U.S. Department of Health and Human Services

HHS Consolidation in Health Care Markets RFI Response

Report prepared by the HHS Office of the Secretary (OS), in consultation with the U.S. Department of Justice and the U.S. Federal Trade Commission.

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Introduction

The cost of health care has been outpacing wage growth for patients for decades, putting strain on both public and private budgets and limiting access.[a] One of the main factors contributing to unsustainable health care inflation has been growing consolidation in the health care sector and the lack of meaningful competition. In December 2023, the Federal Trade Commission (FTC), Department of Justice (DOJ), and Department of Health and Human Services (HHS) announced a tri-agency collaboration to promote competition in health care markets. As part of that effort, a Request for Information (RFI) was released in March 2024, seeking public comment on the impacts of the corporate ownership trend in health care. The cross-government inquiry sought to understand how certain health care market transactions executed by health systems, private insurers, private equity funds and other private investors may increase consolidation and compromise patients' health, quality of care, and affordability, while also threatening workers' safety, satisfaction, and wages, and creating taxpayer burden. This RFI sought to inform potential actions the agencies could take to build on recent steps taken by the FTC, DOJ, and HHS to improve health care competition.

Over 2,000 unique and relevant comments were submitted from across the country, including comments from patients, physicians, health systems, insurers, industry associations, labor unions, and academic researchers. All comments were qualitatively reviewed and categorized by subject matter, relevant source of law, and other pertinent variables. An interagency team reviewed both the tabulations and underlying comments, the results of which informed this report.

This report synthesizes findings and highlights certain key facts, lessons, and ideas gleaned from the comments. It is not intended to be a comprehensive summary of all topics, but instead focuses attention on evidence, trends, and policy ideas that deserve greater scrutiny and consideration. HHS, DOJ, and FTC will continue to use the comments to inform regulatory and policy actions.

Background

The responses to the RFI highlighted two major trends in the health care sector: increasing consolidation of health care markets[b] and a recent influx of private equity and other private investors into health care services. A growing body of empirical studies offers an evidentiary background with which to examine both topics.

Increasing consolidation of health care markets

Over the last thirty years, the health care industry has experienced a dramatic and continuous trend of consolidation across the country. It is now more concentrated than ever.[c] Consolidating transactions have taken place between entities that offer similar services (horizontal mergers), between entities that

[a] See appendix exhibit 1.

[b] Throughout this report, use of the term "market" does not define or connote any antitrust product or service market or geographic market nor imply that any analysis was conducted in accordance with the U.S. Department of Justice and Federal Trade Commission 2023 Merger Guidelines §2.1 that would establish any "market" mentioned herein as an antitrust product or geographic market. There are multiple potential antitrust product and services markets and geographic markets for health insurance and healthcare items and services.

[c] Consolidation refers to the shift to fewer and larger firms, while concentration refers to the extent to which a small number of firms control the market. The two are closely related but maintain these distinct meanings for the purposes of this report.

offer different services along the same supply chain (vertical mergers), and across markets between different regions (cross-market mergers). Almost every sector and type of health care provider has experienced consolidation. Publicly traded for-profit companies, privately held for-profit companies, and non-profit organizations have all taken part in the trend of acquiring and merging health care entities. The RFI sought to hear directly from patients and health care workers about how their experiences have changed after their health care organization was acquired or underwent a merger.

Consolidation has been most pronounced in the hospital sector. In 1990, 65% of Metropolitan Statistical Areas (MSAs) in the country were considered highly concentrated for hospital services;[d] by 2006, the share had increased to 77%,[1] and by 2016, it was 90%.[2] Consolidation trends have continued to this day. A study of 183 MSAs found that between 2017 and 2021, hospital system concentration rose in nearly 70% of MSAs and prices rose in 98%.[3]

Physician and insurance markets have also consolidated significantly during this same period, such that by 2016, 65% of MSAs in the country had highly concentrated specialist physician markets, 39% had highly concentrated primary care physician markets, and 57% had highly concentrated insurance markets.[e-f,2] As of 2024, about 75% of health insurance markets are considered highly concentrated by the same metric (HHI > 2,500).[g,4]

Widespread horizontal consolidation now means that most hospitals are a part of health systems, and very few community hospitals are owned or controlled by individuals or entities based in the community. The share of community hospitals that are part of a larger health system increased from 53% in 2005 to 68% in 2022.[h,5] Multi-hospital systems, including tax exempt non-profit systems, owned 58% of hospital beds in 2000 and 81% in 2020.[i,6] Health systems are expanding their market power both within and across geographic and product markets.[7-9] As a result of this consolidation, patients in nearly half of all metropolitan areas had only one or two hospital systems providing inpatient care.[10]

The health sector has also exhibited significant vertical consolidation, such as when hospitals acquire an independent physician practice, an ambulatory surgery facility, or other adjacent entity. Insurers are also acquiring physician practices through vertical integration.[11-12] Considered together, these acquisitions have had a pronounced impact on the physician market. Between 2012 and 2022 the share of physicians who work in independent practices dropped by 13 percentage points from 60% to 47%.[13] As of 2022, around half of all physicians were employed by larger health systems.[12,14] The percentage of primary care physicians employed by health systems is even greater.[15] Health systems have also been taking ownership stakes in ambulatory surgery centers (ASCs) at higher rates. Today, almost half of all hospitals and health systems at least partially own an ASC, and over a quarter of ASCs are in part owned by a hospital.[16-17]

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[d] Concentration in this study was defined using HHI measures according to the U.S. Department of Justice and Federal Trade Commission 2010 Horizontal Guidelines. DOJ and FTC updated the guidelines in 2023.

[e] Concentration in this study was defined using HHI measures according to the U.S. Department of Justice and Federal Trade Commission 2010 Horizontal Guidelines. DOJ and FTC updated the guidelines in 2023. Markets referenced in this study were Metropolitan Statistical Areas (MSAs).

[f] See appendix exhibit 2.

[g] In 2023 the FTC and DOJ updated merger guidelines, reducing the threshold for a highly concentrated market from HHI 2,500 to HHI 1,800. According to the 2023 guidelines and the same data source, 97% of health insurance markets are considered highly concentrated.

[h] See appendix exhibit 3.

[i] Beds here are the total number of licensed beds / bed capacity in hospitals, not staffed beds.

Empirical research unambiguously shows that hospital system-led acquisitions and mergers are associated with higher prices for services charged to insurers and patients.[18-27] For example, following an acquisition of a hospital by another hospital or in concentrated hospital markets, some studies find that prices increase between 6% and 65% for the merged entity[19-24,27] and increase significantly for neighboring hospitals as well.[22-23] Similar price increases occur when hospitals acquire physicians, with the prices for physicians' services increasing 14% on average after acquisition.[18,25] Price hikes for physician services are larger when the acquiring hospital system is bigger.[26] Acquisitions by health systems can also provide economic leverage to anti-competitively steer referrals within their system.[28] Hospital acquisitions of physician practices have also led to higher Medicare spending and increases in the total cost of care, due to site-of-care shifts and increased volume of services from within-system referrals.[29,30]

Health systems claim that consolidation enables operational efficiencies and more coordinated care. However, research on consolidation and quality suggests the opposite. Several studies show no improvement in quality with consolidation[18,24,31] and some studies show negative impacts.[32-33] For example, one study found that mortality for heart attack patients increases in concentrated markets.[33-34] Additional evidence suggests that consolidation leads to longer travel times and detrimental health consequences for rural communities, which typically see a reduction of key services following acquisitions.[31,35-38]

Research also shows that consolidation reduces wage growth for health care workers. Nominal wages for skilled workers are 4% lower in the four years following a hospital merger, and 7% lower for nursing and pharmacy workers.[j,39] Consolidation has also magnified the restrictive impact of non-compete clauses, such that in 2018, 45% of primary care physicians employed by hospital systems were subject to non-compete clauses, significantly limiting their ability to change jobs, negotiate for enhanced wages, and move to areas of greater need.[40]

Insurer market concentration adversely effects both patients and providers. One study found that large group premiums for employer-sponsored family coverage rose 48% over an 8-year period, and consolidation in average markets accounted for 7 percentage points of this increase.[41] Concentrated insurer markets exhibit monopsony power by lowering payments paid to providers.[20,42] Critically, monopsony-aided reductions to providers are not passed on to consumers in the form of lower premiums and out-of-pocket costs.[43]

The rising cost of health care also puts pressure on employee health benefits. A 1% increase in health care prices caused by a hospital merger lowers both total wages and the number of employees at non-health sector firms by approximately 0.4%. Each percent price increase also reduces per capita labor income by 0.3%, increases flows into unemployment by approximately 0.1 percentage points, lowers federal income tax receipts by 0.4%, and increases unemployment insurance payments by 2.5%. Job losses are most concentrated among low and middle-income workers.[44] The rising cost of health care is one of the economy's most significant drivers of inequality. It operates like a head-tax on every working family, putting enormous economic strain on vulnerable communities and the broader economy.[45-46]

[j] This study found muted wage growth slowdown effects in markets with strong labor unions and that out-of-market mergers that leave local employment unchanged did not effect local wages.

Recent influx of Private Equity (PE) and other private investors

The health care sector has experienced an influx of investment from private equity (PE) and other private investors such as venture capital and Real-Estate Investment Trusts (REITs) over the past 15 years. Health care is one of the top three to five sectors for PE activity, roughly proportional to its share of GDP, and further increased activity is expected.[47-48] Health care businesses purchased by PE firms increased from 352 in 2010 to 937 in 2020, representing $806 billion and covering markets that included both inpatient services and outpatient services, elder and disabled care, and pharmaceuticals.[k,49]

PE-backed companies now own more than 30% of physicians in approximately one quarter of MSAs across the country and control over half of physicians in about 13% of MSAs.[11] PE firms have invested heavily in nursing homes, hospitals, and emergency departments.[50-51] Some estimates suggest that more than 40% of the country's emergency rooms are "overseen by for-profit health care staffing companies owned by private equity firms."[52] Up to a quarter of mental health and substance use facilities in some states are owned by PE.[53]

While the share of PE ownership in some outpatient care delivery settings ranges from approximately 5-15% of practices, PE firms have been especially active recently in acquiring companies in home care, dental care, mental health, dermatology, and vision.[11,54-56] For example, the percentage of dentists affiliated with PE nearly doubled from 2015 to 2021.[57]

A PE fund is typically set up as a limited liability company (LLC) that pools capital from institutional investors—pension funds, endowments, sovereign wealth funds—and high net-worth individuals. PE funds invest in companies for a short duration, typically four to seven years, before exiting through sell-offs, spin-offs, or initial public offerings. The fund makes money through management fees, typically 2% of assets under management that cover operational costs, and performance-based fees (also known as carried interest) that account for 20% of any investment gains above a certain threshold return. Private equity investors benefit from the fact that carried interest is taxed as capital gains rather than as income.

Commenters, researchers, and lawmakers have highlighted two features of the private equity business model as incentivizing problematic conduct.[49,58] First, private equity firms are generally not long-term stakeholders but instead are short-term investors. And second, most of the capital that private equity investors deploy is not their own, which creates moral hazards and encourages risk-taking.

Similar to the impact of consolidation on health prices, an emerging body of literature also shows that PE acquisitions lead to higher prices for insurers and patients in their pursuit of profits.[11,56,59-61] Hospitals acquired by PE firms increase prices by 7-16% and profit by 27%,[59] and PE-acquired physicians' practices increase prices 4-20%.[l,11,60] One study found that prices increased by over twice as much for PE-backed anesthesiologist physician management companies compared to non-PE backed equivalents.[61] In addition to these sharp price increases, evidence suggests that PE-backed firms disproportionately engage in up-coding, providing unnecessary services, exaggerating population health risks, and ordering more high margin tests and procedures.[62] Evidence also shows that PE firms typically acquire more financially stable hospitals, and that PE investment targets high-margin specialties like dermatology, urology, gastroenterology, and cardiology.[11,63]

[k] See appendix exhibit 4.

[l] See appendix exhibit 5.

One common PE strategy, a "roll-up," illustrates how PE investment consolidates markets and drives up prices. A roll-up is when a company acquires and merges multiple small businesses in the same industry into a single consolidated company or common management body for separate entities that enjoys market power.[64] Typically, the stated goal is to reduce costs through economies of scale. However, roll-ups also enable firms to gain market power without the antitrust scrutiny generally triggered by larger transactions. The small serial acquisitions tend to fall below the Hart-Scott-Rodino (HSR) notification threshold (currently $119.5 million), which determines if a transaction must be filed with the FTC for review.

In health care, a roll-up is often of a specific type of facility or groups of specialty providers. PE funds pursue roll-up strategies because they offer reliable sources of revenue and a phenomenon called "multiple expansion," where the rolled-up company can be sold at a higher valuation multiple than the rate at which each of the underlying companies was acquired. The rolled-up entity is often sold to another PE firm or a larger health system or health insurer, which then further increases consolidation.[m] One study found that PE firms held physician practices for an average of three years, during which their holdings of physician practices grew through roll-up strategies by 595% before selling to larger firms.[65]

Through tactics such as roll-ups, PE firms contribute to consolidation and harm consumers by enhancing monopoly power and increasing prices. Additional evidence suggests that PE ownership of health care organizations cause other harms, beyond those caused by consolidation.

Another common PE tactic is to dramatically reduce the operational costs of the newly acquired entity. Reducing costs and increasing efficiency are admirable if done thoughtfully. However, evidence suggests that PE firms pursue cost cutting too quickly, leading to patient safety issues and reductions in quality.[49,66-71] Research shows that following PE acquisitions, physician practices, nursing homes, and other providers exhibit lower staffing levels.[71] However, evidence also points to PE acquisitions inducing demand through increased patient volumes[56,60] and increases in unnecessary tests and procedures.[49,67-68] This results in provider burnout and less patient-physician time.

Additionally, PE investors generally finance their acquisitions with debt for which the acquired company's assets and cash flows serve as collateral. While PE firms typically target more financially sustainable companies, the practice of loading them up with debt is risky and has had negative consequences, especially as interest rates rose after March 2022. In 2023, at least 21% of health care companies that filed for bankruptcy were PE-owned, and most of the distressed health care companies, at risk of bankruptcy, in 2024 are PE-owned.[72] For perspective, PE's estimated total share of provider revenues in the US is just 4%.[54] Three of the PE-backed health care companies that went bankrupt recently cited reduced revenues as a result of the No Surprises Act as a factor in their financial distress.[54,73]

Many PE firms that used borrowed funds to finance hospital purchases sell off hospital assets to generate immediate profits for shareholders while harming hospitals' long-term financial interests.[n,74] Furthermore, when a company declares bankruptcy, it is often able to avoid paying some of its debts, including pensions and benefits to employees. This has happened in notable PE hospital deals and garnered headlines that have contributed to the public concern over PE in health care.[75-78]

[m] There could be other buyers. Depending on strategic fit, other buyers may include health care distributors and manufacturers or large pharmaceutical companies.
[n] See appendix exhibit 6.

Two other forms of financial engineering that commenters highlighted as being problematic are sale-leasebacks and dividend recapitalizations. In a sale-leaseback, a PE firm might sell off property or other assets owned by an acquired organization and then make the organization pay to lease them back from another entity such as a Real Estate Investment Trust (REIT). A PE firm may partner with a REIT on the deal and even extract some of the REIT's revenue from the leased property. Dividend recapitalizations are how some PE firms siphon money out of their acquired companies, stripping them of assets and using proceeds to pay dividends to investors. A dividend recapitalization could be issued at any point at the instruction of the PE fund, not just after the sale of assets. The acquired business then takes on new debt and uses the cash for an investor payout. This practice was aided by lower interest rates during the COVID-19 pandemic and has since become more difficult for PE funds and acquired companies due to the higher cost of debt today. However, up to date information on companies' use of leasebacks and dividend recapitalizations is limited given the intentionally obscured ownership structures the firms will use.

Whereas PE acquired firms predictably raise prices and attempt to reduce costs, studies offer nuanced results on how PE transactions affect health care quality. PE acquisitions of nursing homes and other inpatient facilities have decreased quality, as measured by adverse events and mortality.[49,67-68,79-80] One study found that PE-owned hospitals improve profitability without compromising quality but show evidence of reduced staffing.[81] The quality consistency demonstrated by this study could be explained by a shifting patient mix. Other studies show PE-owned facilities pursuing lower shares of Medicare patients and increased out-transfers of higher-risk (and lower margin) patients to other hospitals.[59,80,82] Studies of outpatient settings show a variety of results depending on the specialty and metrics studied.[49,80,83] There is a need for more research into the impacts of PE ownership across specialties and sites of care. Current research is limited by a lack of publicly available, transparent data.

Review of RFI Comments

The RFI was broadly worded and invited comments on a variety of dynamics related to competition and private equity in the health sector. Comments in response to the RFI reiterated the need for competition in health care markets and shared a variety of personal encounters with troubling aspects of the nation's health care industry. While there was a diversity of comments, certain themes emerged that represent the most commonly held viewpoints. Notably, hardly any commentors praised consolidation or described benefits that results from transactions involving health care entities.

Perhaps the most consistent comments were those expressing frustration with PE-led acquisitions in health care. Over 40% of comments mentioned PE, and around 95% of those that expressed an opinion were negative. In the following section of this report, we highlight common themes and insights reflected in responses to the RFI related to consolidation and to PE transactions.

Theme 1: Provider consolidation leads to higher prices and less access for patients

Commentors pointed to research showing the price impacts of consolidation and consistently illustrated these impacts through their own experiences. Many patients expressed frustration that following the acquisition of their preferred physician practice or facility, they were unable to afford the care they previously enjoyed. Many also mentioned difficulties in making appointments and seeing the physicians they trust and have seen for years. For example, one commentor, who was impacted by the acquisition of a hospital and clinics in her suburban midwestern town by a non-profit health system, shared the following:

> *"Prices have risen from what our service providers charged to what [the new Health System] charges, nearly double. Many physicians have left the area because they can't work well with the [new health] system. So now we have fewer specialty services, and it takes a much longer time to get an appointment, for example nearly 6 months for my dermatology services."*[84]

The commentor additionally reported that prior to the acquisition of the community facility, local urologists were available to see patients, and her husband could have kidney stones removed within a day. However, after the acquisition, when her husband had a kidney stone, it took weeks to get an appointment, which was then canceled, and the health system said his only recourse was to go to the emergency room over an hour away. He had to stay overnight by this emergency facility just to enter the queue to be admitted.

Another patient commented, "my independent OBGYN had to close her practice because she couldn't compete with the hospital systems' referral networks."[85] An oncology specialist from a rural Midwestern state wrote about the decision to leave the rural outreach cancer center at which this anonymous commentor worked after it engaged in a "behind the scenes deal" with a large health system and a for-profit oncology corporation in 2019:

> *"I felt confident that I did not want to provide care within their business model. In fact, several of their locations were already under investigation for Medicare fraud to the tune of millions of dollars. Consequently, a town of 9,000 people lost a board-certified medical oncologist who actually lived in their community."*[86]

Commentors also highlighted the impact on rural areas. The National Organization of State Offices of Rural Health pointed out that in rural areas, "ownership changes have reduced the responsiveness of health care to local market needs" and that "the changes have increased the likelihood of monopolistic or oligopolistic actions in market areas that are already at high risk for these actions."[87] Another commentor highlighted how consolidation has driven rural hospitals in Maine to close. She said the resulting "increased costs, reduced access, and provider turn over are having a profound impact on Mainers."[88]

These stories are not unique. Nearly 200 comments reported patients being unable to access the care they need, particularly in underserved communities, when care models change as a result of a PE acquisition or other merger.

Theme 2: M&A in health care services, especially in PE-backed transactions, results in process changes and quality reductions

Over 400 respondents to the RFI expressed concern over the quality of care following all types of transactions, whether led by a hospital system, an insurer, or a PE-backed entity. Firsthand experiences highlighted corporate process changes that led to quality concerns. For example, following acquisition by a larger health system, physicians reported that they were given instructions "to practice medicine based on cost and revenue," and that some employers started tracking individual productivity using relative value units (RVUs), even requiring "minimum RVUs to stay employed full-time."[89]

Patients and physicians raised concerns about forced changes in referral patterns following acquisitions. Patients complained of losing access to preferred clinicians due to referral restrictions, while physicians

were worried about the impact on quality of patient care as they were put under contractual obligations to keep referrals within their system.[90] Some claimed instructions on referrals were despite the needs of their patients and even in potential violation of the Stark Laws:

> *"Physicians should not be punished by their employer, or face administrative hurdles, for referring outside their health system when it is in the patient's best interest. While we support physicians being able to refer within their hospital or health system's network, we oppose them being contractually obligated to do so..."*[89]

Private equity acquisitions of nursing home and home and community-based services triggered many concerns about quality based on empirical research.[69-71, 91-95] PE entities were described as having an excessive focus on generating rapid financial returns and thus irresponsibly lowering costs by reducing quality of care. Several commentors also cited lower quality following acquisitions due to cost cutting and efficiency initiatives. Commentors shared many similar stories of dramatic cost cutting and process changes that reduced quality following PE acquisitions. Primary concerns included higher patient volumes resulting in less time per patient, staffing cuts and the hiring of less experienced staff, and changes to clinical standards and decision-making processes.

There also was a common experience among physicians that PE-operated providers increased patient volumes and dangerously reduced time per patient after acquisition.[96] A board-certified dermatologist left her practice after a PE acquisition over concerns she was no longer able to properly serve patients:

> *"I was forced to see 45 patients daily with 1 medical assistant. This was unsafe. I am sure documentation was missed. I was routinely told by patients they called with problems and never heard back…I knew that I was going to be the one to go down when something bad happened and I left because I refused to take that fall."*[97]

Another emergency physician said:

> *"They are intentionally understaffing emergency departments as a driver of profit. Patient care is being dangerously impacted, as the physicians are being asked to see an unsafe number of patients because they do not want to staff the emergency departments appropriately."*[98]

Many commentators criticized PE firms for pursuing aggressive staffing cuts and hiring inadequately credentialed staff.[99] Many comments cited research about nursing home staffing cuts such as the finding of "a decline in RN staffing with every progressive year of private equity ownership."[93,100] And emergency physicians noted that larger national PE-backed staffing companies and health systems tended to hire physicians' assistants and nurse practitioners over emergency physicians in part to reduce labor costs since these advanced practice providers (APPs) are paid approximately a third of what emergency physicians are.[98] For example, one said that PE-backed groups employed, "staffing policies that were extremely dangerous to the patients with overstaffing of APPs and understaffing of physicians. Patients were hurt and likely killed because of these staffing policies by these contract management groups."[98]

Commentors also expressed concern with a lack of clinical autonomy following an acquisition of their practice. The American College of Emergency Physicians shared results from a questionnaire of its members: 53% of respondents indicated that their medical decision-making autonomy was curtailed following the merger or acquisition of their practice. They noted that there was now "pressure to take

shortcuts [and] give inappropriate and potentially harmful care" to meet profit-driven metrics, that patients "are treated as numbers rather than individuals," and that care is no longer patient-centered but "metric-centered."[98]

Theme 3: Physicians that worked with PE firms offer mixed reviews

Despite a broad variety of PE-backed transactions in health care, most of the comments focused on PE acquisitions of large hospitals and independent physicians' practices. One common type of deal referenced is when an independent physician sells his/her entire practice or a portion of it to a PE firm. Typically, physician-owners are paid some upfront amount in exchange for a portion of the practice's equity, and then, they are retained as employees of the PE-controlled practice, receiving additional payouts over time, depending on the practice's performance. Future payouts to the physicians may depend on the physicians' continued employment for a certain amount of time, the financial performance of the practice, and the ultimate sales price to the next buyer, among other factors. This arrangement created mixed results for participating physicians. Some physician-owners had positive experiences, whereas some reported feeling misled and disillusioned.[101] One described how the PE-backed company that he sold his practice to:

> *"showed up to [our] office with contract addendums asking us to sign with hidden language to relinquish bonuses or change pay formula…We were collectively underpaid 100k each year because [the PE-owner] failed to calculate this correctly."*[102]

Another physician commentor said:

> *"I sold my company to an investor and the result for families and kids was disastrous... As a clinician who cares about families it was demoralizing to see our thoughtful therapy marketed like the latest Tik Tok trend."*[o,103]

Providers also report lower pay following an acquisition. In a survey shared by the American College of Emergency Physicians, sixty percent of emergency room physicians saw wages reduced and forty percent saw them reduced by over 20%.[98] Of those who saw an increase in wages, some noted sharp tradeoffs, such as, "hourly rate increased but overall [compensation was] much worse when factoring in benefits, insurance, retirement."[98,104] Some commentors note how the sale of a practice to a PE firm generates significant financial rewards for senior partners but hurts junior partners. The senior partners "sell to reap a large payout in the short-term with the intent to retire/leave their practice as soon as their 3-5 year commitment to PE ends"[105] while junior partners are left to persist under harder working conditions and often lower compensation.

Physicians may also work with PE-backed entities without completely selling their practices.[106] The American Independent Medical Practice Association (AIMPA) highlighted how PE-backed management services organizations (MSOs) allowed physicians to continue to operate independently in the face of health system-led consolidation:

[o] The commentor also noted challenges hiring with "corporate minded" HR professionals, disappointing changes to care delivery such as no longer allowing in home care and community services, and a pressure to rapidly scale resulting in provider burnout and concerns over the quality of clinical care. See the related extended version of the comment: Regulations.gov

> *"Physicians want to remain in an independent practice setting where they maintain their autonomy and, yet, they want resources that help them open new office locations in underserved communities, build ambulatory surgery centers where procedures can be done for a fraction of the cost, compete for the best and brightest physicians coming out of residency and fellowship programs, aggregate data across a broader platform of practices…and other best practices to enhance the quality of care…Partnerships between independent practices and private equity-backed MSOs promote lower health care costs and improve working conditions, while fostering high-quality patient care and driving innovation across the health care system."*[107]

Still, other commentors describe the MSO model, where an MSO owned by a PE firm contracts with physician-owned practices as "one of the most common ways to circumvent the corporate practice of medicine bans."[108] A large independent orthopedic practice in Georgia evaluated PE partnerships for over two years before deciding to remain fully independent. A physician there said:

> *"It was clear as day that this was a takeover attempt where near complete control would need to be ceded to the PE entity by way of the MSO…It was also clear that there would be no input from us when the PE entity would sell the MSO and that it would be sold to whomever would pay the highest sales price. In addition, the deal would have gutted our operating agreements."*[108]

Theme 4: There is widespread desire for transparency on PE-led transactions

Many commentors offered critiques on how PE firms operate with a lack of transparency. PE-led transactions are often suddenly announced, without advanced warning, accompanied by little, if any, information, and led by unfamiliar people in unfamiliar entities pursuing unfamiliar business strategies. Commentors of all types including patients, physicians, hospital CEOs, state regulators, and advocacy organizations, expressed a desire for greater transparency and more data on which health care organizations were fully or partially owned by PE.

Patients expressed a desire to know more about their providers, and many expressed the particular desire to know whether and when their primary provider was purchased, owned, or operated by a PE entity. They expressed discomfort with how little information is available about the management and ownership of providers and demanded better transparency because it is necessary to hold organizations accountable for their actions. One patient commentor said:

> *"I am writing as a patient and father of a patient. Generally, I don't know if a provider has been purchased by private equity or another entity. I have never seen a sign at a provider's office or received a notice of a change of ownership...I don't see how any patient can know who they are really dealing with at a medical practice beyond the actual provider (doctor, nurse, etc.)."*[109]

Advocates spoke of the need to know about who owns health care entities, the nature of those ownership arrangements, and the financial practices that underlie PE acquisitions. Such information is necessary to hold organizations accountable to patients, providers, and the surrounding community.[110-114] Researchers described the difficulties of studying the real effects of investment strategies without clearer ownership data, and physicians wrote about being uninformed about ownership changes. Some argued that physicians should be, but rarely are, consulted regarding organizational decisions so they can ensure proper preparation, continuity of patient care, and responsible medical decision making during and following these corporate transactions.[113-117]

Relatedly, several commentors celebrated CMS's rule on disclosures required for nursing and skilled nursing facilities. They requested that the collected data is made public in a user-friendly format that allows for tracking trends over time and ensures reporting compliance.[111] Commentors requested similar transparency measures for acquisitions, including disclosures on corporate ownership structure, recent transactions, and financial data for other health care organizations. They encouraged CMS to use its authority to require states collect this information for Medicaid facilities.[119] Specific suggestions for data collection and public reporting included staffing ratios, quality measures, and reported directives that a PE entity gave doctors and nurses that relate to patient care.

In addition to data transparency, several commentors recommended lowering reporting thresholds for health care transactions and requiring review from the FTC, DOJ, HHS and other state regulators.

Theme 5: People are dissatisfied with private health insurers, especially vertically integrated insurers

Many comments expressed broad frustration with private health insurance. Independent of other comments and themes, patients shared numerous stories of being denied access to care without adequate explanations. One said, "when they deny a service, they send me a ten-page memo in many different languages, but they don't ever include the actual services they are denying."[120] Another frequently voiced concern was simply that these entities are motivated to profit themselves and are naturally against the interests of the public they serve.

Physicians offered similar frustrations of not being able to help their patients get the best care for them. They argue that to the extent consolidation prevents physicians from practicing medicine to the best of their ability, it should be reversed and constrained. One commentor summed up the resulting mistrust of the system created by large vertically integrated insurers:

> *"When the physician is also under the heel of the insurance company, it becomes impossible for the patient to tell, when receiving advice from their physician, whether that is sound medical advice or 'sound financial policy' on the part of the insurance company."*[121]

Many providers expressed concern for the mechanisms employed by large integrated insurers to direct clinical decision-making and to encourage that care is provided by their affiliated entities. A specialty pharmacist argued, "Prescribers are no longer able to provide procedures and medications which would best benefit the patient but instead what is "recommended" by the insurer and cheapest for them."[122] Some commentors also cited reduced reimbursement (from the insurer side of the business) to competitor pharmacies to "push patients to their own pharmacies."[123]

Commentors expressed concern at the sheer size of these large, multi-faceted private health insurance entities. They fear they are sufficiently large that they shift health care markets away from prioritizing patient care toward maximizing profits alone. This corporatization and profiteering leads to dangerous fragility in the system. Dozens of comments referenced the Change Healthcare cyberattack and interpreted it, and the harm it inflicted on small providers, as a warning for the dangers of consolidation.[124-125]

Case Studies on the Impact of Private Equity

A few case studies epitomize some common concerns regarding the influx of private equity and the harm caused to health care markets. These particular stories were referenced by dozens of commenters each, with many commentors sharing their personal interactions with the companies. The following case studies are rooted in information provided through the RFI and substantiated by research on the events. They echo the broader themes and documented concerns discussed above.

A PE-backed health system goes bankrupt

In 2010, a PE firm purchased six struggling community hospitals in the Boston area in a leveraged buyout of $246 million. As part of this acquisition, the PE firm assumed the hospitals' liabilities of over $200 million, converted the hospitals to for-profit entities, and announced a series of ambitious promises: investing $400 million in infrastructure, improving operating efficiencies, cutting costs, upgrading certain facilities, improving quality, and expanding service lines. The firm also agreed to keep facilities operational, refrain from selling assets, and avoid assuming additional debt. Many of these promises were issued to obtain approval from the Massachusetts' Attorney General, whose permission was necessary to convert the hospitals to for-profits.

The few years after the acquisition, the PE firm expanded and bought community hospitals and physicians practices, in an attempt to meet their promises and financial targets by spreading fixed costs, lowering average operational costs, and attracting more patients. The system grew to include 33 hospitals, 25 urgent care centers and 107 skilled nursing facilities in 8 states across the country.[126]

By 2016, the organization was still unprofitable. But by then, many of the obligations and restrictions from the agreement with the Massachusetts Attorney General had expired, so the PE firm acquired more debt and started leveraging the health system's assets for additional revenue to finance additional acquisitions outside of Massachusetts. One notable transaction was the 2016 sale of all its hospital properties and a 10% ownership stake in the health system for $1.2 billion to a REIT headquartered in Alabama. The health system then leased the properties back from the REIT. Following the transaction with the REIT, the PE fund's investors received a generous dividend payment, and most of the sale's proceeds financed additional acquisitions, including a 2017 $2 billion acquisition of a hospital chain with facilities in Utah, Arizona, Colorado, Texas, Arkansas, and Louisiana.[127]

In 2020, the PE fund engineered a sale. Ownership of the health system was transferred to a hospital management group, led by the existing CEO of the health system, and financed by a loan from the REIT that owned the property. The PE fund reportedly made $800 million from its investment, and the CEO paid himself a $111 million dividend to "offset" a $200 million loan guarantee he had made to ensure sufficient cash on hand during the acquisition.[128]

After the PE firm exited its investment, the heavily indebted and financially distressed hospitals continued to struggle. Over 40 comments referenced the condition of hospitals formerly owned by this PE firm. One physician commentor wrote:

> *"Since [the PE-backed health system] has taken over, they changed a few signs, rearranged droves of administrators and have invested NOTHING into any of the physical plants of the hospitals. One hospital in the county is infested with mold, had problems with bats, and has lost air conditioning multiple times causing cancellations and delaying needed patient procedures."*[129]

A regional medical center in Pennsylvania serving a community with few other providers and 20% of residents living below the federal poverty level, stopped providing maternity services and saw its cancer center shuttered due to financial reasons.[130]

Another physician commentor described his experience in 2019 of selling his small practice in Louisiana to [the same PE-backed health system], which had acquired the nearby community hospital in 2017. He explained how the health system did not fulfill its contractual agreements and underpaid the previous physician owners. He said:

> *"I personally am not against for-profit or even PE in health care and absolutely see the premise of hawking a profit margin. But seeing this run from the inside...it's very evident this is solely a real estate asset scheme."*[102]

The physician quit in 2022. Testimony at a Louisiana House Health and Welfare committee meeting in April 2024 similarly describes the poor conditions of the adjacent community hospital. Hospital workers at the Louisiana community hospital described searching the premises for basic medical supplies during procedures, and "one patient died at the hospital awaiting transfer to another hospital, resulting in an immediate jeopardy citation from regulators."[131]

The full health system filed for bankruptcy on May 6, 2024. The health system has been required to sell all of its remaining hospitals, and the REIT that owns the property has a senior position, ahead of other lenders, on its claim for the health system's remaining assets. The health system has also announced it will sell its physician practices. The Louisiana hospital has already been sold. And, the state of Pennsylvania provided additional funding ($4.5 million over three months) to prevent the closure of the regional medical center described above, that provides critical services to a surrounding Pennsylvania community in need.

PE ownership of hospital systems leads to closures and quality concerns

One of the largest alternative asset management firms in the country (assets under management of $651 billion, $77 billion of which are its flagship PE funds[132]) is also one of the largest owners of rural health care providers. Through its ownership stake in two of the largest hospital systems in the US, this PE fund owns 222 hospitals across 36 states, with 71 in rural locations.[133-134]

The PE fund acquired and merged several hospital chains from 2016 to 2021, and in 2021, following a large acquisition, it divided its ownership of the 222 hospitals into two different hospital chains.[135] This allows the PE management to effectively exercise control over all the hospitals through two separate and not-wholly-owned subsidiaries, freeing themselves from potential antitrust concerns.

The PE owners have also pursued typical PE strategies of acquiring large amounts of debt and engineering leaseback deals. These tactics have put the entire health system under financial strain. In recent credit ratings and related new loan issuances, both hospital systems owned by the PE fund received a B2 rating, meaning they can receive loans but are subject to "high credit risk."[136] One sold $700 million in real estate assets to a REIT[137] and now both pays rent on the property and has fewer assets to secure its burdensome debt.

The consequences of these debt obligations are felt by workers and patients. According to commentors, the hospitals have increased prices, cut services, engineered layoffs, underpaid workers, and managed unsafe working conditions. They also produce worse outcomes and receive poor quality ratings and frequent regulatory investigations. Several commentors complained of staffing cuts and related quality concerns, which they attributed to the PE ownership.[91,95-96,103,105,138]

The agencies received close to 20 comments regarding this PE owner's actions. A doctor at a hospital in one of the chains wrote:

> *"[I] arrived for a 7 AM shift change to find the newborn nursery in chaos and an infant actively seizing on one of the Special Care Nursery warmers...the baby had been born about 2 hours before. The unit was very short-staffed and one of the nurses involved in the care of the [mother and baby] was in training. The infant had demonstrated distress at delivery but was placed skin-to-skin/at the mother's breast without a proper/complete assessment – or being properly stabilized."*[139]

When the doctor tried to raise concerns about short staffing and clinical practices, she was given a "without cause" termination notice by the VP of practice operations at the PE-backed company which owned the hospital.

A commentor who had been a physical therapy assistant for 29 years wrote about her experience working at a hospital owned by the PE fund in 2019. She highlighted concerns about infection control and patient safety. In addition, the hospital sought to cut costs by using more time from unlicensed techs and less time with licensed therapists and physicians. The technicians and licensed providers were dressed the same. She commented:

> *"The Director of Rehab who is a licensed PT began asking evaluating Doctors of Physical Therapy to 'refer' patients to PT techs, not licensed physical therapy assistants. The DPT's would not refer to techs because it is a violation of the State Board of Physical Therapy, so the Director began to do more evaluations herself and referred to techs because she had a 'tech productivity' to meet…this is intentional fraud because patients, families and doctors think [the unlicensed techs] are licensed because of the color of their scrubs. This is just the latest scheme to increase PE profit at the risk of patient safety."*[140]

The commentor cited less time between licensed providers and patients as a reason that a patient did not get proper physical therapy training for use of a walker, monitoring of his orthostatic BP, or bed alarm and consequently fell and died. When the PT assistant tried to raise a concern, she was threatened with a HIPAA violation for not following the chain of command.

Additionally, this asset management company financed the acquisition by another PE firm of a large urban safety net hospital that was then closed 18 months later. This 2019 closure was one of the largest urban hospital closures in modern history. The hospital had served a low-income neighborhood in Philadelphia for 171 years and employed 2,500 staff members and 500 medical residents.[141] Its closure led to a 12-20% increase in patients for the emergency rooms for surrounding hospitals.[142] Meanwhile, the real estate had already been sold off and was not included in the bankruptcy filing, allowing investors

to profit from the sale of the real estate while the hospital was shut down without the ability to pay its debts in full.[78]

In August 2022, another one of the PE-owned hospital chain's locations in New Mexico closed its psychiatric ward citing staffing shortages. According to the hospital's lease with the city and county, the discontinuation of psychiatric services could have been grounds for termination. Psychiatry services were reopened a year later as a partnership with another private equity firm. One commentor described how the hospital had broken the provisions of the lease to provide "mental-health care and care to indigents" beyond just the closing of the psychiatric ward and demanded "a thorough investigation," citing patient abuses at the hospital such as discriminating against insurance types and providing care based on the ability to pay.[143] In central Pennsylvania, another medical center in the PE-owned health system terminated its OB/GYN department and pediatric clinics in 2022, favoring expansion of more profitable operating rooms.[135]

Policy Considerations

Both overwhelming research and the perspectives of the RFI respondents urge HHS, FTC, DOJ and states to maintain vigilant attention to the competitiveness of local health care markets, actively apply the competition and other relevant laws, and carefully scrutinize potentially harmful transactions. It is clear from the commentors that the Agencies' past actions have not sufficiently addressed the harms inflicted by anti-competitive activity in the health care sector, and more effective and vigorous antitrust enforcement is necessary to stop or reverse the trend of consolidation.

Many respondents urgently pled for policies that both limit further harmful industry consolidation and mitigate the harms from already highly concentrated markets. Many voiced support for FTC and DOJ actions that counteract the market control of dominant health systems, including the proposed non-compete rule that would help health care workers pursue labor opportunities in consolidated markets and bringing enforcement actions to halt hospital mergers and industry rollups.

Among the common policy demands were calls for more ownership transparency and greater disclosures of PE acquisition activity in health care markets. Patients, physicians, and other stakeholders expressed a strong need to know more about the entities that operate and control health care delivery, including demands for learning more about ownership, prices, staffing ratios, and other characteristics that affect patient care. Commentors praised HHS actions to support transparency, such as in the CMS nursing home ownership transparency rule. They suggest HHS should do more to improve the quality of the data collected and collect and publicize similar ownership data for other types of health care entities.

State agencies have similar authorities to enhance transparency in the health care market. Commentors applauded state policymakers for scrutinizing health care transactions in their communities, using both the antitrust laws and other policy levers to stem harmful consolidation in local markets. For example, legislation recently passed in several states authorize state officials to review certain types of health care transactions.[144] Fifteen states now require their Attorney General, state health department, or related body to receive notice of health care transactions for both non-profit and for-profit entities. Hawaii, New Mexico, Oregon, and Rhode Island require that the state body receive notice, review, and approve all applicable health care transactions. Some states have established bodies such as California's Office of Health Care Affordability and Massachusetts' Health Policy Commission to collect data and review

transactions to ensure competitive local health care markets. Legislators in other states now have multiple policy models from which to choose to enhance transparency. Federal lawmakers could also adopt uniform premerger reporting for health care acquisitions to give enforcers notice and avoid complications with the state-by-state patchwork approach that is emerging.

The RFI comments signal an increasingly important role for HHS in advancing the interests of patients and health care consumers. Enthusiasm for HHS' contributions to enhancing market transparency suggests that the agency should find additional ways both to give consumers the information they demand and to enhance accountability of the health sector for the costs and quality of the service it offers. It also suggests that more can be done beyond transparency. Pursuant to President Biden's Executive Order on Promoting Competition, HHS should be an active contributor to competition policy. HHS must continue to affirmatively promote competition with its relevant authorities wherever possible. President Biden's vision for an all-government competition policy recognizes that making markets work is an all-hands on deck enterprise.

Conclusion

This RFI was issued following over three decades of consolidation in the health care sector. The primary effects of that consolidation are well known both to industry and policy experts, and they were voiced vociferously by respondents to the RFI: the consolidation of health care providers, whether involving hospitals, physicians, or other corporate entities, has led to higher prices, reduced access, and lower quality care.

An equally important finding from our RFI is the volume of comments and criticisms that target transactions engineered by private equity firms. This seems to have struck a nerve in the public. In theory, private investment in health care services could lead to increases in output, reduced prices, and improved quality, but the comments we received—which are consistent with the growing body of research—suggest that the opposite is true. The harmful effects of private equity in the health care delivery system deserves ongoing scrutiny and greater research.

The results from this RFI indicate plainly that the American public is dissatisfied with ongoing trends in the health care sector. Health care consolidation can negatively impact patients' and health workers' safety, quality, and cost of care. PE ownership in health care appears to present new and unique risks related to and apart from consolidation. HHS, DOJ, and FTC must continue to monitor and address these issues, welcome partnerships with states and Congress to prevent harm from further consolidation, and collaborate with public and private partners in identifying effective remedies.

Appendix

Relevant Exhibits

The following charts from the cited sources support data presented in the body of the text of the report.

Exhibit 1: Growth in Overall Inflation (bottom line), Workers' Earnings (2nd line from bottom), Family Premiums (3rd line from bottom), and Workers' Contributions (top line), 1999-2018
Source: https://www.brookings.edu/wp-content/uploads/2020/03/Gaynor_PP_FINAL.pdf

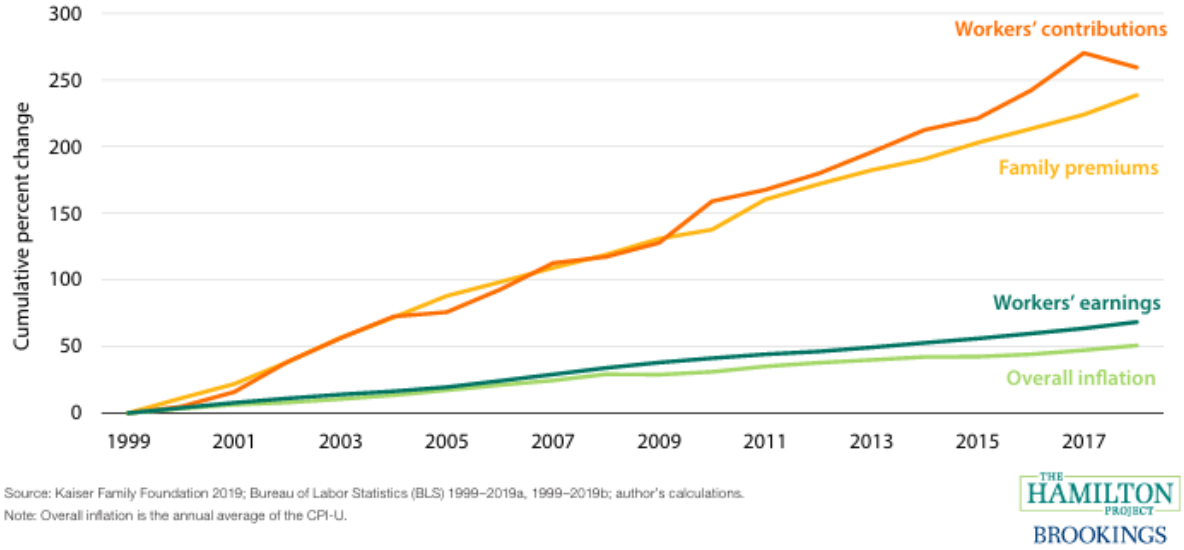


Exhibit 2: Percentages of Metropolitan Statistical Areas (MSAs) whose Herfindahl-Hirschman Index (HHI) was above 2,500 for hospitals (top line), specialist physician organizations (2nd line from top), health insurers (3rd line from top), and primary care physicians (bottom line), 2010–2016
Source: https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556

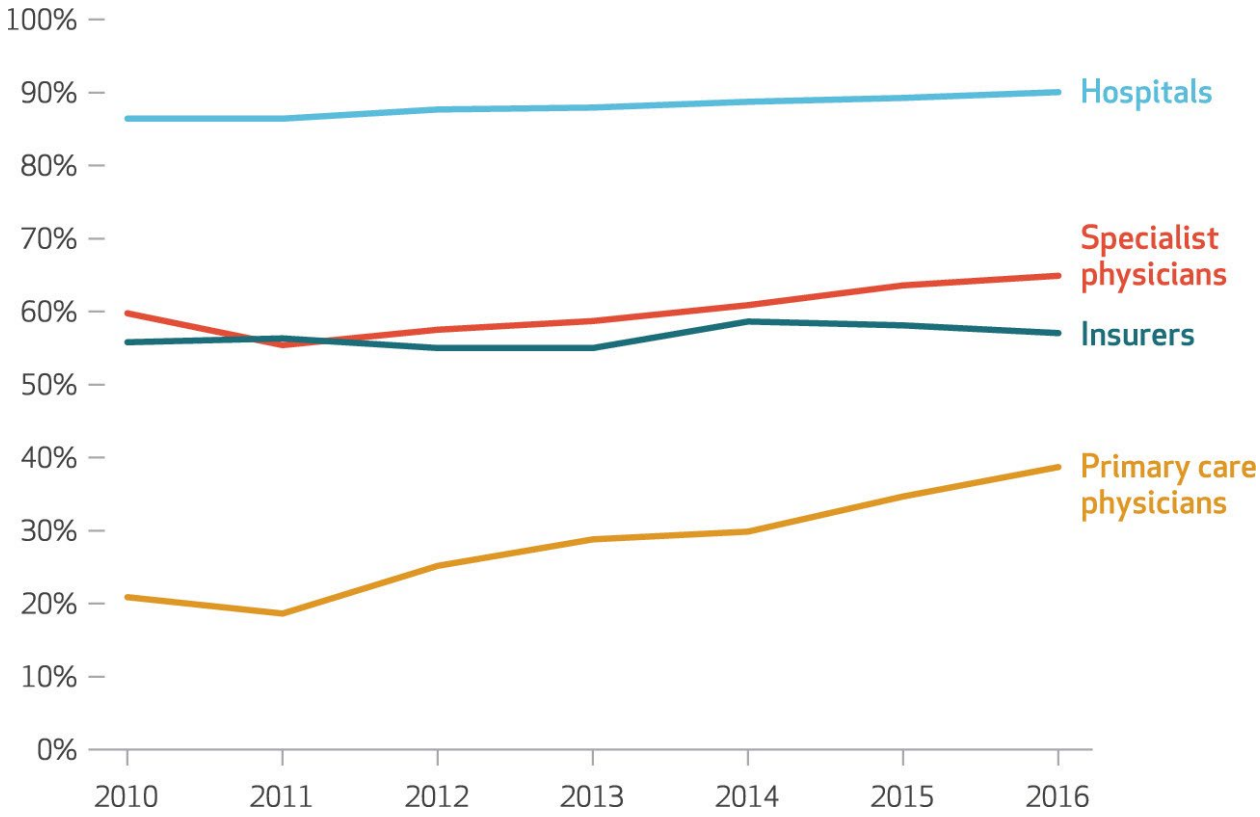


Exhibit 3: Share of hospitals affiliated with Health systems and share of physicians affiliated with hospitals or health systems
Source: https://www.kff.org/health-costs/issue-brief/ten-things-to-know-about-consolidation-in-health-care-provider-markets/

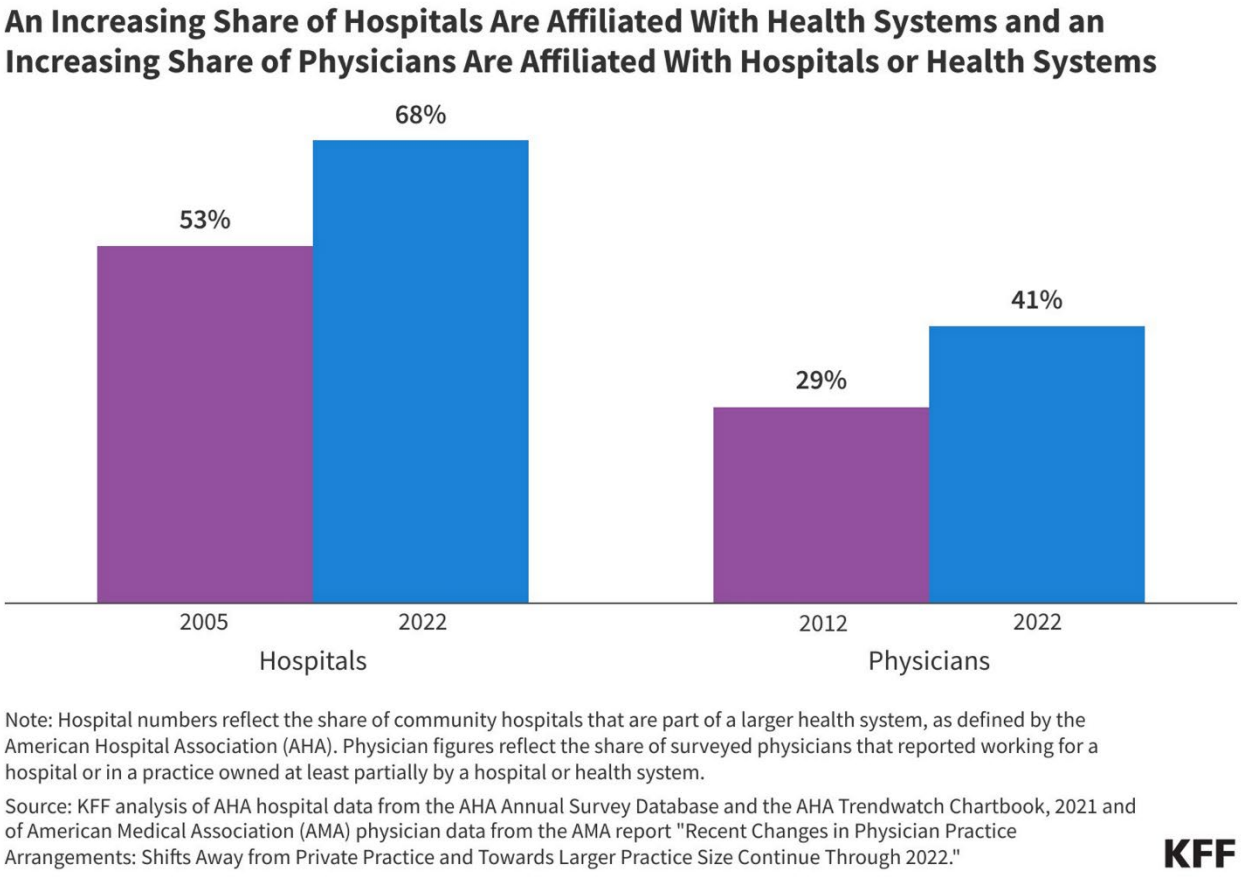
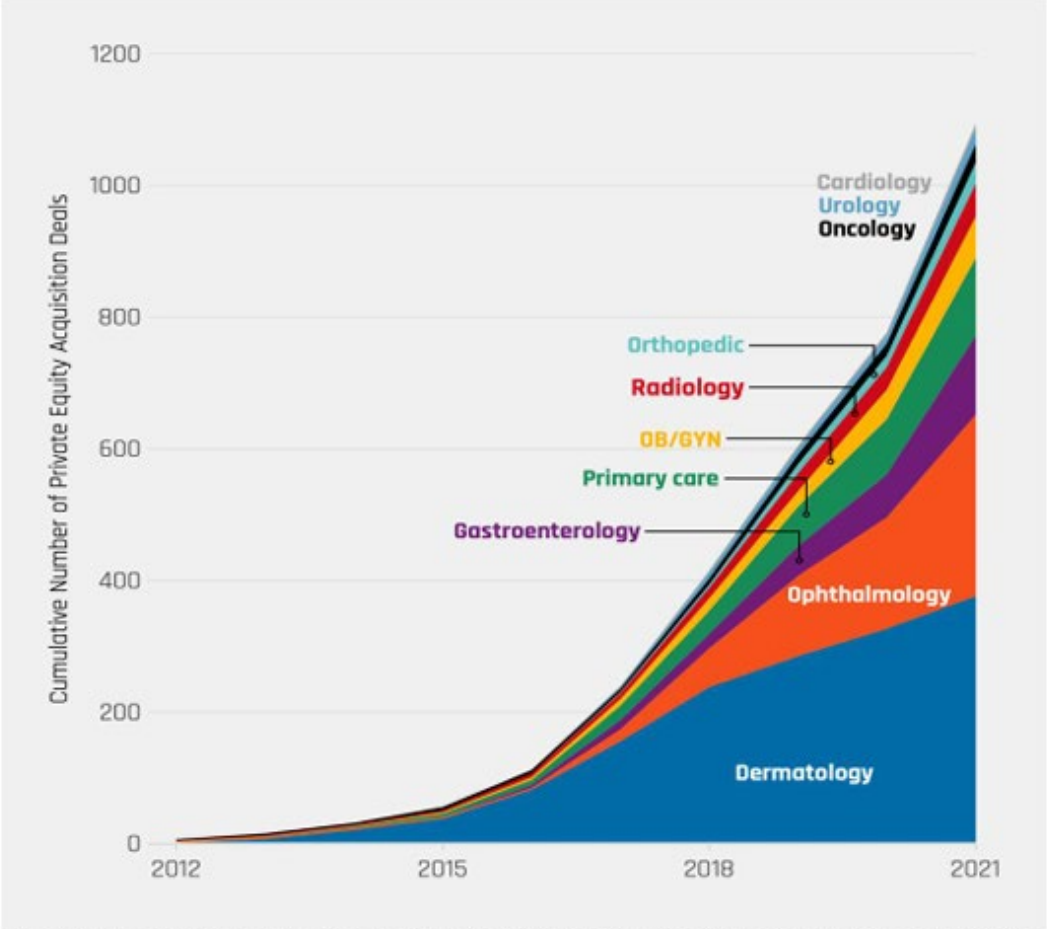
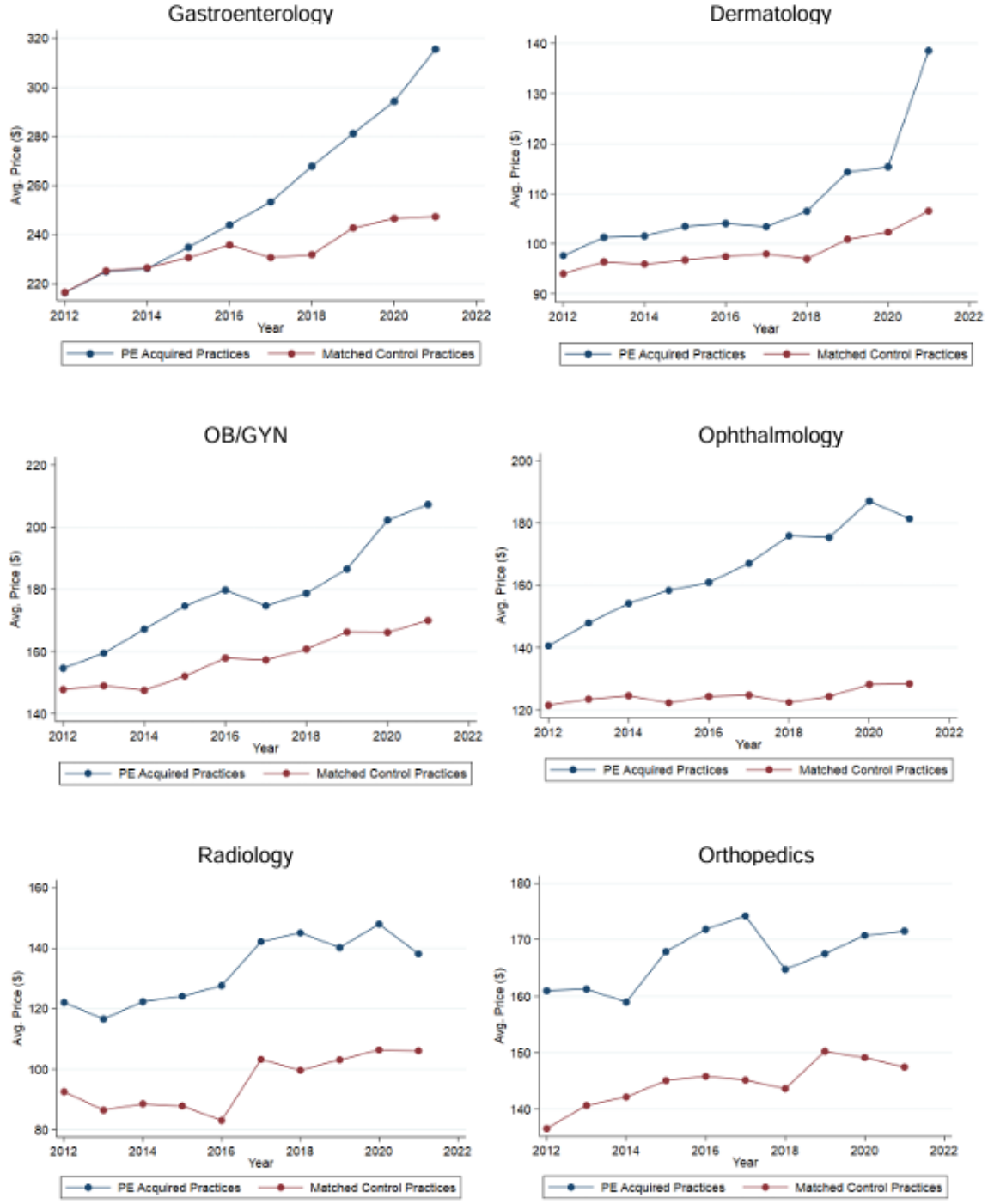


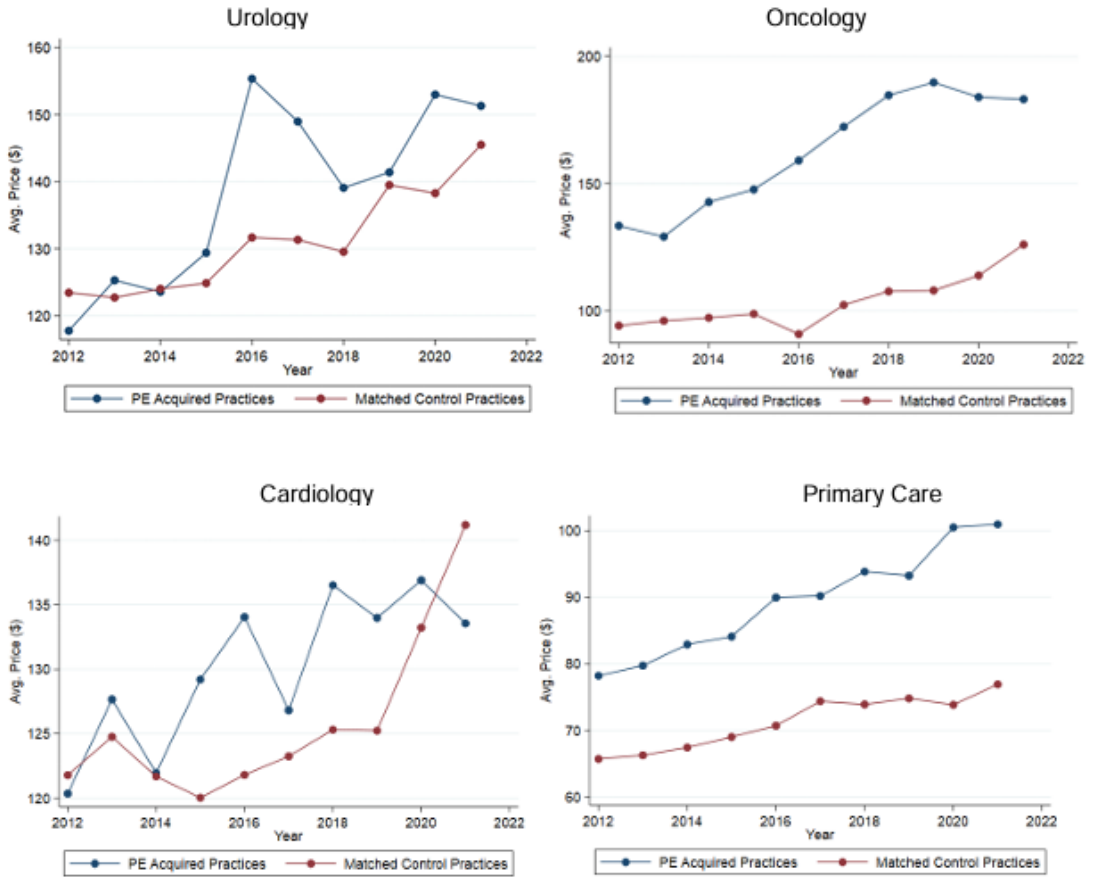
Exhibit 4: Cumulative Number of Private Equity Acquisition Deals of Physician Practices by Specialty, 2012-2021
Source: https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf



Source: Authors' analysis of PitchBook Data, Inc., as of June 15, 2022. PitchBook data has not been reviewed by PitchBook analysts.

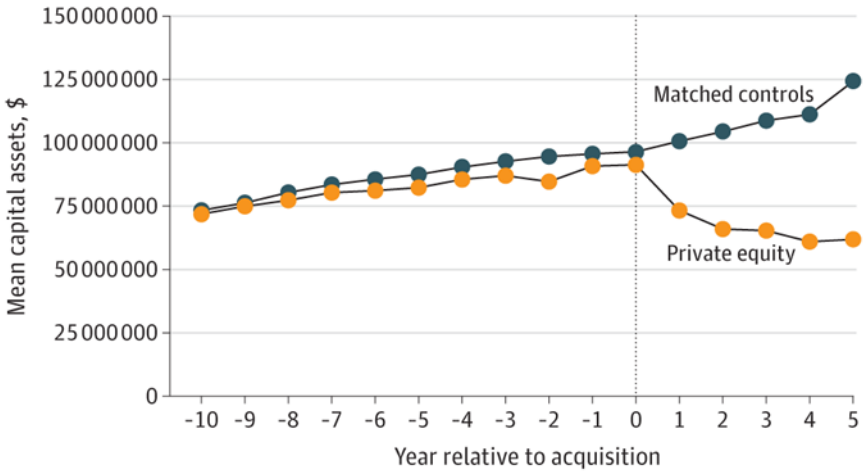
Exhibit 5: Physician prices for 10 specialties, 2012-2021
(Top line represents PE acquired practices and bottom line represents matched control practices)
Source: https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf





Notes: The specialties are listed in order from the specialty that had the greatest number of MSAs in 2021 in which a single PE firm had greater than 30% market share (gastroenterology, 36 MSAs) to the least (primary care, 9 MSAs). Practice-year level prices are calculated by dividing the total allowed amount of all professional claims by the number of professional claims. These practice-year level prices are then weighted by each practice's mean number of patients over the study period to create the points shown in the figure. All treated practices are treated at some point between 2015 and 2021 and are included in the treated group even in years prior to being acquired.
Source: Authors' analysis of claims from HCCI Commercial Claims Research Dataset

Exhibit 6: Mean Capital Assets of Private Equity–Acquired and Control Hospitals Before and After Acquisition (Year 0)
Source: https://jamanetwork.com/journals/jama/fullarticle/2821826?guestAccessKey=00d9206e-c4e5-468b-be37-9ba2a2b551fd&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=073024#google_vignette



Mean Capital Assets of Private Equity–Acquired and Control Hospitals (not acquired) Before and After Acquisition (Year 0). Curves show the mean capital assets of 156 hospitals acquired by private equity firms and 1560 matched control hospitals. Year 0 (dotted vertical line) represents the year of acquisition for each private equity hospital or that same calendar year for its 10 matched control hospitals.

Original RFI Questions

DEPARTMENT OF JUSTICE DEPARTMENT OF HEALTH AND HUMAN SERVICES FEDERAL TRADE COMMISSION

Docket No. ATR 102

Request for Information on Consolidation in Health Care Markets

AGENCY: Department of Justice; Department of Health and Human Services; and Federal Trade Commission.

ACTION: Request for Information.

REQUEST FOR INFORMATION: The agencies are seeking information from stakeholders, including but not limited to patients, consumer advocates, doctors, nurses, health care administrators, employers, private insurers, PBMs, GPOs, nursing homes, hospices, home health agencies, hospitals, and other health care providers, facilities, providers of and entities that provide ancillary health care products or services. The agencies also seek comment from academics and other experts who have studied market consolidation, corporate control in health care, and related issues. Patients and workers are also encouraged to share information on how acquisitions and mergers in the healthcare industry have affected them directly. Respondents may address any, all, or none of the following questions and may address additional topics related to market consolidation, organizational forms, and anticompetitive conduct affecting the health care industry. Please identify, where possible, the question numbers your comments are intended to address. DO NOT include sensitive or confidential information in the comments including: social security numbers, dates of birth, driver's license numbers or other state identification numbers, financial account information, sensitive health information, or competitively sensitive information. Comments will be posted on the Internet and made available to the public (subject to exceptions such as for personal privacy information of persons other than the submitter). The agencies invite written responses to the following questions:

1. **Effects of Consolidation:** How has a transaction involving health care providers (including providers of home- and community-based services), facilities, or ancillary products or services conducted by private equity funds or other alternative asset managers, health systems, or private payers (e.g., a health system, a private payer, or a private equity fund buying independent ambulatory surgery centers, dialysis clinics, PBMs, GPOs, or nursing homes) affected:
    i. *Patients***:** e.g., through changes in their costs of obtaining care, costs of health insurance coverage, medical debt and access to charity care, quality of clinical or non-clinical care, quality of the patient's experience, access to and denials of care, language access, types of goods and services offered, safety, utilization of services, drug utilization, staffing levels, mix of providers and medical support staff, practices regarding prior authorizations, other utilization management, or reimbursement strategies, referral practices, site of service for procedures, ease of access to providers, patient billing, collections, financial assistance practices, access to or sharing of patient information, differences in these areas in rural compared to urban settings, and differences in areas for marginalized patient populations, including differences by race, ethnicity, gender, sexual orientation, income level, disability, Tribal status, or citizenship status.
    ii. *Public and private payers***:** e.g., through changes in their reimbursement rates for in-network providers, out-of-network rates and costs to patients, quality of care including the patient's experience, access to and denials of care, utilization of services, medical loss ratio, coding practices, rates of fraudulent billings or claims, coverage and formulary design, referral practices, claims processing, network adequacy, ability to implement

innovative payment models, ability to implement value-based care plans, and ability to negotiate with the facility and with competing facilities.

iii. *Providers, health care workers, and support staff:* e.g., through changes in their take-home pay, workplace safety, compensation model (e.g., from fixed salary to volume based), policies regarding patient referrals, mix of patients, the volume of patients, the way providers practice medicine (e.g., incentives, prescribing decisions, forced protocols, restrictions on time spent with patients, or mandatory coding practices), administrative or managerial organization (e.g., transition to a management services organization), patient billing, collections, financial assistance practices, data reporting requirements, claims processing, employment benefits, staffing levels, scope and/or duration of non-compete agreements or other restrictions on worker mobility and working conditions such as training repayment agreements, and differences between rural and urban settings as to these issues.

iv. *Employers who provide health insurance for their employees:* e.g., through changes in prices for health insurance coverage, changes in prices for medical care, coverage and formulary design, and/or changes or reductions in choices in facilities or providers for their employees.

2. **Claimed Business Objectives for Transactions:** What were the claimed business goals and objectives for the transaction, and have these goals and objectives been realized post-transaction? These could include but are not limited to claimed efficiencies from scale, innovation in the organization and delivery of care, investments in care and quality improvements, the claimed or projected reduction in costs of delivering care resulting from these innovations and investments, complementarities between business units, or increased business valuations. Who benefited from the realization of claimed business goals and objectives of the transaction? Did the transaction, for example, require the acquired entity to take on any additional debt or restructure the ownership or leasing of any real estate or physical facilities? To the extent the transaction generated any surplus profits, were those profits used to reinvest in the acquired business, finance additional acquisitions, or paid out to shareholders in the form of dividends?
3. **Notable Transactions:** Are there particular types of entities, such as private equity funds or other alternative asset managers, health systems, or private payers, most associated with transactions that result in adverse impacts on entities listed in question 1(i)-(iv)? Are there particular facilities, providers, payers, and ancillary products or services that are most often the targets of these harmful transactions? Who are these targets?
4. **Need for Government Action:** What actions should the Department of Health and Human Services, Federal Trade Commission, and United States Department of Justice consider taking to identify and address transactions that, due to market consolidation or corporate control issues, may have major adverse impacts on entities listed in question 1(i)-(iv)? Should the agencies promote greater transparency and enhanced availability of information to the public on mergers, acquisitions, and other transactions involving health care facilities, providers, payers, and ancillary products or services, and if so, how?
5. **Other Impacts:** Have there been other impacts from health care market transactions that you would like to report to the agencies?

These questions are not meant to be exhaustive, and stakeholders are encouraged to address these and/or other related issues and to submit research and data that inform their comments on these topics. Responses to these questions may result in the need for additional proceedings, including workshops or other public engagement, to learn more about the identified concerns.

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