacts patients, but together their effects can be devastating. When private equity gets involved in health care, no other outcome is conceivable other than patients (and, by extension, their insurers, employers, or the government) will pay much more money for much less care. But by the time these outcomes have fully come to light, private equity's bandits will have stealthily made away with the money and moved on to the next market sector to exploit.

Federal antitrust and false claims laws are important tools for combatting private equity exploitation, but they inherently allow many transactions to fly under the radar. It is the state CPOM laws and health care transaction

notification laws which hold the most promise. States that do not have these laws should adopt them, and both the CPOM and health care transactions laws should be vigorously enforced. The most effective approach would be for each state to entrust the oversight of both laws to the same health care commission, working in tandem with the state's attorney general, to ensure that no health care transaction involving private equity escapes diligent scrutiny for its effects on competition, as well as availability, quality, and cost of care. Ideally, states would embrace the more stringent provisions of the state health care transactions laws, including longer notice periods, cost and market impact reviews, public notice ad commenting, and even approval requirements. This tandem state approach would require every merger, acquisition, consolidation, or other health care transaction (with some modest thresholds significantly lower than HSR's) to be subjected to rigorous scrutiny and oversight. Under the states' purview, each transaction would be examined holistically, with visibility into the structure of the deal and the health care entities and investors involved and would not be allowed to proceed unless the health commission is satisfied that the transaction is not likely to have a material adverse effect upon the competitive landscape and the accessibility, affordability, and quality of health care outcomes. While the approach we argue for here may not stop every harmful merger, acquisition, consolidation, or other transaction involving private equity investment in health care, it is at least a finger in the dike.