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THE HEALING POWER OF ANTITRUST

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ABSTRACT—Millions of Americans live in hospital deserts—communities where people lack geographic access to hospitals and primary care physicians. People living in these deserts often miss doctor appointments, delay necessary care, and stop adhering to their treatment. In this way, hospital deserts exacerbate the health disparities plaguing America. This Article demonstrates that hospital deserts are not inevitable but the result of several business strategies—including noncompete agreements and merging with competitors—and antitrust enforcers' unwillingness to recognize these harmful practices as antitrust violations. To cure the issue of hospital deserts, this Article makes three proposals. First, antitrust enforcers and the courts should expand their merger analyses to include hospital mergers' impact on labor markets. Second, enforcers should treat all noncompete agreements in the healthcare sector as per se illegal. Third, they should accept mergers in rural areas only under the condition that the merged entity will not shut down facilities or cut healthcare services so as to create a hospital desert. By implementing these proposals, antitrust enforcers and the courts can help mitigate the racial and health inequities that currently undermine the social, moral, and economic fabric of America.

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INTRODUCTION

Healthcare in rural America is in crisis. Compared to their urban counterparts, rural residents are more likely to be poor, unemployed, and uninsured.[1] They are also more likely to suffer from a severe chronic condition, disability, or substance abuse disorder.[2] Children and young

[1] *See Data Show U.S. Poverty Rates in 2019 Higher in Rural Areas than in Urban for Racial/Ethnic Groups*, U.S. DEP'T AG. ECON. RSCH. SERV. (last updated Aug. 23, 2021), http://www.ers.usda.gov/data-products/chart-gallery/gallery/chart-detail/?chartId=101903 [https://perma.cc/QK4X-8YH3].

[2] *See About Rural Health*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (May 16, 2024), https://www.cdc.gov/rural-health/php/about/index.html [https://perma.cc/UC9C-7TXS]; *see also Rural and Urban Health*, HEALTH POL'Y INST., https://hpi.georgetown.edu/rural/ [https://perma.cc/6PVS-ZPSP]; *Substance Use and Misuse in Rural Areas*, RURAL HEALTH INFO. HUB (last updated Aug. 2, 2024), https://www.ruralhealthinfo.org/topics/substance-use [https://perma.cc/6QPU-EY8A]; *Many Rural Americans Are Still "Left Behind,"* UNIV. WISC.–MADISON INST. FOR RSCH. ON POVERTY (Jan. 2020), https://www.irp.wisc.edu/resource/many-rural-americans-are-still-left-behind/ [https://perma.cc/

adults in rural America are likewise disproportionately affected.[3] For instance, rural communities experience higher child and infant mortality rates as compared to communities in metropolitan areas.[4]

People of color face even greater health issues in rural America.[5] Racial and ethnic minorities in rural areas are less likely to receive primary care due to prohibitive costs,[6] and they are more likely to die from severe health conditions, such as diabetes or heart disease.[7]

Although rural residents in the nation experience worse health outcomes than urban residents, rural hospitals are closing at an alarming rate.[8] Recent data shows that since 2010, more than 130 rural hospitals have

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5EEP-BPPN]; GINA TURRINI, D. KIETH BRANHAM, LUCY CHEN, ANN B. CONMY, ANDRE R. CHAPPEL, NANCY DE LEW & BENJAMIN D. SOMMERS, ASSISTANT SEC'Y FOR PLAN. & EVALUATION, HP-2021-16, ACCESS TO AFFORDABLE CARE IN RURAL AMERICA: KEY TRENDS AND KEY CHALLENGES 14 (2021); Katrina Crankshaw, *Disability Rates Higher in Rural Areas than Urban Areas: The South Had Highest Disability Rate Among Regions in 2021*, U.S. CENSUS BUREAU (June 26, 2023), https://www.census.gov/library/stories/2023/06/disability-rates-higher-in-rural-areas-than-urban-areas.html [https://perma.cc/H9XD-JBT6]; Brian Thiede, Lillie Greiman, Stephan Weiler, Steven C. Beda & Tessa Conroy, *Six Charts That Illustrate the Divide Between Rural and Urban America*, CONVERSATION (Mar. 16, 2017, 8:12 PM), https://theconversation.com/six-charts-that-illustrate-the-divide-between-rural-and-urban-america-72934 [https://perma.cc/CLF9-PHWE] (indicating the disability rate increases from 11.8% in the most urban counties to 17.7% in the most rural counties).

[3] *See generally* Janice Probst, Whitney Zahnd & Charity Breneman, *Declines in Pediatric Mortality Fall Short for Rural US Children*, 38 HEALTH AFFS. 2069 (2019) (finding a discrepancy in pediatric mortality rates between urban and rural populations).

[4] *Id.* (explaining the discrepancy in pediatric mortality rates between urban and rural populations); *see also* Tanya Lewis, *People in Rural Areas Die at Higher Rates than Those in Urban Areas*, SCI. AM. (Dec. 14, 2022), https://www.scientificamerican.com/article/people-in-rural-areas-die-at-higher-rates-than-those-in-urban-areas/ [https://perma.cc/FKR6-7PL7]; ABBY HOFFMAN & MARK HOLMES, N.C. RURAL HEALTH RSCH. PROGRAM, REGIONAL DIFFERENCES IN RURAL AND URBAN MORTALITY TRENDS (2017), https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2017/08/Regional-Differences-in-Urban-and-Rural-Mortality-Trends.pdf [https://perma.cc/GZG7-BS8B] (delineating differences in all-cause mortality by region); Deborah B. Ehrenthal, Hsiang-Hui Daphne Kuo & Russell S. Kirby, *Infant Mortality in Rural and Nonrural Counties in the United States*, PEDIATRICS, Nov. 2020, at 1, 2 (identifying the positive correlation between rural counties and infant mortality).

[5] *See* Carrie E. Henning-Smith, Ashley M. Hernandez, Rachel R. Hardeman, Marizen R. Ramirez & Katy Backes Kozhimannil, *Rural Counties with Majority Black or Indigenous Populations Suffer the Highest Rates of Premature Death in the US*, 38 HEALTH AFFS. 2019, 2021 (2019).

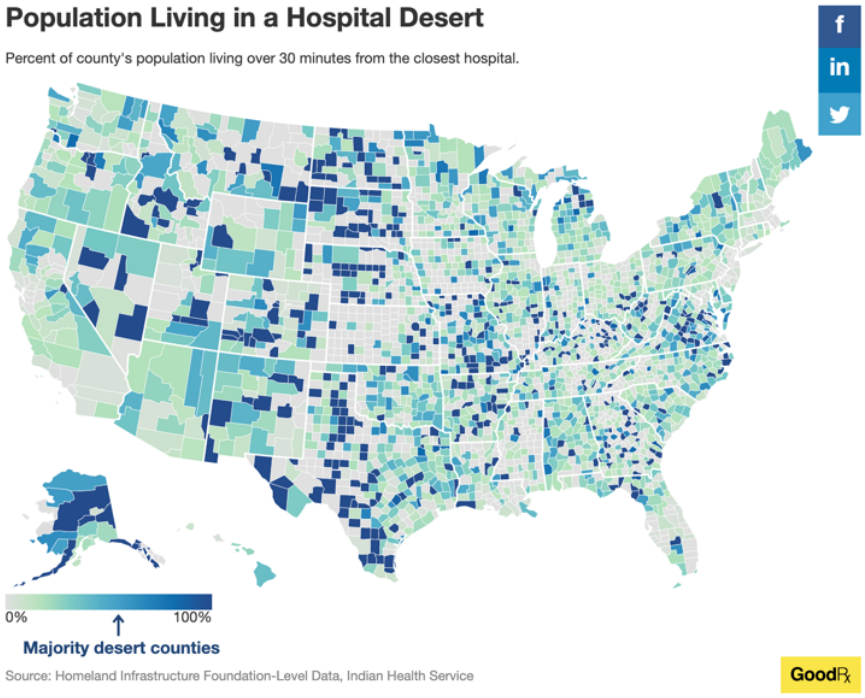
[6] EILEEN O'GRADY, MARY BUGBEE & MICHAEL FENNE, PRIVATE EQUITY DESCENDS ON RURAL HEALTHCARE: PRIVATE EQUITY STAKEHOLDER PROJECT 1, 3–4 (2023), https://pestakeholder.org/wp-content/uploads/2023/02/PE_Rural_Health_Jan2023-compressed.pdf [https://perma.cc/B23D-Y9CD].

[7] *See* Rahul Aggarwal, Nicholas Chiu, Eméfah C. Loccoh, Dhruv S. Kazi, Robert W. Yeh & Rishi K. Wadhera, *Rural–Urban Disparities: Diabetes, Hypertension, Heart Disease, and Stroke Mortality Among Black and White Adults, 1999–2018*, 77 J. AM. COLL. CARDIOLOGY 1480, 1480 (2021); Arch G. Mainous III, Dana E. King, David R. Garr & William S. Pearson, *Race, Rural Residence, and Control of Diabetes and Hypertension*, 2 ANNALS FAM. MED. 563, 563 (2004).

[8] O'GRADY ET AL., *supra* note 6, at 3–4; AM. HOSP. ASS'N, RURAL HOSPITAL CLOSURES THREATEN ACCESS: SOLUTIONS TO PRESERVE CARE IN LOCAL COMMUNITIES 5, 7 (2022), https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf [https://perma.cc/

shut their doors, and more than 30% of all hospitals in rural areas are at immediate risk of closure.[9] Hospital closures are increasing the size and number of hospital deserts—areas where people lack geographic access to hospitals and primary care physicians. As Figure 1 illustrates, in more than 20% of American counties, people live in a hospital desert, and these deserts are primarily located in rural America.[10]

FIGURE 1: HEALTHCARE DESERTS, COUNTY BY COUNTY[11]



S9EP-89SN]; CTR. FOR HEALTHCARE QUALITY & PAYMENT REFORM, RURAL HOSPITALS AT RISK OF CLOSING 1 (2023), https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf [https://perma.cc/K8H5-MXZ2]; *Rural Hospital Closures*, CECIL G. SHEPS CTR. FOR HEALTH SERVS. RSCH. (2014), https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ [https://perma.cc/9F2W-44XM].

[9] *Rural Hospital Closures*, *supra* note 8; *see* O'GRADY ET AL., *supra* note 6, at 4; *see also* Austin B. Frakt, *The Rural Hospital Problem*, 321 [J]AMA 2271, 2271 (2019) (noting 15 of 21 hospitals that closed in 2016 were in rural communities).

[10] *See* AMANDA NGUYEN, JEROEN VAN MEIJGAARD, SARA KIM & TORI MARSH, MAPPING HEALTHCARE DESERTS: 80% OF THE COUNTRY LACKS ADEQUATE ACCESS TO HEALTHCARE 12–13 (2021), https://assets.ctfassets.net/4f3rgqwzdznj/6iU4VnrKD1eIDthc7i1hcl/2d42cfeb3e24e897f281eebfc7708eab/Healthcare_Deserts_Sept_2021.pdf [https://perma.cc/SZ2P-824X].

[11] *Id.* at 13.

Hospital deserts reduce access to care for rural residents and exacerbate the rising health and racial disparities in America. Each time a hospital shuts its doors, rural residents must travel longer distances to receive care. Lower income rural Americans, however, often lack access to a vehicle or the resources necessary to afford the costly travel.

A study examining the relationship between transportation barriers and health outcomes in rural communities sheds light on those concerns: after surveying 593 cancer patients in Texas who lacked access to a vehicle, researchers found that 38% of whites, 55% of African Americans, and 60% of Hispanics may delay cancer treatment due to insurmountable transportation barriers, demonstrating that race also indicates increased vulnerability in hospital-desert counties.[12] Another leading study concludes similarly, showing that rural children are often deprived of much-needed care because of the high transportation barriers that rural communities face.[13] As a result, rural residents often skip doctor appointments, delay necessary care, or stop adhering to their treatment.[14]

Moreover, driving great distances to receive time-sensitive care can increase mortality rates for rural populations.[15] For instance, research

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[12] Samina T. Syed, Ben S. Gerber & Lisa K. Sharp, *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. CMTY. HEALTH 976, 977 (2013).

[13] Roy Grant, Delaney Gracy, Grifin Goldsmith, Morissa Sobelson & Dennis Johnson, *Transportation Barriers to Child Health Care Access Remain After Health Reform*, 168 [J]AMA PEDIATRICS 385, 385 (2014).

[14] JANE WISHNER, PATRICIA SOLLEVELD, ROBIN RUDOWITZ, JULIA PARADISE & LARISA ANTONISSE, KAISER COMM'N ON MEDICAID & THE UNINSURED, A LOOK AT RURAL HOSPITAL CLOSURES AND IMPLICATIONS FOR ACCESS TO CARE (2016), https://files.kff.org/attachment/issue-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care [https://perma.cc/MXL8-XEHU]; *see also* Syed et al., *supra* note 12, at 976 (describing the relationship between transportation availability, poverty, and health outcomes); MARVELLOUS AKINLOTAN, KRISTIN PRIMM, NIMA KHODAKARAMI, JANE BOLIN & ALVA O. FERDINAND, SW. RURAL HEALTH RSCH. CTR., RURAL–URBAN VARIATION IN TRAVEL BURDENS FOR CARE: FINDINGS FROM THE 2017 NATIONAL HOUSEHOLD TRAVEL SURVEY 1 (2021), https://srhrc.tamu.edu/publications/travel-burdens-07.2021.pdf [https://perma.cc/YP3Q-RW9S].

[15] Caitlin Carroll, Arrianna Planey & Katy B. Kozhimannil, *Reimagining and Reinvesting in Rural Hospital Markets*, 57 HEALTH SERVS. RSCH. 1001, 1001–02 (2022) ("Hospital closures are concerning, in part, because of the potential effects on patient health. On the one hand, hospital closure decreases access to care and increases travel times, raising concerns about adverse health outcomes for patients with time-sensitive conditions. This may be exacerbated for Black or Latinx residents, who face additional barriers to access, such as longer travel distances . . . ."); *see also* Martha Hostetter & Sarah Klein, *Restoring Access to Maternity Care in Rural America*, COMMONWEALTH FUND (Sept. 30, 2021), https://www.commonwealthfund.org/publications/2021/sep/restoring-access-maternity-care-rural-america [https://perma.cc/FNX3-6Y43] ("As of 2014, more than half of rural counties in the U.S. were considered maternity care deserts, with no hospital-based obstetric services; worsening access has contributed to increases in maternal mortality and morbidities among rural residents, particularly Black women."); Jayne O'Donnell & Laura Ungar, *Rural Hospitals in Critical Condition*, USA TODAY (last updated Nov. 13, 2014, 7:10 PM), https://www.usatoday.com/story/news/nation/2014/11/12/rural-hospital-closings-federal-reimbursement-medicaid-aca/18532471/ [https://perma.cc/3ATH-8UMS].

indicates that between 2011 and 2019, almost 200 rural hospitals stopped offering obstetric care,[16] forcing rural women to travel up to sixty miles for care and delivery.[17] Traveling long distances to receive necessary care increases the risk of health complications and the stress rural women and their families experience when the time to give birth arrives.[18] Many obstetric emergencies also require a medical response within minutes, rather than the hours it may take rural residents to drive to a hospital.[19] As a result, for rural women, and especially women of color, giving birth to a child is now more dangerous than it was twenty years ago.[20]

Hospital closures harm not only rural communities' health but also their wealth. Rural hospitals are often "economic anchors," acting as the largest employers in their communities and increasing jobs in supporting industries such as construction.[21] In addition to creating jobs, rural hospitals also support local businesses by purchasing their products and services.[22] They

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[16] MICHAEL TOPCHIK, TROY BROWN, MELANIE PINETTE, BILLY BALFOUR & KATE DE LUCA, THE CHARTIS GRP., PANDEMIC INCREASES PRESSURE ON RURAL HOSPITALS & COMMUNITIES: VULNERABILITY, HEALTH INEQUITY AND STAFFING CRISIS AMPLIFIED IN PANDEMIC'S THIRD YEAR 8 (2022), https://www.chartis.com/sites/default/files/documents/Pandemic-Increases-Pressure-on-Rural-Hospitals-Communities-Chartis.pdf [https://perma.cc/4HPM-7ACM].

[17] Dina Fine Maron, *Maternal Health Care Is Disappearing in Rural America*, SCI. AM. (Feb. 15, 2017), http://www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural-america/ [https://perma.cc/WM78-YCRZ]; *see also* Peiyin Hung, Katy B. Kozhimannil, Michelle M. Casey & Ira S. Moscovice, *Why Are Obstetrics Units in Rural Hospitals Closing Their Doors?*, 51 HEALTH SERVS. RSCH. 1546, 1552 (2016) (finding rural women had to travel an average of twenty-nine miles with a range from nine to sixty-five miles to access obstetric care); *Many Women in Low-Income Areas Have Poor Access to Obstetric and Neonatal Care, Study Finds*, YALE SCH. MED. (Mar. 16, 2018), http://medicine.yale.edu/news-article/many-women-in-low-income-areas-have-poor-access-to-obstetric-and-neonatal-care-study-finds/ [https://perma.cc/2M6V-43A2].

[18] *See* Maron, *supra* note 17.

[19] John Cullen, *A Worsening Crisis: Obstetric Care in Rural America*, HARV. MED. SCH.: PRIMARY CARE REV. (Mar. 25, 2021), https://info.primarycare.hms.harvard.edu/perspectives/articles/obstetric-care-rural-america [https://perma.cc/LP46-AKZ9].

[20] *See id.*

[21] Carroll et al., *supra* note 15, at 1002 ("Rural hospitals are often major employers in rural areas, so closure can affect the economic vitality of the local community."); Claire E. O'Hanlon, Ashley M. Kranz, Mario DeYoreo, Ammarah Mahmud, Cheryl L. Damberg & Justin W. Timbie, *Access, Quality, and Financial Performance of Rural Hospitals Following Health System Affiliation*, 38 HEALTH AFFS. 2095, 2095 (2019). For instance, a 2017 American Hospital Association (AHA) report shows that hospitals create about 16 million jobs nationwide. *See* AM. HOSP. ASS'N, HOSPITALS ARE ECONOMIC ANCHORS IN THEIR COMMUNITIES (2017), https://www.aha.org/system/files/content/17/17econcontribution.pdf [https://perma.cc/4LLU-SD4H]; *see also* Tyler L. Malone, Arrianna Marie Planey, Laura B. Bozovich, Kristie W. Thompson & George M. Holmes, *The Economic Effects of Rural Hospital Closures*, 57 HEALTH SERVS. RSCH. 614, 615 (2022).

[22] *See* AM. HOSP. ASS'N, RURAL REPORT: CHALLENGES FACING RURAL COMMUNITIES AND THE ROADMAP TO ENSURE LOCAL ACCESS TO HIGH-QUALITY, AFFORDABLE CARE 2 (2019), https://www.aha.org/system/files/2019-02/rural-report-2019.pdf [https://perma.cc/8YHP-LTCM].

thereby contribute to local tax revenues, increasing funding for infrastructure and public services such as road maintenance and education.[23]

Because hospitals are engines for economic growth and opportunity in rural neighborhoods, hospital closures can devastate a community.[24] When a rural hospital closes, unemployed residents often move to urban areas to pursue alternative employment and make a living. This migration then harms local businesses relying on the community for support. Data reveal that when a hospital abandons the community, the unemployment rate rises by 1.6%, and per capita income declines by 4%.[25]

What causes these harmful closures? Delving into this question, this Article demonstrates that the hospital-closure crisis creating hospital deserts in rural communities also results from several anticompetitive business strategies implemented by both rural and urban hospitals in America. These strategies include unreasonable noncompete agreements, which discourage physicians and nurses from offering their services to rural populations already suffering from a severe shortage of health professionals, and a rash of mergers that have increased consolidation in the hospital industry and have reduced or eliminated access to care for the most vulnerable populations. For these reasons, this Article argues that the hospital-desert problem is also an antitrust problem. Hence, it cannot be adequately treated without the healing power of antitrust law.

This Article proceeds in four Parts. Part I identifies the roots of the problem by exploring the hospital-closure epidemic in rural America. Part II examines some of the ameliorative health-policy measures proposed thus far, including increased use of telemedicine in rural communities and Medicaid expansion. Part II also explains why these measures are insufficient without addressing the hospitals' anticompetitive business practices. Part III sheds light on the antitrust dimension of the hospital-desert problem by examining the business strategies employed by urban and rural hospitals nationwide and demonstrating how these strategies aggravate the hospital-closure crisis in underserved areas. Part III demonstrates that these business strategies have left rural communities without any meaningful access to care. Part IV identifies three ways in which the enforcers and the courts can address the anticompetitive business practices that contribute to the hospital-desert problem in rural areas. First, the enforcers and the courts should expand their hospital merger analysis to include labor market impact. Second, they should

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[23] *Id.*

[24] Frakt, *supra* note 9, at 2272 ("When a hospital closes, all those it employed need to find other jobs. In addition, the jobs in related and supporting industries, including food and laundry services and construction, can also be lost. Those losses exert a downward impact on the local economy.").

[25] *Id.*

treat all noncompete agreements in the healthcare sector as per se illegal. Third, the enforcers and the courts should accept hospital mergers in rural areas only under the condition that the merged entity will not shut down facilities or cut essential services in rural neighborhoods.

This Article is the first to address the need for the enforcers and the courts to alleviate the harms hospital deserts cause to rural communities. Failing to confront them will contribute to the rising racial and health inequities that undermine the social, moral, and economic fabric of America.

I. UNVEILING THE PROBLEM: WHY DO RURAL HOSPITALS SHUT THEIR DOORS?

Before exploring the anticompetitive business strategies that lead to rural hospital closures, it is essential to understand the underlying factors that contribute to the hospital desert problem in rural America. These are the socioeconomic characteristics of rural Americans, low patient volume, and the extreme shortage of physicians and nurses that rural communities experience.

A. The Socioeconomic Characteristics of Rural Americans

As noted, hospitals in rural areas treat patients who are sicker than their urban counterparts.[26] Indeed, rural residents are more likely to suffer from costly diseases, such as diabetes and cancer, or to struggle with depression and substance-abuse disorders.[27] What's more, Americans in rural areas have higher age-adjusted mortality rates than Americans in metropolitan areas.[28]

Rural populations experience worse health outcomes than urban populations due to their socioeconomic conditions and the environment in which they live, work, and play. For instance, a healthy environment is vital

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[26] *See* O'GRADY ET AL., *supra* note 6, at 2; *see also* Elizabeth Dougherty, *If You Build It*, HARV. MED., Spring 2017, https://magazine.hms.harvard.edu/articles/if-you-build-it [https://perma.cc/R8GJ-P245] (noting that isolated and small hospitals that serve rural communities have higher mortality rates for heart problems and pneumonia compared to other hospitals).

[27] Lewis, *supra* note 4, at 4, 6; *see also Substance Use and Misuse in Rural Areas*, RURAL HEALTH INFO. HUB (last updated Aug. 2, 2024), https://www.ruralhealthinfo.org/topics/substance-use [https://perma.cc/47S5-GWAZ] (explaining that "[r]ural adults have higher rates of use for tobacco and methamphetamines" than other adults); Jeff Winton, *Confronting Mental Health Challenges in Rural America*, NAT'L ALL. ON MENTAL ILLNESS (Nov. 17, 2022), http://www.nami.org/advocate/confronting-mental-health-challenges-in-rural-america/ [https://perma.cc/99Y9-T95E] ("Rural Americans experience higher rates of depression and suicide than people who live in urban areas, but they are less likely to access mental health care services."); *Diabetes Self-Management: Rural Policy Brief*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (July 24, 2024), https://www.cdc.gov/rural-health/php/policy-briefs/diabetes-policy-brief.html [https://perma.cc/FGD5-FD8A] ("Diabetes is about 17% more prevalent in rural areas than urban ones.").

[28] Lewis, *supra* note 4, at 4.

for a healthy body.[29] Nonetheless, research demonstrates that rural communities have suffered disproportionate harm due to the climate crisis,[30] water pollution,[31] and "environmental hazards left behind at toxic [industrial] sites."[32] Rural communities and ethnic minorities may also face poorer housing quality, exacerbating the worse health outcomes they experience.[33] The lack of strong social support systems, such as high-quality transportation[34] or robust public school systems, might also negatively affect health outcomes.[35] The high barriers that rural Americans face in accessing healthy foods, such as fresh fruits and vegetables, further prevent them from improving their well-being and health.[36]

While rural communities in the nation experience worse health outcomes than urban communities, they also face higher structural barriers to accessing healthcare. For instance, rural Americans experience higher rates of poverty than urban residents, and as a result, they are more likely to

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[29] *See* Nigel Rice & Peter C. Smith, *Ethics and Geographical Equity in Health Care*, 27 J. MED. ETHICS 256, 256 (2001) (proposing that physical, cultural, and economic variations in the environment may impacts human health).

[30] Patrick Boyle, *Rural Americans Find Little Escape from Climate Change*, ASS'N AM. MED. COLLS. (July 13, 2023), https://www.aamc.org/news/rural-americans-find-little-escape-climate-change [https://perma.cc/88DJ-GWYJ].

[31] Heather Strosnider, Caitlin Kennedy, Michele Monti & Fuyuen Yip, *Rural and Urban Differences in Air Quality, 2008–2012, and Community Drinking Water Quality, 2010–2015—United States*, MORBIDITY & MORTALITY WKLY. REP., June 23, 2017, at 1, 5.

[32] *Advancing Environmental Justice*, U.S. DEP'T INTERIOR, https://www.doi.gov/advancing-environmental-justice/ [https://perma.cc/WZ8N-ZTR3].

[33] *See Housing Quality Approaches*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/toolkits/sdoh/2/built-environment/housing-quality [https://perma.cc/ZSN6-2GVN].

[34] *See Needs Related to Transportation in Rural Areas*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/toolkits/transportation/1/needs-in-rural [https://perma.cc/29AM-N9D9].

[35] *See* CTR. FOR PUB. EDUC., NAT'L SCH. BDS. ASS'N, PART 4: SCHOOL SAFETY AND MENTAL HEALTH OF RURAL STUDENTS: THINGS THAT MATTER, *in* EDUCATIONAL EQUITY FOR RURAL STUDENTS: OUT OF THE PANDEMIC, BUT STILL OUT OF THE LOOP 15, 21 (2023), https://www.nsba.org/-/media/CPE-Report-School-Safety-and-Mental-Health-of-Rural-Students.pdf [http://perma.cc/FBD8-SFAZ] (arguing that rural schools receive much lower funding than urban schools in America, and that this disparity is one reason rural schools cannot offer students school-based mental-health services).

[36] *See Rural Hunger and Access to Healthy Food*, RURAL HEALTH INFO. HUB, https://www.ruralhealthinfo.org/topics/food-and-hunger [https://perma.cc/S9PX-GUCE] (last updated Oct. 29, 2024); *see, e.g.*, Denise Payán, *Addressing Food Insecurity and Promoting Nutrition in Low-Income Communities*, UC IRVINE HEALTH AFFS.: BRIDGING THE GAP (Sept. 21, 2022), https://healthaffairs.uci.edu/news-and-media/digital-publications/bridging-the-gap-addressing-food-insecurity-and-promoting-nutrition-in-low-income-communities/ [https://perma.cc/2XRS-A4ZG] (suggesting people who live in food deserts may nevertheless have access to unhealthy foods, leading to higher rates of chronic disease); *see also* Jessica Caporuscio, *What Are Food Deserts and How Do They Impact Health?*, MED. NEWS TODAY (last updated Mar. 8, 2024), https://www.medicalnewstoday.com/articles/what-are-food-deserts#definition [http://perma.cc/6N6N-XK6Y] (arguing rural areas are more likely to experience food deserts, leading to adverse health effects).

be uninsured or underinsured.[37] Because paying out-of-pocket for regular check-ups, diagnostic tests, and other types of preventive healthcare may be cost-prohibitive for lower income rural Americans, they may not obtain such services at all, even in cases where they urgently need them.[38]

But when low-income citizens are forced to delay much-needed care, they tend to rely more heavily on hospital emergency departments to seek treatment.[39] This creates another problem. The Emergency Medical Treatment and Active Labor Act requires hospitals to offer urgent care to all citizens, even those without coverage. Because rural hospitals treat a higher percentage of uninsured patients than urban hospitals do, they perform a higher rate of uncompensated care.[40] This increases costs, undermines their financial viability, and often expedites their eventual closure.[41] Sound research indicates that uncompensated care is one of the primary reasons why rural hospitals frequently fail to remain in business and treat local residents.[42]

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[37] *See* Jennifer Cheeseman Day, *Rates of Uninsured Fall in Rural Counties, Remain Higher than Urban Counties*, U.S. CENSUS BUREAU (Apr. 9, 2019), https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html [https://perma.cc/PN9Z-W3LS]; *see also* KAISER COMM'N ON MEDICAID & THE UNINSURED, THE UNINSURED IN RURAL AMERICA (2003), https://www.kff.org/wp-content/uploads/2013/01/the-uninsured-in-rural-america-update-pdf.pdf [https://perma.cc/45YP-938G] (describing the connection between poverty and the uninsured in rural America).

[38] *See* Munira Z. Gunja, *Rural Americans Struggle with Medical Bills and Health Care Affordability*, COMMONWEALTH FUND (July 24, 2023), https://www.commonwealthfund.org/blog/2023/rural-americans-struggle-medical-bills-and-health-care-affordability [https://perma.cc/SN37-2L2Y]; *see also* Jennifer Tolbert, Patrick Drake & Anthony Damico, *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Dec. 18, 2023), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ [https://perma.cc/L2NW-KA4B] (detailing the wealth of studies showing the underinsured delay and forgo preventive care routinely).

[39] *See* NGUYEN ET AL., *supra* note 10, at 10.

[40] According to the AHA:

> Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's bad debt and the financial assistance it provides. Financial assistance includes care for which hospitals never expected to be reimbursed and care provided at a reduced cost for those in need. A hospital incurs bad debt when it cannot obtain reimbursement for care provided; this happens when patients are unable to pay their bills, but do not apply for financial assistance, or are unwilling to pay their bills. Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.

Fact Sheet: Uncompensated Hospital Care Cost, AM. HOSP. ASS'N (Feb. 2022), https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost [https://perma.cc/L3HZ-LD26]; *see also* Emmaline Keesee, Susie Gurzenda, Kristie Thompson & George H. Pink, *Uncompensated Care Is Highest for Rural Hospitals, Particularly in Non-Expansion States*, 81 MED. CARE RSCH. & REV. 164, 166 (2024) ("Rural hospitals have more uncompensated care than urban hospitals . . . .").

[41] *See* Tarun Ramesh & Emily Gee, *Rural Hospital Closures Reduce Access to Emergency Care*, CTR. FOR AM. PROGRESS (Sept. 9, 2019), https://www.americanprogress.org/article/rural-hospital-closures-reduce-access-emergency-care/ [https://perma.cc/2RMP-QM2K].

[42] *See id.*

B. Lower Volume of Patients

The low volume of patients that rural hospitals treat also leads to their closures. Lack of economic opportunity leads many Americans to leave rural areas for urban ones, resulting in lower population density.[43] Because rural hospitals treat a lower volume of patients than urban hospitals, rural hospitals fail to achieve the scale necessary to cover their high fixed costs and boost their profit margins.[44] This poses serious problems for their financial stability and frequently leads to closures.

Indeed, in the early 1990s, the Government Accountability Office found that low occupancy was highly correlated with hospital closures.[45] This led Congress to establish the Low Volume Adjustment Program in 2003.[46] Under this program, the Center for Medicare and Medicaid Services (CMS) offered additional payments to qualifying hospitals to help them cover their higher costs due to lower patient volumes.[47] Because only a limited number of hospitals qualified for this benefit, however, several rural hospitals still struggle to cover their high fixed costs and remain afloat.[48]

Low population density is not the only reason rural hospitals struggle with low patient volumes. Higher income rural residents with private health insurance often bypass their local hospitals to receive care from well-equipped urban hospitals.[49] Rural hospitals are more financially vulnerable than their urban counterparts, so they invest less in infrastructure improvements and medical technologies.[50] This motivates higher income rural residents with better coverage to obtain care at urban hospitals.[51] Without this privately insured patient base, rural hospitals have high rates of

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[43] *See id.*; *see also* AM. HOSP. ASS'N, *supra* note 22, at 5 ("While almost 20 percent of the U.S. population lives in rural areas, less than 10 percent of U.S. physicians practice in these communities.").

[44] *See* AM. HOSP. ASS'N, *supra* note 22, at 3.

[45] *Id.* at 3–4.

[46] *Id.*

[47] *Id.* at 12.

[48] *See id.*

[49] *See Patterns of Hospital Bypass and Inpatient Care-Seeking by Rural Residents*, CECIL G. SHEPS CTR. FOR HEALTH SERVS. RSCH., https://www.shepscenter.unc.edu/product/patterns-of-hospital-bypass-and-inpatient-care-seeking-by-rural-residents/ [https://perma.cc/8F7H-MXUC]; *cf.* ALANA KNUDSON, SHENA POPAT, WEN HU, CURT MUELLER & CRISTINA MILLER, CTRS. FOR MEDICARE & MEDICAID SERVS., OFF. OF MINORITY HEALTH, DATA HIGHLIGHT NO. 19, UNDERSTANDING RURAL HOSPITAL BYPASS AMONG MEDICARE FEE-FOR-SERVICE (FFS) BENEFICIARIES IN 2018 (Sept. 2020), https://www.cms.gov/files/document/hospitalbypassamongmedicaredatahighlightsept2020-1-1.pdf [https://perma.cc/N9WW-2Y39] (indicating that even rural residents with Medicare frequently bypass their local hospitals in favor of urban hospitals).

[50] *See* WISHNER ET AL., *supra* note 14, at 5 ("The local community hospital may have been older, and due to financial struggles prior to closure, may have invested less in infrastructure improvements . . . .").

[51] *See id.*

patients receiving coverage through Medicare or Medicaid.[52] These government programs pay significantly lower reimbursement rates than private health insurers.[53] Thus, rural hospitals experience higher negative profit margins than urban hospitals, expediting their closure.[54]

Low patient volumes undermine the financial performance of rural hospitals for yet another reason. Rural hospitals receive "standard flat fees for episodes of care," just like the larger hospitals in metropolitan areas.[55] This may not seem particularly troubling at first; because some cases are naturally costlier than others, "the thinking goes that it will all balance out in the end."[56] But while this thinking makes sense for large urban hospitals, which treat enough patients to achieve an average patient cost that reliably reflects the proportion of seriously ill patients to moderately ill patients in the community, that equilibrium does not exist for hospitals with a lower volume of patients. For this reason, experts warn that even "[o]ne really sick patient can close a rural hospital's doors."[57]

Low patient volumes may hurt not only the financial stability of rural hospitals but also the quality of medical services offered.[58] Research demonstrates that the higher the volume of operations a hospital undertakes, the higher the quality of these procedures.[59] For example, in pediatric care, empirical evidence shows that hospitals treating a higher number of patients with similar health conditions have better adjusted mortality rates.[60] The same applies for specific surgical procedures,[61] such as breast cancer operations.[62]

Because rural hospitals treat a lower volume of patients than urban hospitals, they may either fail "to obtain statistically reliable results" for

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[52] *Id.*

[53] *See* AM. HOSP. ASS'N, *supra* note 22, at 4.

[54] *See* WISHNER ET AL., *supra* note 14, at 6.

[55] *See* Dougherty, *supra* note 26.

[56] *See id.*

[57] *Id.*

[58] *See id.*

[59] Johannes Morche, Tim Mathes & Dawid Pieper, *Relationship Between Surgeon Volume and Outcomes: A Systematic Review of Systematic Reviews*, 5 SYSTEMATIC REVS. 204, 214 (2016).

[60] John M. Tilford, Pippa M. Simpson, Jerril W. Green, Shelly Lensing & Debra H. Fiser, *Volume–Outcome Relationships in Pediatric Intensive Care Units*, 106 PEDIATRICS 289, 293 (2000).

[61] *See* Morche et al., *supra* note 59, at 214 (finding a positive relationship between surgeon volume and procedure outcomes). *See generally* Mathieu Levaillant, Romaric Marcilly, Lucie Levaillant, Philippe Michel, Jean-François Hamel-Broza, Benoît Vallet & Antoine Lamer, *Assessing the Hospital Volume-Outcome Relationship in Surgery: A Scoping Review*, BMC MED. RSCH. METHODOLOGY, Oct. 9, 2021 (summarizing systematic reviews of the surgeon volume–outcome relationship).

[62] *See* Mary Ann Gilligan, Joan Neuner, Xu Zhang, Rodney Sparapani, Purushottam W. Laud & Ann B. Nattinger, *Relationship Between Number of Breast Cancer Operations Performed and 5-Year Survival After Treatment for Early-Stage Breast Cancer*, 97 AM. J. PUB. HEALTH 539, 541 (2007).

performance measures, such as mortality or readmission rates, or they may perform relatively poorly in them.[63] A single death may significantly depress a hospital's statistical performance indicators if they have just a few cases per year.[64] Importantly, these indicators, published by the CMS and the Agency for Healthcare Research and Quality, are often consulted by physicians making referral decisions, as well as by patients and health insurers. For this reason, poor performance indicators may further decrease patient volumes and, hence, undermine rural hospitals' financial health.[65]

C. Extreme Shortage of Physicians and Nurses

America is facing an extreme shortage of healthcare professionals—especially in the post-pandemic era.[66] This shortage disproportionately affects rural America, in particular.[67] Although rural populations account for 20% of the U.S. population, less than 10% of physicians in America offer their services in rural communities.[68] State and federal policymakers have made remarkable efforts to address the shortage of healthcare professionals

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[63] *See* AM. HOSP. ASS'N, *supra* note 22, at 4.

[64] *See* Dougherty, *supra* note 26 ("For a hospital with few cases per year, a single death pushes quality statistics down. And for small rural hospitals that aren't classified as critical access, the financial risk is higher.").

[65] Brian Wallheimer, *Hospitals Ratings Are Deeply Flawed. Can They Be Fixed?*, CHI. BOOTH REV. (Aug. 26, 2020), https://www.chicagobooth.edu/review/hospital-ratings-are-deeply-flawed-can-they-be-fixed [https://perma.cc/C4BY-EE2G] ("The CMS ratings have a particularly strong influence in the industry, in part because they affect a hospital's contract negotiations with insurance companies.").

[66] Dylan Scott, *The American Doctor Deserts*, VOX (June 23, 2023, 5:30 AM), http://www.vox.com/policy/23753724/physician-doctor-shortage-primary-care-medicare-medicaid-rural-health-care-access [https://perma.cc/3KGU-CSEV]; Andis Robeznieks, *Doctor Shortages Are Here—and They'll Get Worse If We Don't Act Fast*, AM. MED. ASS'N (Apr. 13, 2022), https://www.ama-assn.org/practice-management/sustainability/doctor-shortages-are-here-and-they-ll-get-worse-if-we-don-t-act [https://perma.cc/HK7F-E55G]; *see also AAMC Report Reinforces Mounting Physician Shortage*, ASS'N AM. MED. COLLS. (June 11, 2021), https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage [https://perma.cc/B5XV-ZMD4] (estimating a shortage of between 37,800 and 124,000 physicians by 2034); Kristine Liao & Katherine Sypher, *Rural Health and Hospitals: A Focus on Texas*, APM RSCH. LAB (Dec. 21, 2021), https://www.apmresearchlab.org/rural-hospital-closures [https://perma.cc/R8Q6-W844]; Tara Oakman & Vina Smith-Ramakrishnan, *Physician Burnout Will Burn All of Us*, CENTURY FOUND. (Oct. 25, 2023), https://tcf.org/content/report/physician-burnout-will-burn-all-of-us/ [https://perma.cc/QUA5-8W4S].

[67] Elaine K. Howley, *The U.S. Physician Shortage Is Only Going to Get Worse. Here Are Potential Solutions*, TIME (July 25, 2022, 4:07 PM), https://time.com/6199666/physician-shortage-challenges-solutions/ [https://perma.cc/PQH2-W7AV]; *see also* Scott, *supra* note 66 (predicting the physician shortage will result in rural regions being "more severely short-staffed" than other regions); Scott A. Shipman, Andrea Wendling, Karen C. Jones, Iris Kovar-Gough, Janis M. Orlowski & Julie Phillips, *The Decline in Rural Medical Students: A Growing Gap in Geographic Diversity Threatens the Rural Physician Workforce*, 38 HEALTH AFFS. 2011, 2011–12 (2019).

[68] *See* AM. HOSP. ASS'N, *supra* note 22, at 5.

in rural communities.[69] Nonetheless, the uneven distribution of physicians and nurses in the nation persists, with devastating outcomes for rural residents who desperately need treatment.[70]

Rural hospitals struggle to recruit physicians and nurses.[71] Rural hospitals often offer lower wages than hospitals in metropolitan areas.[72] They also require physicians to treat a wider range of illnesses within their communities and to perform various complex procedures—even if they lack the necessary specialized training.[73] Rural hospitals also characteristically have higher workloads and limited resources.[74] For these reasons, recruiting and retaining a workforce is often a challenge for rural hospitals.

But this is not the only reason rural hospitals suffer from a severe shortage of physicians. When a rural hospital shuts its doors, physicians often depart their communities for alternative employment.[75] Nonetheless, when physicians leave their communities due to the closure, they rarely return to the rural community they served before the closure.[76] Specifically, data show that when a rural hospital exits the market, there is an average annual reduction of 9.2% in the supply of all physicians, 8.3% in the supply of primary care physicians, and 4.8% in the supply of obstetrician–gynecologists.[77] The researchers observed that this reduction in supply was even greater after the sixth year following the closure, especially for surgical specialists and primary care physicians.[78]

II. PROPOSED PUBLIC HEALTH SOLUTIONS

Despite the magnitude of the hospital desert problem and the severe harms it causes to the most vulnerable rural Americans, public health experts urge rural communities not to give up hope. For instance, they claim that increased use of telemedicine by underserved communities, Medicaid

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[69] *See id.* at 17.

[70] *Id.* at 7.

[71] Allee Mead, *It Takes a Village: Rural Recruitment and Retention*, RURAL HEALTH INFO. HUB: RURAL MONITOR (Nov. 3, 2021), https://www.ruralhealthinfo.org/rural-monitor/rural-recruitment-and-retention [https://perma.cc/7J9X-YGRG].

[72] *Id.*

[73] Ian T. MacQueen, Melinda Maggard-Gibbons, Gina Capra, Laura Raaen, Jesus G. Ulloa, Paul G. Shekelle, Isomi Miake-Lye, Jessica M. Beroes & Susanne Hempel, *Recruiting Rural Healthcare Providers Today: A Systematic Review of Training Program Success and Determinants of Geographic Choices*, 33 J. GEN. INTERNAL MED. 191, 191 (2018).

[74] Mead, *supra* note 71.

[75] Hayley Drew Germack, Ryan Kandrack & Grant R. Martsolf, *When Rural Hospitals Close, the Physician Workforce Goes*, 38 HEALTH AFFS. 2086, 2087 (2019).

[76] *See id.* at 2089–91.

[77] *Id.* at 2090–91.

[78] *Id.* at 2091.

expansion, and the implementation of local health-promotion initiatives can improve rural residents' well-being and health. For this reason, these measures can also reduce the rate of uncompensated care that rural hospitals are forced to offer, ultimately improving their financial health.

The following Sections weigh the strengths and weaknesses of each proposal mentioned above. This Part argues that such proposals, alone, albeit crucial, may fail to cure the problem. This is because hospital deserts do not result only from the social and demographic characteristics of rural residents, nor the fact that rural hospitals offer higher rates of uncompensated care than urban hospitals. Rather, this problem is also the result of several anticompetitive business strategies employed by both rural and urban hospitals throughout America.

A. Telemedicine

Increased use of telemedicine can improve access to care for underserved communities in rural areas.[79] Telemedicine reduces the need for residents to travel long distances to visit hospitals or physicians.[80] It also reduces the need for people to secure childcare or take time off from work to receive medical advice and treatment.[81] For such reasons, telemedicine can improve rural residents' health and life expectancy, especially for those suffering from chronic diseases whose treatment requires continuous supervision. By improving rural residents' access to primary care, telemedicine could also reduce the frequency of emergency-room visits that burden rural hospitals.

Nonetheless, the assumption that telemedicine always and necessarily improves access to care for rural populations who need treatment should not remain unchallenged. In fact, studies indicate that access to telemedicine has not spread equally to all populations across America. For instance, one recent study has shown that the most vulnerable populations—specifically, racial and ethnic minorities as well as the older, poorer, and less proficient in

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[79] *Telehealth, Telemedicine, and Telecare: What's What?*, FED. COMMC'NS COMM'N, https://www.fcc.gov/general/telehealth-telemedicine-and-telecare-whats-what/ [https://perma.cc/HW3S-PL28] ("Telemedicine can be defined as using telecommunications technologies to support the delivery of all kinds of medical, diagnostic and treatment-related services usually by doctors. . . . [T]his includes conducting diagnostic tests, closely monitoring a patient's progress after treatment or therapy and facilitating access to specialists that are not located in the same place as the patient.").

[80] Jenna Becker, *How Telehealth Can Reduce Disparities*, HARV. L. SCH. PETRIE-FLOM CTR.: BILL OF HEALTH (Sept. 11, 2020), https://blog.petrieflom.law.harvard.edu/2020/09/11/telehealth-disparities-health-equity-covid19/ [https://perma.cc/Q52Y-Q52C].

[81] Sarah C. Hull, Joyce M. Oen-Hsiao & Erica S. Spatz, *Practical and Ethical Considerations in Telehealth: Pitfalls and Opportunities*, 95 YALE J. BIOLOGY & MED. 367, 368 (2022).

English—did not rely on telemedicine to obtain care during the COVID-19 pandemic.[82]

Previous research also supports these findings, demonstrating that most telemedicine users live in metropolitan areas, have higher socioeconomic status, and are often well-educated.[83] Specifically, it indicates that while 11% of internet users with family incomes of $100,000 or more receive care through telemedicine, only 4% of those in families who earn under $25,000 annually utilize this form of care.[84]

The reason for telemedicine's less than stellar record of reaching rural populations is rather obvious. Telemedicine requires patients to use unfamiliar technology and have access to reliable broadband internet service. These limitations restrict the use of telemedicine by lower income communities, racial and ethnic minorities, and older populations who often lack adequate internet access or digital literacy.[85] For instance, among adults

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[82] Kanza Aziz, Jade Y. Moon, Ravi Parikh, Alice C. Lorch, David S. Friedman, John B. Miller & Grayson W. Armstrong, *Association of Patient Characteristics with Delivery of Ophthalmic Telemedicine During the COVID-19 Pandemic*, 139 [J]AMA OPHTHALMOLOGY 1174, 1180 (2021); Jorge A. Rodriguez, Altaf Saadi, Lee H. Schwamm, David W. Bates & Lipika Samal, *Disparities in Telehealth Use Among California Patients with Limited English Proficiency*, 40 HEALTH AFFS. 487, 490 (2021); *see also* Lauren A. Eberly, Michael J. Kallan, Howard M. Julien, Norrisa Haynes, Sameed Ahmed M. Khatana, Ashwin S. Nathan, Christopher Snider, Neel P. Chokshi, Nwamaka D. Eneanya, Samuel U. Takvorian, Rebecca Anastos-Wallen, Krisda Chaiyachati, Marietta Ambrose, Rupal O'Quinn, Matthew Seigerman, Lee R. Goldberg, Damien Leri, Katherine Choi, Yevginiy Gitelman, Daniel M. Kolansky, Thomas P. Cappola, Victor A. Ferrari, C. William Hanson, Mary Elizabeth Deleener & Srinath Adusumalli, *Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic*, [J]AMA NETWORK OPEN, Dec. 29, 2020, at 1, 7 ("Non-English language as the patient's preferred language was independently associated with 16% lower telemedicine visit completion despite adjustment for other factors, which suggests that language barriers to care via telemedicine platforms may be prohibitive.").

[83] NAT'L TELECOMMS. & INFO. ADMIN. & ECON. & STAT. ADMIN., U.S. DEP'T OF COM., EXPLORING THE DIGITAL NATION: AMERICA'S EMERGING ONLINE EXPERIENCE 11 (2013), https://www.ntia.doc.gov/files/ntia/publications/exploring_the_digital_nation_-_americas_emerging_online_experience.pdf [https://perma.cc/WRN3-PNAS]; *see also* Jeongyoung Park, Clese Erikson, Xinxin Han & Preeti Iyer, *Are State Telehealth Policies Associated with the Use of Telehealth Services Among Underserved Populations?*, 37 HEALTH AFFS. 2060, 2066 (2018).

[84] NAT'L TELECOMMS. & INFO. ADMIN. & ECON. & STAT. ADMIN., *supra* note 83, at 11.

[85] One study claims that

> one in four Americans does not have the [Broadband Internet Access (BIA)] or devices needed to engage in video visits. Without BIA, patients cannot fully use telehealth in all its forms: asynchronous messaging via patient portals, remote monitoring devices such as blood pressure monitors, or synchronous video connections to consult with a physician. . . . Some patients, even those with BIA, have declined to use these technologies because of difficulties with digital literacy or privacy concerns.

Natalie C. Benda, Tiffany C. Veinot, Cynthia J. Sieck & Jessica S. Ancker, *Broadband Internet Access Is a Social Determinant of Health!*, 110 AM. J. PUB. HEALTH 1123, 1123 (2020) (footnote omitted) (citing Olivia Sidoti & Wyatt Dawson, *Internet, Broadband Fact Sheet*, PEW RSCH. CTR. (last updated Nov. 13,

aged 65 or older, only 53% have a smartphone, about 60% have access to broadband internet, and 73% have the basic skills they need to use the internet.[86] Among the 73% who use the internet, only 60% know how to find a website and send an email.[87] Additionally, studies reveal that 1 out of 8 Americans lives in deep poverty and that lower income individuals are less likely to own a smartphone or have a reliable cellular-data plan.[88] Privacy concerns may also discourage patients from implementing virtual forms of care.[89] This may be especially true for communities of color[90] due to the deep-rooted racism that pervades the healthcare sector.[91]

Furthermore, when telemedicine is used as the primary form of care, quality of care may also suffer. Quality of care is a multidimensional concept synthesizing the notions of equity, access, continuity, and "acceptability," measured as the level of trust one has in the doctor–patient relationship.[92] Telemedicine may undermine continuity of care, which in turn undermines trust. When patients receive care via telemedicine, they are randomly assigned to different physicians who work in rotation rather than having a consistent physician with whom they have developed a trusting relationship. Because telemedicine fails to ensure continuity of care, Black populations

2024), https://www.pewresearch.org/internet/ fact-sheet/internet-broadband [https://perma.cc/YP3W-FXWW] (reporting 73% of inividuals had BIA in 2019)).

[86] Jennifer C. Price & Dinee C. Simpson, *Telemedicine and Health Disparities*, 19 CLINICAL LIVER DISEASE 144, 145 (2022).

[87] Sarah Nouri, Elaine C. Khoong, Courtney R. Lyles & Leah Karliner, *Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic*, NEW ENG. J. MED. CATALYST, May 4, 2020, at 1, 2.

[88] *See id.*

[89] *See generally* Timothy M. Hale & Joseph C. Kvedar, *Privacy and Security Concerns in Telehealth*, 16 VIRTUAL MENTOR 981 (2014) (discussing the lack of control telehealth patients have over the use of their personal data under current law).

[90] Vivian Yee, Simar S. Bajaj & Fatima Cody Stanford, *Paradox of Telemedicine: Building or Neglecting Trust and Equity*, 4 LANCET DIGIT. HEALTH e480, e480 (2022) ("Black Americans have historically adopted novel medical technologies at lower rates than their White counterparts, due in large part to inaccessibility and well founded suspicion towards medical innovation.").

[91] *Id.*; *see also* J. Corey Williams, *Black Americans Don't Trust Our Healthcare System—Here's Why*, HILL: HEALTHCARE BLOG (Aug. 24, 2017, 11:20 AM), https://thehill.com/blogs/pundits-blog/healthcare/347780-black-americans-dont-have-trust-in-our-healthcare-system [https://perma.cc/G4ZW-3UTV] ("The U.S. medical establishment has a long legacy of discriminating and exploiting black Americans, the indelible memory of which remains deeply embedded in the collective consciousness of the community. Historically, medicine has used black bodies, without consent, for its own advancement; while[] medical theories, technologies, and institutions were used to reinforce systems of oppression.").

[92] AVEDIS DONABEDIAN, AN INTRODUCTION TO QUALITY ASSURANCE IN HEALTH CARE 4 (Rashid Bashshur ed., 2003); *see also* THEODOSIA STAVROULAKI, HEALTHCARE, QUALITY CONCERNS AND COMPETITION LAW: A SYSTEMATIC APPROACH 22 (Tamara Hervey & Thérèse Murphy eds., 2023) (summarizing the dimensions of healthcare quality and emphasizing the importance of balancing these sometimes conflicting factors).

are less likely than white ones to access healthcare through telemedicine.[93] A study illustrates that African Americans suffering from diabetes during the pandemic did not rely on telemedicine to receive care because they distrusted this medical technology.[94]

Thus, although telemedicine is a valuable tool for expanding healthcare access in rural areas, it is far from a silver bullet. In fact, relying solely on telemedicine to do so may widen, rather than mitigate, the rising health and racial inequities disproportionately harming rural America.[95] In addition, because telemedicine may fail to ensure access to primary care for the people who need it most—namely, communities of color and lower income individuals—it may also fail to relieve the financial burdens of struggling rural hospitals and deter their closures.

B. Medicaid Expansion

Telemedicine is not the only measure that can improve access to care for vulnerable populations in rural areas. Medicaid expansion also has the potential to enhance health outcomes for rural residents and to assuage the rampant hospital closure crisis that is plaguing underserved areas.

Medicaid is the main form of health insurance coverage for poor Americans. The 2010 Affordable Care Act (ACA) required states to expand Medicaid. The vision of the ACA was to increase health insurance coverage for almost all Americans with household incomes up to 138% of the federal poverty level.[96] However, in *National Federation of Independent Business v. Sebelius*,[97] the Supreme Court struck down the obligatory expansion of Medicaid.[98] As a result, ten states have not expanded Medicaid to date.[99] Unfortunately, rural hospitals in these states have been the ones to pay the

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[93] Yee et al., *supra* note 90, at 480.

[94] Barry W. Rovner, Robin J. Casten, Anna Marie Chang, Judd E. Hollander & Kristin Rising, *Mistrust, Neighborhood Deprivation, and Telehealth Use in African Americans with Diabetes*, 24 POPULATION HEALTH MGMT. 699, 700 (2021).

[95] *Id.*; *see* Aziz et al., *supra* note 82, at 1178 ("Although telemedicine is increasingly considered to be 1 approach to improve access to care and decrease health care disparities, reports of even greater disparities in the use of telemedicine have surfaced across multiple fields of medicine . . . .").

[96] *See Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (May 8, 2024), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/YLS4-JPMN].

[97] 567 U.S. 519, 588 (2012).

[98] *See* KAISER FAM. FOUND., A GUIDE TO THE SUPREME COURT'S DECISION ON THE ACA'S MEDICAID EXPANSION 4 (Aug. 2012), https://www.kff.org/wp-content/uploads/2013/01/8347.pdf [https://perma.cc/57FB-RZ9A].

[99] *See Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 96.

price. Of all the rural hospitals likely to shut their doors in America, 75% are in non-expansion states.[100]

Empirical evidence demonstrates that a state's decision regarding Medicaid expansion significantly affects the financial performance of area hospitals and the health of state residents.[101] Hospitals located in expansion states have lower uncompensated care costs attributable to uninsured patients than hospitals in non-expansion states.[102] They also generate higher Medicaid revenue from the newly covered and, hence, have higher operating margins.[103] For this reason, Medicaid expansion can assist rural hospitals in reducing the rate of uncompensated care they offer to the uninsured and even defer hospital closures.

A recent study confirms that states that have not expanded Medicaid suffer a higher rate of hospital closures than those that opted for Medicaid expansion.[104] Specifically, this study reveals that states that chose not to expand Medicaid witnessed a significant increase in hospital-closure rates in 2008–2012 and 2015–2016.[105] On the other hand, states that expanded Medicaid saw a decrease in the number of hospital closures during this same period.[106] The same study also identified the primary mechanism that explains the relationship between Medicaid expansion and hospital closures: "the substitution of utilization [of a hospital's services] by patients with Medicaid coverage for utilization [of these services] by uninsured patients."[107] The study thus shows a clear link between Medicaid expansion and improved financial health for struggling hospitals.

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[100] Dylan Scott, *1 in 4 Rural Hospitals Is Vulnerable to Closure, a New Report Finds*, VOX (Feb. 18, 2020, 3:00 PM), https://www.vox.com/policy-and-politics/2020/2/18/21142650/rural-hospitals-closing-medicaid-expansion-states [https://perma.cc/6535-ZHUA].

[101] Fredric Blavin & Christal Ramos, *Medicaid Expansion: Effects on Hospital Finances and Implications for Hospitals Facing COVID-19 Challenges*, 40 HEALTH AFFS. 82, 88–89 (2021); *see also* Richard C. Lindrooth, Marcelo C. Perraillon, Rose Y. Hardy & Gregory J. Tung, *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFFS. 111, 117–18 (2018) (finding a positive correlation between Medicaid expansion and area hospitals' financial performance); David Dranove, Craig Garthwaite & Christopher Ody, *Uncompensated Care Decreased at Hospitals in Medicaid Expansion States But Not at Hospitals in Nonexpansion States*, 35 HEALTH AFFS. 1471, 1471 (2016) ("[I]n states that expanded Medicaid under the ACA, uncompensated care costs decreased from 4.1 percentage points to 3.1 percentage points of operating costs."); Fredric Blavin, *Association Between the 2014 Medicaid Expansion and US Hospital Finances*, 316 [J]AMA 1475, 1476 (2016) ("Medicaid expansion was associated with significant declines in uncompensated care costs and increases in Medicaid revenue in 2014 among hospitals in 19 states that expanded Medicaid compared with hospitals in 25 states that did not expand Medicaid.").

[102] *See* Blavin & Ramos, *supra* note 101, at 87.

[103] *See id.* at 83, 85.

[104] *See* Lindrooth et al., *supra* note 101, at 114.

[105] *Id.*

[106] *Id.* at 114–15.

[107] *Id.* at 117.

However, although expanding Medicaid can improve the profit margins of rural hospitals, reality demonstrates that this measure alone cannot prevent the hospital-closure epidemic in underserved areas. Consider Kentucky, a state that has only recently expanded Medicaid. Although Medicaid expansion helped some hospitals in Kentucky, such as Parkway Regional, operate for longer than they might have otherwise, it ultimately did not prevent their closure.[108] Three other hospitals in the state met the same fate.[109] This indicates that although Medicaid expansion can improve the financial performance of rural hospitals, it cannot, by itself, deter the hospital-closure epidemic.

This is true for at least two reasons. First, Medicaid expansion does not necessarily address all the causes of the hospital-closure crisis, including the shortage of healthcare professionals in rural communities. Second, the compensation hospitals receive for Medicaid patients, while greater than the nothing they receive from patients who are not covered at all, is still too little to cover the overhead costs incurred while treating those patients.[110] In fact, a 2022 report by the American Hospital Association (AHA) explains that Medicaid reimburses less than half of rural hospitals' costs when they treat Medicaid patients.[111] This may partially explain why Medicaid expansion alone cannot eliminate the risk of hospital closures in underserved areas.

C. Health-Promotion Programs

Rural Americans are more likely to suffer from obesity, cancer, or respiratory diseases, and they are less likely to engage in physical exercise[112] or adhere to a healthy lifestyle.[113] Given that some of these problems are (to some extent) preventable, health-policy experts often claim that further expansion of health-promotion programs could help rural residents make choices that will improve their well-being and health.[114]

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[108] *See* WISHNER ET AL., *supra* note 14, at 9.

[109] *Id.*

[110] *See* AM. HOSP. ASS'N, *supra* note 8, at 6.

[111] *See id.*

[112] *See* Matthew Chrisman, Faryle Nothwehr, Ginger Yang & Jacob Oleson, *Environmental Influences on Physical Activity in Rural Midwestern Adults: A Qualitative Approach*, 16 HEALTH PROMOTION PRAC. 142, 142 (2015).

[113] *See About Rural Health*, *supra* note 2.

[114] *See Module 1: Health Promotion and Disease Prevention in Rural Communities*, RURAL HEALTH INFO. HUB (last reviewed Jan. 14, 2024), https://www.ruralhealthinfo.org/toolkits/health-promotion/1/introduction [https://perma.cc/QDK2-TB2C]; *see also Community Health Promotion in Rural Areas*, TUL. UNIV. CELIA SCOTT WEATHERHEAD SCH. PUB. HEALTH & TROPICAL MED.: BLOG (Feb. 14, 2023), https://publichealth.tulane.edu/blog/community-health-promotion-rural-areas/ [https://perma.cc/E9MN-KHEM] (describing how community health-promotion programs address the needs of rural residents).

Many possible programs could promote greater health in rural areas. For starters, nutrition-promotion programs could potentially increase rural communities' awareness about the relationship between food and health.[115] Indeed, studies have established that a healthy diet can optimize health outcomes,[116] while poor nutrition can lead to increased mortality rates.[117] Given the strong correlation between food and health, educating the public about the life-saving benefits of good nutrition may help rural populations improve their health.

Introducing smoking-cessation programs may also improve health outcomes in rural areas.[118] Research indicates that there are wide disparities between urban and rural communities in both tobacco use and "tobacco-related diseases," including cancer.[119] For instance, the American Psychiatric Association reports that not only are rural individuals "more likely to use tobacco," including cigarettes and smokeless tobacco, but they are also more "likely to be exposed to secondhand smoke . . . ."[120] Rural Americans are also more likely to begin smoking at a younger age and to consume higher quantities of tobacco products than urban residents.[121] Thus, introducing smoking-cessation programs in rural areas may reduce the risk of cancer or various respiratory diseases.

Nonetheless, expanding health-promotion programs that may help *individuals* in rural areas may not necessarily help rural *communities* improve their health. Clinical evidence indicates a strong link between health disparities and the social determinants of health.[122] Decades of research illustrate that "the relationship between social advantage and health is incremental, with less advantaged groups experiencing a disproportionate burden of poor health and even relatively advantaged groups showing a

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[115] *See Community Health Promotion in Rural Areas*, *supra* note 114.

[116] Sara N. Bleich, Jessica Jones-Smith, Julia A. Wolfson, Xiazhou Zhu & Mary Story, *The Complex Relationship Between Diet and Health*, 34 HEALTH AFFS. 1813, 1813 (2015).

[117] *See id.*

[118] *See Community Health Promotion in Rural Areas*, *supra* note 114.

[119] *Id.*; *see also* Maria A. Parker, Andrea H. Weinberger, Emma M. Eggers, Erik S. Parker & Andrea C. Villanti, *Trends in Rural and Urban Cigarette Smoking Quit Ratios in the US from 2010 to 2020*, [J]AMA NETWORK OPEN, Aug. 3, 2022, at 1.

[120] *Community Health Promotion in Rural Areas*, *supra* note 114; *see also Smoking and Tobacco Use in Rural Populations*, AM. PSYCH. ASS'N (2016), https://www.apa.org/pi/health-equity/resources/smoking-rural-populations [https://perma.cc/J4T5-JTNC] (noting rural populations are more heavily impacted by tobacco use).

[121] Kelly Buettner-Schmidt, Donald R. Miller & Brody Maack, *Disparities in Rural Tobacco Use, Smoke-Free Policies, and Tobacco Taxes*, 41 W.J. NURSING RSCH. 1184, 1188 (2019).

[122] *See* Ana Penman-Aguilar, Makram Talih, David Huang, Ramal Moonesinghe, Karen Bouye & Gloria Beckles, *Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity*, 22 J. PUB. HEALTH MGMT. PRAC. S33, S34 (2016).

deficit."[123] This is because poorer individuals face higher structural barriers to adopting a healthier lifestyle—such as accessing fresh food or attaining childcare to exercise regularly.[124] Hence, expanding health-promotion programs in rural areas may not necessarily effectuate the types of changes that would improve community health. For the same reason, greater reliance on health-promotion programs may not reduce the rate of hospital closures in rural neighborhoods.

And yet, there are additional reasons why the above measures alone may not mitigate the mounting hospital closures and the resulting hospital deserts in underserved communities. As the following Part shows, these measures are insufficient because they fail to address the antitrust dimension of the hospital-deserts problem. Specifically, they fail to recognize that a major cause of hospital deserts is the anticompetitive business strategies implemented by hospitals nationwide. These strategies, which include mergers with competitors and noncompetes in the labor market, exacerbate the shortage of nurses and physicians that rural communities experience and leave vulnerable residents without essential care. By examining these strategies through an antitrust lens, the following Part illustrates that the wounds hospital deserts inflict on rural populations cannot be treated adequately without the healing power of antitrust law.

III. A STORY NEVER TOLD: MERGERS LEAD TO THE RISING HOSPITAL CLOSURE CRISIS IN RURAL AMERICA

Hospital markets in America are extremely concentrated.[125] This is largely due to the wave of hospital mergers that America experienced in the 1990s.[126] This merger wave led to lower wages, inferior working conditions, and less favorable employment terms for workers in the hospital industry, including noncompete agreements. This Part demonstrates that those harmful effects exacerbated the problem of hospital deserts in America and that each factor can be readily traced back to the merger wave of the '90s. *What caused this merger wave?*

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[123] *See id.*

[124] Theodosia Stavroulaki, *Mergers That Harm Our Health*, 19 BERKELEY BUS. L.J. 89, 97 (2022).

[125] Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, 36 HEALTH AFFS. 1530, 1534 (2017); *see also* Allison Inserro, *Nearly 75% of US Hospital Markets Highly Concentrated, HCCI Report Shows*, AM. J. MANAGED CARE (Sept. 17, 2019), https://www.ajmc.com/view/nearly-75-of-us-hospital-markets-highly-concentrated-hcci-report-shows [https://perma.cc/UG5P-RJYD] (reporting that almost 75% of U.S. hospital markets are designated as "highly concentrated").

[126] *See* AM. BAR ASS'N, HEALTH CARE MERGERS AND ACQUISITIONS HANDBOOK 1 (Michael H. Knight & Michael A. Gleason eds., 2d ed. 2018).

The late 1980s and '90s saw the emergence of new treatment and fee structures. During the first half of the twentieth century, most patients received care from independent physicians whose pricing was mainly fee-for-service (FFS).[127] This form of payment kept with the popular sentiments that more care meant better care and that physicians were the best positioned to identify and recommend the most appropriate form of treatment.[128] Health insurers did not restrict consumers' choice of providers, nor did they strictly circumscribe the types of care they would cover so long as a physician recommended that care.[129]

But beginning in the late 1960s, health experts started raising concerns that physicians had no incentive to compete on price terms because patients often had little or no knowledge about the value of the services they were being offered, and because health insurers would cover the costs of treatment and fully reimburse the performing physician in virtually all cases.[130] Unsurprisingly, these mechanisms motivated physicians to overprovide, and consumers to overconsume, healthcare.[131]

Influenced by these concerns, state and federal health policies began to encourage alternative forms of healthcare delivery and, over the past three decades, have induced varying degrees of price and quality competition among healthcare providers.[132] The rapid growth of managed care in the 1990s resulted from this new policy orientation aimed at inducing competition in the healthcare industry.[133] The growing demand for lower healthcare costs, along with the increasing presence of managed care, placed enormous pressure on hospitals to reduce their costs while simultaneously improving the quality of their services. To attain these goals, hospitals started merging. This spurred a period of rapid and substantial consolidation in the hospital industry: to put it simply, a merger wave.

This trend toward consolidation has never abated. Rather, it has ramped up following the implementation of the ACA, which sought to enhance

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[127] FFS means the payment is based on the number and type of services performed. *See Fee for Service*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/fee-for-service/ [https://perma.cc/A98N-ZEYG]; *see also* U.S. DEP'T OF JUST. & FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 1 (2004), https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice [https://perma.cc/HBZ5-6XTH].

[128] U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 127, at 1–2.

[129] *See id.* at 1.

[130] *See id.* at 2.

[131] *Id.*

[132] *Id.*

[133] STAVROULAKI, *supra* note 92, at 99.

quality and reduce healthcare costs by improving coordination of care among providers through the establishment of Accountable Care Organizations.[134]

But can hospital consolidation really reduce the cost of care while also improving quality? This is not an easy question to address. For instance, mergers may create economies of scale—the more care a hospital provides, the more efficient and less costly each instance of care becomes.[135] Additionally, mergers may allow hospitals to eliminate duplicate services, push down administrative costs, and expand their delivery network.[136] For these reasons, hospitals often allege that a merger can boost the efficiency of their services.[137]

In theory, mergers may also allow hospitals to enhance service quality.[138] For example, acquiring hospitals can bring both their resources and their management expertise to the acquired hospitals, allowing for an expansion of the services delivered.[139] Such an expansion can contribute to quality as patients can access a wider array of services.[140] Again, in theory, a merger can also enhance the average quality of the services offered to patients "by redirecting patient flows."[141] Hence, a hospital system can concentrate services in its higher quality facilities, improving the quality of care that patients of the newly merged entity receive.

Inevitably, mergers also increase providers' patient volumes. In light of medical research identifying a relationship between patient volumes and procedure volumes, the increased patient volumes that a merger brings

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[134] *Id.*; *see also* Patient Protection and Affordable Care Act (ACA) § 3011, 42 U.S.C. § 280j (listing efficiency as a key goal of the ACA). Accountable Care Organizations are groups of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated, high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors. *Accountable Care Organizations (ACOs): General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/priorities/innovation/innovation-models/aco [https://perma.cc/2MQB-D655].

[135] Gregory Curfman, *Everywhere, Hospitals Are Merging—but Why Should You Care?*, HARV. HEALTH PUBL'G: HARV. HEALTH BLOG (Apr. 1, 2015), https://www.health.harvard.edu/blog/everywhere-hospitals-are-merging-but-why-should-you-care-201504017844 [https://perma.cc/M9HJ-4887] (arguing that hospital administrators often claim that hospital consolidation may reduce costs "because in theory, the more care a hospital provides, the more efficient and less expensive it should become").

[136] STAVROULAKI, *supra* note 92, at 99–100.

[137] *See The Benefits of Hospital Mergers*, AM. HOSP. ASS'N: BLOG (Nov. 8, 2017, 9:49 AM), https://www.aha.org/news/blog/2017-11-08-benefits-hospital-mergers [https://perma.cc/BLF2-JHXE].

[138] *See* Kristin Madison, *Hospital Mergers in an Era of Quality Improvement*, 7 HOUS. J. HEALTH L. & POL'Y 265, 274 (2007).

[139] *Id.* at 275.

[140] *Id.*

[141] *Id.*

to a facility may improve the overall quality of the services provided.[142] Furthermore, peer-to-peer influence between hospital personnel can speed the adoption of novel forms of medical treatment.[143] In other words, a merger that encourages sharing experience and medical expertise among physicians and hospital administrators could lead to better care.

But the story does not end there. Reality demonstrates that the acquiring hospitals often target rural hospitals to remove their closest competitor and increase their market power in the hospital-services market.[144] This, however, worsens health outcomes for rural residents who desperately need quality treatment. This is because, as the next Section shows, this business strategy of acquiring competing rural hospitals often leads to the acquisition's closure.

At the same time, by acquiring their closest competitors in rural areas, hospitals also increase their market power in labor markets. This allows hospitals to suppress the wages of healthcare workers, vitiate their working conditions, and impose unfavorable employment terms, such as noncompetes. While hospitals may allege that they employ these strategies to reduce their costs, improve their profit margins, retain their workers, and stay afloat, the upshot is that these strategies contribute to the hospital-closure epidemic in rural America.

This Part examines the vital question of how this happens. In so doing, it explains that the problem of hospital deserts in rural communities is unlikely to be cured without rigorous enforcement of antitrust principles.

A. Effects of Consolidation on the Output Market: Shutdowns and Reduced Access to Care

Mergers among rural hospitals often lead to hospital deserts and, as a result, leave rural communities without meaningful access to care. As noted, this is because rural hospitals often acquire their closest competitors to increase their market power.[145] Consequently, after such a merger is complete, the acquiring hospital shuts down the newly acquired one, leaving

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[142] *See* STAVROULAKI, *supra* note 92, at 99–100.

[143] *See* Madison, *supra* note 138, at 276.

[144] *See* Dunc Williams Jr., Kristin L. Reiter, George H. Pink, G. Mark Holmes & Paula H. Song, *Rural Hospital Mergers Increased Between 2005 and 2016—What Did Those Hospitals Look Like?*, INQUIRY, 2020, at 2 ("A 2017 industry survey of hospital executives conducted by Deloitte and Healthcare Financial Management Association (HFMA) showed that executives from acquiring hospitals most commonly reported merging to increase market share (40%) . . . .").

[145] *See id.* at 3; *see also* WISHNER ET AL., *supra* note 14, at 5 ("[L]arge health systems that owned and managed the hospitals made the decision to close them based not on community needs, but on corporate business considerations that favored other hospitals in their system over the ones they closed."). This study also claims that a "shift from mission to margin" is "a major factor in the hospital closures and in the lack of consideration or planning for the impact on the community." *Id.* at 6.

a hospital desert.[146] Data from the AHA reveal that from 1998 to 2021, approximately 1,887 hospital mergers were announced.[147] After these mergers moved forward, the number of hospitals in the nation reduced from about 8,000 to about 6,000.[148] In other words, over the past two decades, about a quarter of American hospitals have closed their doors.

Not surprisingly, this business strategy has had a devastating impact on the health of rural communities, who are already deprived of good care. Indeed, data show that each time a rural hospital shuts its doors, the mortality rate for rural residents rises. One study finds that a rural hospital closure can lead to a 7.3% increase in the inpatient mortality of Medicare patients and an 11.3% increase in the mortality of Medicaid patients.[149] The same study also reveals that hospital closures contribute to the rising racial disparities in health outcomes. Specifically, researchers found that rural hospital closures increased mortality rates for white patients by 7.4% and for nonwhite patients by 12.6%—even though the rural-closure treatment group included a higher percentage of white patients compared to the control group.[150]

But even in cases where hospital mergers do not lead to closures, they still reduce access to care for rural Americans. A recent study indicates that, following a merger, acquired rural hospitals experience a reduction in the

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[146] *See* O'Hanlon et al., *supra* note 21, at 2096 ("Affiliation may also negatively affect access, as health systems sometimes close rural facilities after acquiring them."); *see also* WISHNER ET AL., *supra* note 14, at 5 (indicating that resources may be preferentially invested in particular communities resulting in the closure of outside facilities); Williams et al., *supra* note 144, at 3 (reporting that "[a]mong the 326 unique rural hospitals that merged, 10 hospitals closed after merging, nine of which closed from 2010 through 2016," many of which were part of multi-hospital acquisitions by healthcare systems); SARA SIROTA, AM. ECON. LIBERTIES PROJECT, THE HARMS OF HOSPITAL MERGERS AND HOW TO STOP THEM 5 (2023), https://www.economicliberties.us/wp-content/uploads/2023/04/Hospital_QuickTake-0421-002.pdf [https://perma.cc/XJ5C-4P6Z] ("Hospital acquisitions often lead to shutdowns of hospital departments or specialized care units."); Oakman & Smith-Ramakrishnan, *supra* note 66 ("These horizontal consolidations have meant some economies of scale, but also multiple closures, especially in rural areas, and investors and administrators are often more concerned about revenue than patient outcomes and health access."); Barbara Feder Ostrov & Lauren Weber, *The Collapse of a Hospital Empire—and Towns Left in the Wreckage*, STATEIMPACT OKLA. (Sept. 24, 2019, 4:00 PM), https://stateimpact.npr.org/oklahoma/2019/09/24/the-collapse-of-a-hospital-empire-and-towns-left-in-the-wreckage/ [https://perma.cc/L9KQ-ZLFG].

[147] Hoag Levins, *Hospital Consolidation Continues to Boost Costs, Narrow Access, and Impact Care Quality*, PENN LDI (Jan. 19, 2023), https://ldi.upenn.edu/our-work/research-updates/hospital-consolidation-continues-to-boost-costs-narrow-access-and-impact-care-quality/ [https://perma.cc/7C64-2ZY2].

[148] *Id.*

[149] *See* Kritee Gujral & Anirban Basu, *Impact of Rural and Urban Hospital Closures on Inpatient Mortality* 11 (Nat'l Bureau of Econ. Rsch., Working Paper No. 26182, 2019).

[150] *Id.*

availability of primary and obstetric care.[151] Another study reveals that only 15.3% of acquired rural hospitals continue to offer acute-care services in the wake of a merger.[152] Data also demonstrate that acquiring hospitals often discontinue vital healthcare services, including psychiatric care, cardiac surgery, and even emergency, maternal,[153] and primary care.[154] What's more, when a religiously sponsored health system acquires rural hospitals, the latter may be forced to cut key reproductive services, prevent gender-affirming care, or deny certain end-of-life care options.[155]

Unfortunately, rural residents forgo much-needed care when acquiring hospitals cut essential services.[156] Absent available choices, rural residents are forced to travel long distances from their homes to receive healthcare. Oftentimes, rural residents prefer not to undergo lab work and diagnostic imaging rather than travel several miles to obtain care.[157]

In addition, when emergency departments shut down, the mental health of rural communities deteriorates at an alarming rate.[158] This is because, especially for lower income rural Americans who lack coverage, entering a hospital's emergency department is the only way they can access acute mental-health services or receive substance-abuse treatment.[159] Not

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[151] *See* O'Hanlon et al., *supra* note 21, at 2100 (noting that post-merger, acquired rural hospitals witnessed a 7%–14% annual reduction in the availability of obstetric services compared to non-affiliated entities as well as a 7%–19% annual reduction in the availability of primary care departments within 5–6 years following the acquisition); *see also* Hung et al., *supra* note 17, at 1556 (noting that rural hospitals are vulnerable to closures that impact patient access to obstetric care); Rachel Mosher Henke, Kathryn R. Fingar, H. Joanna Jiang, Lan Liang & Teresa B. Gibson, *Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas*, 40 HEALTH AFFS. 1627, 1634 (2021) (noting rural hospitals that merged were more likely to eliminate maternal and neonatal care services than unaffiliated hospitals).

[152] Richard J. Bogue, Stephen M. Shortell, Min-Woong Ma Sohn, Larry M. Manheim, Gloria Bazzoli & Cheeling Chan, *Hospital Reorganization After Merger*, 33 MED. CARE 676, 681 (1995).

[153] *See* SIROTA, *supra* note 146, at 4–5; *see also* Levins, *supra* note 147 ("Acquiring systems often move to close services like intensive care, labor and delivery, psychiatric care, and cardiac surgery."); O'Hanlon et al., *supra* note 21, at 2100–01 (finding reduced availability of obstetric services and primary care departments in rural hospitals post-merger); Henke et al., *supra* note 151, at 1634 (noting that mergers led to a reduction of maternal, surgical, and mental healthcare services in rural areas).

[154] *See* O'Hanlon et al., *supra* note 21, at 2101; *see also* Press Release, Nat'l Nurses United, Nurses Call on Federal Trade Commission and Department of Justice to Strengthen Guidelines to Limit Negative Effects of Mergers, Acquisitions on Patients and Healthcare Workers (Apr. 21, 2022), https://www.nationalnursesunited.org/press/nurses-call-on-ftc-and-doj-to-strengthen-merger-guidelines [https://perma.cc/W8MN-A8TY] (arguing that services such as "rural cancer care and wheelchair and seating clinics have been cut completely" following acquisitions).

[155] *See* Levins, *supra* note 147.

[156] *See* WISHNER ET AL., *supra* note 14, at 8.

[157] *See id.*

[158] *See id.* at 7–8 (arguing that unmet need for mental-health and substance-abuse-disorder treatment intensifies following closures of rural hospitals).

[159] *See id.* at 7.

surprisingly, over the past two decades, the suicide rate among rural Americans has been consistently higher than that of urban Americans.[160] For example, between 2000 and 2020, the rate of suicides increased 46% in rural communities compared to 27.3% in urban communities.[161] The limited availability of mental-health services and the shortage of psychologists and psychiatrists in rural America may be correlated with this heartbreaking outcome.[162]

In brief, mergers in rural areas aggravate the hospital-closure crisis that is hurting rural communities. This is because, after the merger, the acquiring hospital often shuts down the newly acquired rural hospital or cuts essential healthcare services, such as emergency care, cardiac surgery, psychiatric services, or even primary and maternal care. Hence, hospital mergers in rural areas often leave underserved communities without meaningful access to care. Naturally, then, such business strategies also contribute to the rising health inequities between rural and urban areas.

B. Effects of Consolidation on the Input Market: Reduced Wages, Burnout, and Unfavorable Employment Terms

Mergers also allow hospitals to increase their market power in input markets, most notably labor markets, and even to attain monopsony power, especially if they operate in rural areas.[163] This increase in market power allows hospitals to suppress their employees' wages and offer employment under unfavorable conditions and employment terms, including imposing

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[160] *Suicide in Rural America*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION (May 16, 2024), https://www.cdc.gov/rural-health/php/public-health-strategy/suicide-in-rural-america-prevention-strategies.html [https://perma.cc/KNP7-HR84].

[161] *See id.*

[162] *See* Benson S. Ku, Jianheng Li, Cathy Lally, Michael T. Compton & Benjamin G. Druss, *Associations Between Mental Health Shortage Areas and County-Level Suicide Rates Among Adults Aged 25 and Older in the USA, 2010 to 2018*, 70 GEN. HOSP. PSYCHIATRY 44, 49 (2021) ("[T]he significant interaction of mental health shortage areas and rurality suggests that suicide rates are higher in more rural areas[,] especially in areas with more limited health resources such as mental health provider shortages."); *see also* Jennifer A. Hoffmann, Megan M. Attridge, Michael S. Carroll, Norma-Jean E. Simon, Andrew F. Beck & Elizabeth R. Alpern, *Association of Youth Suicides and County-Level Mental Health Professional Shortage Areas in the US*, 177 [J]AMA PEDIATRICS 71, 71, 76 (2022) (finding that "US county mental health professional workforce shortages were associated with increased youth suicide rates," and that "[u]nadjusted youth suicide rates were higher in counties with higher rates of uninsured children and in rural areas compared with metropolitan areas").

[163] *See* Carmen Sanchez Cumming, *A Primer on Monopsony Power: Its Causes, Consequences, and Implications for U.S. Workers and Economic Growth*, WASH. CTR. FOR EQUITABLE GROWTH (July 27, 2022), https://equitablegrowth.org/a-primer-on-monopsony-power-its-causes-consequences-and-implications-for-u-s-workers-and-economic-growth/ [https://perma.cc/67V8-TE3F] ("At its most basic, monopsony refers to a market where there is a single buyer of a good or service."). In labor markets, the buyer of services is the employer who purchases the labor of its workers.

noncompete agreements on nurses and physicians.[164] This setup, in turn, threatens the mental health and well-being of such healthcare workers, who, despite their costly training, are deciding to leave the market at ever-increasing rates.[165] These decisions exacerbate the shortage of healthcare workers that hospitals—especially those in rural areas—experience and worsen the hospital-closure crisis, leading to hospital deserts. *How did we get here?*

Nurses and physicians are key inputs for hospital services. Nonetheless, their negotiating power is almost zero when just one hospital operates in their region, because nurses and physicians have specialized skills and knowledge that are not easily transferable to employers in other economic sectors. Consider the following example: a rural town with two hospitals, a shoe factory, a public school, and a shopping mall. If the two hospitals merge, nurses and physicians will have only one potential employer to which they can turn to sell their specialized labor.

In the healthcare industry, monopsony has proven extremely costly to nurses and physicians. When just one hospital operates in a geographic area, that hospital can exploit its market power to reduce wages without risk of losing employees. Empirical findings illustrate the reality of these risks to wages. A recent study assessed the impact of eighty-four hospital mergers between 2000 and 2010 on the wages of healthcare workers, including nurses.[166] The study showed that those mergers, which considerably increased concentration in the relevant hospital markets, also hindered nurses' wage growth.[167] Following such mergers, the annual increase in nurses' wages in these highly concentrated markets was 1.7% slower than in markets characterized by lower concentration levels.[168]

What's more, hospitals exercise monopsony power over healthcare workers by offering employment under unfavorable working conditions, such as heavy workloads, longer working hours, and unpredictable working

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[164] *See id.*

[165] *See* Oakman & Smith-Ramakrishnan, *supra* note 66 (noting that increased consolidation in the hospital industry also contributes to physicians' burnout); Richard Menger, Brenton Pennicooke, Todd Barnes, Sarah Fouke, Phillip Kissel, Thomas Origitano, Ramin Rak, Edie Zusman, Jeffrey Cozzens, Andrew Grande, Steven Toms, Sharon Webb & Sherry Taylor, *Commentary: Impact of Hospital and Health System Mergers and Acquisitions on the Practicing Neurosurgeon: Survey and Analysis from the Council of State Neurosurgical Societies Medical Director's Ad Hoc Representative Section*, 82 NEUROSURGERY 157, 159–60 (2018) (arguing that post-merger neurosurgeons experience higher levels of job dissatisfaction and dissatisfied physicians are more likely to leave their current practice, or the field of medicine entirely, due to high levels of burnout).

[166] Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, 111 AM. ECON. REV. 397, 398, 406 (2021).

[167] *Id.* at 398.

[168] *Id.*

schedules.[169] A 2005 empirical study that examined the impact of hospital mergers on the working conditions of nurses provides strong support for those concerns, highlighting that after a hospital merger takes place, "nurses are consistently asked to work harder," and the effort demanded of them is much greater.[170] Another study raises similar concerns, illustrating that, post-merger, nurses often experience increased responsibilities, higher levels of emotional exhaustion, and job dissatisfaction.[171] Similarly, studies find that following a hospital merger, physicians are more likely to experience burnout and less likely to recommend their institution to their network.[172] Another report raises similar concerns, showing that hospital consolidation contributes to physicians' burnout, "making it harder for them to prioritize patient care, earn patient trust, and build relationships."[173] That report also illustrates that the high levels of burnout undermine the mental health of all physicians—but that they disproportionately affect physicians of color and female physicians.[174]

But these are not the only ways hospitals exercise their monopsonistic power over their workforce. Hospitals further reinforce their market power

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[169] *See* ANDREA FLYNN, RAKEEN MABUD & EMMA CHESSEN, ROOSEVELT INST., THE PLIGHT OF HEALTH CARE IN RURAL AMERICA: HOW HOSPITAL MERGERS AND CLOSURES HARM WOMEN 1, 8 (2019).

[170] Janet Currie, Mehdi Farsi & W. Bentley MacLeod, *Cut to the Bone? Hospital Takeovers and Nurse Employment Contracts*, 58 INDUS. & LAB. REL. REV. 471, 471, 487, 491 (2005).

[171] Bonnie M. Jennings, *Restructuring and Mergers*, *in* PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES 2-95, 2-98 (Rhonda G. Hughes ed., 2008) ("[R]estructuring efforts and mergers can be related to lower job satisfaction among nurses and increased burnout."); *see also* Press Release, Nat'l Nurses United, *supra* note 154 ("[M]ergers and acquisitions 'dilute[] the bargaining power of workers over terms and conditions of employment' with negative effects on wages and working conditions like safe staffing levels. In addition to harming patient safety, 'intentional understaffing, lack of health and safety precautions, and other poor working conditions have driven nurses away from bedside nursing[']. . . ." (quoting National Nurses United Lead Regulatory Policy Specialist Carmen Comsti).

[172] Carley Thornell, *Physicians Report that Organizational and Technology Changes Are Among the Biggest Burnout Factors*, ATHENA HEALTH (July 2, 2021), https://www.athenahealth.com/knowledge-hub/clinical-trends/physicians-report-organizational-technology-changes-among-biggest-burnout-factors [https://perma.cc/44QW-53XE]; *see also* Jill McKeon, *Healthcare Mergers and Acquisitions Linked to Physician Burnout*, TECHTARGET (July 8, 2021), https://www.techtarget.com/revcyclemanagement/news/366601334/Healthcare-Mergers-and-Acquisitions-Linked-to-Physician-Burnout [http://perma.cc/DD83-2YZX] (reporting that physicians who experience a merger or acquisition are more likely to experience burnout and less likely to recommend their organization); Gwen Byrne, *The Physician's Dilemma: Navigating Healthcare Consolidation and the Unionization Renaissance*, ONLABOR (Nov. 3, 2023), https://onlabor.org/the-physicians-dilemma-navigating-healthcare-consolidation-and-the-unionization-renaissance [https://perma.cc/B9C9-7BDB] ("Physicians who have never experienced a merger are more likely to recommend their organization to friends or family and feel more positive about collaboration with colleagues."); Menger et al., *supra* note 165, at 159–60 (arguing that post-merger neurosurgeons experience a higher level of job dissatisfaction).

[173] Oakman & Smith-Ramakrishnan, *supra* note 66.

[174] *Id.*

in labor markets by imposing unfavorable employment terms on their employees, such as noncompetes. A noncompete clause in an employment contract reduces a worker's mobility based on distance, time, and scope.[175] A typical noncompete in the healthcare industry might read: "Upon termination of employment, physician will not practice medicine for two years within a ten-mile radius of all current practice sites."[176] One 2020 study examining the range of noncompetes in hospitals across five states found that 45% of primary care physicians were bound by noncompete agreements in 2007.[177] Hospitals can enforce such harmful terms irrespective of whether the worker resigns or is removed from the job, and because noncompetes block workers from freely moving to new jobs, they deter them from pursuing higher paying and more fulfilling jobs.[178] By reducing job mobility, noncompetes also undermine employers' incentives to increase wages and improve their employees' working conditions.

One leading study measuring the relationship between noncompetes and wages concluded that banning noncompetes would increase average earnings for workers in America by 3.3% to 13.9%.[179] Another study reached similar conclusions, finding that after Oregon stopped enforcing noncompetes for hourly workers, their wages increased by 2% to 3%.[180]

But noncompetes may do more harm than just leading to lower wages. Noncompetes in the healthcare sector also increase nurses' and physicians' burnout, encouraging them to leave the market at increasing rates.[181] The heartbreaking story of Dr. Jacqui O'Kane, a primary care physician who

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[175] *See* Erik B. Smith, *Ending Physician Noncompete Agreements—Time for a National Solution*, [J]AMA HEALTH F., Dec. 3, 2021, at 1, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2786894 [https://perma.cc/YJ33-W2RH].

[176] *Id.*

[177] Kurt Lavetti, Carol Simon & William D. White, *The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians*, 55 J. HUM. RES. 1025, 1042 (2020); *see also* Harris Meyer, *Banning Noncompete Contracts for Medical Staff Riles Hospitals*, KFF HEALTH NEWS (Mar. 27, 2023), https://kffhealthnews.org/news/article/banning-noncompete-contracts-for-medical-staff-riles-hospitals/ [https://perma.cc/42CY-KT33] ("A 2018 survey found that nearly half of primary care physicians in California, Illinois, Georgia, Pennsylvania, and Texas were bound by noncompetes.").

[178] *See* Luke Goldstein, *How Noncompete Agreements Hamstrung America's Pandemic Response*, AM. PROSPECT (Feb. 16, 2023), https://prospect.org/health/02-15-2023-doctors-pandemic-noncompete-hospitals/ [https://perma.cc/CVU7-RZDX].

[179] Non-Compete Clause Rule, 88 Fed. Reg. 3482, 3486 (proposed Jan. 19, 2023) (to be codified at 16 C.F.R. pt. 910).

[180] *Id.*

[181] *See* Goldstein, *supra* note 178 ("Noncompetes both contributed to the early retirement or burnout of doctors and then dissuaded many out of work physicians from re-entering health services to help at hospitals in need during the pandemic."); *see also* Oakman & Smith-Ramakrishnan, *supra* note 66 (arguing that eliminating noncompete clauses from physicians' employment contracts could reduce the levels of burnout they experience).

signed a labor contract with a primary care clinic in a small and underserved town in southern Georgia in 2020, illustrates this problem.[182] After Dr. O'Kane started her new job, her employer pressured her to treat more patients.[183] To meet her employer's demands, Dr. O'Kane, a mother of two, had to work day and night. Unable to balance her immense workload and make time for her family, Dr. O'Kane decided to establish her own practice.

However, her contract with the hospital contained a noncompete which prevented her from practicing within fifty miles of the hospital for two years after her contract ended.[184] Thus, only if she sold the family house, moved several miles, and enrolled her children in a new school could she start her own practice.[185] Dr. O'Kane faced a tragic dilemma: either stay in an unhealthy working environment to avoid the move, or leave her patients, town, and community to establish her own practice. Many physicians and nurses face similar dilemmas, and many decide to instead switch industries or seek early retirement.[186]

But Dr. O'Kane is not alone. After the Federal Trade Commission (FTC) requested public comments on the effects of noncompete clauses in the healthcare industry, several physicians seized the chance to highlight the severe harms that noncompetes cause. Some participants pointed to the fact that the majority of noncompetes are unreasonable in terms of geographic scope, as they often prohibit physicians from practicing medicine within a hundred-mile radius of the employing hospital.[187] Others explained that noncompetes eliminate their ability to practice medicine in a five-county area.[188]

In other words, noncompetes leave physicians with very limited options: either they must accept any unfair employment terms imposed by their current employer or they must move themselves and their families to a different city or even a different state.[189] Many physicians have noted

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[182] *See* Meyer, *supra* note 177.

[183] *See id.*

[184] *Id.*

[185] *Id.*

[186] Goldstein, *supra* note 178.

[187] *See, e.g.*, Ward Becker, Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts (Jan. 30, 2020), https://www.regulations.gov/comment/FTC-2019-0093-0166 [https://perma.cc/CZ4P-BFQL] ("[H]ospitals buy[] primary care and specialty physicians' practices over large geographic areas . . . .").

[188] *See* Anonymous Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts (Feb. 4, 2020), https://www.regulations.gov/comment/FTC-2019-0093-0218 [https://perma.cc/3QJ5-3DDL].

[189] *See* Scott Mintzer, Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts (Feb. 6, 2020), https://www.regulations.gov/comment/FTC-2019-0093-0232 [https://perma.cc/

that such dilemmas increase their levels of burnout and stress, which ultimately undermines their productivity[190] and encourages them to leave medicine at increasing rates.[191]

The prospect of eventually having to choose between unhealthy working conditions and uprooting one's life may also deter many Americans from entering the healthcare job market in the first place. Noncompetes thus limit the pool of nurses and physicians who might be available for recruitment by rural hospitals even before these agreements are ever signed. This may contribute to the shortage of healthcare workers currently plaguing rural America and aggravate the hospital-closure epidemic.[192]

Noncompetes contribute to the hospital-closure crisis in rural America in additional ways. By eliminating job mobility, noncompetes imposed by rural hospitals discourage nurses and physicians from offering their services in competing hospitals in rural areas.[193] This is because the nurses and physicians who work in rural hospitals and are subject to noncompetes, but who wish to switch employers, must move away from the rural area to free themselves from the noncompete clauses and find new work. Forcing such

9P98-RXGU]; Anonymous Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts (Jan. 30, 2020), http://www.regulations.gov/comment/FTC-2019-0093-0180 [https://perma.cc/M2UC-ERV]; Anonymous Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts (Jan. 30, 2020), http://www.regulations.gov/comment/FTC-2019-0093-0160 [https://perma.cc/LG4H-NYC]; Shannon Pettypiece, *Biden's Push to Ban Noncompete Agreements Could Have Big Implications for Health Care*, NBC NEWS (Feb. 13, 2023, 12:49 PM), https://www.nbcnews.com/politics/economics/biden-ban-non-compete-agreements-health-care-industry-rcna70099 [http://perma.cc/63PM-25F5].

[190] *See* Martha Bardsley, Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts (Jan. 30, 2020), https://www.regulations.gov/comment/FTC-2019-0093-0162 [https://perma.cc/BX2Q-E3AN]; *see also* Raymond Dragann, Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts (Jan. 30, 2020), https://www.regulations.gov/comment/FTC-2019-0093-0176 [https://perma.cc/37A4-CCCD] ("[Noncompetes] leave[] physicians trapped in a situation that promotes job dissatisfaction leading to compromised patient care and physician burnout."); Melissa Pell, Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts (Jan. 30, 2020), https://www.regulations.gov/comment/FTC-2019-0093-0141 [https://perma.cc/V3V8-7XU6] ("[Noncompetes] contribute[] to the low morale and burnout that a large percentage of physicians in the US struggle with.").

[191] *See* Goldstein, *supra* note 178.

[192] Pettypiece, *supra* note 189 (arguing that opponents of noncompetes contend "that the agreements are suppressing wages, contributing to doctor shortages in rural areas and stifling competition"); Am. Nurses Ass'n, Comment Letter on Non-Compete Clause Rule 2 (Mar. 2, 2023), https://www.regulations.gov/comment/FTC-2023-0007-16285 [https://perma.cc/K5A4-JJLG].

[193] Coll. of Emergency Physicians, Comment Letter on Non-Compete Clause Rule 1, 4 (Mar. 7, 2023), https://www.regulations.gov/comment/FTC-2023-0007-17057 [https://perma.cc/NUJ8-J3PG] (urging the FTC to examine how noncompetes exacerbate the shortage of physicians in underserved areas).

healthcare workers to leave underserved areas naturally exacerbates the shortage of nurses and physicians in rural hospitals.[194]

Consider the following example: A noncompete that prevents a cardiologist from practicing medicine for two years within a sixty-mile radius of an employing hospital upon termination of the physician's contract. If most cardiologists in a given geographic area are subject to a similar noncompete, competing rural hospitals may be unable to recruit cardiologists even if they offer them higher wages and more favorable employment terms. Unable to offer their communities cardiac-care services without a sufficient number of cardiologists, some rural hospitals may be forced to cut this essential service, while still others may decide to close their doors entirely.

The COVID-19 pandemic made this problem's nature and scope very clear. The overwhelming need for hospital staff during the peak of the pandemic exposed how noncompetes can undermine a hospital's ability to treat patients, save lives, and serve its community.[195] When hospitals across America saw surges of COVID-19 patients in the midst of the pandemic, many hospitals, especially in underserved areas, lacked the necessary staff to manage the influx of patients and meet their immediate needs.[196] Absent the necessary ICU beds or on-call medical staff to treat the increasing volume of COVID-19 patients, several hospitals simply had to send sick people back home, leaving them without access to care.[197] This likely contributed to the high mortality rates rural communities experienced during the COVID-19 pandemic.[198]

Absent the high percentage of noncompetes, some rural hospitals may have been able to cover their increased needs during the pandemic by recruiting additional nurses and physicians—either those unemployed at the time or those who could be spared by hospitals with more robust staffing. However, when the pandemic hit, several hospitals requested courts to enforce noncompetes against healthcare workers who wanted to accept

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[194] *See id.* at 4 (quoting survey responses from members of the American College of Emergency Physicians as saying that "[i]n rural America where doctor shortages are a daily event this further restricts supply if [a] doctor must relocate outside [a] region" and that noncompetes "penalize[] underserved areas for which a doctor might stay if able to make a lateral move to a hospital in the same area").

[195] *See* Goldstein, *supra* note 178.

[196] *See* TECH. RES., ASSISTANCE CTR., & INFO. EXCH., U.S. DEP'T OF HEALTH & HUM. SERVS., RURAL HEALTH AND COVID-19 1, 2 (last updated Aug. 19, 2020), http://files.asprtracie.hhs.gov/documents/aspr-tracie-rural-health-and-covid-19.pdf [https://perma.cc/H6XA-NGUZ].

[197] *See* Goldstein, *supra* note 178.

[198] *COVID Incidence, Mortality Rates Remain Much Higher in Rural Areas*, IOWA COLL. PUB. HEALTH (Dec. 8, 2021), https://www.public-health.uiowa.edu/news-items/covid-incidence-mortality-rates-remain-much-higher-in-rural-areas/ [https://perma.cc/2AF6-GDM9] ("Hospital closures and shortages of health care providers may contribute to the high mortality rates from COVID-19 in rural areas.").

calls for extra help from hospitals that lacked the resources to treat their patients.[199] This undermined the ability of understaffed hospitals to meet the increased healthcare needs of their communities.

Advocacy groups and other higher-ups at rural hospitals, however, tell a different story. For instance, the AHA recently argued that rural hospitals could not retain nurses and physicians without noncompetes.[200] Reality, however, indicates that this is not necessarily true. As noted, rural hospitals struggle to recruit and retain nurses and physicians primarily because they cannot compete with urban hospitals in terms of payment and benefits.[201] But imposing a noncompete on employees will not address the problem: first, because noncompetes further suppress wages for employees; and second, because a noncompete is an unfavorable employment term for employees. For these reasons, a noncompete may deter potential healthcare workers from choosing a hospital-employer that forces them to sign such a term, especially if the hospital is in an underserved area that offers them a poorer wage.

This may be especially problematic for healthcare industry specialists with rural backgrounds. Robust research demonstrates that medical students from rural backgrounds may be more willing to offer services in rural areas.[202] The same research also indicates that "racial/ethnic minority groups that are traditionally underrepresented in medicine (URM) are more likely to practice in underserved communities and provide care to minority populations."[203] If, however, rural hospitals condition employment offers to these groups of healthcare workers on a noncompete, that may discourage them from practicing medicine in rural areas. Thus, the imposition of noncompete clauses may thwart the chance of attracting even the most viable candidates to underserved communities.

In brief, because noncompetes may lead to lower wages and inferior working conditions, they often motivate nurses and physicians to leave the market or discourage potential healthcare workers from ever entering the field at all. This contributes to the shortage of physicians and nurses,

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[199] *See* Goldstein, *supra* note 178.

[200] Melinda Reid Hatton, Gen. Couns. & Sec'y, Am. Hosp. Ass'n, Comment Letter on Non-Compete Clause Rule 10 (Feb. 22, 2023), https://www.regulations.gov/comment/FTC-2023-0007-8138 [https://perma.cc/AX4J-LYFX].

[201] *See* Mead, *supra* note 71.

[202] *See* Shipman et al., *supra* note 67, at 2012; *see also* John A. Owen, Mark R. Conaway, Beth A. Bailey & Gregory F. Hayden, *Predicting Rural Practice Using Different Definitions to Classify Medical School Applicants as Having a Rural Upbringing*, 23 J. RURAL HEALTH 133, 135 (2007) ("Recruiting more applicants who match this definition of rural background should increase the number of rural physicians.").

[203] Shipman et al., *supra* note 67, at 2012.

disproportionately affecting rural hospitals and leading to additional closures. By impeding healthcare workers' mobility, noncompetes imposed by rural hospitals also prevent physicians and nurses from offering their services in rural areas that urgently need workers in the healthcare industry.[204] Hence, noncompetes may undermine rural hospitals' ability to attract the volume of healthcare workers they need to offer profitable healthcare services, such as surgeries.[205] Again, for some of these hospitals, departing their communities may be inevitable.

Given the concerns expressed above, two crucial questions emerge. First, can antitrust law cure the hospital-desert problem? And second, can antitrust law heal the wounds and losses that hospital deserts impose on the most vulnerable Americans? The Part that follows takes a deep dive into answering these questions.

IV. ENFORCERS AS HEALERS: CAN ANTITRUST ENFORCERS REMEDY THE HOSPITAL CLOSURE CRISIS AFFECTING RURAL AMERICA?

The previous Part identified American hospitals' business strategies that have exacerbated the rural hospital-closure crisis. This Part delves into the role antitrust law can play in alleviating this problem.

First, this Part examines the anticompetitive effects of noncompete clauses and contends that the nation's courts should find that such agreements in the healthcare sector constitute per se violations of section 1 of the Sherman Act. Second, this Part proposes that antitrust enforcers start assessing the impact of hospital mergers on wages and the working conditions of employees in the healthcare industry. Third, this Part contends that enforcers should only accept hospital mergers in rural areas on the condition that the acquiring hospital will neither (1) shut down the acquired hospital nor (2) cut the healthcare services it offers to rural residents.

A. Section 1 of the Sherman Act and Noncompetes

1. The Anticompetitive Effects of Noncompetes

The noncompete agreements that hospitals widely impose on workers in the healthcare industry are both the product and instrument of the monopsony power hospitals enjoy in America. As noted, hospitals initially

[204] *See* Coll. of Emergency Physicians, *supra* note 193, at 4; *see also* Anonymous Comment on FTC Workshop on Non-Compete Clauses Used in Employment Contracts, *supra* note 188 ("Non-compete clauses are included in virtually every physician contract, and they have become the standard for employment contracts with the corporate take over [sic] of medicine. These antiquated restrictions on physician practice are only hurting patients by further limiting access to care in areas of physician shortages.").

[205] *See* Germack et al., *supra* note 75, at 2090.

gained monopsony power due to the wave of hospital mergers in the 1990s. Presently, hospitals can impose noncompete agreements on employees because of this monopsony power. Those noncompetes then function to keep healthcare workers from leveraging fallback options in negotiations for wages and working conditions because they prevent workers from either starting their own practices or migrating to other potential employers in a specific geographic area. Because noncompetes eliminate job mobility, they lead to reduced wages[206] and harmful working conditions.[207]

What's more, by drastically reducing the available talent pool in the healthcare industry, noncompete agreements between a given hospital and its employees may prevent competing hospitals from meeting their employment needs. This is especially the case for rural hospitals that struggle to attract nurses, physicians, and clinicians and thus frequently fail to meet the healthcare needs of their communities.[208] Because noncompetes significantly harm competition in labor markets and reduce consumer choice, they are subject to section 1 of the Sherman Act, which prohibits every contract that unreasonably restrains trade.[209]

Although the courts could apply antitrust law in a way that addresses the harms that noncompetes cause to rural communities, thus far, they have failed to do so. But that is not to say they could not. Specifically, courts can apply section 1 of the Sherman Act to better protect workers in the healthcare industry, which will, in turn, promote public health.

2. Noncompetes and the Rule of Reason

The Supreme Court applies two types of antitrust analysis to examine whether an agreement violates the Sherman Act. These are the "per se"

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[206] Eric A. Posner, *The Antitrust Challenge to Covenants Not to Compete in Employment Contracts*, 83 ANTITRUST L.J. 165, 187–90 (2020).

[207] Press Release, Fed. Trade Comm'n, FTC Proposes Rule to Ban Noncompete Clauses, Which Hurt Workers and Harm Competition (Jan. 5, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/01/ftc-proposes-rule-ban-noncompete-clauses-which-hurt-workers-harm-competition [https://perma.cc/9XWK-DQJ7] ("Noncompetes block workers from freely switching jobs, depriving them of higher wages and better working conditions, and depriving businesses of a talent pool that they need to build and expand.").

[208] *See* Aallyah Wright, *Rural Hospitals Can't Find the Nurses They Need to Fight COVID*, STATELINE (Sept. 1, 2021, 12:00 AM), https://stateline.org/2021/09/01/rural-hospitals-cant-find-the-nurses-they-need-to-fight-covid/ [https://perma.cc/B68R-8LM6]; *see also* Corey Meador, *In Rural Areas with Health Care Shortages, These Doctors Are Answering the Call*, PBS NEWS (Apr. 9, 2021, 11:03 AM), https://www.pbs.org/newshour/health/rural-areas-health-care-shortages-these-doctors-are-answering-the-call [https://perma.cc/WC8V-Z8F4] (describing the difficulties of recruiting physicians to serve in rural communities, especially during the global pandemic).

[209] 15 U.S.C. § 1 ("Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."); *see* Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918).

and "rule of reason" analyses.[210] Per se unlawful agreements are those agreements that are so harmful to competition and consumers that they are unlikely to produce any essential procompetitive benefits. Courts treat such agreements as categorically illegal.[211] For example, any agreement between competitors to fix prices or restrict output is considered illegal per se.[212]

Agreements not condemned as illegal per se are examined under the rule of reason test. Essentially, the rule of reason test asks whether an agreement among market players promotes or hurts competition.[213] The Supreme Court first formulated this test in *Chicago Board of Trade v. United States*.[214] In that 1918 case, the Chicago Board of Trade had adopted a "call rule" prohibiting members of the grain exchange "from purchasing or offering to purchase . . . wheat, corn, oats or rye 'to arrive' at a price other than the closing bid at the Call."[215] Although this agreement was literally a form of price fixing, Justice Louis Brandeis found that the agreement was justified because it leveled the playing field for the purchase and sale of agricultural commodities on the open market.[216] "The true test of legality," Justice Brandeis explained, "is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition."[217]

To delve into this question, Justice Brandeis explained:

> [T]he court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or

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[210] FED. TRADE COMM'N & U.S. DEP'T OF JUST., ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS 3 (2000), https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf [https://perma.cc/6LDC-UVGA].

[211] *Id.*

[212] The Supreme Court described the distinctive features of these naked anticompetitive agreements in *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). It held that "[a]ny combination which tampers with price structures is engaged in an unlawful activity," and that "[u]nder the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal per se." *Id.* at 221, 223.

[213] Theodosia Stavroulaki, *Equality of Opportunity and Antitrust: The Curious Case of College Rankings*, 17 J. COMPETITION L. & ECON. 903, 922 (2021).

[214] 246 U.S. 231 (1918).

[215] *Id.* at 237.

[216] *Id.* at 240–41.

[217] *Id.* at 238.

> the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.[218]

Although the Supreme Court's ruling in *Chicago Board of Trade* laid the foundation for the rule of reason test, at the same time, it left some important questions unanswered.[219] Indeed, in *Chicago Board of Trade*, the Court did not identify the analytical framework for future courts to use in assessing whether an agreement among competitors would undermine competition.[220] Nonetheless, over time, lower courts limited the number of agreements among competitors that were treated as per se illegal, and the rule of reason test became more widely used.[221]

One positive consequence of this frequent usage is that the rule of reason test has become much more structured.[222] A study that reviewed all rule of reason cases from 1977 to 1999 revealed that, when applying the rule of reason test, courts generally follow a "burden-shifting approach."[223] First, the plaintiffs must demonstrate the agreement's main anticompetitive effects;[224] next, if the plaintiffs meet their initial burden, the defendants must show that the anticompetitive agreement produces some procompetitive benefits;[225] and finally, if the defendants meet their burden, the plaintiffs must show either "that the restraint is not reasonably necessary or that the defendant's objectives could be achieved by less restrictive alternatives."[226] Only after all three stages are complete will courts balance the agreement's procompetitive effects against the harm caused to competition.[227]

To date, courts have examined noncompetes under the rule of reason. There are two main reasons for this. First, noncompetes are purely vertical agreements: they exist between two different levels of a given market (i.e., employee and employer) as opposed to between direct competitors in a market (i.e., two employers). Because these agreements are vertical restraints of trade, they are not considered as harmful to competition and consumers as horizontal restraints, such as cartels.[228]

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[218] *Id.*

[219] Andrew I. Gavil, *Moving Beyond Caricature and Characterization: The Modern Rule of Reason in Practice*, 85 S. CAL. L. REV. 733, 742–43 (2012).

[220] Stavroulaki, *supra* note 213, at 923.

[221] *Id.*

[222] *See id.*

[223] Michael A. Carrier, *The Rule of Reason: An Empirical Update for the 21st Century*, 16 GEO. MASON L. REV. 827, 827 (2009).

[224] *Id.*

[225] *Id.*

[226] *Id.*

[227] Stavroulaki, *supra* note 213, at 923.

[228] *See* Posner, *supra* note 206, at 173.

Second, noncompete agreements have the potential to yield some procompetitive benefits. Reduced mobility, the argument goes, benefits employers by allowing them to recover the costs of training their workers.[229] Absent the noncompetes, employees could free ride on their employers' investments by obtaining skills at a job and then migrating to another employer who could afford to pay better because the new employer did not have to incur costs to train the employee in the first place. This risk of free riding would disincentivize employers from investing in their workers' education, talents, and skills. Thus, from an employer's perspective, a noncompete agreement may be the only effective way to protect their investment from the free riding that might occur if a new employer "commandeer[s]" the former employer's investment.[230]

In theory, noncompetes also have the potential to benefit employees. By signing noncompetes, employees reduce their job mobility and their opportunity to seek alternative employment; for this reason, employers may offer them higher wages.[231] Hence, if enforcers banned noncompetes without a lengthy legal and economic analysis of their alleged procompetitive benefits, they would risk harming employers and employees.

But, as in life, so also in the case of noncompetes, theory does not always comport neatly with reality. For instance, according to a 2014 empirical study, workers in various labor markets in the United States who are bound by noncompete agreements do not receive a "compensating wage differential" from their employers.[232] What's more, the notion that, absent noncompetes, employers may have little incentive to invest in their employees' skills and training relies on the assumption that typical American labor markets function according to models of well-regulated, competitive markets. In such markets, the barriers that employees face in moving from one job to another are quite low, and hence, employees have options for migrating between jobs to maximize some benefits, either higher wages or better working conditions.

But this assumption does not reflect reality. Labor markets in America are concentrated, and thus, they do not behave according to competitive models.[233] Because only a few employers exist in labor markets, especially

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[229] *Id.* at 176.

[230] Herbert Hovenkamp, *Noncompete Agreements and Antitrust's Rule of Reason*, REGUL. REV. (Jan. 16, 2023), https://www.theregreview.org/2023/01/16/hovenkamp-noncompetes-and-rule-of-reason/ [https://perma.cc/9LVX-BXFB].

[231] *See* Posner, *supra* note 206, at 176.

[232] Eric A. Posner, Suresh Naidu & Glen Weyl, *Antitrust Remedies for Labor Market Power*, 132 HARV. L. REV. 536, 545 (2018).

[233] *See* José Azar, Ioana Marinescu & Marshall Steinbaum, *Labor Market Concentration*, 57 J. HUM. RES. (SPECIAL ISSUE) S167, S179 (2022).

in rural areas,[234] employees cannot easily switch employers, even if their current job does not meet their qualifications, expectations, or even needs.

Labor market concentration, however, is not the only reason workers may be deterred from leaving a low-paying or otherwise unfulfilling job to seek alternative employment. High switching costs may also discourage workers from finding a new job. Because many employees may lack the necessary resources to invest in pursuing a new job, they may keep their current jobs even if a higher paid and more fulfilling job is available in the market.[235] Because labor markets in America are neither competitive nor frictionless, the argument that noncompetes yield procompetitive benefits because they reduce the risk of free riding is simply unconvincing.

Additionally, the argument that employers impose noncompetes on their employees simply because they want to protect their legitimate business interests and trade secrets is ill-founded. Reality indicates that employers impose noncompetes even in markets where they invest little to no money in the training of their employees and where those employees have no trade secrets to protect. Consider the example of Jimmy John's franchises, which for years included noncompetes in all of its labor contracts.[236] Essentially, these noncompetes banned Jimmy John's workers from working for any sandwich shop (including another Jimmy John's franchise) within three miles of *any* Jimmy John's franchise for a two-year period. Because numerous Jimmy John's shops may operate in any given city, the employer's noncompetes severely limited its workers' ability to switch employers if they wished to pursue a new sandwich job.[237] Surely, Jimmy John's did not seriously invest in its employees' education and skills, nor did they possess anything that could be fairly characterized as "trade secret" knowledge. Nonetheless, the franchise chain imposed noncompetes on its employees to restrict competition for sandwich workers.

But Jimmy John's is not the only employer to impose noncompetes in cases where its investment in employees' training, knowledge, and skills is negligible. Hospitals too fail to invest appreciably in their workers' training, especially when compared to the workers' investment: nurses and physicians acquire the vast majority of the education and knowledge they need to

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[234] Hiba Hafiz, *The Law of Geographic Labor Market Inequality*, 172 U. PA. L. REV. 1183, 1188–89 (2024).

[235] Posner, *supra* note 206, at 181 (arguing that search costs often prevent employees from seeking a better job even if this job is available in the market).

[236] *Id.* at 165; *see also* Dave Jamieson, *Jimmy John's Makes Low-Wage Workers Sign 'Oppressive' Noncompete Agreements*, HUFFINGTON POST (Oct. 13, 2014, 4:03 PM), https://www.huffpost.com/entry/jimmy-johns-non-compete_n_5978180 [https://perma.cc/7ZYH-P6Q3] (noting the "surprising" breadth of the Jimmy John's noncompete clause that covered low-wage employees).

[237] *See* Posner, *supra* note 206, at 165.

practice before they are recruited to work in a given hospital.[238] Nonetheless, 37%–45% of physicians in America are subject to noncompetes.[239] One recent study found that almost half of all U.S. primary care physicians who signed employment contracts with hospital systems in five states are subject to noncompetes.[240]

Applying the rule of reason test in cases where its costs outweigh its benefits, however, is clearly a mistake. Consider a noncompete in the nursing industry. When analyzing the noncompete under the rule of reason test, the plaintiff–nurse must show that (1) the hospital-employer possesses market power, and (2) the noncompete would significantly harm competition in the labor market for nurses. Antitrust scholarship warns that meeting this burden of proof is nearly impossible for individual plaintiffs seeking to challenge noncompetes.[241] This is because lawyers in noncompete cases will typically represent a single employee seeking to prove that their noncompete is unreasonable. The application of the rule of reason, though, requires the plaintiff to prove anticompetitive harm to the entire labor market.[242] Specifically, this showing would require the plaintiff to demonstrate that the noncompete caused wages to decrease in the entire labor market.

Professor Eric Posner observes that, while economic theory suggests that a reduction in competition among employers would lead to suppressed wages, "the effect would be impossible to show statistically in the case of a single noncompete that prevents a single employer from hiring a single worker where the market presumably contains thousands of employees and dozens or hundreds of employers."[243] For this reason, applying the rule of reason test in noncompete cases greatly raises plaintiffs' litigation costs, ultimately preventing many employees, including nurses and physicians,

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[238] William F. Sherman, Akshar H. Patel, Bailey J. Ross, Olivia C. Lee, Claude S. Williams IV & Felix H. Savoie III, *The Impact of a Non-Compete Clause on Patient Care and Orthopedic Surgeons in the State of Louisiana*, 14 ORTHOPEDIC REVS., 2022, at 1, 2 ("In medicine, the services provided by the surgeon are learned and acquired prior to employment; the employer is not providing proprietary trade secrets, knowledge, or skills that would protect the employer from unfair competition. Instead, the purpose of the NCC is largely to deter a physician from leaving an employer by not allowing them to continue to practice in the same community, which can give an unfair leverage to employers/large hospital systems.").

[239] Tanya Albert Henry, *What Employed Physicians Should Know About Noncompete Clauses*, AM. MED. ASS'N (2024), http://www.ama-assn.org/medical-residents/transition-resident-attending/what-employed-physicians-should-know-about [https://perma.cc/7NNM-TS8J].

[240] *See* Meyer, *supra* note 177.

[241] *See* Posner, *supra* note 206, at 173–74.

[242] *See id.* at 173.

[243] *See id.* at 174.

from doing so.[244] As a result, employers, including hospitals, are encouraged to expand the use of noncompetes, even in cases where they lack any legitimate business interest to impose them.[245]

Arguably, class action suits could overcome some of the above challenges; however, thus far, a limited number of courts have been willing to certify a class to bring such a challenge.[246] Moreover, because employment contracts are confidential, it is difficult for lawyers to prove that a noncompete binding for their client is also binding for their client's coworkers.[247] These obstacles to succeeding under the rule of reason undermine the deterrence effect of antitrust law, which could otherwise protect workers from employers' exercise of monopsony power.[248]

And yet, there are more reasons why applying the rule of reason test in the case of noncompetes may be a mistake. Consider *NCAA v. Alston*.[249] This case involved the compensation limits the NCAA and its members imposed on student athletes.[250] A district court in California examined this case under the rule of reason.[251] While the district court refused to condemn the NCAA's rules restraining undergraduate athletic scholarships and other forms of compensation related to students' athletic performance, it condemned those

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[244] *See* Meyer, *supra* note 177 (arguing that it can cost tens of thousands of dollars in legal fees to challenge a noncompete clause).

[245] *See, e.g.*, Mintzer, *supra* note 189 ("[A]n overly-restrictive clause might be litigated in court; but that requires an enormous, expensive legal fight that most of us can't manage (even in medicine!). Who can afford to fight against the hospital or health plan worth billions of dollars with an army of attorneys at its disposal? In medicine, employers routinely insist upon clauses that they know would not hold up in court simply because they know the employee would be in no financial position for the legal fight. . . . [T]here is simply no justification for the existence of these clauses. They reduce the free movement of labor (with major economic impact), cause personal distress, give employers far too much power, and, in our industry, disrupt health care. They should be banned, altogether, at the federal level."); *see also* Anonymous Comment on FTC's Workshop on Non-Compete Clauses Used in Employment Contracts (Jan. 31, 2020), https://www.regulations.gov/comment/FTC-2019-0093-0156 [https://perma.cc/7FYU-VPED] ("Non-compete clauses are more financial than legal constraints. Everybody understands that the non compete [sic] clause at my institution is absurd. We all know that any individual who left my institution would eventually win their case. We also know that we would be overwhelmed by legal costs. The message by my institution is if you practice in Philadelphia, or leave with another person you currently practice with, we will destroy you financially so no one will ever dare to do anything like that again.").

[246] *See* Posner, *supra* note 206, at 174.

[247] *Id.*

[248] *Id.* at 175 ("Employers face virtually no legal consequences under the antitrust laws if they use noncompetes for anticompetitive purposes.").

[249] 594 U.S. 69 (2021).

[250] *Id.* at 73.

[251] *Id.* at 81.

NCAA rules that limited what education-related benefits schools could make available to student–athletes.[252]

In applying the first step of the rule of reason test, where the plaintiff must prove the restraint's anticompetitive effects, the court observed that the NCAA exercised its monopsony power in "the market for 'athletic services in men's and women's Division I basketball and FBS football . . . .'"[253] The NCAA and its members, the court observed, "have the 'power to restrain student-athlete compensation in any way and at any time they wish . . . .'" without reducing their market power.[254] The court found that the NCAA's compensation limits created significant anticompetitive effects in this market because they capped the compensation offered to recruits.[255] Absent these restraints, the court said, students would attain higher compensation.[256]

Then, the district court went on to examine the business justifications offered by the NCAA.[257] Although the court rejected most of them, it took time to closely examine one, which it ultimately accepted: that the NCAA's compensation rules preventing "unlimited payments unrelated to education" could help differentiate college sports from professional sports and thus increase consumer demand.[258] Without the imposed restraints, the court said, a unique product—amateur college sports—would not be available to consumers.[259] Hence, the NCAA's compensation rules expanded consumer choice. On appeal filed by both sides, the Ninth Circuit Court of Appeals affirmed the district court's ruling.[260] The Supreme Court also affirmed.[261]

But this procompetitive benefit—preservation of amateurism—was created in the NCAA's seller-side consumer market (i.e., output market) rather than the market for athletic services (i.e., input market) in which the anticompetitive effects of the NCAA's compensation rules were felt.[262] Thus, the Supreme Court did not exclude the possibility that, when section 1 of the Sherman Act applies, the procompetitive benefit in one market can

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[252] *Id.* at 73.

[253] *Id.* at 81 (quoting *In re* Nat'l Collegiate Athletic Ass'n Athletic Grant-in-Aid Cap Antitrust Litig., 375 F. Supp. 3d 1058, 1067 (N.D. Cal. 2019)).

[254] *Id.* at 81–82 (quoting Nat'l Collegiate Athletic Ass'n Athletic Grant-in-Aid Cap Antitrust Litig., 375 F. Supp. 3d at 1070).

[255] *Id.* at 82.

[256] *Id.*

[257] *Id.*

[258] *Id.* at 83–84.

[259] *Id.* at 82.

[260] *Id.* at 69.

[261] *Id.* at 107.

[262] *Id.* at 82.

outweigh its anticompetitive effect in another.[263] Future courts that hear cases challenging noncompete clauses in the healthcare industry may adopt the line of reasoning in *Alston*. This, however, could have devastating effects on physicians, nurses, patients, and, ultimately, public health.

Recall the example of a hospital that imposes a noncompete on nurses. Under the rule of reason test, the plaintiff–nurse would need to prove that their hospital-employer has substantial market power and that the noncompete suppresses competition in the entire labor market. In the unlikely case that the plaintiff–nurse met this high burden of proof under the first step of the rule of reason test, the burden of proof would shift to the defendant–hospital, which would need to show the restraint's procompetitive benefits. For instance, the hospital may contend that the noncompete produces cost savings that benefit consumers in the hospital-services market. The argument would be that noncompetes reduce hospitals' labor costs by suppressing nurses' wages. This allows them to reduce the rates they charge health insurers, which ultimately benefits the purchasers of health insurance services, notably employers and consumers. Alternatively, the defendant–hospital may allege that the noncompetes ensure the continuity of healthcare services and contribute to health outcomes. Because the Court in *Alston* did not exclude the possibility that the procompetitive benefits produced in one market can outweigh the anticompetitive harms in another, hospitals could potentially defend their noncompetes on the basis that the likely efficiencies they produce in the hospital services market surpass any harm they cause to competition in the labor market.

Clearly, the *Alston* type of analysis can lead to unfair outcomes. First, such analysis risks ignoring that noncompetes contribute to the shortage of nurses and physicians and, thus, to the hospital-closure crisis plaguing rural America. Second, this analysis would favor only limited, short-term theories of potential procompetitive benefits while ignoring the long-term harm that noncompetes ultimately inflict: a reduced workforce and fewer hospitals with fewer healthcare services in rural communities.

Third, such an analysis would contribute to the monopsony power that hospitals already enjoy, especially in rural areas. More importantly, if the enforcers and the courts allow the procompetitive effects in one market to outweigh the anticompetitive effects in another, they will apply antitrust law in a way that reflects the notion that one group of consumers (i.e., the employers) deserves more protection than another (i.e., the workers).

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[263] Ted Tatos & Hal Singer, *The Abuse of Offsets as Procompetitive Justification: Restoring the Proper Role of Efficiencies After* Ohio v. American Express *and* NCAA v. Alston, 38 GA. ST. U. L. REV. 1179, 1205 (2022).

But antitrust law does not support this notion. Indeed, antitrust law is based on the idea that all individuals deserve the fruits of well-functioning markets: lower prices, increased quality, and wider choice. For this reason, if courts apply antitrust law in a way that privileges employers' interests over the interests of workers, they risk ignoring a basic tenet of antitrust policy: that all consumers *equally* deserve the protection of antitrust principles.[264] They also risk contributing to the social and economic inequality that antitrust law was initially designed to combat,[265] which remains rampant in America.[266]

There are several reasons why this would be the case. To start, *Alston*-style analysis would result in a redistribution of wealth from employees to employers. If any branch of government has the authority to make policies that affect the distribution of wealth in the nation, it would be Congress rather than antitrust enforcers and the courts. By supporting the view that an employer's legitimate interests can outweigh the harm that noncompetes cause to workers and patients, the courts may end up assuming the role of Congress by permitting the majority of noncompetes in the healthcare industry. Moreover, this view stands contrary to research demonstrating how these agreements aggravate the shortage of healthcare workers in America and, ultimately, the hospital-closure epidemic.

One could argue that it is unlikely that all courts will apply the Supreme Court's analysis in *Alston* to noncompete cases. Courts might instead take inspiration from *United States v. Philadelphia National Bank*, which maintained that the procompetitive justifications in one market cannot outweigh the anticompetitive harms in another.[267] *Philadelphia National Bank* centered around the merger of the second and third largest commercial banks in the Philadelphia metropolitan area.[268] The proposed transaction would have resulted in Philadelphia's largest commercial bank.[269] To rebut the government's findings of anticompetitive effects, the merging parties raised an efficiency defense. Specifically, they alleged that the post-merger bank "with its greater prestige and increased lending limit, would be better able to compete with large out-of-state (particularly New York) banks,

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[264] *See* Christopher R. Leslie, *Food Deserts, Racism, and Antitrust Law*, 110 CALIF. L. REV. 1717, 1753 (2022).

[265] *See* Sandeep Vaheesan, *Accommodating Capital and Policing Labor: Antitrust in the Two Gilded Ages*, 78 MD. L. REV. 766, 771 (2019).

[266] *See generally* Jonathan B. Baker & Steven C. Salop, *Antitrust, Competition Policy, and Inequality*, 104 GEO. L.J. ONLINE 1 (2015) (discussing the growing economic inequality in the United States since the 1980s).

[267] 374 U.S. 321 (1963).

[268] *Id.* at 330.

[269] *Id.* at 331.

would attract new business to Philadelphia, and in general would promote the economic development of the metropolitan area."[270]

The Court was not convinced. Rather, the Court supported the view that if procompetitive benefits in one market could outweigh anticompetitive benefits in another, every firm in the industry could, without breaching the Clayton Act, "embark on a series of mergers" that ultimately would make it the leading industry player.[271] For this reason, the Court did not allow the proposed merger to advance.

Given the Court's ruling in *Philadelphia National Bank*, some courts may still be willing to hold that the welfare gains employers enjoy cannot outweigh the welfare losses employees suffer.[272] However, because *Philadelphia National Bank* is a merger case, some courts may contend that the Court's ruling in *Philadelphia National Bank* does not apply to cases analyzing claims under section 1 of the Sherman Act, and hence, *Alston*'s line of reasoning is more appropriate for analyzing noncompete agreements.

Importantly, the FTC has not shut its ears to these concerns. Recently, the FTC adopted a federal regulation (Noncompete Rule) that bans most noncompete agreements across America.[273] The rule explains that entering into noncompete agreements with workers violates section 5 of the Federal Trade Commission Act (FTC Act).[274] For existing noncompete clauses, the rule distinguishes between workers and senior executives.[275] For senior executives, the existing noncompete agreements remain enforceable.[276] Noncompete agreements with any other workers, however, are void after the effective date, September 4, 2024.[277] The FTC adopted this rule after initially proposing a regulation banning all noncompete clauses and after considering numerous public comments and empirical studies indicating the negative impact of noncompetes on workers' wages and working conditions.[278]

But these are not the only steps that the FTC has taken to protect workers from the harmful effects of noncompetes. In November 2022, the

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[270] *Id.* at 334 (footnote omitted) (citing 12 U.S.C. § 84).

[271] *Id.* at 370.

[272] *See* Laura Alexander & Steven C. Salop, *Antitrust Worker Protections: The Rule of Reason Does Not Allow Counting of Out-of-Market Benefits*, 90 U. CHI. L. REV. 273, 278 (2023) (arguing that the *Philadelphia National Bank* approach to mergers should apply to all buyer-side restraints analyzed under the Sherman Act).

[273] Non-Compete Clause Rule, 89 Fed. Reg. 38342 (May 7, 2024) (to be codified at 16 C.F.R. pts. 910, 912).

[274] *Id.* at 38342.

[275] *Id.*

[276] *Id.*

[277] *Id.*

[278] *Id.*

FTC also published a policy statement to elaborate on its power under section 5 of the FTC Act, which prohibits unfair methods of competition.[279] In this statement, the FTC underlines that it is authorized to protect employees nationwide from any unfair methods of competition.[280] Since then, the FTC has announced several actions against companies which have imposed noncompete agreements on their employees in breach of section 5 of the FTC Act.

For instance, the FTC initiated proceedings against Prudential, a Michigan-based security firm, on the theory that its noncompetes were exploitative and caused harm to competition.[281] Given these concerns, the FTC ordered Prudential to terminate all noncompetes for all security guards in Prudential's employ and to notify these employees that the noncompetes were now unenforceable.[282]

Similarly, the FTC has initiated actions against Owens-Illinois and Ardagh, targeting the use of noncompetes in the glass-manufacturing sector.[283] In its complaint, the FTC emphasized that the company's use of noncompetes "locked up highly specialized workers" and thus deprived rival firms of access to qualified labor.[284] The FTC again required the employer to inform its employees that the noncompetes were no longer enforceable.[285]

But the FTC is not alone in this battle. Many states have also taken steps to reduce the harmful effects of noncompetes on laborers and consumers. For instance, California, Minnesota, North Dakota, and Oklahoma have each banned all noncompete agreements.[286] Other states, including Illinois, Oregon, and Virginia, have chosen to ban the use of noncompetes only for lower paid workers.[287] Still, other states, such as New Mexico, Florida, and

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279 *See* FED. TRADE COMM'N, COMM'N FILE NO. P221202, POLICY STATEMENT REGARDING THE SCOPE OF UNFAIR METHODS OF COMPETITION UNDER SECTION 5 OF THE FEDERAL TRADE COMMISSION ACT (Nov. 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/P221202Section5PolicyStatement.pdf [https://perma.cc/GAK4-SB9Q].

280 *See* FED. TRADE COMM'N, FACT SHEET: FTC PROPOSES RULE TO BAN NONCOMPETE CLAUSES, WHICH HURT WORKERS AND HARM COMPETITION 3 (Jan. 5, 2023), https://www.ftc.gov/system/files/ftc_gov/pdf/noncompete_nprm_fact_sheet.pdf [https://perma.cc/2E9P-B64P] ("[T]he FTC recently released a policy statement to reinvigorate Section 5 of the FTC Act, which bans unfair methods of competition, explicitly noting that the Commission is obligated to protect workers from unfair methods of competition.").

281 *Id.*

282 *Id.*

283 *Id.*

284 *Id.*

285 *Id.*

286 *US Non-Compete Agreement Laws by State*, SIXFIFTY, https://www.sixfifty.com/resource-library/non-compete-agreement-by-state/ [https://perma.cc/5ETG-RJ9N].

287 *Id.*

Delaware, have either limited or completely banned noncompete agreements in the healthcare industry.[288]

But despite these developments, a national solution to the problems posed by noncompetes remains crucial for the healthcare sector. As things stand, nurses and physicians may be more willing to move to states that have completely banned the use of noncompetes. This environment gives these states a competitive advantage in the market for skilled healthcare workers. Accordingly, states that have not limited the use of noncompetes, such as Mississippi, are at a competitive disadvantage. This market imbalance may ultimately worsen the shortage of healthcare workers that states like Mississippi face, which may, in turn, lead to more hospital closures and worse health outcomes for vulnerable residents.

Importantly, although the FTC's Noncompete Rule could address this market imbalance, the fate of this rule is still uncertain. After the rule's adoption, several business groups filed lawsuits challenging its validity in Pennsylvania, Florida, and Texas.[289] Since then, legal experts have expressed concern that the Noncompete Rule may not survive. Those concerns were recently confirmed when a federal judge in Texas prevented the FTC from enforcing the Noncompete Rule.[290] In her opinion, the judge claimed that the FTC exceeded its statutory authority in adopting the Noncompete Rule.[291] In addition, the judge believed that the Noncompete Rule was overbroad and, hence, "arbitrary" and "capricious."[292] For these reasons, she concluded that the Noncompete Rule should not be enforced or take effect on September 4, 2024.[293] A federal judge in Florida also took the view that the FTC lacked the statutory authority to introduce the Noncompete Rule.[294] The FTC appealed both decisions.

But even if the Noncompete Rule survives these legal challenges, some have raised concern that it may not adequately protect healthcare-industry workers, including nurses and physicians.[295] This is because the FTC Act grants the FTC authority over for-profit organizations but not over nonprofit

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[288] *Id.*

[289] Harris Meyer & KFF Health News, *Lina Khan's Noncompete Crackdown Could Leave Most Doctors and Nurses out in the Cold*, FORTUNE (May 27, 2024, 6:01 AM), https://fortune.com/2024/05/27/lina-khan-noncompete-ban-doctors-nurses/ [https://perma.cc/8TW9-PTZX]; Props. of the Vills., Inc. v. FTC, No. 24-cv-316-TJC-PRL, 2024 WL 380380 (M.D. Fla. Aug. 15, 2024).

[290] Ryan, LLC v. Fed. Trade Comm'n, No. 24-CV-00986-E, 2024 WL 3879954, at *27 (N.D. Tex. Aug. 20, 2024).

[291] *Id.* at *17.

[292] *Id.* at *23–24.

[293] *Id.* at *27.

[294] *See Props. of the Vills., Inc.*, 2024 WL 380380, at *9.

[295] *See* Meyer & KFF Health News, *supra* note 289.

and charitable organizations.[296] Nonetheless, more than 60% of community hospitals in the nation operate as nonprofit firms.[297] For this reason, experts warn that the Noncompete Rule may not necessarily protect all workers in nonprofit hospitals. The FTC has responded to these concerns, emphasizing that the rule introduces a two-part test to assess whether a firm is organized as a not-for-profit.[298] The FTC said that "it looks to both the source of the income, i.e., to whether the corporation is organized for and actually engaged in business for only charitable purposes, and to the destination of the income, i.e., to whether either the corporation or its members derive a profit."[299] Hence, the FTC has not excluded the possibility that the Noncompete Rule will cover some nonprofit hospitals.

Given the above concerns, the courts' role in protecting physicians, nurses, and patients from the severe harm noncompetes cause them remains crucial.

B. Section 7 of the Clayton Act and Monopsony Power

The previous Section illustrated that hospital mergers have detrimental effects not only on output but also on input (labor) markets. When hospitals merge in concentrated markets, the number of employers available for physicians, nurses, and healthcare workers further decreases. This allows hospitals to exercise monopsony power in the labor market by suppressing their employees' wages and reducing the quality of their working conditions.

Empirical evidence illustrates those concerns. Robust studies prove that increased consolidation in the hospital industry has resulted in suppressed wages for nurses in America.[300] When wages fall, employees have a higher incentive to leave the market. This explains, at least partially, the severe shortage of nurses that America is currently experiencing, especially in rural areas. An illustrative 2021 study that surveyed rural hospitals in America revealed that 96% of the respondent hospitals struggled to fill nursing positions.[301] Due to these shortages, almost 50% of survey respondents said they were forced to turn away patients. Others reported that they had no other

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[296] *See* Non-Compete Clause Rule, 89 Fed. Reg. 38342, 38356–57 (May 7, 2024) (to be codified at 16 C.F.R. pts. 910, 912).

[297] *See* Meyer & KFF Health News, *supra* note 289.

[298] *See* Non-Compete Clause Rule, 89 Fed. Reg. at 38357.

[299] *Id.* (quoting *In re* Coll. Football Ass'n, 117 F.T.C. 971, 995 (1994)).

[300] *See* Prager & Schmitt, *supra* note 166, at 398.

[301] *See* THE CHARTIS GRP., THE COVID-19 PANDEMIC'S IMPACT ON RURAL HOSPITAL STAFFING: VACCINE HESITANCY AND NURSE STAFFING SHORTAGES JEOPARDIZE ACCESS TO CARE 1, 2 (Nov. 2021), http://www.chartis.com/sites/default/files/documents/The-Pandemics-Impact-on-Rural-Hospital-Staffing.pdf [https://perma.cc/2LK4-FZ4B].

option than to suspend offering specific hospital services altogether.[302] This forced suspension undermines the ability of rural hospitals to make profits and remain afloat.

But increasing wages alone may not fix the problem. Nurses do not leave the market solely because they are underpaid. Nurses themselves have emphasized that chronic understaffing, immense patient loads, and brutal working hours have left them feeling crushed.[303] Facing these burdens for less than adequate pay and being unable to easily switch to a different nursing job with better working conditions, many nurses simply leave the nursing industry.[304] A study exploring why nurses in America increasingly leave their profession illustrates these concerns.[305] The study reveals that, among the nurses who reported leaving their jobs in 2017, 31.5% cited burnout as the primary reason. Other contributing factors included working in a stressful environment, inadequate staffing, increased workloads, poor pay, and a lack of support from leadership.[306]

Surely burnout is, and has always been, a risk inherent in a nurse's job—and many nurses admit as much[307]—but the problem has reached a crisis point. The data speak volumes: a 2022 survey of 12,581 nurses by the American Nurses Foundation found that 57% felt "exhausted" over the past two weeks, 44% reported that they were overworked, 43% experienced burnout, and 23% revealed that they experienced symptoms of depression,[308] while only 20% of the surveyed nurses felt valued.[309] The COVID-19

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[302] *Id.*

[303] *See* Goldstein, *supra* note 178 ("In public comments to the FTC, health workers document how, for over a decade, chronic understaffing left them crushed under mountainous loads of patients and working brutal hours."); *see also* Megha K. Shah, Nikhila Gandrakota, Jeannie P. Cimiotti, Neena Ghose, Miranda Moore & Mohammed K. Ali, *Prevalence of and Factors Associated with Nurse Burnout in the US*, [J]AMA NETWORK OPEN, Feb. 2021, at 1, 1 (detailing how working conditions coupled with noncompete agreements have driven many health workers out of the industry); Heather Landi, *Third of Nurses Plan to Leave Their Jobs in 2022, Survey Finds*, FIERCE HEALTHCARE (Mar. 22, 2022, 11:13 AM), http://www.fiercehealthcare.com/providers/third-nurses-plan-leave-their-jobs-2022-survey-finds [https://perma.cc/M82B-D8BL].

[304] *See* Goldstein, *supra* note 178.

[305] *See* Shah et al., *supra* note 303, at 1.

[306] *Id.*

[307] Bradford Pearson, *Nurses Are Burned Out. Can Hospitals Change in Time to Keep Them?*, N.Y. TIMES (last updated Apr. 5, 2023), https://www.nytimes.com/2023/02/20/well/nurses-burnout-pandemic-stress.html [https://perma.cc/Q8VJ-ZUQU].

[308] AM. NURSES FOUND., PULSE ON THE NATION'S NURSES SURVEY SERIES: ANNUAL ASSESSMENT SURVEY (2022), http://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/what-you-need-to-know/annual-survey--third-year/contentassets/anf-impact-assessment-third-year_v5.pdf [https://perma.cc/GTR9-HHRQ].

[309] *Id.*

pandemic exacerbated the problem by adding yet another factor: a rise in violence and hostility toward healthcare workers.[310]

But studies increasingly convey that these harmful effects relate not only to the COVID-19 pandemic. They are also strongly correlated with the increased consolidation in the hospital industry and the monopsony power exercised by hospital–employers.[311] As noted, research demonstrates that when a hospital merger occurs, nurses face higher rates of burnout, job dissatisfaction, and heavier workloads.[312] In light of these concerns, National Nurses United (NNU) recently urged the FTC and the Department of Justice (the Agencies) to strengthen antitrust scrutiny in the hospital sector to prevent hospitals from exploiting their market power in the labor market.[313] In her request, NNU's Lead Regulatory Policy Specialist Carmen Comsti emphasized the ways in which exercises of market power in the labor market have threatened the health and safety of nurses while also worsening health outcomes for patients.[314] Hospitals' monopoly power, Comsti explained, has reduced access to healthcare services for patients and has "depresse[d] wages and dilute[d] the power of workers to advocate for better working conditions and patient safety."[315]

Nurses are not alone in this struggle. Physicians are also leaving medicine or seeking early retirement to avoid burnout and cope with feelings of chronic stress and exhaustion. One recent study conducted by the Agency for Healthcare Research and Quality explores why physicians in America constantly feel overwhelmed.[316] This study found that more than half of the surveyed physicians "reported experiencing time pressures when conducting physical examinations,"[317] while nearly a third said that "they needed at least 50 percent more time than was allotted for this patient care function."[318]

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[310] NAT'L NURSES UNITED, WORKPLACE VIOLENCE AND COVID-19 IN HEALTH CARE: HOW THE HOSPITAL INDUSTRY CREATED AN OCCUPATIONAL SYNDEMIC 8, 11 (Nov. 2021), https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_WPV_HS_Survey_Report_FINAL.pdf [https://perma.cc/X39W-8QFR].

[311] *See* Sara Heath, *Do Hospital Mergers and Acquisitions Drive Physician Burnout?*, TECHTARGET (Sept. 18, 2024), https://www.techtarget.com/revcyclemanagement/news/366611114/Do-hospital-mergers-and-acquisitions-drive-physician-burnout [https://perma.cc/6KDF-PW7Y].

[312] Currie et al., *supra* note 170, at 473–74, 491; *see also* Jennings, *supra* note 171; Press Release, Nat'l Nurses United, *supra* note 154.

[313] Press Release, Nat'l Nurses United, *supra* note 154.

[314] *Id.*

[315] *Id.*

[316] AGENCY FOR HEALTHCARE RSCH. & QUALITY, PUB'N 17-M018-1-EF, PHYSICIAN BURNOUT (July 2017), https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/clinicians-providers/ahrq-works/impact-burnout.pdf [https://perma.cc/D8TA-CGSC].

[317] *Id.*

[318] *Id.*

Approximately a quarter also conveyed that "they needed at least 50 percent more time for follow-up appointments."[319] Respondents cited chaotic working conditions, a lack of control over the work pace, and unfavorable organizational cultures as some factors contributing to their emotional exhaustion.[320]

As with nurses, market consolidation has been one of the most critical factors in creating the working conditions that have caused physicians to experience burnout and job dissatisfaction. This was amply demonstrated in a public workshop organized by the FTC, aiming to examine the effects of hospital consolidation in input and output markets. At this workshop, several participants stressed that hospitals' monopsony power has led to lower wages and inferior working conditions for physicians.[321] For example, one participant—Sue Sedory on behalf of the American College of Emergency Physicians—shared the results of a survey conducted by her organization that attested to the effects of mergers on emergency physician practices.[322] The results indicated that almost 60% of the respondents had experienced a pay cut of more than 20% following a merger involving their employing hospital.[323] Other physicians indicated that the mergers negatively affected their autonomy, which caused them a moral injury.[324] This impingement on their decision-making freedom made some physicians feel

[319] *Id.*

[320] *Id.*

[321] *See generally* Sue Sedory, Exec. Dir. & Chief Exec. Officer, Am. Coll. of Emergency Physicians, Statement at the Federal Trade Commission and U.S. Department of Justice Listening Forum on Effects of Mergers in Health Care Industry 14–15 (Apr. 14, 2022), http://www.ftc.gov/system/files/ftc_gov/pdf/FTC-DOJ-Listening-Forum-%20Health-Care-Transcript.pdf [https://perma.cc/E45S-NNQK] ("[W]hile some noted a positive impact in negotiating[] more fairly with insurance companies, most noted numerous anti-competitive labor related effects, including reduced wages and or non cash benefits.").

[322] *Id.* at 14–15.

[323] *Id.* at 14.

[324] *Id.*; Lois Uttley, Senior Advisor to the Hosp. Equity & Accountability Project, Cmty. Catalyst, Statement at the Federal Trade Commission and U.S. Department of Justice Listening Forum on Effects of Mergers in Health Care Industry, *supra* note 321, at 15; Sailesh Konda, Dermatologist, Univ. of Fla., Statement at the Federal Trade Commission and U.S. Department of Justice Listening Forum on Effects of Mergers in Health Care Industry, *supra* note 321, at 24; Mercy Hilton, Pediatric Emergency Physician, Statement at the Federal Trade Commission and U.S. Department of Justice Listening Forum on Effects of Mergers in Health Care Industry, *supra* note 321, at 27; *see also* Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES (June 15, 2023), https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html [https://perma.cc/2RFN-ERHA] ("The pull of these forces left many doctors anguished and distraught, caught between the Hippocratic oath and 'the realities of making a profit from people at their sickest and most vulnerable.'").

alienated from their healing mission, encouraging them to leave medicine altogether even though some viewed medicine as their calling.[325]

Meanwhile, if hospital markets were less concentrated, nurses and physicians might not so readily look for the exit. Indeed, if hospitals rigorously competed to attract labor, they would have greater incentive to improve their employees' salaries and working conditions, which would naturally prevent some early exits. Nonetheless, due to rampant hospital consolidation across America, hospitals simply lack any incentive to do so.

This state of affairs illustrates that antitrust has failed workers in the healthcare sector. Section 7 of the Clayton Act allows the enforcers and the courts to prevent any merger or acquisition whose effect may be to "substantially lessen competition" or "create a monopoly" in any relevant market, including output and input markets.[326] Nonetheless, thus far, whenever the enforcers and the courts have assessed the impact of hospital mergers on competition, they have primarily focused on the effects of those mergers on the prices and quality of hospital services.[327] Thus, they have omitted assessment of hospital mergers' impact on competition in input (labor) markets. This shortcoming, however, is not trivial. Any detrimental effect on the welfare of healthcare workers will also eventually negatively impact consumers, inasmuch as lower wages and inferior working conditions force nurses, physicians, and clinicians to leave the market, thereby limiting rural residents' access to care.

To address these and other concerns, in 2021, the Biden Administration issued an executive order urging the FTC to increase antitrust enforcement in the healthcare industry and to combat the harmful effects of monopsony power in multiple industries, including the hospital sector.[328] In a complaint filed to prevent the merger between Lifespan Corporation and Care New England Health System, the two largest healthcare providers in Rhode

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[325] Robert McNamara, former President, Am. Acad. of Emergency Med., Statement at the Federal Trade Commission and U.S. Department of Justice Listening Forum on Effects of Mergers in Health Care Industry, *supra* note 321, at 19; Vicki Norton, Bd. Member, Am. Acad. of Emergency Med., Statement at the Federal Trade Commission and U.S. Department of Justice Listening Forum on Effects of Mergers in Health Care Industry, *supra* note 321, at 22–23.

[326] U.S. DEP'T OF JUST. & FED. TRADE COMM'N, MERGER GUIDELINES § 1, at 1, § 2.2, at 7 (Dec. 18, 2023), https://www.justice.gov/d9/2023-12/2023%20Merger%20Guidelines.pdf [https://perma.cc/KK4U-YV4V].

[327] Theodosia Stavroulaki, *Integrating Healthcare Quality Concerns into the US Hospital Merger Cases, A Mission Impossible?*, 39 WORLD COMPETITION 593 (2016) (examining how the enforcers assess the non-price effects of hospital mergers and finding that the enforcers focus primarily on assessing the impact of hospital mergers on output markets); *see also* Posner et al., *supra* note 232, at 539–40 (claiming that the enforcers do not generally assess the impact of mergers on labor markets but rather focus more on the anticompetitive effects of mergers on output or product markets).

[328] Exec. Order No. 14,036, 3 C.F.R. 609 (2024).

Island, the FTC signaled a commitment to expanding its merger analysis and assessing the harmful effects of hospital mergers on the labor market.[329] Indeed, in addition to alleging that the merged entity at issue would control at least 70% of the market for inpatient acute care and inpatient behavioral-health services, Chair Lina Khan and Commissioner Rebecca Slaughter also emphasized that the proposed transaction had the potential to restrain competition in the relevant labor markets.[330]

Specifically, they emphasized that "just as consumers are worse off when mergers diminish competition for goods and services based on price, quality, and innovation, workers [also] suffer when mergers diminish competition for their labor and employers are insulated from competition driving improved wages, benefits, working conditions, and other terms of employment."[331] Following the FTC's complaint, the entities abandoned the proposed merger.[332]

The fact that the FTC is now looking more closely at the effects on labor markets is an obvious improvement over previous merger assessments in the hospital sector. This, however, leaves open the question of how the enforcers aim to assess the effects of mergers on workers in the hospital industry.

The answer is not straightforward. For instance, the 2010 Horizontal Merger Guidelines (HMG) explicitly noted the importance of considering monopsony power in merger analysis,[333] explaining that "[m]ergers of competing buyers can enhance market power on the buying side of the market, just as mergers of competing sellers can enhance market power on the selling side of the market."[334] The HMG also explained that, when evaluating whether a merger is likely to enhance market power on the buying side of the market, "the Agencies employ essentially the framework . . . for evaluating whether a merger is likely to enhance market power on the selling

[329] FED. TRADE COMM'N, COMM'N FILE NO. 2110031, CONCURRING STATEMENT OF COMMISSIONER REBECCA KELLY SLAUGHTER AND CHAIR LINA M. KHAN REGARDING FTC AND STATE OF RHODE ISLAND V. LIFESPAN CORPORATION AND CARE NEW ENGLAND HEALTH SYSTEM 2 (Feb. 17, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/public_statement_of_commr_slaughter_chair_khan_re_lifespan-cne_redacted.pdf [https://perma.cc/4R49-TB64].

[330] *Id.* at 1.

[331] *Id.*

[332] Nick Thomas, *Lifespan, Care New England Won't Say No to a Possible Merger as New Leadership Beds In*, BECKER'S HOSP. REV. (Mar. 17, 2023), https://www.beckershospitalreview.com/finance/lifespan-care-new-england-wont-say-no-to-a-possible-merger-as-new-leadership-beds-in [https://perma.cc/2LLY-9N8U].

[333] U.S. DEP'T OF JUST. & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 32–33 (Aug. 19, 2010), https://www.justice.gov/atr/file/810276/dl?inline [https://perma.cc/GS6N-ZB4J].

[334] *Id.* at 32.

side of the market."[335] The recently published 2023 Merger Guidelines also take the same approach. Specifically, these guidelines say that

> [a] merger between competing buyers may harm sellers just as a merger between competing sellers may harm buyers. The same—or analogous—tools used to assess the effects of a merger of sellers can be used to analyze the effects of a merger of buyers, including employers as buyers of labor.[336]

The existing framework for assessing market power in output (i.e., product) markets is the Herfindahl–Hirschman Index (HHI) framework.[337] The HHI for an output market "equals the sum of the squares of the market share . . . of the firms that compete within that product market, multiplied by 100."[338] An HHI of zero indicates a perfectly competitive market, while "an HHI of 10,000 represents a product market dominated by a single monopolist."[339] The index's value increases when just a few firms are selling a product or when one monopolizes the market. This is because, under these market conditions, the harm caused to competition due to concentration is substantial.[340]

The Agencies use the HHI to assess whether a specific merger among competitors raises serious anticompetitive concerns and, hence, is illegal.[341] For instance, an HHI above 1,800 indicates that a market is "highly concentrated."[342] When two firms seek to merge in a highly concentrated market and the envisaged merger would significantly increase the HHI, enforcers will block the merger based on the presumption that it creates anticompetitive concerns.[343]

The Agencies can conduct a similar analysis when they assess the impact of a merger on labor. First, the Agencies would have to define the relevant market in which the anticompetitive effects—namely, suppressed wages and inferior working conditions—are likely to be felt. Second, they would assess how the envisaged merger may impact the labor market

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335 *Id.*; *see also* U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 326, § 2.10, at 26, § 4.3.D.8, at 48 (discussing how the Agencies analyze effects of merging buyers).

336 U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 326, § 2.10, at 26 (footnote omitted); *see also id.* § 4.3.D.8, at 48 (discussing how labor is viewed as an input in monopsonist merger analysis).

337 *Id.* § 2.1, at 5.

338 *See* Ioana Marinescu & Eric A. Posner, *A Proposal to Enhance Antitrust Protection Against Labor Market Monopsony* 4 (Roosevelt Inst., Working Paper, 2018), https://rooseveltinstitute.org/wp-content/uploads/2020/07/RI_ProposalToEnhanceAntitrustProtection_workingpaper_201812.pdf [https://perma.cc/4A7F-N7HB].

339 *Id.* at 4.

340 *Id.*

341 *See* U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 326, § 2.1, at 5.

342 *Id.*

343 *Id.*

concentration. If the proposed merger substantially increased concentration in the labor market, the Agencies would have good reasons to stop the merger. Then, they would assess any potential efficiencies raised by the merging parties, which may outweigh any potential anticompetitive effects.[344]

But how would the Agencies define relevant markets when they assess the impact of a hospital merger on labor? Although the HMG were silent on the issue, the 2023 Merger Guidelines offer some guidance.[345] They explain that when the Agencies define a labor market, they will consider

> the job opportunities available to workers who supply a relevant type of labor service, where worker choice among jobs or between geographic areas is the analog of consumer choices among products and regions when defining a product market. The Agencies may consider workers' willingness to switch in response to changes to wages or other aspects of working conditions, such as changes to benefits or other non-wage compensation . . . .[346]

The 2023 Merger Guidelines also note that "[g]eographic market definition may involve considering workers' willingness or ability to commute, including the availability of public transportation."[347]

Although the 2023 Merger Guidelines shed some light on the factors the Agencies may likely consider when defining the relevant labor markets, they do not delve into the specific methodology that the Agencies would apply. This seems to be an important omission, especially considering the scarcity of merger cases discussing the anticompetitive effects of monopsony on labor.[348] Nonetheless, leading scholars such as Professors Ioana Marinescu and Eric Posner have extensively discussed the question of how the Agencies should define the relevant market when they assess the effects of mergers on labor, which can serve as a guidepost for enforcement

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[344] *Id.* § 2.10, at 26.

[345] *Id.* § 4.3.D.8, at 48.

[346] *Id.*

[347] *Id.*

[348] *See* Ioana Marinescu & Eric A. Posner, *Why Has Antitrust Law Failed Workers?*, 105 CORNELL L. REV. 1343, 1375 (2020) (noting the scarcity of such cases). *But see* Press Release, Off. of Pub. Affs., U.S. Dep't of Just., Justice Department Obtains Permanent Injunction Blocking Penguin Random House's Proposed Acquisition of Simon & Schuster (Oct. 31, 2022), https://www.justice.gov/opa/pr/justice-department-obtains-permanent-injunction-blocking-penguin-random-house-s-proposed [http://perma.cc/4EL8-JKAT] (noting that "the U.S. District Court for the District of Columbia ruled in favor of the Justice Department in its civil antitrust lawsuit to block book publisher Penguin Random House's proposed $2.2 billion acquisition of Simon & Schuster" because "[t]he court found that the effect of the proposed merger would be to substantially lessen competition in the market for the U.S. publishing rights to anticipated top-selling books," having specifically considered the merger's impact on authors' compensation).

in future cases.[349] This labor market definition analysis consists of three elements: "type of job (or skills); geographic scope; and time."[350]

First, Marinescu and Posner suggest that the Agencies should define a labor market "by the type of job."[351] To do so, they should rely on a list created by the Bureau of Labor Statistics called Standard Occupational Classifications (SOC),[352] and, more specifically, "an occupation at the six-digit SOC level, which represents a fairly specific definition of a job or occupation."[353] For instance, according to this classification system, "registered nurses" can constitute a specific job.

Second, the Agencies should define the geographic scope of the market.[354] This should be the geographic region "where most workers work and live, and more specifically a commuting zone (CZ)."[355] Commuting zones are geographic regions "comprising clusters of counties" that the United States Department of Agriculture established after detecting commuting patterns.[356]

Third, the labor market should be limited in terms of time because people seeking employment can only stay unemployed for a specific period.[357] For instance, Marinescu and Posner note that "[t]he median duration of unemployment was about a quarter of a year in 2016."[358] For this reason, they conclude that the Agencies should define the market as the combination of "a six-digit SOC occupation, a commuting zone, and a [fiscal] quarter . . . ."[359] Considering this analysis, registered nurses in Philadelphia in the first quarter of 2016, for example, could constitute a separate labor market.

After defining a labor market using this three-step analysis, the Agencies can then assess the HHI in a specific labor market as they would in product markets. The only difference would be that the market share, in this case, is "the firm's share of a labor market, rather than its share of a

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[349] *See* Marinescu & Posner, *supra* note 348, at 1389; *see also* Ioana Marinescu & Herbert Hovenkamp, *Anticompetitive Mergers in Labor Markets*, 94 IND. L.J. 1031, 1048–51 (2019) (arguing market analysis should be defined by "geography, occupation, and time").

[350] Marinescu & Posner, *supra* note 348, at 5.

[351] *Id.*

[352] *Id.*

[353] *Id.*

[354] *Id.*

[355] *Id.*

[356] *Id.* at 5–6.

[357] *Id.*

[358] *Id.*

[359] *Id.*

product market."[360] To assess labor market concentration, the Agencies should examine "the number of vacancies in a particular labor market and calculate the HHI based on each firm's share of those vacancies."[361] For instance, "[a] [labor] market where four firms post 25% of jobs . . . is highly concentrated with an HHI of 2,500."[362]

But even if the Agencies applied a similar analysis and, hence, showed that the merger may significantly increase the concentration levels in the labor industry, the analysis may not necessarily stop there. More likely, the defendant–employers would try to rebut the Agencies' findings by showing that the merger may yield substantial efficiencies that benefit competition in the product market.

Consider, as an example, a merger between two hospitals in a rural area where competition for labor among employers is almost zero. Assume that the Agencies demonstrate that the merger may significantly increase concentration in the market for registered nurses, and hence, it should be prohibited because of the high levels of HHI in this specific labor market. The defendant–hospitals would most likely try to rebut the showing of anticompetitive effects in the market for registered nurses by alleging that the merger may lead to significant cost savings due to lower labor costs. These cost savings would be passed on to consumers in the form of lower hospital rates and, ultimately, lower health insurance premiums. Thus, the argument would go that although the merger may harm one group of consumers (the workers), it may benefit another (the purchasers of hospital and health insurance services). *But would the Agencies be convinced by such a claim?*

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[360] *Id.* at 4.

[361] *Id.*

[362] *Id.* The FTC also followed a similar approach in a recent hospital merger case. In its public comments on the proposed merger between SUNY Upstate and Crouse Health System, the FTC assessed its anticompetitive effects on both the product and the labor markets, specifically respiratory therapists and registered nurses. To do so, the FTC followed a two-step approach. First, it assessed the premerger level of concentration in the labor market. Second, it evaluated how the proposed merger would change the concentration level for hospitals as employers "in the commuting zone for nursing labor." Fed. Trade Comm'n, Comment Letter on the Certificate of Public Advantage Application of State University of New York Upstate Medical University and Crouse Health System, Inc. 28–29 (Oct. 7, 2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2210126NYCOPACommentPublic.pdf [https://perma.cc/B5DU-5D7T]. The FTC concluded that "the labor markets for both registered nurses and respiratory therapists will be highly concentrated after the proposed merger and that the merger would increase concentration significantly." *Id.* at 29. Eventually, the parties abandoned the merger altogether. *See* Press Release, Fed. Trade Comm'n, Statement of Elizabeth Wilkins, Director of the FTC's Office of Policy Planning, on the Decision of SUNY Upstate Medical University and Crouse Health System, Inc. to Drop Their Proposed Merger (Feb. 16, 2023), https://www.ftc.gov/news-events/news/press-releases/2023/02/statement-elizabeth-wilkins-director-ftcs-office-policy-planning-decision-suny-upstate-medical [https://perma.cc/TD2H-Z8EU].

Recall *Philadelphia National Bank*. In that case, the Supreme Court asserted that if anticompetitive effects in one market could be offset by procompetitive benefits in another one, every firm in the industry could, without violating the Clayton Act, "embark on a series of mergers" that ultimately would make it the only real player in the market. For this reason, the Court stopped the proposed merger. Considering this, the Agencies may argue that, even if the proposed merger produces cost efficiencies, those efficiencies might occur in the hospital-services and health-insurance-services markets, not in the labor market. In line with the Court's reasoning in *Philadelphia National Bank*, the Agencies may therefore claim that the merger between the two hospitals violates section 7 of the Clayton Act due to the significant anticompetitive concerns it creates in the labor market. As a result, such a merger should be prohibited.

The 2023 Merger Guidelines also support this line of thinking.[363] Specifically, they say that

> [i]f [a] merger may substantially lessen competition or tend to create a monopoly in upstream markets, that loss of competition is not offset by purported benefits in a separate downstream product market. Because the Clayton Act prohibits mergers that may substantially lessen competition or tend to create a monopoly in *any* line of commerce and in *any* section of the country, a merger's harm to competition among buyers is not saved by benefits to competition among sellers.[364]

The Agencies may also try to rebut the hospitals' efficiencies claim by raising an additional concern: that even if the merger produces the envisaged cost efficiencies, such efficiencies may create welfare gains for one group of consumers—the purchasers of hospital and health-insurance services—only in the short run. This is because, if the proposed merger could lead to monopsony power in the market for registered nurses, the wages of such nurses could be substantially reduced. Because reduced wages may motivate the affected nurses to depart their community, this community would suffer from a severe shortage of nurses in the long term. This would lead to reduced access to care for the affected rural residents and, ultimately, additional closures. Thus, because *all consumers* would be harmed in the long run, the merger should be blocked.

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[363] *See generally* U.S. DEP'T OF JUST. & FED. TRADE COMM'N, *supra* note 326, at 27 (identifying procedures and enforcement mechanisms used by the Agencies to determine whether mergers violate antitrust laws).

[364] *Id.*

C. Section 7 of the Clayton Act and Monopoly Power

When two firms decide to merge, the Agencies and the Offices of the States' Attorneys General "possess leverage" in reviewing the merger.[365] Under the Hart–Scott–Rodino Act, parties pursuing mergers that exceed a certain value must file a thorough merger notification with the Agencies and await their assessment.[366] After this process is complete, the Agencies have three primary options: (1) they can allow the merger to move forward on the basis that it does not raise any significant anticompetitive concerns; (2) they can challenge the merger because their review indicates that it may cause harm to competition and consumers; or (3) they can negotiate a consent decree with the merging parties. In this latter case, the Agencies will allow the merger to proceed only if the merging parties agree to conform to specific merger conditions that aim to improve competitive conditions in the market.[367]

There are two main types of merger conditions: behavioral and structural. The structural merger conditions usually require the merging entities to divest themselves of specific assets.[368] By requiring divestitures, the enforcers try to ensure that competition is not eliminated in the market in which the merger will likely create anticompetitive effects.[369] On the other hand, behavioral conditions usually require the merging parties to engage in specific conduct or refrain from it. For instance, the Agencies may require the merging entity not to increase prices after the merger is consummated. They could also require the merging parties to license their intellectual property or not to engage in discriminatory practices when they deal with their trading partners.[370]

The previous Section demonstrated that the hospital-closure crisis at least partially results from several mergers among hospitals in rural areas that eliminate access to care for rural populations, further exacerbating the problem of hospital deserts in underserved areas in America. As noted, many hospitals in these areas choose to acquire their closest competitors to eliminate them from the market and increase their market power in both

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365 *See* Leslie, *supra* note 264, at 1771.

366 *Id.*; *see also Premerger Notification and the Merger Review Process*, FED. TRADE COMM'N, https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/mergers/premerger-notification-merger-review-process [https://perma.cc/23S6-LKUH].

367 *Premerger Notification and the Merger Review Process*, *supra* note 366.

368 *See* ANTITRUST DIV., U.S. DEP'T OF JUST., ANTITRUST DIVISION POLICY GUIDE TO MERGER REMEDIES 23–25 (June 2011), https://www.justice.gov/sites/default/files/atr/legacy/2011/06/17/272350.pdf [https://perma.cc/845N-83VN].

369 *Id.* at 8.

370 Mark A. Lemley & Christopher R. Leslie, *Antitrust Arbitration and Merger Approval*, 110 NW. U. L. REV. 1, 51 (2015).

the hospital-services and labor markets. Thus, post-merger, the acquiring hospital either shuts down the facilities of the target rural hospital or cuts some of its essential healthcare services, including emergency, primary, and maternal care.

Given these concerns, the Agencies could consider accepting hospital mergers in rural areas only under specific conditions. Specifically, the Agencies could require either (1) that the merging parties not shut down any facilities operating pre-merger or (2) that the merging parties not cut any type of healthcare services in underserved areas. In this way, the Agencies could mitigate—at least to a certain extent—the hospital-desert problem that so profoundly harms rural Americans.

Using the antitrust weapon of merger conditions to prevent acquiring hospitals from shutting down the facilities of acquired entities has considerable advantages. For starters, it would disincentivize the acquiring hospitals from acquiring their closest competitors in rural areas only to remove them from the market and further exploit their market power in both the input and output markets. In addition, while monitoring whether the merging entities have continued to conform with the agreed merger conditions may be costly for the Agencies in theory, this would not be the case in practice. This is because any attempt by the acquiring hospital to shut down the healthcare facilities of the acquired hospital or to cut its vital services could be easily detected by the Agencies.

One could justifiably question the deterrence effect of such merger conditions. Nonetheless, merger conditions are legally binding, meaning that when the Agencies successfully negotiate an agreement with the merging entities, the latter will either honor that agreement or pay a substantial price. Indeed, if the Department of Justice finds that the merging entities have ignored their commitments under negotiated merger conditions, it has the authority to file a criminal or civil contempt action (or even both) requesting imprisonment, monetary penalties, or injunctive relief.[371] Given the severity of the above sanctions, the merging parties have strong incentives to conform to the merger conditions negotiated with the Agencies.

Another counterargument may be that if the Agencies accept hospital mergers in rural areas only under those merger conditions, they may discourage hospitals from pursuing mergers that can produce cost or qualitative efficiencies, which would thus help the acquiring entities improve their financial condition and the quality of their services. But this argument overlooks research studies demonstrating that mergers among hospitals

[371] *See* ANTITRUST DIV., U.S. DEP'T OF JUST., MERGER REMEDIES MANUAL 34–35 (2020), https://www.justice.gov/atr/page/file/1312416/download [https://perma.cc/G9XP-82K4].

rarely, if ever, yield any cost or qualitative efficiencies. Although hospitals in America often claim that they need to merge with their competitors to reduce costs and enhance the quality of their services, studies show that mergers do not necessarily help hospitals attain these goals. Indeed, leading scholars such as Professor Leemore Dafny have shown that hospital consolidation often leads to higher prices for privately insured consumers and worse patient experiences.[372] In the same vein, Professor Martin Gaynor has emphasized that consolidation in the hospital industry leads to higher prices for hospitals and health insurers "without offsetting gains in improved quality or enhanced efficiency."[373]

Other studies have shown that hospital mergers often fail to lead to cost efficiencies or even help failing rural hospitals improve their profit margins.[374] For instance, a study examining the performance of struggling rural hospitals after they have been acquired warns that, although rural hospitals may choose to merge with their competitor because they hope to experience rapid capital infusion, lower debts, and higher profit margins, they may not attain these results.[375] Hence, research does not necessarily support the argument that the proposed merger conditions may deter mergers that would allow rural hospitals to avoid exit. For this reason, the Agencies should consider accepting mergers in underserved areas only under those proposed conditions.

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[372] *See, e.g.*, Nancy D. Beaulieu, Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye & J. Michael McWilliams, *Changes in Quality of Care After Hospital Mergers and Acquisitions*, 382 NEW ENG. J. MED. 51, 51–52 (2020) (finding an association between hospital acquisition and modestly worse patient experiences).

[373] *Antitrust Applied: Hospital Consolidation Concerns and Solutions: Hearing Before the S. Comm. on the Judiciary, Subcomm. on Competition Pol'y, Antitrust, & Consumer Rts.*, 117th Cong. 2, 6 (2021) (statement of Martin Gaynor, E.J. Barone University Professor of Economics and Public Policy, Heinz College, Carnegie Melon University), https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf [https://perma.cc/CPM8-8BLP].

[374] *See, e.g.*, Mark Holmes, *Financially Fragile Rural Hospitals: Mergers and Closures*, 76 N.C. MED. J. 37, 38 (2015). The author notes that

> [w]hen a hospital is financially challenged, it may sometimes merge with (or be acquired by) a larger hospital system. A recent study during the 2005–2012 period found that hospitals with lower profitability and higher debt—that is, financially fragile hospitals—were more likely to merge. Merging hospitals experienced a decrease in operating margin—meaning they were even less profitable . . . . Thus, even though a challenged hospital may find that a merger is a viable option, its finances generally worsen after a merger . . . .

Id. (citing MARISSA NOLES, KRISTIN L. REITER, GEORGE H. PINK & G. MARK HOLMES, N.C. RURAL HEALTH RSCH. PROGRAM, RURAL HOSPITAL MERGERS AND ACQUISITIONS: WHO IS BEING ACQUIRED AND WHAT HAPPENS AFTERWARD? (2014), https://www.shepscenter.unc.edu/wp-content/uploads/2014/08/MergersAcquisitionsAugust2014.pdf [https://perma.cc/T9PL-Y6NR]).

[375] Marissa J. Noles, Kristin L. Reiter, Jonathan Boortz-Marx & George Pink, *Rural Hospital Mergers and Acquisitions: Which Hospitals Are Being Acquired and How Are They Performing Afterward?*, 60 J. HEALTHCARE MGMT. 395, 403 (2015).

CONCLUSION

Millions of Americans lack geographic access to hospitals and primary care physicians because they live in hospital deserts. While rural areas face structural challenges in supporting hospitals, in truth, these deserts are neither natural nor inevitable. In fact, they also result from several business strategies implemented by hospitals in America. These strategies, which include using noncompete agreements in the labor market and merging with competitors, reduce access to care for rural residents and aggravate the shortage of nurses and physicians, which plagues underserved areas. By shedding light on these strategies, this Article has illustrated that the wounds and losses hospital deserts inflict on the most vulnerable Americans cannot be treated adequately without the healing power of antitrust law.

This Article has made three proposals. First, antitrust enforcers and the courts should expand their merger analyses by assessing the impact of hospital mergers on labor markets rather than focusing solely on the impact of those mergers on the price and quality of hospital services. Second, they should treat all noncompete agreements in the healthcare sector as per se illegal. And third, they should accept mergers in rural areas only under the condition that the merged entity will not shut down facilities or cut healthcare services in rural communities already lacking access to care. By implementing these proposals, the courts can help mitigate the racial and health disparities that so profoundly harm America.