



ISSUE BRIEF: COMPETITION

Matching competition policy in the U.S. healthcare industry to address a new generation of challenges in provider markets

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Overview

Antitrust policy in the U.S. healthcare sector is perennially 10 years behind the industry. But at the start of the Biden administration in early 2021, there was hope for a change. After nearly 40 years of what has been called a complete antitrust policy failure,¹ the administration's promise to pursue aggressive competition policies—and ultimately enhance competitiveness—was met with near-desperate relief.

The promise began with campaign promises and culminated in the July 2021 “Executive Order on Promoting Competition in the American Economy.”² The executive order included an especially spectacular “whole-of-government policy” that included specific applications to the healthcare sector and its hospital markets. Competition policies for the health sector must originate not just from the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission—the two federal agencies tasked with enforcing the antitrust laws—but also from the many agencies in the U.S. Department of Health and Human Services.

Unfortunately, it is not clear whether this executive order resulted in significant policy changes thus far. Most healthcare competition policies remain within the domain of the two federal antitrust agencies, and antitrust enforcement actions in the healthcare sector have focused on preventing mergers between hospitals and hospital systems.³ Yet costly and anticompetitive consolidation persists. Indeed, in many respects, consolidation accelerated throughout the healthcare sector, and both the antitrust agencies and the Biden administration's other healthcare policymakers have shown little appetite to counter these harmful trends.

To be sure, the two agencies deserve substantial credit for what, in certain respects, amounts to an invigorated enforcement effort. The agencies have targeted and halted several proposed hospital mergers, thereby saving consumers and patients from the extortive prices, declines in quality, and other typically severe costs of hospital market power. These antitrust policies would have been welcome a couple of decades ago, but they do not address the market's current challenges.

An updated competition policy for the healthcare sector—one that is not playing catch-up to the industry—requires embracing two key insights. First, antitrust enforcement cannot be limited to preventing further hospital mergers. Instead, other forms of pernicious consolidation and anticompetitive conduct deserve not

just attention but priority. Second, antitrust enforcement cannot amount to the entirety of competition policy. The whole-of-government approach to competition policy must include additional state and federal policymakers and additional legal authorities that can uniquely meet the costly lack of competition in healthcare provider markets.

This issue brief will detail how the U.S. hospital sector succumbed so thoroughly to market consolidation, and then presents the key competition challenges in this current market. The brief then makes several suggestions for how policymakers can match antitrust policies to current hospital market conditions, specifically by engaging the federal Centers for Medicare and Medicaid Services in competition policy, confronting state immunities from federal antitrust enforcement, and bolstering fiduciary duties in the Employment Retirement Income Security Act of 1974. As this brief will demonstrate, each of these actions offer untapped tools available to policymakers and, taken together, would represent a significant advance in matching competition policy to today's challenges.

Hospital consolidation and the gradual emergence of 1990s antitrust policy

Healthcare competition policy begins with, and should be prioritized for, the lack of competition among healthcare providers, and especially among hospitals. Hospitals account for more than 30 percent of our nation's total healthcare expenditures, with physicians and clinics consuming less than 20 percent, and pharmaceuticals spending less than 10 percent.

Hospital markets also are the most monopolized and least competitive. Consolidation among pharmaceutical benefits managers and health insurers causes much angst among policymakers, as it should, but those markets do not exhibit the degree of monopolization of the hospital sector.

Consolidation by healthcare providers began with an aggressive wave of hospital mergers in the 1990s. By 1995, hospital mergers-and-acquisition activity was nine times its level at the start of the decade, and by 2003, almost 90 percent of Americans living in the nation's larger metropolitan statistical areas faced highly concentrated hospital markets.⁴ This wave of hospital consolidation, predictably, alone was responsible for price increases of at least 5 percent for inpatient services and similarly responsible for 40 percent increases where merging hospitals are closely located to one another.⁵

A second merger wave from 2006 to 2009 significantly increased the hospital concentration in 30 additional metropolitan statistical areas.⁶ And over the past 15 years, the vast majority of Americans have been subject to monopoly power in their local hospital markets.

It is hard to overstate how harmful this consolidation wave was to U.S. patients and consumers. An abundance of research examining hospital acquisitions over those two merger waves reveals some basic truths:

- When nearby hospitals merge, prices go up.⁷
- Cities with fewer competing hospitals exhibit higher prices.⁸
- Even hospitals acquired by distant health systems increase prices more than unacquired, standalone hospitals.⁹

In fact, most of our nation's unsustainable healthcare costs are driven by hospital care, and most of that price inflation over the past three-and-a-half decades has been due to hospital mergers.¹⁰

Although the Federal Trade Commission and other antitrust enforcers were aware of these developments, effective antitrust policies to counter this consolidation meaningfully began only in the late 2000s. Antitrust policymakers failed to halt the rapid consolidation of hospital markets in part because many judges¹¹ and health policy leaders¹² used to believe, falsely, that hospital consolidation led to efficiencies and better care delivery. It took years of painstaking academic research to arrive at today's updated understanding of how hospital monopolies exact economic harm and how much damaging monopoly power is generated by hospital mergers.

Although hospital systems have continued to consolidate, antitrust policymakers are now armed with better analytical techniques and a wealth of evidence that they've started employing to stop the most egregiously anticompetitive mergers. Enforcement actions finally started credibly stopping mergers in the 2010s.¹³ Yet these improved antitrust enforcement tools came after many local hospital markets were already consolidated.

Current antitrust enforcement actions in the healthcare sector continue this focus on preventing mergers between hospitals and hospital systems.¹⁴ Halting these mergers has saved consumers and patients from the typically severe costs of hospital market power, including extortive prices and declines in quality. The current Federal Trade Commission—the federal antitrust agency with primary responsibility for scrutinizing hospital mergers—deserves credit for taking action against the worst of these combinations.¹⁵

But consolidation among healthcare providers now takes a variety of different forms. These new consolidation trends, which are at least as costly as those that now preoccupy antitrust enforcement, require different policy strategies. If policymakers continue relying on antitrust policies that were forged from the experiences of a couple decades ago, then they cannot address the market's current challenges.

Current competition challenges in U.S. healthcare markets

The current marketplace presents three distinctly different consolidation challenges, none of which can be halted with current policies or antitrust enforcement strategies and together require a thorough competition policy update. These challenges are:

- Established monopolies and exclusionary conduct
- Hospital acquisitions of independent physicians
- Cross-market mergers

Let's examine each of these challenges in turn.

Established monopolies and exclusionary conduct

U.S. antitrust policy must confront the reality that most local hospital markets are already highly concentrated, so greater focus should address anticompetitive conduct by these current hospital monopolies. The most pressing competitive danger these current monopolies pose is the entrenchment of their dominance and their foreclosure of more efficient entrants.

Hospitals and hospital systems are doing this through a variety of well-tested techniques. One is using their dominance to impose “all-or-nothing” contracts, which require insurers to pay for all of a hospital system’s services or drop out of the market altogether. This strategy prevents insurers from contracting with select healthcare providers—creating so-called narrow networks—that can direct patients to higher-value providers and stimulate competition between rival facilities.

Hospital monopolists bundle their services together, which forces patients to pay for a system's costly services if they want to rely on their critical services. In order to have access to the only trauma center in town, for example, patients must also commit to the hospital system's oncologists and cardiologists—practices that would be vulnerable to competition from other providers and telemedicine companies. Hospital monopolists work to squeeze out small, nimble providers that might offer lower-cost alternatives to the multi-specialty giants. And if hospital monopolists fail to drive them out, they purchase them.

Another tactic hospitals use to exploit market power is collaborating with dominant insurers. Conventional wisdom suggests that dominant insurers and dominant hospital systems would be at loggerheads over the prices of medical services. In fact, these large entities often collude with each other to keep out other competitors. By promising each other that they won't give smaller entities more favorable terms—these arrangements are commonly called most-favored-nation, or MFN, contracts—giant insurance payers and giant healthcare providers secure each other's dominance.

This collusion among giants was discovered in Massachusetts in 2000¹⁶ and challenged by the U.S. Department of Justice in Michigan in 2010.¹⁷ But quiet cooperation between dominant payers and providers nonetheless remains widespread. Many large insurers pursue similar strategies with insurance brokers, demanding that they market their products either exclusively or on favorable terms. An important case involving this conduct recently took place in Florida,¹⁸ and other insurance markets are similarly foreclosed because of dominant hospital-insurer collaboration.

These efforts prevent new insurers and upstart healthcare providers—those most likely to introduce new business strategies and care models—from gaining traction in the marketplace. Victims of this market “foreclosure” usually are innovators: insurers with new price transparency features, physician-led ambulatory surgical centers that offer specialty care, and behavioral health providers that use new virtual technologies. Low-cost and high-value “centers of excellence,” which encourage patients to travel to destinations with specialized experts, also are harmed.

Dominant hospitals and insurers are well aware of the threats that innovations pose to their business models. They know the healthcare market of the future puts less primacy on inpatient care and more on virtual care. They know that healthcare services are provided at higher quality and lower costs at facilities that do not suffer from the overhead and governance burdens of costly multispecialty centers. And they know that telemedicine and hospitals-at-home companies pose existential threats to their dominance.

These dynamic considerations need to factor into long-term and farsighted competition policies. The immediate lesson, however, is that challenging hospital mergers does little to stop the harm from already-dominant systems, many of which are engaging in anticompetitive conduct that forecloses competition and enshrines their market power. A regular staple of healthcare policy must be to monitor consolidated markets, confront anticompetitive conduct, and ensure that patients can still benefit from the dynamism of competition.

Hospital acquisitions of independent physicians

Antitrust policies also must prioritize confronting a new and equally harmful consolidation trend. Over the past decade—and especially once the COVID-19 pandemic took hold—hospitals have been acquiring physician practices at a rapid rate. Nearly three-quarters of the nation’s physicians are now employed by hospitals or corporate entities, compared to less than one-third less than two decades ago.

Current antitrust policy considers hospital acquisitions of physician practices as “vertical” mergers that are largely innocuous because they do not increase the concentration in either hospital or physician markets. But mounting evidence shows that these acquisitions lead to higher costs, probably because many of these transactions are better described as mergers of substitutes rather than compliments.

In other words, many outpatient clinics offer similar services as those offered in hospitals, so when hospitals acquire physician practices, they eliminate competition. Worse, outpatient care is less costly than similar services offered inside hospitals, and medical advances continually expand what can be done in outpatient settings. The loss of independent physician practices means the loss of the often better and almost always less expensive alternative.

The dynamic consequences of these acquisitions—the harms to innovation—are probably even more costly. Controlling physicians means controlling referrals, and hospitals rely on referrals for their most lucrative services. Reciprocally, the biggest threat to hospital dominance is if physicians direct their patients elsewhere, and the current market now offers real alternatives to traditional hospital care: specialty providers, regional providers with telemedicine follow-ups, hospital-at-home care, and even physician practices that expand into secondary care.

Moreover, many of these new practice models are built atop digital analytics, virtual technologies, and innovative financing that have the potential to produce new care models that might upend hospital monopolies altogether.

Perhaps what is most frightening to hospitals is that many of these innovations are designed to promote population health such that people are kept out of the hospital. Indeed, these innovations are intended to drastically reduce patients' need for hospitals altogether. So, when hospitals acquire the source of these potential innovations, they don't merely enshrine their monopoly positions. They also engineer a future in which we continue our dependence on them.

Cross-market mergers

A third consolidation challenge emerging with greater frequency is the so-called cross-market hospital merger. These mergers are better described as "hospital megamergers," among them the 2022 union of Advocate-Aurora Health with Atrium Health's hospital systems, which combined 67 hospitals and 1,000 sites of care across six states in the Midwest and Southeast United States.

Antitrust authorities describe these as cross-market or out-of-market mergers because they involve providers that do not compete within a single geographic hospital services market. For instance, Atrium's hospitals operated in North Carolina, South Carolina, Georgia, and Alabama, whereas Advocate-Aurora's were located in Illinois and Wisconsin. From a traditional lens, the merger of the two giant hospital systems did not eliminate competition in any regional hospital market. As such, their treatment under current merger law is uncertain.

Nonetheless, research indicates that out-of-market systems acquiring independent hospitals leads to price increases, with larger price effects when the merging hospitals are within close proximity of each other (while remaining in separate markets) and when the merging hospitals contract with common insurers.¹⁹ Additional evidence suggests that these mergers endow hospital systems with pricing power over regional insurers and large employers.²⁰

Antitrust enforcement, when acting only with familiar models and with reliable predictions, is to be commended for its care and precision. But the experience of antitrust policy in hospital markets reveals not care but instead excessive caution. To be sure, antitrust enforcement agencies can only pursue policies that are supported by our federal judiciary, and our federal judges have an unfortunate history of failing to block even the most egregious hospital mergers.

Still, antitrust enforcement is, at least in part, designed to prevent market harm before it takes place. A competition policy that lags decades behind consolidation trends is doomed to fail.

Suggestions for a revived competition agenda in the healthcare sector

A prerequisite to making U.S. healthcare markets more competitive requires understanding the particular dysfunctions it nurtures. One dysfunction is that hospital monopolies are easily formed and rarely punished. A second is that hospital monopolists' lobbying of state legislatures for protections against competition generates lucrative rewards. A third is that intermediary healthcare purchasers, such as dominant insurers, have shown little eagerness either to contest healthcare provider market power or to pursue meaningful innovations to how they purchase care for their subscribers.

If Americans are to enjoy the fruits of a competitive healthcare marketplace, policymakers need to address all three of these market failures.

It is worth repeating the conventional calls for continued and enhanced support of the two federal antitrust agencies, which historically have simply not had the resources necessary to stem the steady waves hospital acquisitions. But in addition to the frequent and important requests for invigorated and adequately resourced antitrust policy agencies, three additions could meaningfully bolster competition policy in the U.S. health sector:

- Engaging the federal Centers for Medicare and Medicaid Services in competition policy
- Confronting state immunities from federal antitrust enforcement
- Bolstering fiduciary duties in the Employment Retirement Income Security Act of 1974

Each of these actions, taken together, would go a long way toward matching competition policy with current U.S. hospital market practices.

Engaging the federal Centers for Medicare and Medicaid Services in competition policy

Historically, the Centers for Medicare and Medicaid Services, or CMS, has focused its attention almost exclusively on policies that involve the financing of healthcare. Perhaps the agency paid little attention to the consolidation of healthcare providers because Medicare enjoys pricing power, but this was an error. Even if hospital monopoly power does not directly impose higher prices onto the Medicare program, it does have two adverse consequences for Medicare.

First, a reduction in competition translates into a reduction in the quality of care. Medicare beneficiaries have surely suffered because they lived in markets with little competition between hospitals. And second, because hospital monopolies enjoy enormous pricing power over private commercial insurers, the hospitals experience less pressure to economize on the costs of care.

Accordingly, hospitals that enjoy monopoly power in commercial markets exhibit higher costs and, indirectly, cause Medicare payments to increase for the same healthcare. For these reasons, the Centers for Medicare and Medicaid Services's policy responsibilities and objectives are deeply shaped by the concentration of U.S. hospital markets, and it therefore should be armed and encouraged to advance procompetition policies. Additionally, because the agency gathers enormous amounts of patient outcomes data, it is uniquely well-positioned to assess the costs of monopoly and to identify the benefits of competition.

The Centers for Medicare and Medicaid Services could contribute to healthcare competition policy in a number of ways. First, and most simply, it could invest in an office of provider competition policy, which could either sit alongside or within the Center for Medicare and Medicaid Innovation, the agency's innovation center. Such an office could use the wealth of CMS data to issue reports, identify markets where competition is limited or is painfully needed, and offer suggested avenues for encouraging entry. And because payment is so central to the entry and survival of healthcare provider strategies, competition policies that are integrated with payment policies would offer important complementarities.

The Centers for Medicare and Medicaid Services could also play a more central role in administering merger policies. Just as certain industry mergers must gain the approval of the U.S. Department of Transportation and the Federal Communications Commission in their industrial bailiwicks, in addition to clearing the antitrust laws, the agency could either offer assessments or issue authorizations of proposed mergers. The hospital sector certainly would be more efficient and offer more value if hospitals were required to pass through a more scrutinizing approval process.

Confronting state immunities from federal antitrust enforcement

In the past year, the North Carolina Senate unanimously approved a bill that would give antitrust immunity to one of the state’s major health systems.²¹ Just as there is consensus among health policy experts that hospital competition is desirable—that it brings value, improves quality, and reduces prices—there is consensus that antitrust immunity is undesirable because it does the opposite.

Why would the state Senate offer such a sweeping and harmful antitrust immunity? Sadly, this is a reflection of the political economy of healthcare, in which hospitals are often the largest employers and most powerful economic entities in the regions in which they are located. For these reasons, they often enjoy outsized political influence, at the expense of dispersed patients and consumers.

Over the past decade, just as the Federal Trade Commission increased its scrutiny of healthcare provider consolidation, hospitals have increasingly turned to their state legislatures to sanction them to pursue transactions that the antitrust laws would prohibit. So-called certificates of public advantage, or COPAs, which give permission to specific mergers under stated conditions, are one exercise of this state action immunity. COPAs are now operative in multiple states,²² but the bill passed in North Carolina sought even more sweeping immunity.

Competition advocates who decry monopolies and seek competitive markets know that the states, particularly when they act as a grantor of specific political favors, can be the most harmful impediment to meaningful competition policy. Congress should be aware that many states are using the “state action doctrine” to evade federal antitrust enforcement, and Congress should know that it has the power to preempt states’ efforts to invoke the doctrine.

Bolstering fiduciary duties in the Employment Retirement Income Security Act of 1974

Because much of healthcare is purchased through intermediaries, such as insurers and employers, consumers and patients alike rely heavily on both the wisdom of and the legal obligations imposed upon those intermediaries. Like all intermediaries, however, these healthcare purchasers are imperfect agents. For this reason, the U.S. Congress passed the Employee Retirement Income Security Act, or ERISA, in 1974, which imposes a fiduciary duty on employers when they manage employee-benefit dollars.

ERISA enforcement has historically focused exclusively on protecting employee pensions and retirement plans, but it equally applies to employee health benefits as well.²³ That means that employers that administer ERISA plans have a fiduciary obligation to be faithful stewards of their employees' healthcare dollars. Too frequently, employer-sponsored health plans do not invest in shopping for high-value healthcare and instead pay the inflated prices that established hospitals offer. This not only wastes employee dollars but also allows lethargy to spread throughout the market.

The Employee Retirement Income Security Act offers legal levers to compel employer-sponsored plans to be more active, demanding, and creative shoppers for healthcare. Some employers have taken seriously their roles as careful fiduciaries for their employees' healthcare, and several have forged valuable programs that should become the norm for most U.S. employers: teaming up with centers-of-excellence programs, collaborating with local primary care providers, contracting in bulk for high-volume tertiary care, and similarly creative healthcare purchasing. Policymakers can learn from these innovations, and ERISA enforcement could compel many employers to do so.

Conclusion

There is an urgent need to recognize the unusually serious consequences, for both consumers and the general welfare, of leaving our nation's healthcare consumers exposed to monopolized healthcare markets. If consumers were both aware of the true cost of their health coverage and conscious that they, rather than someone else, are paying for it, they surely would demand more value from their healthcare purchases.

Aggressive antitrust enforcement can prevent further economic harm and perhaps can undo costly damage from healthcare providers that, in error, were permitted to become monopolists. To be sure, such a policy includes aggressive hospital merger review, but it requires much more. Greater attention—and an antitrust policy update—is necessary to address new waves and types of provider consolidation.


Creative market and regulatory initiatives will be needed to unleash the competitive forces that consumers need. Where there is danger, there is opportunity. Competition-oriented policies can and should yield substantial benefits both to premium payers and to an economy that badly needs to find the most efficient uses for resources that appear to be increasingly limited. This might involve including federal agencies (such as the Centers for Medicare and Medicaid Services) and legal authorities (such as the Employee Retirement Income Security Act) that have not been part of the traditional competition policy toolbox.

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