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The Federal Trade Commission made big news in September 2023 when it filed a complaint against a major anesthesiology provider, U.S. Anesthesia Partners, ***and*** its private equity sponsor, Welsh Carson. The complaint, which seeks an injunction and equitable relief, alleges that the company and its sponsor formed a monopoly by acquiring nearly every large anesthesia practice in Texas and then used that market dominance to extract monopoly profits. The complaint also alleges that the company entered into anticompetitive price-setting and market-allocation contracts with independent providers.

The practice described in the U.S. Anesthesia Partners suit, known as a "roll-up," is a common strategy employed by private equity firms through which smaller businesses in adjacent markets are acquired and consolidated. Large healthcare networks acquire smaller practices for similar reasons. That consolidation enables companies to build a greater presence, operate more efficiently, and can allow them to attract better talent. But that same consolidation can also create the risk of anticompetitive effects.

The FTC's suit is noteworthy because federal competition regulators have historically focused on the companies themselves, not their financial sponsors. The case is in step with statements by competition regulators about increased scrutiny of the healthcare industry, and of acquisitions by private equity firms, in particular.[2] In the last decade or so, private equity investments in healthcare have skyrocketed from $43 billion in annual deal volume in 2017 to a record $151 billion in 2021 (and $90 billion in 2022).[3] The high volume of private investment and consolidation in healthcare has led to public scrutiny of these acquisitions and of price increases that may follow.[4] Those price increases can include, by some reports, higher prices for services and "surprise out-of-network billing," by which providers charge patients for any charges not covered by their insurance.[5]

Since the FTC's suit against U.S. Anesthesia Partners was filed in 2023, private equity firms have exhibited a decreased appetite for acquisitions in the healthcare sector, citing antitrust concerns.[6] But that reticence may end up being misplaced. U.S. Anesthesia Partners and Welsh Carson have contested the FTC's claims and characterizations and defended their actions as lawful under the antitrust laws. The district court agreed in part and dismissed the FTC's suit against Welsh Carson in May 2024.

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[2] On January 14, 2020, the FTC ordered six insurance companies to provide information so that the FTC can study the effects of physician-group and healthcare facility mergers from 2015 through 2020. See Michael G. Vita, *Physician Group and Healthcare Facility Merger Study*, FED. TRADE COMM'N (Apr. 14, 2021), https://www.ftc.gov/enforcement/competition-matters/2021/04/physician-group-healthcare-facility-merger-study. In a recent example, when discussing the DOJ's forthcoming revisions to the merger guidelines, U.S. Assistant Attorney General Jonathan Kanter invoked comments by a nurse and doctor about the negative effects of consolidation in healthcare as indicative of the American public's "demand[ ] that [the DOJ] do more . . . to protect a competitive economy." *Assistant Attorney General Jonathan Kanter Delivers Remarks at the 2023 Georgetown Antitrust Law Symposium*, OFF. OF PUB. AFFAIRS, U.S. DEP'T OF JUST. (Sept. 19, 2023), https://tinyurl.com/yc2rnt5x.

[3] Deborah Filipek, *Healthcare News of Note: Healthcare Private Equity Deals Amounted to a Strong $90B in 2022*, HEALTHCARE FIN. MGMT. ASS'N (Apr. 28, 2023), https://tinyurl.com/4acesvzz; *Global Healthcare Private Equity Report 2024*, Bain & Company, https://www.bain.com/insights/topics/global-healthcare-private-equity-report/.

[4] Reed Abelson, *Who Employs Your Doctor? Increasingly, a Private Equity Firm*, N.Y. TIMES (July 10, 2023), https://tinyurl.com/4w7rcw7r; Robert Pearl M.D., *Private Equity and the Monopolization of Medical Care*, FORBES (Feb. 20, 2023), https://tinyurl.com/ya4cjmhy; Grace Niewijk, *New Findings Show Private Equity Investments in Healthcare May Not Lower Costs or Improve Quality of Care*, UNIV. OF CHI. MED. (July 25, 2023), https://tinyurl.com/3na8f59x.

[5] Reed Abelson, *When Hospitals Merge to Save Money, Patients Often Pay More*, N.Y. TIMES (Nov. 14, 2018), https://tinyurl.com/44h4rx4w; Loren Adler et al., *Measuring Private Equity Penetration and Consolidation in Emergency Medicine and Anesthesiology*, HEALTH AFFAIRS SCHOLAR, https://tinyurl.com/ymunnxf9.

[6] Chris Cumming, *Private Equity Puts Brakes on Healthcare Roll-Ups After Government Scrutiny*, WALL ST. J. (June 4, 2024), https://www.wsj.com/articles/private-equity-puts-brakes-on-healthcare-roll-ups-after-government-scrutiny-6fc64f5a.

The sponsor's investment in U.S. Anesthesia Partners and receipt of profits, the court reasoned, could not sustain the agency's claim under Section 13(b) of the FTC Act, which requires an ongoing violation of the antitrust laws.[7] Time will tell whether the FTC's suit marks a new trend in enforcement against private equity sponsors.

Although the FTC's suit is novel for naming a private equity sponsor as a defendant, the key elements of its claims are not new. Since the 1990s, federal and state regulators have sued to stop or unwind mergers based on market concentration or allegedly anticompetitive conduct after the consolidation of physician practices. And competitors, insurers, and consumers have brought claims challenging similar acquisitions and mergers, and practices by dominant firms.[8]

Antitrust cases based on the consolidation of physician practices share several common attributes. Most involve claims under Sections 1 and 2 of the Sherman Act — which prohibit unlawful restraints of trade, and obtaining or maintaining a monopoly through exclusionary conduct, respectively — and Section 7 of the Clayton Act, which prohibits mergers that substantially lessen competition or create a monopoly.[9] In many of these cases, plaintiffs allege both horizontal restraints (same industry and level of production pyramid) and vertical restraints (same industry, different levels) on competition in the relevant markets. Some of those claims have succeeded, or at least survived a motion to dismiss. Others have not. Below are some of the types of conduct commonly alleged, and the distinctions courts have drawn so far between permissible and anticompetitive behavior. Healthcare groups — and private equity firms that invest in them — should take note.

I. Horizontal Restraints

Historically, the most successful antitrust claims against physician practice mergers and acquisitions have been theories of "horizontal" restraint. These claims allege that the merging of two or more practices diminishes competition for the same service or type of physician. High concentration in markets for medical specialties, for example, can make it more likely that the merged entity could unilaterally increase prices and decrease competition for non-price components, like patient experience.[10] Two key factors that are often outcome determinative for these claims at the pleading stage are market definition and the presence of other anticompetitive activity.

A. Market Definition

Market definition often proves dispositive for horizontal claims against physician practices. The relevant market tends to be narrowly defined both in geographic scope and medical services. Often, the product or service that defines the relevant market does not correspond to a specialty, but instead relates to a procedure or service.[11] In one instance, for example, regulators did not pursue enforcement against a merger that resulted in a high concentration of pulmonologists in the Albuquerque area because many other types of physicians provided the same services and would still compete.[12]

The relevant geographic market for healthcare services is usually local, often limited to a city and its surrounding metropolitan area. Disputes

[7] *Federal Trade Comm'n v. U.S. Anesthesia Partners*, 4:23-cv-03560, 2024 WL 2137649, at *4-5 (S.D. Tex. May 13, 2024). U.S. Anesthesia Partners also moved to dismiss, but the district court denied its motion. USAP attempted to appeal that denial to the Fifth Circuit as a collateral order, but the Fifth Circuit disagreed and dismissed the appeal. *Federal Trade Comm'n v. U.S. Anesthesia Partners*, No. 24-20270, (5th Cir. Aug. 15, 2024), Dkt. 33-2.

[8] In one recent example, private plaintiffs brought similar claims against private equity firm Lion Capital for its alleged involvement in price-fixing as to its then-portfolio company, Bumble Bee tuna. See *In re Packaged Seafood Prods. Antitrust Litig.*, No. 3:15-md-02670 (S.D. Cal.). In August 2023, the district court denied Lion Capital's motion for summary judgment in part. *Id.*, Dkt. 3103. Trial is currently scheduled for July 2024. *Id.*, Dkt. 3124.

[9] *FTC v. U.S. Anesthesia Partners, Inc.*, No. 4:23-cv-03560 (S.D. Tex.), Dkt. 1 at ¶¶ 347, 353-54, 407.

[10] See, e.g. *In the Matter of Renown Health*, No. 11-cv-0101, 2012 WL 3200596 (FTC Aug. 3, 2012).

[11] David A. Ettinger, *Physician Practice Acquisitions: Can They Survive Antitrust*, 8 HEALTH LAW 14 (1995).

[12] *Id.*

about the geographic market tend to be limited to a few surrounding zip codes, which depend on evidence of patients' willingness to travel for the medical services.[13] In a recent case, the Third Circuit endorsed this approach to market definition, holding that the relevant market was determined by both the patient location and location of the physician services offered.[14] The FTC's suit against U.S. Anesthesia Partners similarly limits the defined market to the metropolitan areas of three Texas cities, rather than the entire state.[15]

Because both the geographic and medical service markets are often narrowly defined, a merger can result in substantial or total control over the defined market. In some cases, market concentration — even without evidence of anticompetitive effect — has been enough for a complaint to survive a motion to dismiss or succeed at trial. For example, a federal court enjoined the acquisition of a medical practice by a healthcare system that would have nearly eliminated competition in four service lines in the metropolitan area around Bismarck, North Dakota. Key to the court's holding was the small population and size of the market for the medical services: the small population in and around Bismark simply did not need the number of new physicians that would be necessary to restore competition in the concentrated medical services. [16]

But small markets and populations will not necessarily result in a finding of an antitrust violation. In another case, a district court rejected a competitor's effort to enjoin the merger of two physician practices — despite evidence that the merged entity would control 100 percent of the market for three medical services in and around Vicksburg, Mississippi — because there was a "natural monopoly" in the area. The court's ruling rested not on the size of the area's population, but on the small headcount of physicians who provided those services. While the merger would result in near-total control of the urology and ENT markets, there were only two or three doctors providing those services to begin with. Without a merger, those specialists would not be able to secure coverage so that they could take time off. The court reasoned that in such a naturally small market, the antitrust laws did not demand that the few physicians compete.[17]

B. Horizontal Restraints Plus Anticompetitive Conduct

Horizontal claims are generally more successful when they also allege that the defendant engaged in anticompetitive conduct following an acquisition. Popular — and often successful — theories of anticompetitive conduct include evidence that the merged entity had, or intended to, raise the reimbursements rates with insurers.[18] In the Bismarck, North Dakota case, for example, the district court and Eighth Circuit found that the merging parties' plans to raise reimbursement rates provided further support for the plaintiffs' case that the acquisition would be anticompetitive.[19] In a more stark example, an insurer challenged a series of acquisitions by a Shreveport, Louisiana hospital system because the hospital had, among other things, forced incoming physicians to cancel their existing insurance contracts with the plaintiff and refused to contract with the plaintiff unless it agreed to an exorbitant 90 percent rate of reimbursement. Based on those allegations, the court denied the hospital's motion to dismiss, concluding that its practices foreclosed the insurer from the market.[20]

Another example of "extra" anticompetitive conduct is the use of noncompete clauses. In the Shreveport case, the court found that allegations that the defendant's use of noncompete clauses in its employment

[13] *HTI Health Servs., Inc. v. Quorum Health Grp., Inc.*, 960 F. Supp. 1104, 1122-23 (S.D. Miss. 1997).

[14] *FTC v. Hackensack Meridian Health, Inc.*, 30 F.4th 160, 169 (3d Cir. 2022).

[15] *FTC v. U.S. Anesthesia Partners,* No. 4:23-cv-03560, Dkt. 1 at ¶¶ 235-36, 245, 253.

[16] *FTC v. Sanford Health*, No. 1:17-cv-0133, 2017 WL 10810016, at *19-21 (D.N.D. Dec. 15, 2017), *aff'd*, 926 F.3d 959 (8th Cir. 2019).

[17] *HTI Health Servs., Inc.*, 960 F. Supp. at 1128.

[18] *Saint Alphonsus Med. Ctr.-Nampa, Inc. v. St. Luke's Health Sys. Ltd.*, 778 F.3d 775, 787-88 (9th Cir. 2015).

[19] *FTC v. Sanford Health*, 2017 WL 10810016, at *17 (D.N.D. Dec. 15, 2017).

[20] *BRFHH Shreveport, LLC v. Willis Knighton Med. Ctr.*, 176 F. Supp. 3d 606, 613 (W.D. La. 2016).

agreements with physicians were plausibly anticompetitive. Those clauses not only prohibited the physicians from working in the larger geographic area, but also imposed huge penalties if the physician left the hospital.

II. Vertical Restraints

Many recent cases have also included theories of vertical restraints and challenge the consolidation of healthcare groups operating at different levels of production, distribution, or supply. Compared to horizontal restraints, vertical restraints caused by the merger of two non-competing business lines tend to be more difficult to prove. The assumption is that vertical integration improves efficiency, which is a valid business purpose, not an antitrust violation. For that reason, challenges against healthcare roll-ups premised on theories of vertical restraint have proven less successful, though some have passed the motion to dismiss stage. The alleged anticompetitive conduct in these suits run the gamut, including confirmatory vertical acquisition, exclusive contracts, or tying arrangements.

A. A Vertical Acquisition or Something Else?

Claims challenging the vertical expansion of a larger healthcare system through the acquisitions of individual or very small practices often face an additional preliminary step: proving that a practice was acquired, not just that new talent was hired. If an antitrust suit's only grievance is that a hospital hired more doctors, it will fail.

This issue was key to a suit brought by Saint Francis Hospital, the smaller of the two biggest hospital systems in Hartford, Connecticut against its larger competitor, Hartford Healthcare Corporation ("HHC"). Saint Francis alleged that HHC acquired physician practices through a "campaign of intimidation," which allowed it to maintain market dominance for commercially insured and certain Medicare patients, and to control referrals. HHC moved to dismiss, arguing, among other things, that it did not "acquire" solo physicians' practices but merely hired its rival's employees. [21]

The district court ultimately denied HHC's motion, finding that it "outright took over" independent physician practices because it acquired talent, the non-physician staff, and the practices' leases.[22] Those takeovers were not the mere acquisition of talent, but vertical acquisitions of other practices. To get there, the court relied on a test first articulated in the Shreveport case, discussed above, which examined whether the defendant had acquired the practice's physical assets, not just the talent. Though the Saint Francis court expressed some skepticism that the test should turn entirely on whether *physical* assets were transferred, it nonetheless relied on the test and concluded that the plaintiff's allegations passed muster.[23]

Even claims that may adequately allege an acquisition of physician practices may stumble on another roadblock — a cognizable antitrust injury — and ultimately trip up on a motion to dismiss. In a similar case, a smaller hospital system, SCPH Legacy Corporation, sued its larger rival, Palmetto Health, after Palmetto acquired hundreds of doctors — all but two employees — from SCPH's orthopedic clinic. SCPH claimed that while it was negotiating the sale of its assets to a third hospital system, Palmetto conspired with the clinic's executives to orchestrate a mass resignation, which reduced SCPH's sale price by $50 million. Though Palmetto's hiring of the 300 orthopedists increased its market share, the district court dismissed the claims for lack of antitrust injury. The willing departure of SCPH's orthopedists and Palmetto's increased market share — no matter the impact on SCPH — did not violate the antitrust laws. [24]

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[21] *Saint Francis Hosp. & Med. Ctr., Inc. v. Hartford Healthcare Corp.*, 655 F. Supp. 3d 52, 62-66 & n.2 (D. Conn. Feb. 13, 2023).

[22] *Id.* at 80. The court noted that whether HHC had actually acquired the assets of any particular physician practice presents a question of fact. *Id.*

[23] *Id.* at *16 n.9.

[24] *SCPH Legacy Corp. v. Palmetto Health, Prac. Partners in Healthcare, Inc.*, No. 3:16-cv-2863, 2017 WL 1437329, (D.S.C. Feb. 24, 2017), *aff'd sub nom. SCPH Legacy Corp. v. Palmetto Health*, 724 F. App'x 275 (4th Cir. 2018).

B. Exclusive Referral Agreements and Insurance Contracts

Healthcare markets are different from many other service markets because the presence of insurance networks limits providers' ability to compete on quality or price. Physician referrals therefore have a significant impact on which providers patients use. These dynamics can create leverage that plaintiffs have claimed can be used anticompetitively.

One suit in which plaintiffs successfully asserted a theory of anticompetitive referral agreements was brought by a group of doctors and practices near Orlando against HealthFirst, a major health system in the area. The plaintiffs alleged that HealthFirst used its market power to coerce independent doctors to join its system or enter into exclusive-referral arrangements to maintain its monopoly.[25] Specifically, they claimed that if a physician declined to enter into exclusive-referral arrangements with HealthFirst, it would first exclude them from its network, then stop its physicians — and other independent doctors — from referring patients to them, and finally revoke their hospital privileges. The plaintiffs defeated HealthFirst's motion to dismiss and its motion for summary judgment as to both the monopolization and restraint-of-trade claims based on the exclusive-referral theory. The parties ultimately settled on the second day of trial, for what one source reported to be $100 million.[26]

In another example (where the plaintiff fared worse) Methodist Health Services Corporation, the second-largest hospital in Peoria, Illinois, sued the largest hospital in the area, St. Francis, claiming that its contracts with insurance companies violated both Sections 1 and 2 of the Sherman Act. Specifically, Methodist alleged that because St. Francis was the only hospital in the area that offered certain essential services — a "must-have" hospital, in healthcare terms — that market power allowed it to coerce insurance plans into excluding Methodist from their provider networks and to charge Methodist supracompetitive rates. Although Methodist survived a motion for judgment on the pleadings, the district court granted summary judgment in favor of St. Francis. Notwithstanding St. Francis's undisputed market power, the district court concluded that there was insufficient evidence that St. Francis foreclosed Methodist from competing at any of the three levels of the insurance market — wholesale contracts with insurers, intermediate contracts with employers within the network, and retail choice among patients. Key to that decision was Methodist's failure to identify which insurance companies and customers that it was foreclosed from.[27]

C. Tying Agreements

Tying agreements — those in which a seller conditions the purchase of one product or service on the buyer's agreement to purchase a separate product or service — are also a common theory of vertical restraint in healthcare cases. Tying allegations are commonly related to access or the denial of access to certain facilities (such as inclusion of certain hospitals in a network), but can also include access to a product, such as a unique medical device or drug regimen.

A consumer class action against Sutter Health presents a recent, unsuccessful example of a tying claim. The suit was brought by indirect purchasers and alleged that Sutter Health used its market power to coerce insurers that wanted to access any of Sutter Health's hospitals or services to include them all in-network. The hospital allegedly penalized insurers that refused to agree by charging higher rates for out-of-network care when the insurer excluded even one of Sutter Health's hospitals or service lines from the network.[28] Sutter Health, for its

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[25] *Omni Healthcare, Inc. v. Health First, Inc*., No. 13-cv-1509, 2015 WL 275806, at *1 (M.D. Fla. Jan. 22, 2015).

[26] Rick Neale, *Health First Antitrust Lawsuit Settled in Federal Court*, Florida Today (Aug. 16, 2016), https://tinyurl.com/bdcu26xk; Naseem S. Miller, *One Day Into Trial, Health First Settles Case*, Orlando Sentinel (Aug. 16, 2016), https://tinyurl.com/3485eeh3 (noting $100 million settlement).

[27] *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, No. 13-cv-01054, 2016 WL 5817176, at *1, 10-15 (C.D. Ill. Sept. 30, 2016), *aff'd*, 859 F.3d 408 (7th Cir. 2017).

[28] See, e.g. *Sidibe v. Sutter Health*, No. 3:12-cv-04854, 2021 WL 879875, at *5-6 (N.D. Cal. Mar. 9, 2021); *Sidibe v. Sutter Health*, No. 12-cv-04854, 2013 WL 2422752, at *14 (N.D. Cal. June 3, 2013).

part, contended that its insurance pricing was not a tie that conditioned sales of one product on sales of another, but was a "systemwide" contract that served as the hospital's mechanism for setting its own prices.[29] After a decade of litigation, the plaintiffs proceeded to trial on claims under California's antitrust law, the Cartwright Act, and lost — the jury returned a complete defense verdict.[30] A separate, similar suit brought by various group health plans (direct purchaser plaintiffs) that also raised Cartwright Act claims had a successful outcome against Sutter Health in state court. The direct purchaser's suit ultimately settled for $575 million, and imposed restrictions on Sutter's practices for at least 10 years under the supervision of a court-appointed monitor.[31]

In another example, an Albuquerque oncology practice alleged that the local integrated healthcare system and its insurance plan had monopolized the market for, among other things, comprehensive oncology services by limiting referrals to plaintiff's doctors and requiring plaintiff's patients to purchase chemotherapy drugs from defendant's hospital pharmacy instead of the plaintiff's chemotherapy center. The hospital moved for summary judgment, arguing that its conduct was purely unilateral and not anticompetitive. As a general rule, unilateral conduct is rarely found to run afoul of the antitrust laws because businesses are usually free to choose whether or not to do business with others and set their own prices. There are two exceptions to that rule — predatory pricing or bidding, or a refusal to deal — that can give rise to antitrust liability for otherwise purely unilateral conduct. The district court found that neither exception applied. It concluded that the plaintiff had not proven predatory bidding, because the defendant had not "bid up" prices of services to push the plaintiff out. And the court found no refusal to deal, because the parties had in fact continued to deal and were in the process of renegotiating contracts. The court concluded that the most the evidence showed was a desire to maximize immediate and overall profits, which was not anticompetitive. The district court did agree with plaintiffs that, in refusing to negotiate its contract with plaintiff, defendant appeared to bring its monopoly power to achieve a competitive advantage for its sister organization, a cancer center. But that kind of "leveraging" of a monopoly, on its own, the court concluded, is not anticompetitive. [32]

III. Lessons Learned

The FTC's suit against U.S. Anesthesia Partners is part of a larger wave in antitrust enforcement by regulators that shows no signs of ebbing. Investors in the healthcare space, hospitals and private practices should be aware of this trend and what historically has — and has not — been considered anticompetitive when assessing a potential acquisition or merger. Private plaintiffs seeking to ride this wave should be equally attuned to these issues and regulatory actions. Because of the nuances of the healthcare industry and geographic considerations, plaintiffs should exercise special care when articulating the anticompetitive conduct and market definition to ensure their claim is legally cognizable.

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[29] See, e.g. *Sidibe v. Sutter Health*, No. 3:12-cv-04854, 2021 WL 879875, at *6 (N.D. Cal. Mar. 9, 2021).

[30] Jury Verdict, *Sidibe v. Sutter Health*, No. 3:12-cv-04854 (N.D. Cal. Mar. 11. 2022), Dkt. 1530.

[31] *Attorney General Bonta Announces Final Approval of $575 Million Settlement with Sutter Health Resolving Allegations of Anti-Competitive Practices*, STATE OF CAL. DEP'T OF JUST. (Aug. 27, 2021), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-final-approval-575-million-settlement-sutter#:~:text=The%20settlement%20requires%20Sutter%20to,%2C%E2%80%9D%20said%20Attorney%20General%20Bonta; *Sutter Health Settlement with UEBT and the California Attorney General*, https://www.sutterhealth.org/about/settlement.

[32] *New Mexico Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs.*, 418 F. Supp. 3d 826, 830-31, 847-51 (D.N.M. 2019), *aff'd sub nom. New Mexico Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs.*, 994 F.3d 1166 (10th Cir. 2021).