17

The Canary in the Coal Mine

Private Antitrust Law and New Dynamics in Health Care Markets

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17.1 INTRODUCTION

All is not well in America's health care system. The United States consistently spends significantly more than any other nation on health care goods and services, reaching US$4.3 trillion and nearly US$11,000 per capita in 2021.[1] Despite being an outlier in health care spending, American quality of care metrics and health outcomes lag behind those of other comparator nations.[2] A 2023 report by the Commonwealth Fund found that Americans have the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality rates, the highest rates of people with multiple chronic conditions, and among the highest suicide rates of thirteen peer nations.[3]

While numerous factors contribute to American health care woes, a primary cause is the failure of the market-based health care system to protect competition in the ways needed to control prices, promote innovation, and improve quality. Health care markets at all levels are more consolidated and complex than ever

[1] Ctrs. for Medicare & Medicaid Servs., National Health Spending Grew Slightly in 2021, CMS Newsroom (Dec. 14, 2022), https://www.cms.gov/newsroom/press-releases/national-health-spending-grew-slightly-2021; Org. for Econ. Coop. and Dev. (OECD), Health Spending (2023), https://data.oecd.org/healthres/health-spending.htm.

[2] See, e.g., Chih Kuang Liang & Lian-Kung Chen, National Health Care Quality and COVID-19 Case Fatality Rate: International Comparisons of Top 50 Countries, 98 Archives of Gerontology and Geriatrics 104587 (2022); OECD, Life Expectancy at Birth (2023), https://data.oecd.org/healthstat/life-expectancy-at-birth.htm; OECD, Life Expectancy at 65 (2023), https://data.oecd.org/healthstat/life-expectancy-at-65.htm; OECD, Infant Mortality Rates (2023), https://data.oecd.org/healthstat/infant-mortality-rates.htm.

[3] Munira Z. Gunja et al., U.S. Healthcare from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes, Commonwealth Fund Issue Brief (Jan. 31, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022) (comparing the US with Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland, and the United Kingdom).

before, involving new market structures and actors that often confound and complicate traditional norms of antitrust enforcement. As health care prices continue to increase and quality stagnates, academics and health policy analysts have repeatedly called for stronger enforcement of antitrust laws in health care as well as stronger regulation to control prices.[4] This chapter argues that private antitrust law, the law governing market behavior by and between private actors, has a unique and essential role to play in protecting consumers and competitive markets by identifying and challenging anticompetitive behaviors arising from new dynamics in health care. Private law has an ability to extend, inform, and enhance public law initiatives by state and federal antitrust enforcers.

17.2 THE CURRENT STATE OF HEALTH CARE MARKETS

American health care entities have evolved dramatically over the last fifty years, creating several new dynamics in health care markets, including the rise of health systems and health monoliths, the use of new negotiation and contracting practices, and the introduction of new market actors and business models. The consolidation of American health care markets has occurred through just about any means possible – horizontal, vertical, cross-market, and cross-industry. A recent study found that approximately 95 percent of metropolitan areas had highly concentrated hospital markets, 78 percent had highly concentrated specialist physician markets, and 58 percent had highly concentrated insurer markets.[5] This consolidation has led to the rise of health care systems – jointly owned or managed health care entities, such as physician practices, hospitals, and skilled nursing facilities[6] – and health monoliths – massive health care entities that extend beyond providers to include some combination of payors or insurers, pharmaceutical services, and data management services. Research has repeatedly demonstrated that consolidation drives health care price increases,[7] has minimal quality impacts,[8] and tends to reduce patient satisfaction rates.[9]

[4] Leemore Dafny, Addressing Consolidation in Healthcare Markets, 325 JAMA 927 (Mar. 9, 2021); Martin Gaynor et al., Making Health Care Markets Work: Competition Policy for Health Care, 317 JAMA 1313 (Apr. 2017); David Dranove & Lawton R. Burns, Big Med: Megaproviders and the High Cost of Health Care in America 88–95 (2021).

[5] Jaime S. King et al., Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States, The Source on Healthcare Price and Competition Rsch. Rep. (June 2020), https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/?portfolioCats=1165%2C1166%2C1167.

[6] Nancy D. Beaulieu et al., Organization and Performance of U.S. Health Systems, 329 JAMA 325, 326 (2023).

[7] Health Care Industry Consolidation: What Is Happening, Why It Matters, and What Public Agencies Might Want to Do about It, Hearing before the H. Comm. on Energy and Com. Subcomm. on Oversight and Investigations, 115th Cong. (2018) (testimony of Leemore S. Dafny) https://docs.house.gov/meetings/IF/IF02/20180214/106855/HHRG-115-IF02-Wstate-DafnyL-20180214.pdf.

[8] Gaynor et al., supra note 4, at 8–9; Nancy D. Beaulieu et al., Changes in Quality of Care after Hospital Mergers and Acquisitions, 982 N. Engl. J. Med. 51, 56 (2020).

[9] Beaulieu et al., supra note 8, at 56.

While public antitrust enforcers have had recent success in blocking horizontal health care mergers,[10] they have had significantly more difficulty in preventing consolidation arising in less traditional ways, such as vertical, cross-market, and cross-industry transactions. From 1970 to 2019, the percentage of hospitals that were part of a multi-hospital health system grew from 10 to 67 percent.[11] Many of these multi-hospital systems merged to become multi-market systems spanning sub-state regions (e.g., northern California), states, multi-state regions (e.g. mid-West, South), and the nation. Between 2009 and 2019, 55 percent of the 1,500 hospitals targeted for acquisition were in a different geographic market than the acquiring health system.[12] Historically, public antitrust enforcers have held that such cross-market mergers cannot cause anticompetitive harm, and as such they garnered little to no attention from federal or state officials, allowing rapid growth of multi-market systems. Recent studies now suggest that cross-market mergers can enable hospital systems to raise prices systemwide due to increased market power in contract negotiations with multi-market insurers, a phenomenon known as system power.[13] Despite this evidence, public antitrust enforcers have brought few challenges to cross-market hospital mergers.

Vertical transactions have also unified market actors at different levels of the supply chain, such as payors, hospitals, physicians, pharmacy benefit managers, and health data informatics companies, raising significant questions about foreclosure of competitors throughout the markets.[14] A national study of over 40,000 physicians found that between 2010 and 2018, the percentage of physicians who worked in a practice owned by a hospital increased from 24.1 percent to 45.6 percent.[15] Health system ownership of physician groups typically results in changes in referral patterns and hospital choice, increased prices for both the physicians and hospitals involved, and marginal quality effects.[16]

[10] Hearing on Oversight of the Federal Trade Commission before the Comm. on the Judiciary, 117th Cong. 6 (July 13, 2023) (statement of the Federal Trade Commission), https://www.ftc.gov/system/files/ftc_gov/pdf/p210100housejudiciarytestimony07132023.pdf.

[11] Brent D. Fulton, Health Care Market Concentration Trends in the United States: Evidence and Policy Responses, 36 Health Affs. 1530 (2017); Michael F. Furukawa et al., Consolidation of Providers into Systems Increased Substantially 2016–2018, 39 Health Affs. 1321 (2020).

[12] Brent D. Fulton et al., The Rise of Cross-Market Hospital Systems and Their Market Power in the US, 41 Health Affs. 1652, 1655 (2022).

[13] Leemore Dafny et al., The Price Effects of Cross-Market Hospital Mergers: Theory and Evidence from the Hospital Industry, 50 Rand J. Econ. 286 (2019); Matthew S. Lewis & Kevin E. Pflum, Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions, 48 Rand J. Econ. 579 (2017); Matt Schmitt, Multimarket Contact in the Hospital Industry, 10 Am. J. Econ. Pol'y 361 (2018).

[14] Thomas L. Greaney, Navigating the Backwater: Vertical Mergers in Health Care, CPI Antitrust Chron. (May 2019), https://ssrn.com/abstract=3389569.

[15] Christopher M. Whaley et al., Physician Compensation in Physician-Owned and Hospital Owned Practices, 40 Health Affs. 1865, 1869 (2021).

[16] Vilsa Curto et al., Price Effects of Vertical Integration and Joint Ventures between Physicians and Providers in Massachusetts, 41 Health Affs. 741, 745 (2022); Lawrence C. Baker et al., The

Beyond providers, health care entities have begun to engage in vertical, cross-industry transactions resulting in health care monoliths, like United Health Group (United), which has acquired thirty-five health care companies in the past decade alone. United owns and operates the largest health insurance company in the United States, a network of 53,000 physicians in 15 states, a pharmacy benefits manager (PBM) that processes over a billion prescriptions each year, a health care data analytics company, and a health care claims-editing company. The Department of Justice's (DOJ's) recent unsuccessful vertical challenge of United's acquisition of Change Healthcare, Inc., the leading supplier of claims processing software that serviced many of United's competitors, demonstrates some of the challenges of antitrust enforcement in this area.[17] Overall, the provider, payor, pharmaceutical, and insurance markets in health care demonstrate "textbook conditions" for harm from vertical mergers – high levels of concentration, high and durable barriers to entry, and poor market function – and open the door for merged firms to exclude their upstream or downstream rivals, either by raising their costs or cutting off access to resources.[18] Private market actors, either as consumers, payors, or competitors, can provide insights into the effects of vertical and cross-market consolidation on market function that can inform both future negotiations with health care providers and public antitrust enforcement.

Another major shift in health care markets in recent decades arises from the influx of investment from private equity firms, which have largely been able to consolidate market power in ways that avoid interference from public antitrust enforcers. Private equity investment in the health care industry has increased dramatically in the past twenty years, increasing from US$5 billion in 2000 to US$100 billion in 2018.[19] As of December 2022, one-quarter of all emergency departments nationwide were staffed by private equity-owned emergency medicine staffing companies.[20] While private equity firms have invested broadly across health care markets, they have increasingly acquired specialist physician practices.[21] As a result of their growing market power,

Effect of Hospital/Physician Integration on Hospital Choice, 50 J. Health Econ. 1 (2016); Lawrence C. Baker et al., Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending, 33 Health Affs. 756 (2014); Marah Noel Short & Vivien Ho, Weighing the Effects of Vertical Integration versus Market Concentration on Hospital Quality, 77 Med. Care Res. Rev. 538 (2020).

[17] United States, State of Minnesota and State of New York v. UnitedHealth Group Inc. and Change Healthcare, Inc., No. 1:22-cv-00481 at *4 (D.D.C., filed Feb. 24, 2022).

[18] Greaney, supra note 14.

[19] Eileen Appelbaum & Rosemary Batt, Private Equity Buyouts in Healthcare: Who Wins, Who Loses? 5 (Ctr. for Econ. and Pol'y Rsch., Working Paper No. 118, 2020), https://cepr.net/report/private-equity-buyouts-in-healthcare-who-wins-who-loses/.

[20] Leann Adelman, 2023 State of the Emergency Medicine Employer Market, Ivy Clinician (Feb. 2023), https://www.ivyclinicians.io/resources/whitepapers/2023-state-of-the-em-employer-market.

[21] Richard M. Scheffler et al., Monetizing Medicine: Private Equity and Competition in Physician Practice Markets, Am. Antitrust Inst., UC Berkeley Petris Ctr., & Wash. Ctr. for

private equity-owned health care entities have been able to demand restrictive employment covenants from contracting providers[22] and payment increases between 8 percent and 18 percent for certain specialist services.[23]

While any entity consolidating market power and demanding anticompetitive contract terms would raise antitrust concerns, private law provides an essential mechanism for consumers and competitors to demonstrate the anticompetitive harms arising from private equity business models and contracting practices, which are relatively new in the health care markets and have typically avoided federal antitrust attention. Private equity firms invest money from wealthy individuals and institutional investors into businesses in hopes of quickly increasing profitability and then returning a large profit to investors before exiting the business.[24] Private equity firms often follow a "buy and build" model that grows an asset through a series of "add on" acquisitions in the same industry.[25] Thomas Wollman termed the practice of building market power through a series of sequential smaller acquisitions that fly under federal antitrust enforcement radar "stealth consolidation."[26] Stealth consolidation is possible in part due to loopholes in the Hart-Scott-Rodino Act (HSR), which requires merging entities to notify the federal government of a proposed merger if the total value of the merger is higher than the HSR reporting threshold, set at US$114.4M for 2023.[27] When a deal does not reach the HSR threshold, the likelihood of a federal investigation drops precipitously.[28] Interestingly, private equity health care acquisitions are often secured for just under the HSR reporting threshold.[29] As a result, private equity firms, as well as other market actors, have been able to make sequential smaller acquisitions and amass market power without public

Equitable Growth 6 (July 10, 2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf.

[22] See, e.g., Am. Acad. Emergency Med. Phys. Group, Inc. v. Envision Healthcare Corp. et al., No. 3:22-cv- 00421-CRB (N.D. Cal. Dec. 20, 2021) (Envision Complaint).

[23] Scheffler et al., supra note 21, at 6. For example, private equity acquisitions have been associated with price increases in specialty practice areas, including oncology (16.4%), gastroenterology (14.0%), OB/GYN (8.8%), ophthalmology (8.7%), radiology (8.2%), and orthopedics (7.1%). When a single private equity firm owned more than 30% market share, the price increases were even greater – gastroenterology (18.2%), dermatology (13.3%), and OB/GYN (16.3%). Id.

[24] Erin Fuse Brown & Mark Hall, Private Equity and the Corporatization of Health Care, 76 Stan. L. Rev. 527, 537 (2024).

[25] Aslihan Asil et al., Misaligned Measures of Control: Private Equity's Antitrust Loophole, 18 Va. L. & Bus. Rev. 51, 52 (2023).

[26] Thomas G. Wollmann, Stealth Consolidation: Evidence from an Amendment to the Hart-Scott-Rodino Act, 1 Am. Econ. Rev. 77, 78 (June 2019).

[27] Fed. Trade Comm'n, HSR Threshold Adjustments and Reportability for 2023 (Feb. 16, 2023) https://www.ftc.gov/enforcement/competition-matters/2023/02/hsr-threshold-adjustments-reportability-2023.

[28] Wollmann, supra note 26, at 87.

[29] Scheffler et al., supra note 21, at 42.

antitrust intervention.[30] In addition, private equity firms have been able to use their market power to engage in other anticompetitive behavior, such as demanding exclusive employment contracts and noncompete clauses that hinder competition.[31] As stated in a 2021 report by the American Antitrust Institute and the Petris Center at UC Berkeley, "when the fundamental characteristics of the private equity business model are combined with the unique structure of the US health care market, the results are potentially catastrophic for patients, payors, and the long-term stability of the health care supply chain."[32]

17.3 THE ROLE OF PRIVATE LAW IN GOVERNING HEALTH CARE MARKETS

Private law offers a complementary pathway to public antitrust enforcement to identify competitive harms arising from new health care market dynamics and test a variety of legal strategies for challenging them. Private law incorporates social norms, national values, and business customs into its purview.[33] From an antitrust perspective, it establishes the market norms and conditions necessary to protect competition and consumers in contracts and other business dealings between market actors. Being adaptable to the ever-changing norms of business, private law grants market participants the ability to enforce those conditions through contractual agreements and challenge breaches of those norms and conditions when violated. As such, it is often the market actors who directly experience the leveraging of market power or the anticompetitive effects of certain contract terms that are in the best position to identify the potential competitive harms arising from new market dynamics and bring an antitrust challenge.

Private antitrust enforcement was always intended to support, inform, and supplement public antitrust enforcement led by the Federal Trade Commission (FTC), DOJ, and state attorneys general. The Clayton Act established a private right of action for individuals who are injured or threatened with injury by the anticompetitive actions of other market actors.[34] Congress further encouraged private antitrust enforcement by awarding treble damages, or three times the damages incurred, to successful private litigants. Having noted that the award of treble damages reflected Congress' intent that consumers and other injured market actors serve as "private

[30] Id. at 91–92.

[31] Envision Complaint, supra note 22, at para. 41.

[32] Richard M. Scheffler et al., Soaring Private Equity Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk, Am. Antitrust Inst. & UC Berkeley Petris Ctr. 5 (May 18, 2021), https://www.antitrustinstitute.org/wp-content/uploads/2021/05/Private-Equity-I-Healthcare-Report-FINAL-1.pdf.

[33] John C. P. Goldberg, Introduction: Pragmatism and Private Law, 125 Harv. L. Rev. 1640, 1657 (2012).

[34] 15 U.S.C. §§ 15, 26. The Clayton Act specifically enables a private right of action for violations of the Sherman or Clayton Act. 15 U.S.C. §12(a).

attorneys general,"[35] the Supreme Court stated that "[t]he treble-damages provision wielded by the private litigant is a chief tool in the antitrust enforcement scheme, posing a crucial deterrent to potential violators."[36]

Despite this intent, private antitrust enforcement and private law solutions more broadly, however, have been largely omitted from policy debates and recommendations about how to preserve competitive markets in health care.[37] Scholars and policymakers almost uniformly propose public law solutions to health care market challenges, including transaction notification, review, and approval processes; enhanced public antitrust enforcement; revisions to federal merger guidelines; provider rate caps; and state health care affordability regulations.[38] But public antitrust enforcers and regulatory bodies can only implement those solutions if they have a clear line of sight into market function.

In health care, market dynamics, such as contracting, pricing, employment negotiations, and corporate alliances, are murky at best. Nondisclosure agreements and trade secret protections have become ubiquitous throughout health care agreements, shielding prices and contract terms from view.[39] By witnessing firsthand the impact on consumers and competition, private market actors have the best vantage point by which to identify when new combinations, contract terms, and behaviors can be anticompetitive.

17.4 PRIVATE LAW AS AN ANTITRUST ENFORCEMENT MECHANISM

In the rapidly evolving health care landscape, private antitrust enforcement can draw attention to the kinds of combinations (mergers, acquisitions, and joint ventures) and behaviors that can harm consumers or competition but might otherwise escape public antitrust enforcement scrutiny. Significant strides have been made through antitrust actions from private litigants both in isolation and in partnership with public authorities.[40]

One of the most pivotal health care merger challenges for the FTC was initiated by a private plaintiff and rival, Saint Alphonsus Med. Center – Nampa, Inc., against St. Luke's Health Systems, Ltd., for its attempt to acquire Saltzer Medical Group,

[35] Hawaii v. Std. Oil Co., 405 U.S. 251, 262 (1972).

[36] Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614, 635 (1985).

[37] Anne Marie Helm, Optimizing Private Antitrust Enforcement in Health Care, 11 St. Louis U. J. Health L. & Pol'y 5, 6 (2017) (both noting the disregard of private antitrust and arguing in favor of optimizing private antitrust enforcement to improve healthcare markets).

[38] See, e.g., King et al., supra note 5; Brown & Hall, supra note 24; Michael E. Chernew et al., A Proposal to Cap Provider Prices and Price Growth in Commercial Health Care Market, The Hamilton Project 10 (Mar. 2020), https://www.brookings.edu/wp-content/uploads/2020/03/CDP_PP_WEB_FINAL.pdf.

[39] Waters, infra note 54, at 6.

[40] Helm, supra note 37, at 12–13 and accompanying notes (listing numerous cases in which providers, payors, and consumers were plaintiffs in antitrust suits, some of which were joined by public antitrust enforcers).

P.A., the largest independent multi-specialist physician group in Idaho.[41] The FTC and the Idaho attorney general later joined the case, which resulted in the full divestiture of Saltzer's physicians and assets.[42] Although the case was decided on horizontal grounds arising from estimated post-merger concentration levels and price increases in the primary care physician market, St. Alphonsus, as a private litigant, illuminated the risks associated with both the horizontal and vertical aspects of the merger – noting the risk of increases in PCP rates and the foreclosure risks to other hospitals due to the potential for the acquired PCPs to shift referrals to St. Luke's.

Private litigants have also successfully challenged anticompetitive monopolistic behaviors between providers and insurers. In *West Penn Allegheny Health System, Inc. v. UPMC; Highmark, Inc.*, Pittsburgh's second-largest health system sued the dominant health system and insurer for violations of the Sherman Act §§1 and 2.[43] The case highlighted both the opportunities for collusion and competitive harms, such as artificially depressed rates and exclusion of a rival, that can arise from agreements between dominant providers and insurers to protect one another's interests.

Private plaintiffs have generally been more willing than public enforcers to bring novel challenges to anticompetitive behaviors. For example, in *Sidibe v. Sutter Health*, a group of private patients brought the first antitrust challenge to a health care system for using contract terms that leveraged market power across geographic markets.[44] Sutter Health had been strategically acquiring "must have" hospitals and other provider organizations throughout Northern California for many years. The *Sidibe* plaintiffs were the first to certify a class of patients suing for harms arising from a multi-market health system's use of anticompetitive contract clauses and tying behaviors to link providers across geographic and product markets to demand systemwide price increases from multi-market insurers.[45] While the plaintiffs have still not seen resolution of their claims,[46] their arguments laid the foundation for *UFCW and Employers Benefit Trust v. Sutter Health*, which resulted in a groundbreaking settlement for the plaintiffs and the California Attorney General, setting up a wave of follow-on cases.[47]

[41] Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 782 (9th Cir. 2015), aff'g 2014 WL 407446 (D. Idaho 2014).

[42] Id.

[43] West Penn Allegheny Health System, Inc. v. UPMC; Highmark, Inc., 627 F.3d 85 (3d Cir. 2010).

[44] Fourth Amended Complaint Demand for Jury Trial at 30, Sidibe v. Sutter Health, 4 F. Supp. 3d 1160 (N.D. Cal. 2022).

[45] Order Granting Motion to Certify Class under Rule 23(B)(3) and Denying Motion for Sanctions, Sidibe v. Sutter Health, No. 3:12-cv-04854 (N.D. Cal. July 30, 2020).

[46] Sidibe v. Sutter Health, No. 22-15634 Opinion (9th Cir. 2024) (reversing and remanding the district court case for a new trial).

[47] UFCW & Employees Benefit Trust vs. Sutter Health, Case No. CGC-14-53-8451 (Cal. Super. Ct. Apr. 7, 2014).

In 2014, the United Food and Commercial Workers (UFCW) union and the United Employers Benefit Trust (UEBT) filed a similar action against Sutter Health for using anticompetitive contract terms and other practices to demand supracompetitive rates.[48] The plaintiffs alleged that Sutter leveraged its presence as the dominant hospital provider in some markets to increase prices for all of its providers and facilities. Sutter accomplished this largely through the use of anticompetitive contract clauses, including "all or nothing" clauses that require insurers and employers to contract with all of Sutter's facilities at elevated rates, or none at all; anti-tiering and anti-steering clauses that prevent insurers from signaling or incentivizing enrollees to seek care from higher value providers; and nondisclosure clauses that prevent health plans from disclosing negotiated rates with employers, patients, or the public.[49] The plaintiffs further argued that these contract terms were mutually reinforcing in ways that strengthened Sutter's market leverage. For example, the all-or-nothing clauses leveraged market power to demand supercompetitive rates, while the nondisclosure clauses and anti-tiering/anti-steering clauses prevented consumers from being able to price discriminate, effectively shielding Sutter from price competition.[50] The plaintiff's claims, which largely mirrored the arguments made in *Sidibe*, brought significant attention to the ability of health systems to leverage market power across product and geographic markets, which had not been previously thought possible.[51]

The case gained even more momentum when the California Attorney General joined, uniting public and private antitrust enforcement and giving credence to the novel arguments made in the case. The Attorney General also contributed new arguments, such as alleging that Sutter also engaged in punitive pricing practices through "de facto all-or-nothing" behaviors.[52] Instead of placing the all-or-nothing provision directly into the contract, a system engaging in de facto all-or-nothing behaviors would impose conditions on an insurer that wants to exclude a newly acquired provider, such as: (1) raising the rates for already contracted providers in future negotiations or (2) preventing the insurer from excluding system providers from the plan by using excessive out-of-network pricing of "must have providers" to essentially force the health plan to accept the system's price and network inclusion demands. In the end, Sutter settled with the plaintiffs for (1) US$575 million, (2) prohibitions on the system's ability to condition pricing on network inclusion of providers and facilities and use of other anticompetitive contract clauses, and (3) the

[48] Id. at paras. 14–18.
[49] Id. at para. 20.a–c.
[50] Id. at paras. 21–22.
[51] See, e.g., Katie Thomas, Sutter Health to Pay $575 Million to Settle Antitrust Lawsuit, N.Y. Times (Dec. 20, 2019), https://www.nytimes.com/2019/12/20/health/sutter-health-settlement-california.html.
[52] Complaint for Violations of the Cartwright Act, People ex rel. Becerra v. Sutter Health, No. CGC 18-565398 (Cal. Super. Ct. Mar. 20, 2018), 2018 WL 1584066, https://oag.ca.gov/system/files/attachments/press_releases/Sutter%20Complaint.pdf.

imposition of cap on out-of-network rates.[53] News of the settlement sent shockwaves through the health care industry, as some of the contracting practices initiated by Sutter had served as a model for other health systems.[54]

The magnitude of the settlement, the novelty of the claims involved, and the eventual alignment of public and private antitrust enforcement in the Sutter case demonstrate the importance of private antitrust actions as a mechanism for identifying and challenging anticompetitive behaviors as they develop in the ever-changing health care landscape. In the wake of the Sutter settlement, private litigants brought several similar actions against multi-market health systems engaging in similar behavior throughout the country, sending out warning signals and changing behavior across the country.[55]

Private litigants have also brought attention to and challenged the market behaviors of private equity investors in health care. For example, in December 2021, the American Academy of Emergency Physician Group (AAEM-PG), a professional association of emergency medicine physicians, sued Envision Healthcare, a multi-specialty physician group and health care management team that includes over 25,000 physicians and 1,600 employees at over 780 hospitals nationwide, for violation of California's Unfair Competition Law and its prohibition of the corporate practice of medicine.[56] Kohlberg Kravis Roberts & Company (KKR), a leading global private equity firm that manages over US$100 billion in assets and has a strategic interest in health care, owns Envision.

The suit alleged significant competitive harm arising from Envision's use of restrictive covenants in physician employment contracts that bar physicians from joining or forming another group of emergency medicine physicians to compete in medical or management services markets serviced by Envision.[57] Such provisions can harm consumers and competition by hindering the growth of existing competitors, limiting market entry, reducing the supply of available emergency physicians,

[53] Amended Order Granting Plaintiffs' Renewed Motion for Preliminary Approval of Settlement at 6–7, 16, UFCW & Emps. Benefit Tr. v. Sutter Health, No. CGC 14-538451 (Cal. Super. Ct. Mar. 10, 2021).

[54] See Rob Waters, California's Sutter Health Settlement: What States Can Learn about Protecting Residents from the Effects of Health Care Provider Consolidation, Millbank Mem'l Fund 6 (2020), https://www.milbank.org/publications/californias-sutter-health-settlement-what-states-can-learn-about-protecting-residents-from-the-effects-of-health-care-provider-consolidation/.

[55] See, e.g., Uriel Pharmacy v. Advocate Aurora Health, No. 2:22-cv-00610 (E.D. Wis. filed May 24, 2022) (alleging use of anticompetitive tying [all or nothing clauses], anti-steering clauses, gag clauses, exclusive contracting practices, and noncompete clauses); Davis et al. v. HCA Healthcare and Mission Health System, No. 21 CV 03276 (N.C. Sup. Ct. filed Aug. 10, 2021) (alleging use of anticompetitive tying [all or nothing clauses], anti-steering clauses, and gag clauses); Brown et al. v. Hartford Healthcare (Conn. Super. Ct. filed Feb. 14, 2022) (alleging use of anticompetitive tying [all-or-nothing clauses], anti-steering clauses, gag clauses, exclusive contracting practices, and noncompete clauses).

[56] Envision Complaint, supra note 22, at para. 20.

[57] Id. at paras. 42–44.

and facilitating price increases. Interestingly, the doctors challenging the case did not ask for financial damages; instead, they asked the court to enjoin Envision from engaging in the corporate practice of medicine, inducing medical groups to include restrictive covenants in their contracts, and providing incentives in exchange for patient referrals. In addition, plaintiffs asked the court to make declarations that the private equity business model in health care, as implemented by Envision and other private equity-owned health care groups in the state, violates competition laws, interferes with providers' clinical decision-making authority and referral patterns, and harms patients.[58] While the case garnered significant media attention and survived Envision's Motion to Dismiss, it has recently stalled following Envision's filing for bankruptcy. The plaintiffs state that they will persist in the suit because of their desire for injunctive and declarative relief.

In modern health care markets, private litigants have a critical role to play in identifying and challenging anticompetitive effects arising from new consolidation strategies, contracting models, market entrants, and investment schemes. Private antitrust enforcement serves as the first line of defense protecting health care market participants, reinforces the business norms of the health care market, and provides insight for the evolution of public antitrust enforcement.

17.5 INFORMING PUBLIC ANTITRUST ENFORCEMENT

Public antitrust enforcers have struggled to keep up with changes in the health care markets for decades. Although they have experienced numerous recent successes in challenging horizontal hospital and insurer mergers, this success has not been replicated with non-horizontal combinations, such as vertical, cross-market, or cross-industry acquisitions. The enforcement challenges have arisen largely from a misalignment between the current realities of health care market dynamics and the norms and assumptions of traditional antitrust enforcement, such as distinct geographic and product markets, direct buyer and seller relationships, price and quality transparency, and a lack of price shielding from third parties. In addition, the relationships between actors in health care markets have become significantly more complex and less transparent.

Private law allows for greater acknowledgment of this complexity by exposing the nature of the relationships between market actors, such as providers and payors, physicians and hospitals, and between health systems and their employees, in ways that reflect use of market power. Furthermore, private health care litigants have proven more willing than public antitrust enforcers to bring cases based on less traditional antitrust claims that have more uncertain outcomes, which is potentially due to less public oversight and fewer resource constraints. As such, the relationships between private actors and the claims brought in private antitrust litigation can

[58] Id. at para. 81.

illuminate both changing dynamics in health care markets, as well as gaps in public antitrust enforcement.

17.6 RECOMMENDATIONS AND CONCLUSION

Paying closer attention to the private law aspects of health care can improve antitrust enforcement and market function. When private law arrangements fail or exhibit evidence of market power abuses, antitrust law should intervene. Antitrust scholars, enforcers, and policymakers should analyze private law contracts, transactions, and relationships between health care entities to better predict the evolution of market function. For example, the FTC and DOJ could replicate its recent listening sessions on the effects of mergers on the health care industry by inviting discussions on the impacts of private contracts and agreements arising from the new dynamics in health care, such as vertical, cross-market, cross-industry, and private equity-based combinations.[59] Policymakers and antitrust enforcers should use this information to improve public and private antitrust enforcement. Several of the insights raised in private antitrust suits or through private contractual relationships between health care entities were recently incorporated into the 2023 Merger Guidelines, which blended guidance for all forms of consolidation (horizontal, vertical, cross-market, and cross-industry) for the first time in decades.[60] For instance, Guideline 5 specifically addresses concerns arising from vertical acquisitions, Guideline 6 addresses concerns potentially arising from cross-market acquisitions that can extend multimarket power, and Guideline 8 permits antitrust enforcers to review a proposed acquisition in the context of being one part of a series of related acquisitions.

As health care markets continue to consolidate across geographic, product, and industry lines, new participants enter the market with goals beyond providing quality health care, and prices continue to increase, both public and private antitrust enforcement must adapt and evolve to address these new market dynamics. Private antitrust enforcement can serve as the canary in the coal mine by identifying anticompetitive behaviors and developing and testing novel strategies and arguments in court in isolation or in partnership with public antitrust authorities.

[59] Fed. Trade Comm'n, FTC and DOJ Host Listening Forum on Effects of Mergers on Healthcare Industry (Apr. 14, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/FTC-DOJ-Listening-Forum-%20Health-Care-Transcript.pdf.

[60] U.S. Dep't of Justice and Fed. Trade Comm'n, 2023 Merger Guidelines(Dec. 18, 2023), Antitrust Division | 2023 Merger Guidelines | United States Department of Justice.