PRIVATE EQUITY'S ENTRY INTO HEALTHCARE REVEALS GAPS IN COMPETITION POLICY

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The large and increasing amount of money under private equity ("PE") management and the huge push by PE into healthcare, raises concerns and challenges for healthcare policy, but also for competition policy. Emerging evidence about the adverse impact of PE investment in healthcare on competition, prices, quality of care, and patient health is a serious concern. These troubling findings raise the question of how, if at all, antitrust law and antitrust enforcers should treat conduct and deals involving PE owners. While one of the virtues of the antitrust laws is their broad applicability, application of those laws to particular markets and companies is only effective when it is rooted in the realities of competition in those markets and the competitive incentives that those companies face. PE's impact on healthcare reveals significant gaps in the tools and methods for using the antitrust laws to protect competition. We conclude, however, that competition laws applicable only to PE are not generally needed; rather, when policymakers, regulators, and enforcers are applying competition laws to PE-owned companies, they need to take account of the unique incentives facing PE managers, the competitive implications of the PE ownership structure, and types of competition concerns that tend to arise surrounding PE deals. In markets that already face limited competition, such as healthcare, the incentives and ownership structures of PE may exacerbate existing competition concerns and anticompetitive impacts, potentially necessitating PE-specific policies.

The large and increasing amount of money being managed by private equity ("PE") firms, and the huge push by PE into healthcare, raises concerns and challenges for healthcare policy, but also for competition policy. The PE business model and the business practices of PE firms threaten already limited competition in healthcare. By consolidating healthcare providers, offloading assets, cutting services, and loading acquired companies with debt, PE firms' move into healthcare is associated with increasingly concentrated markets providing higher cost and lower quality healthcare to patients.[2]

PE investment in healthcare has exploded over the last decade, and is projected to grow even more rapidly as we emerge from the pandemic.[3] The number of PE deals in healthcare as gone from 325 in 2010 to 1,085 in 2021.[4] Annual PE healthcare deal values have gone from at $41.5B in 2010 to $119.9B in 2019.[5] A multitude of PE funds have been raised to focus on healthcare and healthcare markets. PE funds have expanded to all areas of healthcare, with a primary focus on physician practices. Currently we are seeing expansive growth of PE in specialties such as dermatology, ophthalmology, and gastroenterology.

Lawmakers and regulators have expressed concern about the effects on patients and markets from this surge of PE investment. Jonathan Kanter, Assistant Attorney General for Antitrust, said that the PE business model is "often very much at odds with the law and very much at odds with the competition we're trying to protect."[6] FTC Chair Lina Kahn, joined by Commissioners Slaughter and Bedoya, likewise expressed skepticism about PE generally and in healthcare in particular.[7] President Biden highlighted PE ownership of nursing homes as a policy concern in his 2022 State of the Union address.[8]

These words from policymakers are beginning to translate into action. A recent FTC consent decree involving an acquisition of a veterinary practice by a PE fund imposed additional reporting requirements on future mergers involving the PE-owned entity.[9] The White House directed CMS to enact rules to implement ownership reporting requirements from the ACA that will shine light on PE ownership.[10] Rep. Jayapal introduced legislation in the House to require disclosure of PE ownership of nursing homes,[11] and several states have enacted legislation expressly or implicitly directed at increasing supervision of PE deals in healthcare.[12]

All of this attention from policymakers and regulators begs the question of whether PE funds should be treated differently than other owners under the antitrust laws and competition policy. Put differently, do PE firms present such extreme or unique competition concerns that

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2 See Martin Gaynor, Kate Ho & Robert J. Town. *The industrial organization of health-care markets*. 53 J. of Econ. Lit. 2 (2015) and references therein; see also Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions*, U.S. Senate Subcommittee on Competition Policy, Antitrust, and Consumer Rights (Washington, DC May 19, 2021), https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf; Brent D. Fulton, *Healthcare Market Concentration Trends in the United States: Evidence and Policy Responses*, 9 Health Affairs 36, 1530-1538 (2017).

3 Nirad Jain, Kara Murphy, Franz-Robert Klingan, Dmitry Podpolny & Vikram Kapur, *Healthcare Private Equity Outlook: 2022 and Beyond*, Report, Bain & Co. (Mar. 15, 2022).

4 Petris Center at University of California, Berkeley, analysis of Pitchbook Data, prepared by Ola Abdelhadi. Data has not been reviewed by PitchBook analysts.

5 Richard M. Scheffler, Laura M. Alexander & James R. Godwin, *Soaring PE Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*, The American Antitrust Institute & The Petris Center at the School of Public Health, University of California, Berkeley (May 18, 2021), https://www.antitrustinstitute.org/work-product/study-finds-private-equity-investment-accelerates-concentration-and-undermines-a-stable-competitive-healthcare-industry/. Deal values fell in 2020, presumably due to the COVID-19 pandemic, but are expected to rebound to above pre-pandemic levels. Preliminary results from our forthcoming study funded by the Laura & John Arnold Foundation supports the hypothesis of continued strong growth in PE spending in healthcare.

6 Stefania Palma & James Fontanella-Khan, *Crackdown on Buyout Deals Coming, Warns Top US Antitrust Enforcer*, Financial Times, May 19, 2022.

7 Statement of Chair Lina M. Khan Joined by Comm'r Rebecca Kelly Slaughter and Comm'r Alvaro M. Bedoya In the Matter of JAB Consumer Fund/SAGE Veterinary Partners, Comm'n File No. 2110140, Federal Trade Commission (June 13, 2022);

8 President Joseph R. Biden, Jr., Remarks by President Biden in State of the Union Address to the United States Congress (Mar. 1, 2022) ("[A]s Wall Street firms take over more nursing homes, quality in those homes has gone down and costs have gone up. That ends on my watch."), https://www.whitehouse.gov/briefing-room/speeches-remarks/2022/03/02/remarks-by-president-biden-in-state-of-the-union-address/. See also FACT SHEET: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes, The White House (Feb. 28, 2022), https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/.

9 *In the Matter of JAB Consumer Partners SCA SICAR, National Veterinary Assocs., Inc., and SAGE Veterinary Partners, LLC*, Docket No. C-4766 (Aug. 2, 2022); see also Statement of Chair Lina M. Khan, supra n.2 ("Private equity firms have been particularly active in healthcare…. A focus on short-term profits in the healthcare context can incentivize practices that may reduce quality of care, increase costs for patients and payors, and generate appalling patient outcomes.").

10 FACT SHEET, *supra* n.3. See also Patient Protection & Affordable Care Act, Pub. L. No. 111-148 § 6101 (Mar. 23, 2010) (requiring disclosure of each member of the governing body of a nursing facility, all of its officers, directors, and managers, as well as their organizational structures and their relationships to one another), https://bit.ly/3vXClGk.

11 Healthcare Ownership Transparency Act, H.R. 6885, 117th Cong. (2022).

12 See, e.g. Wash. Rev. Code § 19.390 (2019) (establishing reporting requirements for mergers and acquisitions of hospitals, hospital systems, and provider organizations).

they merit special or different treatment under the law? The answer to this question is complicated, and depends on understanding how PE funds are structured, the incentives their managers face, and their strategies for profitability. We conclude that, for the most part, competition laws applicable *only to* PE are not needed; rather, when policymakers, regulators, and enforcers are applying competition laws to PE-owned companies, they need to take account of the unique incentives facing PE managers, the competitive implications of the PE ownership structure, and the types of competition concerns that tend to arise surrounding PE deals. In the particular case of mergers, such informed assessment of deals involving PE also requires updating the HSR reporting requirements.

I. THE STRUCTURE OF PE FIRMS

PE firms are structured as partnerships of fund managers.[13] Fund managers raise money for individual PE funds from institutional and other wealthy investors, which the fund managers then invest and oversee. Most of the money that PE funds use to acquire companies, however, comes not from the managers or the investors, but from large investment banks in the form of debt. A typical PE fund manager contributes only 2 percent of the fund's total assets. Institutional and other investors contribute about 20 percent, and the remaining 70-80 percent of the fund's "equity" is debt financing from banks.

A typical PE fund has a ten-year lifespan from the point at which it begins taking on investors until it returns the investment, adjusted for gains or losses, to the investors. During those 10 years, the fund will buy and sell companies, typically aiming to hold each company for 3-5 years. PE funds generally seek to use those 3-5 years to improve these companies by restructuring struggling firms, investing capital so they can expand, and providing needed management expertise, with the goal of selling them at a profit. These profits generate returns for the fund investors and for the PE managers. But this is not the only (or even the primary) way that PE managers make money.

PE funds typically operate on a "2-and-20" fee model, whereby the PE managers take an annual management fee of 2% of the money invested in the fund each year, plus 20 percent of the profits at the end of the fund. On top of these fund-level fees, however, PE funds also impose management and consulting fees on the businesses they acquire. In addition, as managers of the acquired businesses, PE managers often put in place business deals between the companies acquired by the fund and the fund, its investors, or the fund manager's affiliates. These deals can include supply agreements, licensing deals, or the sale of assets of the acquired companies to real estate investment trusts or other investors.

PE funds measure sales prices for companies in terms of multiples of EBITDA (earnings before interest, taxes, depreciation, and amortization). To profitably divest an acquired company, the PE fund must find a way to increase the company's multiple, its EBITDA, or both. To increase EBITDA, the PE fund will look for quick ways to cut costs and increase revenue. In the healthcare setting, cutting costs often involves cutting workers or replacing highly paid (and highly qualified) workers with lower paid (and less qualified) workers. It might also involve switching to cheaper supplies, such as sutures and tubing, or reducing hours or closing entire facilities. These cuts may adversely affect quality, which is often not transparent to patients or payers in healthcare. To raise healthcare revenues, PE managers have been known to put pressure on healthcare workers to perform more profitable procedures or to shift the business focus from a less profitable practice to a more profitable practice.[14] PE managers might also engage in aggressive billing and collection practices to increase revenues.[15]

To increase the EBITDA multiple, future growth in EBITDA is necessary, often through acquisitions. There are at least two reasons for this strategy. First, PE firms engage in what they call "consolidation plays." As the name implies, a fund will seek to consolidate a fragmented industry or market with a goal of becoming a dominant player in that market. Achieving such dominance gives the firm pricing power and allows the PE fund to demand a higher multiple in a subsequent sale. Second, larger companies have access to more and cheaper debt.[16] By growing an acquired company, the PE fund positions it to take on more debt, which makes it a desirable acquisition target for a second PE fund that wants to further leverage the company. The goal of the PE fund in most cases is to grow by acquisition to both consolidate competitors and leverage the company as much as possible.

13 For an in-depth examination of the legal framework, business models, and compensation structures of PE funds, see generally Eileen Appelbaum & Rosemary Batt, PE at Work: When Wall Street Manages Main Street (Russell Sage Foundation 2014).

14 J.S. Resneck Jr., *Dermatology Practice Consolidation Fueled by Private Equity Investment: Potential Consequences for the Specialty and Patients*, 154 Jama Dermatology 1, at 13-14 (2018), https://doi.org/10.1001/jamadermatol.2017.5558.

15 See e.g. *UnitedHealthCare Services, Inc. v. Team Health Holdings, Inc.*, Memorandum & Order , 3:21-00364-DCLC-JEM 3 (May 10, 2022).

16 J. Bailey, *Why It May Pay to Buy Before Selling the Firm*, Wall St. J. (Feb. 25, 2003).

The structure of PE firms and the way they structure their mergers allows much of this growth and consolidation to take place without any (or any effective) review. Under the typical financial structure of PE funds, whereby the various partners at a single PE firm oversee a multitude of individual funds, the reporting requirements often fail to provide antitrust authorities with sufficient information to accurately evaluate the competitive risk from fund acquisitions. For example, a newly formed PE fund's first acquisition is generally not reportable, because the fund does not meet the "size of the person" test due to how rules about ultimate parent entities are determined.[17] But PE firms typically have multiple funds covering the same market areas and the manager of a newly-formed fund often oversees other funds that do hold assets in related areas. So, even though the newly-formed fund is exempt from HSR reporting on its first acquisition of a target company, the PE manager and the PE firm may well have significant holdings that compete with that target company.

Even without this "first-one-free" gap in HSR reporting, the buy-and-build model deployed by PE funds allows the funds to accumulate significant market power, particularly in products that compete in localized geographic markets, without any oversight from federal competition authorities. As we detailed in our recent report, PE funds deal amounts, particularly in healthcare, often fall just below the threshold for HSR reporting and pre-approval.[18] Through a "buy-and-build" approach, PE funds will buy a medium or large company in an industry and then use a series of small acquisitions of competitors and companies in adjacent markets, each falling below the HSR reporting thresholds, to build the original acquisition target into a powerful market player. As a result, many PE acquisitions are never reviewed by antitrust regulators and are not assessed by the FTC and DOJ for their impact on competition.

In discussing PE, though, it is critical to appreciate how hard it is to conduct effective research on PE investment and its effects. The vast majority of PE firms are not publicly traded or subject to any significant SEC reporting. As just discussed, many of the acquisitions made by PE funds using buy-and-build or roll-up models are not subject to HSR reporting. Even when acquisitions are subject to HSR reporting, outdated reporting requirements fail to capture the full scope of the PE fund's ownership interests.[19] Pitchbook, the gold standard for PE deal data, is forced to estimate up to 90 percent of its deal values due to lack of publicly available data.[20] Before President Biden's direction earlier this year, the ACA's provisions calling for increased reporting on ownership of nursing homes had not been implemented and no such data was available.[21] We—the authors of this piece—are currently working under a grant from Arnold Ventures[22] to conduct empirical research on the competition impacts of PE investment in healthcare provider markets. Such research is sorely needed to better understand the scope and extent of competition impacts from PE, but is currently significantly hampered by a lack of disclosure and centralized datasets on PE ownership.

II. THE PE BUSINESS MODEL IN HEALTHCARE

While the PE model can be problematic in all sectors, it is particular so in healthcare where lives are on the line, quality is often not transparent, and competition is far from robust. First, the high-risk, high-reward PE investment strategy leaves healthcare facilities and providers burdened with debt and without a cushion of assets, making them vulnerable in the face of a systemic shock, like a pandemic or a market downturn.

Second, while consolidation can lead to efficiencies, consolidation can also lead to increased market power, which can in turn lead to reduced choice, reduced quality, and increased prices. This issue is particularly acute in the healthcare setting, where PE firms regularly deploy a "buy-and-build" or "roll up" strategy. Most physician practice acquisitions are too small[23] to require HSR reporting to antitrust authorities and, as a result, most go unreviewed.[24] Using this method, PE funds have been able to accumulate some remarkable and concerning market shares,

17 16 C.F.R. § 801.11(e) (allowing an entity that is its own ultimate parent entity and without a regularly prepared balance sheet to exclude funds used for the purpose of acquisitions).

18 Richard M. Scheffler, Laura M. Alexander, & James R. Godwin, *Soaring PE Investment in the Healthcare Sector: Consolidation Accelerated, Competition Undermined, and Patients at Risk*, The American Antitrust Institute & The Petris Center at the School of Public Health, University of California, Berkeley (May 18, 2021), https://www.antitrustinstitute.org/work-product/study-finds-private-equity-investment-accelerates-concentration-and-undermines-a-stable-competitive-healthcare-industry/.

19 See Premerger Notification; Reporting and Waiting Period Requirements, 85 Fed. Reg. 77053 (proposed Dec. 1, 2020) (proposal to expand definition of "person" to better capture relevant information about PE holdings).

20 The low percentage of reported deal values raises concerns about the precision of Pitchbook's estimated total deal values. Those concerns are partially mitigated by recognizing that few if any large deals are unreported, because deals above a certain dollar threshold trigger SEC and FTC reporting requirements. Nevertheless, the PitchBook numbers must be taken for what they are: the best available estimate.

21 Taylor Lincoln, *Is it Private Equity? We Can't See*, Public Citizen (Sept. 1, 2022), https://www.citizen.org/article/nursing-home-transparency/.

22 Grant No. 21-06178 to the American Antitrust Institute.

23 For 2022, the HSR reporting threshold is $101M. *Revised Jurisdictional Thresholds for Section 7A of the Clayton Act*, 87 Fed. Reg. 3541 (Jan. 24, 2022).

24 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0054.

for example in multiple healthcare specialties in local and regional markets. PE controls 69 percent of the market for dermatologists in Salem, OR; 78 percent of the market for dermatologists in Lansing-East Lansing, MI; 80 percent of the market for anesthesiology physician groups in Wilmington, NC; and 91 percent of the market for radiology physician groups in Idaho Falls, ID.[25]

Take the case of Team Health. Team Health, the country's largest physician staffing company, has twice been taken private by PE firm Blackstone, for the second time in early 2017. In just the first year after Blackstone's 2017 takeover, Team Health's presence in emergency medical staffing, already large, exploded. The number of metropolitan statistical areas ("MSAs") in which Team Health owned emergency medicine practices went from 34 in 2016 to 47 in 2017. The number of MSAs where Team Health owned more than 50 percent market share of emergency medicine went from 3 to 6 in that same time period. In Knoxville, where Team Health is headquartered, its market share in emergency medicine went from 38.5 percent in 2016 to 82.5 percent in 2020.[26] Nearly all of this growth was fueled by acquisitions and none of those acquisitions were challenged by antitrust authorities.

Third, research suggests that PE investors are more responsive than non-PE investors to market incentives.[27] In markets with robust competition, then, PE funds are by-and-large particularly adept competitors. The corollary of this finding, though, is that PE companies are also particularly adept at exploiting market power and market and regulatory failures in markets where they exist. Healthcare is a poster child for such markets.

Healthcare markets have a number of characteristics that make them exceptionally vulnerable to exploitation by PE.[28] Healthcare markets are highly concentrated and lacking in competition. To the extent PE is driving further consolidation in healthcare, PE is making this existing concentration problem worse. But, even if PE is not the only driver of the consolidation, it may be particular adept at exploiting it.

Beyond high levels of concentration, healthcare markets are further characterized by opaque product quality, heavy government subsidies, and a disconnect between demand and payments driven by third-party payer models, all of which serve to hamper effective competition. Studies have shown that in such markets, PE ownership can be associated with higher prices, lower quality, and worse health outcomes.[29]

Anecdotally, there are reasons to worry that PE strategies may serve to exacerbate the very issues that impair health competition in these markets. For example, overbilling hampers competition by disconnecting services demanded from prices charged for those services (in addition to directly inflicting financial harm on payers). Overbilling is not just a civil issue impacting patients and markets; when the payer is the government, overbilling can also amount to criminal fraud. The False Claims Act, which imposes criminal liability on medical professionals who engage in overbilling, however, requires that the medical profession knows about the overbilling. Because of way PE funds separate the billing function from the providers, the providers generally lack the required knowledge for False Claims Act liability.

This separation between physicians and patient billing also means that physicians have little oversight over whether their patients are being fairly billed in their name for the services provided. Yet, when a group of physicians opposed to the corporate practice of medicine recently proposed a rule that would require ER staffing companies (like those being acquired by PE funds) to periodically furnish their physicians with data on what is being billed under their license numbers, the American College of Emergency Physicians (ACEP) had a troubling response: it engaged outside lawyers to evaluate whether such disclosure could expose physicians to liability under the False Claims Act because the provision of the information would leave them "knowing" of inflated billings.[30]

Overbilling is not a problem limited to PE ownership,[31] and not all aggressive billing amounts to criminal fraud, but one of the established PE strategies for generating the short-term improvements in revenues needed to make their business model work is to stretch the boundaries of ethical and accurate billing practices to their limits (and sometimes beyond their limits). The same characteristics that make PE exceptionally

25 Petris Center at University of California, Berkeley, analysis of Pitchbook Data, prepared by Ola Abdelhadi. Data has not been reviewed by PitchBook analysts.

26 Petris Center at University of California, Berkeley, analysis of Pitchbook Data, prepared by Ola Abdelhadi. Data has not been reviewed by PitchBook analysts.

27 Atul Gupta, Sabrina T. Howell, Constantine Yannelis, & Abhinav Gupta, *Does PE Investment in Healthcare Benefit Patients? Evidence from Nursing Homes*, Working Paper (March 9, 2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3537612.

28 See Scheffler, et al., *supra* n.21 at 5-6.

29 *Id.*

30 Maureen Tkacik, *Wall Street in Pressing ER Docs to Fleece Patients*, The Lever (Oct. 27, 2021).

31 See, e.g. Michael Geruso & Timothy Layton. *Upcoding: Evidence from Medicare on Squishy Risk Adjustment*. 128 J. of Pol. Econ. 3 (2020); Elaine Silverman & Jonathan Skinner. *Medicare upcoding and hospital ownership*. 23 J. of Health Econ. 2 (2004).

responsive to competitive pressures also make PE exceptionally responsive to opportunities to exploit market power and market failures like those seen in healthcare. This is a competition problem.

III. IMPLICATIONS FOR COMPETITION LAW & POLICY

Recognition that PE raises competition concerns does not necessarily imply that private-equity-specific competition rules and policies are necessary. While PE funds may have incentives to engage in certain strategies that are anticompetitive, it is those strategies that should be prohibited, regardless of whether they are perpetrated by PE funds or other owners.[32] The ultimate issue in the antitrust inquiry—does the merger or conduct reduce or prevent competition—does not change based on whether the merger involves PE-ownership. Because many of the most concerning practices from PE funds are not exclusive to PE funds, it is important the laws are able to reach others engaged in those practices as well, even if not as often or to the same degree as PE funds. The Sherman and Clayton Acts speak in broad principles and do not try to imagine or legislate against the myriad ways that companies might try to accrete market power, collude, or monopolize markets; they instead express a legislative choice for competition over monopolization and collusion. Although PE funds have invented new ways (or perfected old ways) of undermining competition, this should not impact the ability of the antitrust laws to push back against those methods, provided that the competition dynamics underpinning them are properly understood.

What the competition concerns surrounding PE do suggest, however, is that PE firms and their strategies reveal gaps and holes in current competition rules and policy — in reporting requirements, in the treatment of small and seriatim mergers — that should be filled with regard to all parties, not PE firms only. Antitrust law and policy should be hardened generally against certain anticompetitive mergers and conduct, regardless of whether perpetrated by PE firms, tech firms, or traditional corporations, including non-profits. Research has suggested that PE funds are particularly adept at exploiting gaps in existing enforcement policy, laws, and regulations. They function, essentially, as divining rod for regulatory cracks. Finally, the structures and business models of PE firms imply that they face different competitive incentives and models of profitability than more traditional ownership structures. It is critical that in applying the antitrust laws to PE firms, courts and enforcers understand and take account of those differing incentives and their implications for the competitive effects of mergers and conduct involving PE-owned firms.

The HSR requirements, for example, were enacted in 1976, and have undergone only limited updates. While several attempts have been made since the early 80s to adapt HSR reporting to account for new ownership structures like PE,[33] they have been only partially successful.[34] It is critical that HSR filing requirements are updated to better capture the relationships between funds, fund managers, investors, and target companies, so that the antitrust agencies will have the information they need to evaluate the likely competitive impact of PE acquisitions. The "first-one-free" gap, which immunizes a new PE fund's first purchase from HSR filing, should also be closed.

Another area where observation of PE suggests attention is needed is serial acquisitions and small mergers involving localized markets.[35] Part of the solution is surely to increase scrutiny and enforcement by states, who are in many ways better positioned to police local markets and who have always played a significant role in healthcare. But many PE funds are implementing acquisition strategies that cover multiple states and regions, suggesting that federal enforcement and attention is also needed. Moreover, enforcement challenges posed by serial acquisitions and acquisitions of small companies (such as nascent competitors) are a problem that extends well beyond healthcare and beyond private equity.

Finally, in healthcare in particular, interventions that are more specific to PE and other complex business models may be needed. If research continues to show that PE ownership in healthcare can be associated with increased prices, decreased quality, and increased mortality and morbidity, broadly applicable antitrust laws may be insufficient to address PE's negative effects on healthcare competition and health outcomes. Instead, a coordinated response from the Secretary of Health and Human Services, the Centers for Medicare and Medicaid Services, and Congress with the support of the President will be needed to ensure higher mortality and morbidity from poorly functioning healthcare markets and low quality of care are not the price paid for PE profits.

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32 The No Surprise Act, signed into law on Dec. 27, 2020, and which outlaws surprise billing by ER doctors and other providers, is a good example of legislation that targets undesirable and anticompetitive business practices pioneered and exploited by PE-owned companies but that is broadly applicable without regard for PE ownership status; by its terms, the law outlaws surprise billing by all providers, regardless of their PE ownership status. No Surprises Act, H.R. 3630, 116th Cong. (2020).

33 See Premerger Notification; Reporting and Waiting Period Requirements, 76 Fed. Reg. 42,471 (July 19, 2011) (adding the "associate" definition targeted at PE funds and master limited partnerships

34 See e.g. Premerger Notification; Reporting and Waiting Period Requirements, 85 Fed. Reg. 77053 (proposed Dec. 1, 2020) (proposal to expand definition of "person" to better capture relevant information about PE holdings), on which the FTC has taken no action since the comment period closed.

35 See T.G. Wollmann, *How to Get Away with Merger: Stealth Consolidation and its Real Effects on US Healthcare* (No. w27274), National Bureau of Economic Research, Inc., https://doi.org/10.3386/w27274.

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