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May 26, 2026

The Honorable Andrew Ferguson
Chairman
Federal Trade Commission
600 Pennsylvania Ave NW
Washington, DC 20580

The Honorable Omeed A. Assefi
Acting Assistant Attorney General
Department of Justice, Antitrust Division
950 Pennsylvania Avenue NW
Washington, DC 20580

Re: March 25, 2026 FTC and DOJ Request for Public Comment Regarding Making Improvements to the Premerger Notification and Report Form

Dear Chairman Ferguson and Acting Assistant Attorney General Assefi:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinical partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) thanks the Federal Trade Commission and Department of Justice (collectively, the Agencies) for the opportunity to comment on the effectiveness of the Hart-Scott-Rodino Antitrust Improvements Act's ("HSR Act") premerger notification requirements.

The AHA is especially grateful that the Agencies have taken a realistic approach to the questions it asks during this comment period. For example, we applaud the Agencies for emphasizing their desire to detect "anticompetitive mergers while imposing *no more burden than necessary* on competitively beneficial or neutral transactions." We also appreciate the Agencies' recognition that certain updates to the HSR form "may impose burdens on filers that outweigh their probative value to the Agencies' analysis of whether the underlying transaction, if consummated, may violate the antitrust laws."

The Agencies should apply the same measure of common sense and practicality as they move forward with this process. While it may be true that "the information required by the prior, nearly 50-year-old form [is] insufficient to review modern mergers and acquisitions," that is untrue with respect to hospital mergers. The original HSR form worked perfectly well in the hospital context. Antitrust enforcers were able to identify problematic mergers, make a second request, and challenge those transactions they believed to be anticompetitive. Any changes to the form will impose burdens that

outweigh any expected benefits. Accordingly, the AHA again respectfully urges the Agencies to exclude hospital mergers from any revisions to the HSR form.

To avoid repetition, the AHA has attached its previous comment letter, as well as its amicus brief in *Chamber of Commerce of the United States of America v. Federal Trade Commission*. Both submissions explain in detail our concerns with revising the HSR form. We briefly summarize those concerns below and provide updated information about the current financial, policy and legal environment that the Agencies should bear in mind when evaluating whether to exclude hospitals from any revised HSR form.

***First*,** mergers play a vital role in helping hospitals and health systems overcome continuing financial challenges. Hospitals across America face relentless inflation, chronic government underpayments, and surging costs of labor, supplies and drugs. Changes in a federal policy — from tariffs to the expiration of the enhanced premium tax credits — are reducing already-thin hospital margins. *See* Neha Patel and Shubham Singhal, McKinsey: *What to expect in US healthcare in 2026 and beyond* (Jan. 12, 2026), https://www.mckinsey.com/industries/healthcare/our-insights/what-to-expect-in-us-healthcare ("Between 2025 and 2027, hospitals will face headwinds from the impact of tariffs, subsidy expirations, and changes in federal policy, all of which are expected to reduce EBITDA margins by 40 to 100 basis points."). And hospitals are only beginning to feel the negative financial impact of the One Big Beautiful Bill Act.

Consider the early data from 2026. According to Strata's Monthly Healthcare Industry Financial Benchmarks report, "[p]atient demand and revenue growth slowed while expenses intensified, leading to an operating margins dip." Laura Dydra, *Hospital margins take a dive*, Becker's Hospital Review (Mar. 12, 2026), https://www.beckershospitalreview.com/finance/hospital-margins-take-a-dive. In particular, "[t]otal expenses increased 5.4% year over year in January while gross operating revenue rose 3.9%, leaving a significant gap for many organizations." *Id*. "Non-labor expenses drove expense growth, at 6.4%," with drug expenses up 6.8%. *Id*. As a result, "[h]ospitals with less than 100 beds reported a 3.9 percentage point margin drop while hospitals with 500-plus beds reported a 2.5 percentage point decrease." *Id*.

A second recent study corroborates these figures. According to Kaufman Hall, between January 2025 and January 2026, total expenses rose 5%, driven by increases in labor and supply costs, with drug expenses growing by 7%. *See* Kaufman Hall, National Hospital Flash Report: January 2026, https://www.kaufmanhall.com/sites/default/files/2026-03/KH-NHFR-Report_January-2026-Metrics.pdf. The study also found that bad debt and charity care increased by 8% from January 2025 to January 2026, continuing trends that were present throughout 2025. Summarizing this analysis and looking ahead to the remainder of 2026, a Kaufman Hall representative explained: "Increased expenses, especially in labor, and the persistent increase in bad debt and charity care are not likely to ease this year. Overall structural costs are poised to go up. Hospitals will need to be strategic about

where to allocate resources and how to manage spending in what could be a challenging economic environment." Kaufman Hall, Hospitals begin 2026 challenged by expenses and bad debt (Mar. 19, 2026), https://www.kaufmanhall.com/news/hospitals-begin-2026-challenged-expenses-and-bad-debt.

Given these headwinds, mergers can be economic lifelines for struggling hospitals across America. Often, these transactions are the difference between a hospital closing its doors and continuing to provide care to communities. Respectfully, the Agencies should be especially wary of chilling these transactions with needless and costly administrative requirements.

Second, there is no indication that hospital mergers have historically evaded FTC review. To the contrary, as we detailed in our September 2023 comments, the existing review framework already supports robust scrutiny of hospital mergers. The FTC does not appear to have any problems when challenging such mergers. For example, the FTC filed 17 enforcement actions challenging hospital mergers in the 1990s, and it has filed 15 lawsuits challenging hospital mergers since 2010. Hospital mergers also are subject to many other regulatory and supervisory frameworks; state officials often review hospital mergers and bring their own challenges.

Most important, as we noted in our amicus brief, the FTC could not identify examples of anticompetitive mergers that evaded FTC scrutiny under the prior notification regime but that would have triggered scrutiny under the Updated Form. The district court acknowledged this reality:

> The FTC relies heavily on a study of hospital mergers that were submitted for premerger review, co-authored by two economists at the FTC's Bureau of Economics. 89 Fed Reg. at 89,221 (citing Keith Brand et al., *In the Shadow of Antitrust Enforcement: Price Effects of Hospital Mergers from 2009–2016*, 66 J. L. Econ. 639 (2023)). Per the FTC, the study identified certain hospital mergers that were subject to the premerger notification process that later had anticompetitive effects (i.e., price increases). The FTC suggests that the prior Form failed to provide the agency with "sufficient information to trigger additional investigations that could have blocked these harmful mergers before they were consummated." Docket No. 57 at 29 (quoting 89 Fed. Reg. at 89,221). But the study itself also stated that the FTC issued Second Requests in reviewing these problematic mergers, which means that the prior Form worked as it should have—triggering additional review by the agency. Brand, *supra*, at 662. The failure of the agency to prevent the mergers therefore had nothing to do with the Form's alleged deficiencies but rather with "[in]sufficient resources to challenge th[os]e mergers," "evidence [being] too weak," or plain error. *Id.* at 662–63.

Chamber of Commerce of the United States of America, Case No. 6:25-cv-9, 2026 WL 402498, at *9 (N.D. Tex. Feb. 12, 2026). At least with respect to hospitals, then, there is no need to update the HSR form to achieve the Agencies' goals.

***Third*,** the Updated Form's requirements are unnecessarily burdensome. As we detailed in our September 2023 comment letter, the new questions do not bear on issues that typically arise in hospital mergers or even use language that makes sense in the hospital context. Like Chairman Ferguson, for example, we believe any requirement to offer a transaction rationale will benefit high-priced law firms — not the Antitrust Agencies, and certainly not their clients. Concurring Statement of Comm'r Andrew N. Ferguson, In re Amendments to the Premerger Notification and Report Form and Instructions, and the Hart-Scott-Rodino Rule 16 C.F.R. Parts 801 and 803, Matter No. P239300, at 14 (Oct. 10, 2024).

Ultimately, the AHA, like Chairman Ferguson, would "prefer a deeper cut." *Id*. Imposing heightened reporting requirements on hospital mergers would add substantial burdens while providing no meaningful benefit. We respectfully ask the Agencies to "cut" out hospitals and health systems altogether from any updated HSR form.

We appreciate your careful consideration of these issues. Please contact me at cgolder@aha.org with any questions.

Sincerely,

/s/

Chad Golder
General Counsel and Secretary

American Hospital Association™
Advancing Health in America

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September 5, 2023

The Honorable Lina Khan
Chair
Federal Trade Commission
600 Pennsylvania Avenue NW
Washington, DC 20580

Comments to FTC Re: 16 CFR Parts 801-803—Hart-Scott-Rodino Coverage, Exemption, and Transmittal Rules, Project No. P239300

Dear Chair Khan:

On behalf of our nearly 5,000 member hospitals, health systems, and other health care organizations, the American Hospital Association (AHA) opposes the Federal Trade Commission's (FTC) proposed amendments to the Hart-Scott-Rodino (HSR) form and instructions.

The AHA shares the concerns expressed by other commenters. In particular, the AHA agrees that the proposed changes to the HSR form, if adopted, would impose a substantial burden on filing parties, yet are largely unnecessary to screen transactions for closer review. Moreover, the amended rules would require filing parties to submit more information than the agencies could feasibly review in 30 days. At best, this is an improvident use of staff and taxpayer dollars; at worst, it is an arbitrary and capricious regulation for which the costs vastly outweigh the benefits.[1] Indeed, this needlessly expensive proposal calls into question whether the amendments are intended to make the initial investigation phase more "efficient," as the FTC claims,[2] or simply to deter mergers in the first place. Either way, the proposed amendments function as little more than a tax on mergers.[3]

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[1] *E.g.*, *City of Centralia v. Fed. Energy Regul. Comm'n*, 213 F.3d 742, 749 (D.C. Cir. 2000) ("Centralia contends, and we agree, that FERC's order is arbitrary and capricious for want of reasoned decisionmaking. On the record here, the costs of [FERC's] prescription far outweigh any benefits to fish or the general environment and is therefore unreasonable." (quotation marks and citation omitted)).
[2] 88 Fed. Reg. 42178, 42184 (June 29, 2023).
[3] Commissioner Noah Phillips, *Disparate Impact: Winners and Losers from the New M&A Policy* at 5, 10-11, Eighth Annual Berkely Spring Forum on M&A and the Boardroom (April 27, 2022), *available at*

The AHA also shares other commenters' concerns that the proposed amendments would force merging parties to make subjective judgments, including judgments about (i) current and future competition and (ii) how much detail to include in narrative responses. Such requirements, by their nature, invite disputes over compliance. Rather than focusing on the merits of a transaction, the agencies may be tempted to second-guess or nitpick the parties' responses. This will not merely waste valuable time; it also will generate uncertainty about transaction timelines and whether waiting periods will run as anticipated. This is the opposite of good government.

The AHA also writes to address the negative — and wholly unnecessary — impact these proposed amendments would have on hospitals and health systems in particular. Over the past several decades, enforcers have closely scrutinized mergers in the health care industry. Since 1990, the FTC alone has filed over *40* administrative complaints related to transactions involving hospitals or health systems.[4] This trend shows no signs of slowing; if anything, it has accelerated over the past decade.[5] We are aware of no evidence that hospital mergers have evaded scrutiny due to blind spots in the HSR rules. The FTC's aforementioned enforcement statistics — which do not reflect the numerous transactions that were investigated but not challenged — are powerful evidence that the FTC has no trouble spotting a health care transaction that it views as potentially harmful. And based on the FTC's own comments, the new rules appear to be aimed at transactions involving "technology companies" or private equity firms.[6] But hospital mergers rarely (if ever) involve nascent technology or complex investment vehicles, and thus do not present the concerns that purportedly justify the new rules. **In short, there is nothing broken about the FTC's ability to screen hospital**

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https://www.ftc.gov/system/files/ftc_gov/pdf/Phillips_Keynote-Berkeley_Forum_on_MA_FINAL.pdf ("[T]he Commission has adopted several policies openly taxing M&A in a way that does nothing for competition and also disparately impacts smaller players.… In their zeal to tax M&A however they can, especially in ways that courts cannot police, those running the antitrust agencies and their supporters are already inviting perverse consequences. They are driving up costs and sowing uncertainty that disparately impact smaller players, putting them at a competitive disadvantage to the biggest companies.")

[4] Fed. Trade Comm'n, *Overview of FTC Actions in Health Care Services and Products* 51-90 (Jan. 2023) ("FTC Health Care Overview") (identifying forty-three administrative complaints filed against hospital mergers or transactions involving health systems since 1990).

[5] *Id.* at 51-71 (identifying thirteen lawsuits challenging hospital mergers since 2010, including six since 2020); Pet. for Temp. Inj. Relief, *Fed. Trade Comm'n v. La. Children's Med. Ctr.*, No. 23-cv-1103 (D.D.C. Apr. 20, 2023), ECF No. 3 (complaint filed after release of FTC Health Care Overview).

[6] *See* 88 Fed. Reg. 42718, at 42719 (claiming that mergers "in sectors of the economy that rely on technology and digital platforms . . . present a unique challenge for the Agencies"); *id.* at 42188 ("The complex structure of investment entities is not adequately captured by the current Form[.]"); *id.* at 42203 (referring to acquisitions by "five of the largest technology companies").

transactions for further review. Accordingly, there is no need to subject hospitals to burdensome rules aimed at other sectors of the economy.

The FTC's proposed amendments to the HSR form put forward sweeping changes that are almost too numerous to list here. From the AHA's perspective, the most problematic of these amendments include:

- The requirement to report all prior acquisitions, regardless of size, for a 10-year period, in industries where the merging parties have horizontal overlaps;[7]
- The requirement to provide a narrative description of horizontal overlaps and supply relationships;[8]
- The requirement to provide information about labor markets;[9] and
- The requirement to produce drafts of Item 4 materials and ordinary course reports.[10]

These proposed amendments are unnecessary to determine whether horizontal transactions between hospitals—or vertical transactions between hospitals and physician groups or payors—warrant a Second Request. The agencies have a clear playbook and ready sources of information about hospital deals. They do not need narrative responses, information about labor issues, disclosures about prior transactions, or draft documents to assess whether a given hospital merger might impact competition in a given market. Even worse, these amendments would materially increase the cost of compliance for hospitals pursuing a merger or acquisition. They would require a substantial investment in executive time and outside legal spend. And these unnecessary cost increases would come at a time when hospitals face unprecedented economic challenges.

Accordingly, the FTC should withdraw the proposed amendments (except those needed to comply with recent legislation) and leave the current reporting regime in place.

I. As past experience demonstrates, the agencies do not need more information to identify hospital-related transactions that warrant closer review.

The FTC's arguments for the proposed amendments reduce to a single claim: The current process fails to generate information sufficient to assess whether a transaction

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[7] 88 Fed. Reg. at 42202-04.
[8] *Id.* at 42214.
[9] *Id*. at 42215.
[10] *Id*. at 42213-14.

warrants a Second Request.[11] Regardless of whether this claim holds water in general, it is plainly not true with respect to hospital mergers.

Going back to at least the 1990s, the agencies have taken a hard line on mergers between competing hospitals. Between 1990 and 1999, the FTC alone filed 17 enforcement actions challenging hospital mergers.[12] Following a series of agency losses in the late 1990s, the rate of enforcement dropped during the early 2000s before rebounding — and accelerating — over the past three administrations. Since 2010, the FTC has filed 15 lawsuits challenging hospital mergers, including seven in the past three years alone.[13] In at least two other instances during that time, the FTC closed investigations after the parties (i) abandoned their transaction following staff's recommendation to sue or (ii) settled with a state attorney general.[14]

In addition to cases involving mergers between hospitals, federal agencies also have challenged a number of transactions between hospitals — or health systems that own hospitals — and other provider groups.[15] The agency playbook for these matters essentially mirrors that used in hospital mergers: In both settings, the FTC emphasizes local markets and relies on testimony from commercial insurers to demonstrate that a transaction is likely to harm competition.[16]

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[11] *See, e.g.*, Statement of Chair Khan Regarding Proposed Amendments to the Premerger Notification Form and the Hart-Scott-Rodino Rules at 3 (June 27, 2023) ("[T]he information currently collected by the HSR form is insufficient for our teams to determine, in the initial 30 days, whether a proposed deal may violate the antitrust laws."); *see also id*. (claiming proposed amendments seek to fill "key gaps" by requiring more information about "deal rationale," "how a particular investment vehicle is structured," and "key aspects of competition").

[12] FTC Health Care Overview at 51-71.

[13] *See* FTC Health Care Overview at 51-71; Pet. for Temp. Inj. Relief, *Fed. Trade Comm'n v. La. Children's Med. Ctr.*, No. 23-cv-1103 (D.D.C. Apr. 20, 2023), ECF No. 3 (complaint filed after release of FTC Health Care Overview).

[14] *See* FTC Health Care Overview at 76 (discussing Atrium Health/Houston Healthcare); Fed. Trade Comm'n, Press Release, "Statement of the Federal Trade Commission Concerning Its Vote to Close the Investigation of a Proposed Transaction Combining Massachusetts Healthcare Providers" (Nov. 29, 2018), *available at* https://www.ftc.gov/news-events/news/press-releases/2018/11/statement-federal-trade-commission-concerning-its-vote-close-investigation-proposed-transaction (discussing CareGroup/Lahey Health/Seacoast/BIDC). Because there is no public record of all instances in which hospitals abandoned merger plans following scrutiny by DOJ or FTC, the figures above understate the extent to which the Agencies' overzealous enforcement has derailed or deterred procompetitive transactions.

[15] *See, e.g.*, *Fed. Trade Comm'n v. Sanford Health*, No. 17-cv-133 (D.N.D. filed June 22, 2017); *In re CentraCare Health*, Dkt. No. C-4594 (F.T.C. filed Oct. 5, 2017); *Fed. Trade Comm'n v. St. Luke's Health Sys., Ltd.*, No. 13-cv-00116 (D. Idaho filed Mar. 12, 2013); *In re Renown Health*, Dkt. No. C-4366 (F.T.C. filed Aug. 3, 2012); *In re Reading Health Sys.*, Dkt. No. 9353 (F.T.C. filed Nov. 16, 2012); *In re Alan B. Miller*, Dkt. No. C-4309 (F.T.C. 2010).

[16] *See, e.g.*, *Fed. Trade Comm'n v. Advoc. Health Care Network*, 841 F.3d 460, 465 (7th Cir. 2016) (noting testimony from "several major insurers" that "it would be difficult or impossible to market a network to employers in metropolitan Chicago that excludes both NorthShore and Advocate"); *Fed. Trade*

Enforcement statistics, of course, tell only part of the story. In addition to the cases noted above, the agencies have investigated and cleared numerous other transactions,[17] and the Bureau of Economics has published at least eight studies of health care mergers[18] with another forthcoming.[19] And federal enforcers do not stand alone. State agencies — including attorneys general and departments of health — also routinely investigate and challenge hospital mergers. Recent examples include Madera/Trinity (California 2022),[20] Fairview/Sanford (Minnesota 2022),[21] CareGroup/Lahey/Seacoast/BIDCO (Massachusetts 2018),[22] and Partners/South Shore (Massachusetts 2015).[23]

This zealous enforcement history confirms at least two critical points. First, the agencies have no difficulty identifying hospital-related mergers that, in the agencies' view,

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Comm'n v. St. Luke's Health Sys., Ltd., No. 1:13-cv-00116, 2014 WL 407446, at *9 (D. Idaho Jan. 24, 2014) (noting testimony from Blue Cross of Idaho, the "largest health plan in Idaho," that physician group was "a must have provider for Blue Cross in Nampa"), *aff'd* 778 F.3d 775 (9th Cir. 2015); *see also* Complaint, *In re CentraCare Health*, Dkt. No. C-4594, 2016 WL 5930294, at *1 (F.T.C. Oct. 5, 2016) (alleging that "CentraCare and SCMG compete to be included in health insurance plans, and compete for patients within those health insurance plans").

[17] Sometimes the agencies acknowledge these investigations publicly, *see, e.g.*, Letter to Counsel for Saint Raphael Healthcare System (June 1, 2012), *at* https://www.ftc.gov/sites/default/files/documents/closing_letters/yale-new-haven-hospital/saint-raphael-healthcare-system/120601yalenewhavenltr.pdf, but otherwise no data exists to quantify the (likely high) percentage of hospital transactions that are investigated.

[18] Fed. Trade Comm'n, Physician Group and Healthcare Facility Merger Study (Apr. 14, 2021), *available at* https://www.ftc.gov/enforcement/competition-matters/2021/04/physician-group-healthcare-facility-merger-study.

[19] Press Release, Fed. Trade Comm'n, "FTC to Study the Impact of Physician Group and Healthcare Facility Mergers" (Jan. 14, 2021), *available at* https://www.ftc.gov/news-events/news/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers.

[20] Letter from Attorney General Bonta to Jean Tom re: Proposed Change in Control and Governance of Madera Community Hospital (Dec. 15, 2022) (imposing conditions on approval of proposed transaction between Madera Community Hospital, Saint Agnes Health, Saint Agnes Medical Center, and Trinity Health Corporation), *available at* https://oag.ca.gov/system/files/media/madera-community-hospital-decision-12152022.pdf.

[21] Press Release, "Attorney General Ellison announces public input on proposed merger of Fairview Health Services and Sanford Health" (Nov. 21, 2022), *available at* https://www.ag.state.mn.us/Office/Communications/2022/11/22_Sanford-Fairview.asp.

[22] Press Release, "Statement of Federal Trade Commission Concerning Its Vote to Close the Investigation of a Proposed Transaction Combining Massachusetts Healthcare Providers" (Nov. 29, 2018), *available at* https://www.ftc.gov/news-events/news/press-releases/2018/11/statement-federal-trade-commission-concerning-its-vote-close-investigation-proposed-transaction (noting consent decree with Massachusetts attorney general).

[23] Priyanka Dayal McCluskey & Robert Weisman, "Healey opposes deal with Partners HealthCare," *Boston Globe* (Jan. 26, 2015), *available at* https://www.bostonglobe.com/business/2015/01/26/healey-says-she-prepared-bring-suit-against-partners-judge-rejects-settlement-with-coakley/QRmA2ZN498HefLbqyFb9mI/story.html.

deserve a closer look. The agencies know precisely what information they need during the initial waiting period, and they know precisely what factors warrant further scrutiny. Second, there is no shortage of third parties who stand ready to identify potentially harmful transactions. These include health insurers (who are no doubt on speed-dial at the FTC given the prominence these parties play in hospital merger challenges, even as they routinely evade comparable scrutiny from the Department of Justice's Antitrust Division), competing health care providers, state attorneys general,[24] and state departments of health. Moreover, to the extent the agencies are concerned about harm to labor markets, many hospitals have a unionized nursing staff, and labor unions that have ample incentive to identify harm that might arise from a transaction.

II. The proposed amendments would impose a substantial and unnecessary burden on hospitals.

As the FTC concedes but downplays, the proposed amendments would increase the burden on filing parties.[25] The question, therefore, is whether the purported benefits of the additional information justify the increased burden — that is, whether the new information will materially improve the agencies' ability to identify mergers that warrant a Second Request. With respect to hospitals, the answer is resoundingly "no."

The FTC proposes sweeping changes to the HSR form that are too numerous to list here and have been well-critiqued by other commenters. We focus our comments on a handful of amendments that, in our view, are most problematic.

Narrative Description of Horizontal Overlaps. One proposed addition to the HSR form requires a filing party to "list and describe" each of its "current or known planned products or services" that "competes with (or *could compete with*)" any "current or known planned product or service" of the other party.[26] "Current or known planned products or services" include anything the party "researches, develops, manufactures, produces, sells, offers, provides, supplies, or distributes."[27] For any overlapping product or service, the filing party must then compile and submit additional information about revenues and customers.[28]

This provision, if adopted, would materially increase HSR compliance costs. Read literally, it requires every filing party to analyze each product or service it offers — or

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[24] State attorneys general already play an active role in premerger review and challenging hospital transactions, and this will only continue as more and more states are contemplating or enacting laws requiring pre-consummation notice of transactions between health entities, including hospitals and provider groups. *See, e.g.,* The Source on Healthcare Price and Competition, "Market Consolidation: Overview," *available at* https://sourceonhealthcare.org/market-consolidation/.
[25] *See* 88 Fed. Reg. at 42184 ("The Commission recognizes that, in total, these proposed changes would be significant and impose additional burden on some filing parties.").
[26] 88 Fed. Reg. at 42214 (emphasis added).
[27] *Id.*
[28] *Id.*

"plans" to offer — and make subjective judgments about whether that product or service competes with or "could" compete with a product or service (whether in the market or merely "planned") of the other party. For any product or service where the answer is "yes," the filing party must then submit detailed additional information. And all this will occur under the threat of massive civil penalties should the agencies later disagree with a party's judgment. The inevitable result is that filing parties will feel compelled to engage antitrust counsel (and potentially an economist) even on deals that present no risk to competition.

Yet for all this additional burden, this new requirement would generate no actionable information with respect to hospital mergers. The agencies are well aware of the products and services that health care providers offer. There are no secret overlaps or competitive issues lurking in the shadows. Requiring hospitals or provider groups to describe all areas in which they compete (or "could" compete) would just require merging firms to confirm what the agencies already know.

Narrative Description of Supply Relationships. The proposed amendments also require a filing party to describe supply relationships between the parties to the transaction, or between the filing party and competitors of the other party.[29] Then, for each product or service involved in those supply relationships, the filing party must provide detailed information about sales and customers.[30]

This amendment presents the same concerns as the horizontal overlap requirement. Specifically, it forces parties to make similar judgments about actual or potential competition (and the amount of detail to provide). And it seeks information about hospital inputs that is typically known to the FTC. This proposed amendment would thus compel a significant investment in executive time and legal spend, with little or no real-world benefit to the agencies.

Prior Acquisitions. The FTC proposes amending the HSR form to require parties to report all prior domestic acquisitions over a 10-year period, regardless of size or location, in industries where the merging parties have horizontal overlaps.[31] For many parties, identifying all prior acquisitions over a 10-year period in overlapping industries, no matter how small the transaction or how trivial the overlap, will require significant engagement by company personnel. This is especially true where executives with relevant "institutional knowledge" are no longer with the company.

Here too, this proposed amendment would generate no actionable information with respect to hospital mergers. The FTC points to acquisitions by "five of the largest

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[29] *Id.*
[30] *Id.*
[31] 88 Fed. Reg. at 42202-04.

technology companies" as evidence that more information about prior acquisitions is necessary to identify "concerns about the filing[] parties' acquisition or roll-up strategies."[32] This has no relevance in the context of hospital mergers. As the case law makes clear, whether a given transaction violates Clayton Act § 7 turns on the facts and circumstances of that specific combination —*i.e.*, whether it will harm competition in a specific product market in a specific geography — and not on whether one or both parties previously acquired health care providers in other markets.[33] A complete list of prior acquisitions over a 10-year period is unnecessary to screen hospital-related transactions for closer review.

Labor Competition. The proposed amendments also require filing parties to provide detailed information about labor markets and workplace safety.[34] There is no reason for this requirement in the context of hospital mergers. Given the agencies' hyper-local focus in hospital transactions, it is inconceivable that a hospital-related merger could plausibly harm competition in any labor market without also presenting at least some competitive risk in a downstream market. Indeed, prior hospital merger challenges have borne out that the FTC has no trouble identifying and complaining about potential labor market concerns,[35] and we are aware of no hospital merger challenge based solely upon labor competition. There is simply no need for additional information about labor competition during the initial waiting period.

Draft Item 4 Materials and Ordinary Course Reports. Lastly, in addition to the documents called for by Item 4, the proposed amendments require filing parties to produce drafts of Item 4 materials and ordinary course reports that relate to competition.[36] Like the narrative descriptions of overlaps and supply relationships, this new requirement will require assistance from counsel. And, like the narrative responses, there is no reason to believe draft documents or reports will reveal previously unknown competitive issues in the health care sector. This requirement will therefore increase the burden on hospitals with no apparent benefit to the agencies.

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[32] 88 Fed. Reg. at 42203.
[33] *See, e.g.*, *Advoc. Health Care Network*, 841 F.3d at 464 ("To show that the merger may lessen competition, the Commission and Illinois *had to identify a relevant geographic market where [the] anticompetitive effects of the merger would be felt.*" (emphasis added)). The AHA is not aware of any case finding a hospital-related merger unlawful under § 7 (or any other antitrust law) absent proof of likely competitive harm in at least one specific antitrust market.
[34] 88 Fed. Reg. at 42215.
[35] *See, e.g.*, Concurring Statement of Commissioner Slaughter & Chair Khan, *In re Lifespan Corp.*, File No. 2110031, 2022 WL 558287, at *1 (F.T.C. Feb. 17, 2022) ("[W]e also would have supported an allegation that the effect of the proposed transaction may be to substantially lessen competition in a relevant labor market").
[36] 88 Fed. Reg. at 42213-14.

III. The agencies should be focused on ways to *decrease*, not increase, compliance costs to health care providers.

The FTC's proposed amendments could not come at a worse time for hospitals and health systems. Many health care providers, including community hospitals, face economic challenges that jeopardize access to care. These challenges include historic inflation, which has driven up the cost of medical supplies and equipment; critical workforce shortages, which have forced hospitals to rely on more expensive contract labor; rising drug costs, with the median price of a new drug now exceeding $200,000; and inadequate government reimbursements in the face of rising costs.[37]

These challenges come on the heels of the COVID-19 pandemic and, as a result, are particularly devastating to hospitals and health systems. During the early phases of the pandemic, hospitals were on the front lines delivering care to patients. They acted as *de facto* public health agencies; they incurred significant increases in costs due to workforce and supply shortages; and they lost money hand over fist.[38] During the first four months of the pandemic alone, U.S. hospitals lost over *$200 billion* in revenue.[39] In addition, because many individuals deferred care during the pandemic, hospitals saw a dramatic rise in patient acuity.[40] At the same time, due to workforce shortages at other levels of the health care system, hospitals were unable to discharge patients to other care settings (*e.g.*, skilled nursing facilities), creating patient bottlenecks and leaving beds occupied without reimbursement.[41]

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[37] *See* Am. Hosp. Ass'n, *The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise* at 1 (Apr. 2023) (2023 Cost of Caring Report), *available at* https://www.aha.org/costsofcaring. Labor expense increases are particularly noteworthy. Overall labor expenses increased by 20.8% between 2019 and 2022. Even after accounting for the fact that patient acuity (as measured by the case mix index) increased during this period, labor expenses per patient increased 24.7%, and contract labor expenses grew by a staggering 257.9% in 2022 relative to 2019 levels. These increases are particularly challenging, because labor on average accounts for about half of a hospital's budget.

[38] *Id.* These losses were so high due in part to price gouging by hospital personnel staffing agencies, which imposed enormous rate hikes for travel nurses and other personnel during a time when hospitals had no choice but to pay the inflated rates. The AHA has repeatedly called this issue to the FTC's attention, yet the FTC has failed to take any action. *See* Letter from M. Hatton to Acting Chairwoman Slaughter at 2 (Feb. 4, 2021) (noting studying showing that rates for travel nurses "in some instances had tripled"), *available at* https://www.aha.org/system/files/media/file/2021/02/aha-urges-ftc-examine-anticompetitive-behavior-nurse-staffing-agencies-commercial-insurers-2-4-21.pdf

[39] Am. Hosp. Ass'n, *Hospital and Health Systems Face Unprecedented Financial Pressures Due to COVID-19* at 1 (May 2020), *available at* https://www.aha.org/system/files/media/file/2020/05/aha-covid19-financial-impact-0520-FINAL.pdf.

[40] 2023 Cost of Caring Report at 1. Caring for more complex patients has also contributed to increased hospital costs. The average length of stay increased by nearly 10% in 2021 relative to 2019 levels. Caring for sicker patients often requires more staff time, the use of more intensive treatments and higher cost drugs, as well as the need for more supplies and equipment.

[41] *Id.*

As a result of these factors, hospital expenses increased by roughly 17.5% between 2019 and 2022 — more than double the increase in Medicare reimbursement for inpatient care during that same period.[42] This had a profound effect on hospitals' financial performance. Nineteen rural hospitals closed in 2020 alone.[43] Over half of U.S. hospitals ended 2022 operating at a loss.[44] Things have only worsened in 2023: according to one study, the first quarter of 2023 had the highest number of bond defaults by hospitals in over a decade.[45]

Against this backdrop, the federal government should be looking for ways to ease the financial burden on hospitals and health care providers. Regrettably, the FTC's proposed amendments to the HSR form and instructions would have the opposite effect.

IV. Conclusion

The FTC wishes to impose onerous new rules on *all* filing persons, including hospitals, based on concerns that are valid (if at all) only with respect to a small minority of transactions. This is not just bad government — it is irresponsible.

These proposed changes come at a time when many health care providers, including community hospitals, face unprecedented economic challenges. Rural hospitals in particular are at risk, despite being critical access points for care and economic anchors for the communities they serve. They are least able to afford the increased costs and burdens of HSR compliance; accordingly, they will be hardest hit should the proposed amendments take effect. But rural hospitals are not the only concern. Across *all* hospitals and health systems, the new requirements would add to the complexity and costs of operating in today's uncertain environment.

If adopted, the proposed amendments are certain to chill hospital merger activity — including transactions that enhance quality, reduce cost, and increase access to care[46] — yet are plainly unnecessary to ensure the agencies have sufficient information during the HSR waiting period. Perhaps that chilling effect is the agency's ultimate goal, however. If so, it will function for most as an arbitrary and capricious tax on pro-competitive behavior. The FTC should withdraw the proposed amendments except to

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[42] *Id.*
[43] *Id.* at 2.
[44] *Id.*
[45] *Id.* Despite these financial pressures, hospital price growth has remained low. In fact, in 2022, growth in general inflation (8%) was more than double the growth in hospital prices (2.9%). *Id*.
[46] *See, e.g.*, Sean May, Monica Noether & Ben Stearns, *Hospital Merger Benefits: An Econometric Analysis Revisited* at 1 (Aug. 2021) (showing that "hospital acquisitions are associated with a statistically significant 3.3 percent reduction in annual operating expenses per admission at acquired hospitals" and that "performance on key indicators of quality is improved" following hospital mergers), *available at* https://www.aha.org/guidesreports/2021-08-16-hospital-merger-benefits-econometric-analysis-revisited.

the extent they are required to implement the Merger Filing Fee Modernization Act of 2022.

Sincerely,

/s/

Melinda Reid Hatton
General Counsel and Secretary

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, BUSINESS ROUNDTABLE, AMERICAN INVESTMENT COUNCIL, and LONGVIEW CHAMBER OF COMMERCE, *Plaintiffs*, *v.* FEDERAL TRADE COMMISSION and ANDREW N. FERGUSON, in his official capacity, *Defendants*.	Case No. 6:25-cv-0009-JDK

BRIEF OF AMICI CURIAE AMERICAN HOSPITAL ASSOCIATION AND FEDERATION OF AMERICAN HOSPITALS IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTERESTS OF AMICI CURIAE*

The American Hospital Association (AHA) represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. Its members are committed to improving the health of the communities they serve and to helping ensure that care is available and affordable for all Americans.

The Federation of American Hospitals is the national representative of more than 1,000 leading taxpaying hospitals and health systems throughout the United States. Its members provide patients in urban and rural communities with access to high-quality, affordable healthcare. Those members include teaching and non-teaching acute, inpatient-rehabilitation, behavioral-health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer-care, and ambulatory services.

Hospitals, including amici's members, currently face severe fiscal challenges and have continued to suffer from the after-effects of the COVID-19 pandemic. Historic inflation and workforce shortages have driven up costs, Medicare reimbursements have lagged behind, and hospitals collectively have lost billions of dollars in the last five years. As a result, numerous hospitals have been forced to close, impeding surrounding communities' access to much-needed care.

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* No counsel for a party authored this brief in whole or in part. No party, no counsel for a party, and no person other than amici, their members, or their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

Mergers are a critical tool to address those concerning and destabilizing trends. Often, mergers represent struggling hospitals' only realistic path to survival. Mergers can produce economies of scale, resulting in vital reductions to operating expenses, improvements to the standard of care, and decreases in patient mortality. And they can preserve and even enhance competition by ensuring that multiple healthcare providers in a given geographic area are able to remain in operation and continue serving their communities.

The Federal Trade Commission (FTC), however, has needlessly taken a major step backwards by adopting a misguided and unnecessary overhaul of its premerger-notification process. The FTC's existing notification process had functioned well for decades and earned accolades from many quarters, and the agency itself had lauded its longstanding regime. But in the regulation under review, the FTC abruptly revamped that process in a manner that severely undermines its efficiency without enhancing its efficacy. The FTC's new protocol demands a mountain of additional information at the initial step of its review of a merger—including lengthy and contestable "descriptions" about a merger's impact on competition—while threatening penalties for giving the agency a purportedly "wrong" answer.

The FTC's overhauled regime will significantly increase the complexity and costs of pursuing valuable merger activity in the hospital sector, all while producing little or no benefit to the FTC or the public. Amici and its members have a significant interest in contesting the FTC's de facto tax on merger activity.

INTRODUCTION AND SUMMARY OF ARGUMENT

For nearly half a century, the FTC and Department of Justice (DOJ) have vigorously exercised their authority under the Hart-Scott-Rodino (HSR) Act to review proposed mergers for compliance with the antitrust laws, including many proposed mergers involving hospitals. Throughout that time, the FTC had struck an effective balance in its premerger-notification process: Parties to a merger had to submit a mandatory notification providing limited but key information about the transaction. The agencies then had 30 days to review that information and determine whether more comprehensive disclosures were needed.

That sensible, streamlined process has been widely lauded by businesses, scholars, and the FTC alike for its efficacy and simplicity. Decades of experience demonstrate that the agencies generally have had no difficulty determining from that initial submission whether additional review is warranted. That has been true of mergers in the hospital sector as well. The agencies' track record and scholarship cited by the FTC itself has confirmed that those agencies have had no trouble under the existing process discerning whether more information and closer review are needed.

Yet in a regulation adopted in the final months of the outgoing Administration, the FTC sabotaged its own success by displacing its longstanding, straightforward framework for premerger notifications with a needlessly onerous new paradigm. Following a "comprehensive redesign of the premerger notification process," *Premerger Notification; Reporting and Waiting Period Requirements*, 88 Fed. Reg. 42,178,

42,180/3 (June 29, 2023), the FTC adopted a new first-step form that requires virtually all companies pursuing a merger to disclose voluminous information to the agency in exacting detail. The FTC's transmogrified form goes far beyond facts that the FTC or DOJ could plausibly need to determine whether further review is warranted—or that the agencies realistically could digest in 30 days. The rewritten premerger-notification form even includes a new requirement to submit "narratives" of legal argument—which the agency later relabeled "description[s]"—about the proposed merger's competitive effects. *Premerger Notification; Reporting and Waiting Period Requirements*, 89 Fed. Reg. 89,216, 89,310/1 (Nov. 12, 2024) (Final Rule).

The FTC's overhaul of its HSR-disclosure regime is an ersatz solution in search of a problem. Tellingly, the agency has not identified a single specific, problematic merger that slipped through its existing mandatory-disclosure process but that its reimagined form would have flagged for further review. The regulation's massively outsized burdens and lack of any antitrust benefit make the FTC's real aims clear: to impose a tax on mergers and thereby discourage their occurrence.

The FTC attempted to reverse engineer a basis for its economy-wide transformation of the premerger protocol by citing supposed risks from mergers in the hospital industry. But the FTC has matters backwards. Far from supporting a dramatic expansion of premerger notifications, the experience of hospital mergers further confirms that the FTC's new rule is arbitrary and unwarranted. That is so for at least three reasons.

First, in holding out hospital mergers as purported evidence that problematic mergers have gone undetected, the FTC ignored the vital benefits—including preserving and enhancing competition—that hospital mergers foster but that the FTC's de facto merger tax threatens to destroy. Ensuring continued access to healthcare is a paramount concern for hospitals. But unprecedented challenges—including inflation, chronic underpayments by the government, and the lingering effects of the pandemic—have made it harder than ever for hospitals to survive. The recent passage of new legislation will only exacerbate these problems. Mergers help to answer those existential challenges by permitting hospitals to reduce costs and keep their doors open to their communities.

Second, the FTC's hospital-merger claim fails on its own terms. The FTC struggled unsuccessfully to offer a single example of a hospital merger raising antitrust concerns that its longstanding initial disclosures failed to flag but that its new mandated disclosures would catch. The FTC instead tried to backfill with a handful of academic studies, but those studies undermine the FTC's contentions. And the FTC's and DOJ's history of merger review and enforcement in the hospital context belies any FTC claim that its current notification process has resulted in underenforcement.

Third, the FTC's new regime is a misfit for hospital mergers for multiple reasons, and that mismatch vividly illustrates the arbitrariness of the FTC's blunderbuss approach. The FTC's prior, time-tested protocol afforded the agency flexibility to request additional information that is actually relevant to the sector and

transaction at issue. But the FTC's one-size-fits-all rule will reflexively require information from hospitals that—whatever its value for other transactions—is irrelevant to healthcare mergers. The Final Rule's untailored approach thus will impose significant and unwarranted costs on those sectors of the economy that can least bear it for no discernible return. The FTC also ignored various other legal frameworks that look out for potentially anticompetitive conduct in the hospital industry, undercutting the FTC's premise that purportedly problematic hospital mergers support imposing a heavy-handed disclosure regime.

The Court should hold unlawful and set aside the FTC's Final Rule as arbitrary and capricious and permanently enjoin the regulation's enforcement.

ARGUMENT

The FTC invoked supposed experience with the hospital sector to support its Final Rule. Yet the agency ignored the medical profession's prime directive: First, do no harm. The FTC's wholesale rewriting of its premerger-notification form is not merely unnecessary to address any real-world problem in the healthcare industry, but in fact threatens significant harm to hospitals and the communities they serve. The agency's costly cure will prove far worse than the non-existent malady.

I. The FTC Ignored The Vital Role Of Mergers In Helping Hospitals Overcome Severe Economic Difficulties

The FTC flouted the bedrock tenet of administrative law that "an agency cannot simply ignore 'an important aspect of the problem'" it is addressing, *Ohio* v. *EPA*, 603 U.S. 279, 293 (2024) (quoting *Motor Vehicle Manufacturers Ass'n of United States, Inc.* v. *State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 43 (1983)), by

disregarding the critically important role mergers play in the hospital industry. When invoking hospitals in the Final Rule as support for its new, highly burdensome premerger-notification regime, the FTC simply posited that there are "information gaps in the current" disclosure regime and that the agency has an "interest in preventing hospital mergers that may violate the antitrust laws." 89 Fed. Reg. at 89,268/2-3. But the FTC glossed over the crucial fact—which amici and other commenters highlighted—that mergers are highly beneficial, even essential, in enabling the hospital industry to navigate severe economic challenges. And the agency was willfully blind to the negative effects that its new de facto tax on mergers will correspondingly create.

A. Hospitals Face Acute Economic Challenges

Hospitals today face unprecedented economic difficulties. As AHA warned in its comment letter, "[t]he FTC's proposed amendments could not come at a worse time for hospitals and health systems." AHA Cmt. 9. Historic inflation has caused the cost of medical supplies and equipment to soar, and workforce shortages have further increased hospitals' costs. See AHA, *America's Hospitals & Health Systems Continue To Face Escalating Operational Costs & Economic Pressures as They Care for Patients & Communities* 1 (Apr. 2024) (*Costs of Caring*), https://tinyurl.com/p3c54b5p. Between 2021 and 2023, for example, hospitals' labor expenses increased by more than $42.5 billion. *Id.* at 7. And hospitals were forced "to turn to expensive contract labor to fill gaps," resulting in $51.1 billion expended on contract staff in 2023 alone. *Ibid.*

Such dramatic labor-cost surges are particularly problematic for hospitals because labor on average accounts for "nearly 60% of the average hospital's expenses." *Ibid.*

Instead of keeping pace with cost increases, however, hospitals' funding increasingly has lagged behind. Overall inflation jumped 12.4% from 2021 to 2023, but Medicare reimbursements rose only 5.2%. *Costs of Caring* 1. Those underpayments resulted in a revenue "shortfall of almost $100 billion" in 2022 alone. *Id.* at 2. And that troubling trend continued into 2023, when the industry suffered another $27.5 billion shortfall in underpayments from the Medicaid program. See AHA, *Fact Sheet: Medicaid Hospital Payment Basics* (Feb. 2025), https://tinyurl.com/3tp83d5d. Hospitals also are still suffering from the after-effects of the COVID-19 pandemic. During the first four months of the pandemic alone, U.S. hospitals lost over $200 billion in revenue. See AHA, *Hospitals & Health Systems Face Unprecedented Financial Pressures Due to COVID-19*, at 1 (May 2020), https://tinyurl.com/54a862uh.

These unprecedented challenges have had predictable and enduring adverse effects on hospitals. Over *half* of U.S. hospitals ended 2022 operating at a loss, and 19 rural hospitals closed in 2020 alone. *Costs of Caring* 1. Continuing financial difficulties have only exacerbated that trend: At least 39 other hospitals closed throughout 2023 and 2024, and 2025 has already witnessed 10 additional closures. See Madeline Ashley, *10 hospital closures already in 2025 – what's going on?*, Becker's Hospital Review (Mar. 21, 2025), https://tinyurl.com/yckfhyhu. Credit-rating agencies have also "issu[ed] rating downgrades," compounding hospitals' difficulties by making it harder to borrow money and "make needed capital investments." *Costs of Caring* 2.

The recent enactment of the One Big Beautiful Bill Act, Pub. L. No. 119-21, 139 Stat. 72 (2025), will worsen this already-difficult financial situation. Although individual hospitals across the country are still assessing exactly how the law will affect their own finances, "[a]ll providers will be affected"—and "[f]or some, the magnitude of change could threaten their ability to sustainably serve their local population."[1] Just one part of that law, a portion related to state-directed payments and provider taxes, is estimated to cut Medicaid spending by $340 billion.[2] That sharp

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[1] *The more things change: Navigating the next healthcare crisis under the One Big Beautiful Bill*, Kaufman Hall (July 17, 2025), https://tinyurl.com/32rs688e; see also PWC, *The One Big Beautiful Bill Act (OBBBA): A trillion-dollar turn in US health policy* (July 10, 2025), https://tinyurl.com/5n8dcjdj ("Hospitals, especially rural providers, will face growing financial pressure[.] With more uninsured patients and fewer Medicaid dollars, providers may see increases in uncompensated care, with rural hospitals being particularly vulnerable despite a $50 billion funding provision. * * * Healthcare providers, especially hospitals and health systems, may experience significant pressures as federal Medicaid funding shrinks, and the number of uninsured patients grows."); Gabriella Cruz Martínez, *What to Know About New Medicaid Cuts: Is Your Local Hospital Closing Soon?*, Kiplinger, https://tinyurl.com/5aa4uea6 (last accessed Aug. 8, 2025) ("Some experts predict that cuts to Medicaid will impact nearly every state, with most expected to see more than 25% of their hospitals shut down. In 11 states, the risk is even higher, with 50% or more of hospitals at risk."); Travis Jackson et. al, *One Big Beautiful Bill Act Has Many Impacts for Nonprofit Health Systems*, McDermott Will & Schulte (May 29, 2025), https://tinyurl.com/8267xtrm (observing that "the Act would threaten already thin operating margins at nonprofit hospitals and health systems" and that "[a]ny increase in operating expenses or decrease in reimbursement that results from the Act may push many nonprofit hospitals across the thin line that separates profitability from financial distress").

[2] Congressional Budget Office, *Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline*, at Title VII tab (July 21, 2025), https://tinyurl.com/4mafcv44.

reduction will result in direct decreases in payments to many hospitals. Both before and after this legislation, hospitals have found themselves in desperate need of mechanisms to combat these concerning trends.

B. Mergers Are Crucial To Help Hospitals Survive

Mergers present a key answer to these financial problems and are often vital to hospitals' survival in daunting economic landscapes—a reality that commenters repeatedly made clear during the rulemaking. As one commenter informed the FTC, "[o]ften, a merger is the last hope for keeping a hospital open and continuing access to hospital services in the community." Tex. Hosp. Ass'n Cmt. 2. And "[i]n many of those cases, competition is actually enhanced by the survival of the merged entity through improvements in clinical care and the creation of economies of scale that can ultimately lower costs." *Ibid.* As another commenter observed, there are several "cases in which a hospital would have been closed, gone bankrupt, or severely cut services if it had not merged with another system." Wash. State Hosp. Ass'n Cmt. 1.

Empirical evidence bears out the critically important role that mergers play in mitigating these challenges. As still another commenter explained, one recent study found that "hospital acquisitions are associated with a statistically significant 3.3 percent reduction in annual operating expenses," as well as a "statistically significant reduction in inpatient readmission rates" and patient "mortality." Iowa Hosp. Ass'n Cmt. 2 n.7 (quoting Sean May et al., *Hospital Merger Benefits: An Econometric Analysis Revisited*, AHA (Aug. 2021), https://tinyurl.com/2776pbsf).

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The FTC was amply apprised that mergers can be a lifeline for hospitals and bring about substantial policy benefits. And the agency was put on notice that the costly changes it had proposed to its premerger-notification process would impose serious negative real-world effects on the hospital sector by imposing a de facto tax on mergers and thus discouraging valuable merger activity. Yet despite invoking hospitals' experience to support its overhaul, the FTC ignored warnings about harmful effects on hospitals. And it never attempted to show how a hypothetical increase in enforcement activity that its new form might (or might not) generate would outweigh those here-and-now harms. Nor can the FTC now defend its decision to adopt the Final Rule in the face of those concerns on the ground that it "was aware of the [commenters'] concern[s]." *Ohio*, 603 U.S. at 295. "[A]wareness is not itself an explanation." *Ibid.* The agency's obligation is to confront concerns and explain its position.

II. The Hospital Sector Provides No Support For The FTC's Concerns That Problematic Mergers Had Historically Evaded Agency Review

Even apart from the FTC's failure to address serious, harmful side effects of its Final Rule, the agency's effort to spin the hospital industry's experience as evidence of a problem that its revised premerger-notification regime could solve is unsupported. The FTC broadly asserted that "hospital mergers in particular" pose anticompetitive risks yet had been slipping through the cracks of merger review because of purported "information gaps that now exist with regard to hospital and other healthcare acquisitions." 89 Fed. Reg. at 89,268/2-3. But that assertion is not borne out by the FTC's record of enforcement actions or by its cited studies. To the contrary,

both the agency's track record and its studies cut against its allegations that the existing regime somehow frustrated enforcement activity in the hospital sector.

A. The FTC Offers No Examples Of Problematic Hospital Mergers That Its New Rule Is Needed To Identify

Despite predicating its extensive rulemaking largely on purported issues with hospital mergers, the FTC supplied *no* specific examples of an anticompetitive merger that evaded FTC scrutiny under the former notification regime, but that would have triggered scrutiny under the overhauled regime. See Foley & Lardner Cmt. 2. The agency instead threw up its hands. The FTC asserted that it was "not practical" for the agency to "identify specific illegal transactions that [it] 'missed' during their pre-merger review." 89 Fed. Reg. at 89,219 n.14. But if a federal regulator is unwilling to do the work to identify whether a purported problem with its current rules even *exists*, it cannot rationally press forward with rewriting its regulations to address that hypothetical problem.

The FTC's track record of enforcement under its prior notification regime proves that it has had no trouble identifying hospital or related mergers that the agency deemed cause for concern. Since at least the 1990s, the FTC has "taken a hard line" on hospital mergers. AHA Cmt. 4. Its pattern of enforcement actions has borne out that stance. The FTC filed 17 enforcement actions challenging hospital mergers in the 1990s, and it has filed 15 lawsuits challenging hospital mergers since 2010—including seven suits in the past three years alone. See FTC, *Overview of FTC Actions in Health Care Services & Products* 51-71 (Apr. 2022), https://tinyurl.com/2vj832up; see also Dkt. 1, *FTC* v. *Louisiana Children's Medical Center*, No. 23-cv-01103 (D.D.C. Apr. 20,

2023) (complaint filed). The actual number of contemplated enforcement actions may well be much higher, given that there is no public record of deals that were abandoned after FTC scrutiny. See AHA Cmt. 4 n.14.

In short, if the FTC felt impeded in investigating hospital mergers by inadequate information under its prior premerger-notice regime, the agency's actions show no sign of it. And even if the FTC could show any merger-specific information gap, it would be one of the agency's own making: If its initial review left relevant questions unanswered, the agency could have simply flagged the transaction for a closer look.

B. The FTC's Cited Studies Undermine Its Position

Rather than attempt to show how its prior notification form was frustrating enforcement in the hospital context, the FTC leaned heavily on a handful of studies as putative evidence of anticompetitive merger activity in the hospital sector at large. But that reliance backfires because the studies if anything show that the FTC's existing system was working just fine in the hospital industry as elsewhere.

Most prominently, the FTC invoked a study suggesting that some "hospital mergers" had "caused significant price increases." 89 Fed. Reg. at 89,268 & n.316; see *id.* at 89,221 & nn.24-25 (citing Keith Brand et al., *In the Shadow of Antitrust Enforcement: Price Effects of Hospital Mergers from 2009 to 2019*, 66 J.L. & Econ. 639, 662 (2023) (Brand)); see also *id.* at 89,396 n.19 (statement of Chair Khan, joined by Commissioners Slaughter and Bedoya) (invoking same study as "support[ing]" the FTC's adoption of the Final Rule). But that study—two authors of which worked for the FTC, see Brand 639—affirmatively *disclaims* a link between asserted

anticompetitive behavior and gaps in the FTC's notification regime. The authors note that hospital mergers with the "highest * * * price effects" were *also* those mergers that the FTC had singled out for "a Second Request" under its old notification form. *Id.* at 662. In other words, "the agencies were successful (on average) in identifying in the preliminary phase of the investigation which mergers were most likely to be anticompetitive." *Ibid.* The authors further concluded that the FTC had ultimately permitted those transactions to be completed for reasons having nothing to do with purported deficiencies in the notification regime: "the agencies may not have had sufficient resources to challenge th[ose] mergers"; may have erroneously diagnosed the mergers as "not anticompetitive" despite selecting them for additional scrutiny; may have concluded "that the evidence supporting a challenge was too weak"; or may have concluded "that improvements in quality would offset any price increases." *Id.* at 662-663. Simply modifying the premerger-notification form would change none of that.

So too with another study by public-policy scholars that the FTC selectively cited. See 89 Feg. Reg. at 89,240 n.193 (citing Zarek Brot-Goldberg et al., *Is There Too Little Antitrust Enforcement in the US Hospital Sector?* 12, U. Chi. Becker Friedman Inst. for Econ, Working Paper No. 2024-59 (May 2024) (Brot-Goldberg), https://tinyurl.com/ytjujjy8). The FTC invoked that study for the general proposition that agencies have "limited resources" for "merger enforcement." *Id.* at 89,240/1. But the agency omitted the authors' conclusion: that underenforcement did not stem from resource constraints on *identifying* purportedly problematic mergers, but from

resource constraints on *addressing* those concerns after the FTC had already identified them. In their own words, the authors "view[ed] this 'underenforcement' as coming from choices made by the government (either through low FTC funding or through the FTC being unwilling to take on certain cases), rather than from failures in *ex ante* merger screening methods or the visibility of transactions related to deal size and HSR thresholds." Brot-Goldberg 12.

Ironically, the Final Rule only exacerbates those resource constraints. Far from easing the burden on the FTC, the rule will only bog down the agency with voluminous additional material that it cannot realistically review in the first phase's 30-day window. The same constraints that the study authors found have impaired enforcement thus will now also frustrate even the premerger-review process.

That the FTC was forced to stretch and quote selectively from its own sources confirms that its hospital-based rationales for the Final Rule are a smokescreen. "[A]n agency rule [is] arbitrary and capricious" if the agency offers "an explanation for its decision that runs counter to the evidence before the agency." *State Farm*, 463 U.S. at 43. And "there is no APA precedent allowing an agency to cherry-pick a study on which it has chosen to rely in part." *American Radio Relay League, Inc.* v. *FCC*, 524 F.3d 227, 237 (D.C. Cir. 2008). The FTC's explanation—premised on distorting its own ersatz evidence—confirms that the Rule is arbitrary and should be set aside.

III. The Hospital Sector Illustrates Why The Rule's One-Size-Fits-All Approach Is A Misfit For Many Industries And Will Prove Harmful

Beyond the absence of evidence—and the evidence of absence—of any problem the FTC's overhaul of its existing premerger-notification regime was needed to solve,

the Final Rule will needlessly create new problems that its prior, flexible framework avoided. The FTC's revised notification regime imposes a blanket new protocol to search for purported anticompetitive behavior across the entire U.S. economy. That untailored approach will impose new compliance costs on parts of the economy, such as hospitals, where the information now demanded will be irrelevant or unhelpful.

Consider the FTC's new requirement that companies supply an "Overlap Description," which would purportedly help the FTC identify "whether" a merging company "compete[s] with the other merging party." 89 Feg. Reg. at 89,411/1. As part of the Overlap Description, the merging company must:

(1) list all "current or known planned products or services * * * that competes with (or *could* compete with) a current or known planned product or service of the acquiring person";

(2) "[f]or *each* such product or service listed," disclose "[t]he sales (in dollars) for the most recent year";

(3) describe "all categories of customers of the target that purchase or use the product or service (e.g., retailer, distributor, broker, government, military, educational, national account, local account, commercial, residential, or institutional)"; and

(4) describe "[t]he top 10 customers in the most recent year (as measured in dollars), and the top 10 customers for each customer category identified."

Id. at 89,387 (emphases added). Compliance with this multi-pronged requirement will be unavoidably onerous. Every filing party must analyze every product or service it already offers or *plans* to offer; it then apparently must make subjective, speculative judgments about whether that product competes with or *could* compete with a product or service actually provided or that *could* be provided by the acquiring party. Moreover, the information solicited will be inapposite in many sectors, including

hospitals. The vast majority of hospitals have *patients*—not "broker," "residential," and "distributor" customers. How hospitals should even respond is thus unclear. Such information is conceivably relevant to *other* types of transactions, but the compliance costs in the hospital context will far outstrip the visibility the FTC gains (if any) into the hospital sector from making hospitals jump through these hoops.

Similarly, the FTC's new form demands disclosure of "prior acquisitions of U.S. entities or assets and foreign entities with sales in or into the U.S." in the prior year that "produced a competitive overlap product or service as described in the Overlap Description." 89 Fed. Reg. at 89,376. "For each such overlap," the filer then must "list all acquisitions of entities or assets deriving dollar revenues in an * * * overlapping product or service made by the acquiring person in the five years prior to the date of the instant filing, even if the transaction was non-reportable." *Id.* at 89,377. This new dragnet disclosure mandate will be similarly burdensome. Yet it will serve little if any purpose in certain sectors where the competition concerns it targets are absent. The FTC purported to justify this new disclosure based on "concerns about roll-up strategies," *i.e.*, "serial acquisitions." *Id.* at 89,325/2. Whatever validity that concern might have for other industries, it has no relevance in the context of hospital mergers. Whether a given transaction violates Section 7 of the Clayton Act turns on whether it will harm competition in a specific "geographic market," not on whether one or both of the parties previously acquired healthcare providers in *other* markets. *United States* v. *Marine Bancorporation, Inc.*, 418 U.S. 602, 621 (1974); see *FTC* v. *Advocate Health Care Network*, 841 F.3d 460, 464 (7th Cir. 2016) ("To show that the

merger may lessen competition, the [FTC] had to identify a relevant geographic market where anticompetitive effects of the merger would be felt."). Once again, one size does not actually fit all. The FTC's mismatched mandate will thus impose burdens in particular sectors for no demonstrated benefit.

Yet even though these disclosures are a misfit for hospitals and other industries, companies nonetheless have powerful incentives to prepare these materials with great care—and thus incur substantial compliance costs—for fear of facing civil penalties. See, *e.g.*, FTC, *GameStop CEO Ryan Cohen to Pay Nearly $1 Million Penalty to Settle Antitrust Law Violation* (Sept. 18, 2024), https://tinyurl.com/yr9n3txc; FTC, *FTC Fines Biglari Holdings Inc. for Repeatedly Violating Antitrust Laws* (Dec. 22, 2021), https://tinyurl.com/yers4u4s. Indeed, in enforcing compliance with its disclosure process, the FTC gets to play prosecutor, judge, and jury, adjudicating whether companies' subjective "descriptions" suffice and imposing penalties for perceived misstatements. See *Illumina, Inc.* v. *FTC*, 88 F.4th 1036, 1047 (5th Cir. 2023) ("[T]he FTC's structure * * * combines prosecutorial and adjudicative functions."). Regulated entities have little choice but to supply information that serves no purpose.

Finally, the FTC misstated and largely disregarded the significance of complementary enforcement regimes at the State level. As commenters pointed out, see AHA Cmt. 5, hospitals are subject to multiple other regulatory and supervisory frameworks that further diminish concerns that anticompetitive hospital mergers would escape appropriate review. State officials and agencies—including attorneys

general and departments of health—routinely investigate and challenge hospital mergers. Recent challenges have arisen to transactions involving:

- Madera and Trinity (California 2022), see Office of Cal. Att'y Gen., *Letter from Attorney General Rob Bonta to Jean Tom re: Proposed Change in Control and Governance of Madera Community Hospital* (Dec. 15, 2022), https://tinyurl.com/bdn3xasr;

- Fairview and Sanford (Minnesota 2020), see Office of Minn. Att'y Gen., *Attorney General Ellison announces public input on proposed merger of Fairview Health Services and Sanford Health* (Nov. 21, 2022), https://tinyurl.com/3h8crcrx;

- CareGroup, Lahey, Seacoast, and BIDCO (Massachusetts 2018), see FTC, *Statement of Federal Trade Commission Concerning Its Vote to Close the Investigation of a Proposed Transaction Combining Massachusetts Healthcare Providers* (Nov. 29, 2018), https://tinyurl.com/4kb57hpv (closing investigation after state consent decree); and

- Partners and South Shore (Massachusetts 2015), see *Statement of Attorney General Healey on Court's Rejection of Proposed Consent Judgment With Partners HealthCare*, Mass.gov (Jan. 29, 2015), https://tinyurl.com/5n8nm4us.

State regulators also routinely monitor hospital mergers through Certificates of Public Advantage, which are issued to hospitals when regulators deem the benefits of a merger to outweigh potential effects on competition. See, *e.g.*, *Certificate of Public Advantage*, Tex. Dep't of Health & Human Servs., https://tinyurl.com/s3ds7cxj (last accessed Aug. 8, 2025).

To the extent the FTC acknowledged these parallel regimes at all, it simply noted that "several States have enacted premerger notification laws for certain healthcare acquisitions"—a fact the FTC asserted somehow *supports* its own effort to subject hospitals to its costly notification overhaul. 89 Fed. Reg. at 89,268/3. That assertion is upside-down. If state regulators are already scrutinizing hospital

acquisitions through their own notification regimes, then there is *less* need for the FTC to ramp up its own disclosure requirements. That is particularly true because the FTC admitted, *id.* at 89,240/1, and its own studies confirm, see pp. 13-15, *supra*, that the agency's "limited resources" make it less likely that it will even be able to act on the additional information produced.

CONCLUSION

The FTC's one-size-fits-all solution to a "problem" that the agency failed to substantiate is irrational several times over. The FTC ignored the economic harms that its Final Rule will inflict on the hospital sector, relied on studies that demonstrate the opposite of what the agency claimed, and failed to explain how its costly new notification process will even produce actionable information. The Court should hold unlawful and set aside the FTC's Final Rule as arbitrary and capricious, and it should grant Plaintiffs' motion for summary judgment and vacate the rule.

Dated: August 8, 2025

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of Court for the United States District Court for the Eastern District of Texas by using the court's CM/ECF system on August 8, 2025.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the Court's CM/ECF system.

Dated: August 8, 2025

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