Rulemaking Analysis: Pre-merger Notification Rule for Medical-Practice Groups
May 27, 2025

In order to combat ever-increasing market concentration and rising costs in the health care market, the Rhode Island Attorney General ("RIAG") proposes a rule that would require medical-practice groups to notify the RIAG of any merger, consolidation, or acquisition that would result in (1) ownership or control by a significant equity investor (defined to include private equity (PE) companies), (2) a group of eight (8) or more physicians, physician assistants, and/or nurse practitioners, or (3) any formation of a management services organization or similar entity created to administer contracts with health insurance carriers or third-party administrators on behalf of a medical-practice group. The following analyses demonstrate that the proposed rule will result in the greatest net benefit to the State of Rhode Island and will have minimal impact on small businesses.

I. Statement of Need

a. Problem being addressed and goal of the policy change

State attorney general oversight of merger and acquisition activity in the health care services industry is essential to protect consumers and contain costs. Increased consolidation of health care providers "has driven American health care prices to new heights" without an attendant increase in quality of care.[1] The proposed rule (the "rule") ensures that the RIAG is made aware of non-hospital health care transactions and is thus able to effectively exercise its antitrust authority in the health care services industry. The goal of the proposed rule is to provide the Attorney General with sufficient notice to investigate potentially anticompetitive transactions in the health care market before they are consummated.

b. Background information

Per-person spending on health care in Rhode Island is 2.45 times higher today than it was in 2000.[2] As of 2020, Rhode Island spent more on health care per capita than 74% of states.[3] Studies show that market consolidation has been a leading driver of increased health care prices.[4] In 2022, 14.9% of R.I. survey respondents "had problems paying medical bills, with some being unable to pay for necessities like food, heat or rent."[5] Rhode Islanders have used savings, incurred debt, and filed for bankruptcy due to medical costs.[6]

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[1] Katherine L. Gudiksen et al., *Who Can Rein in Health Care Prices? State and Federal Efforts to Address Health Care Provider Consolidation,* THE MILBANK MEMORIAL FUND ISSUE BRIEF, 1 (2021), https://www.milbank.org/wp-content/uploads/2021/06/Gudiksen_Who-can-control-hc-costs_ib_v4.pdf.

[2] Rhode Island Office of the Health Insurance Commissioner, *Health Care Spending and Quality in Rhode Island*, OHIC ANNUAL REPORT, 5, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-05/Health%20Care%20Spending%20and%20Quality%20in%20Rhode%20Island_FINAL%202023%2005.pdf.

[3] KFF, *Health care expenditures per capita by state of residence,* https://www.kff.org/other/state- indicator/health-spending-per-capita/ (last visited May 8, 2025).

[4] Jaime S. King et al., *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States*, THE SOURCE, 6 (2020), https://ssrn.com/abstract=3627865 .

[5] OHIC, *supra* note 2, at 6.

[6] *Id.*

RIAG plays an essential role in protecting Rhode Island consumers, including by assuring access to quality, affordable health care . Under R.I. GEN. LAWS § 6-36-9, the RIAG is tasked with enforcing the state's antitrust laws, which serve to prohibit "unreasonable restraints of trade and monopolistic practices" in order to ensure that "the prices of goods and services … be fairly determined by free-market competition."[7] And under the Hospital Conversions Act, the Attorney General has the power to "adopt rules and regulations to accomplish the purpose" of the Hospital Conversions Act ("HCA").[8] The defined purposes of the HCA include "establish[ing] a review process and criteria for review of hospital conversion" and "assur[ing] the viability of a safe, accessible and affordable health care system."[9]

The HCA requires parties to obtain RIAG approval prior to a hospital conversion or consolidation.[10] At the federal level, the Hart-Scott-Rodino Act ("HSR") requires federal notification of deals that will surpass certain monetary thresholds.[11] And yet, "the bulk of the growth of the largest [physician] groups" from 2007 to 2013 did not necessarily result from large or horizontal transactions, but from "hiring new physicians or acquiring very small groups."[12] Relatedly, transactions in which private equity companies serially invest in or acquire medical-practice groups, directly or indirectly, have become increasingly prevalent since 2012.[13] These vertical transactions, which may be below the HSR reporting threshold and go undetected, have been shown to lead to health care market consolidation, and worse patient outcomes for hospitalization and mortality.[14] And while the RIAG has the authority to block consolidations that are "monopolistic" or "unreasonable restraints of trade," there is no rule requiring notification to the RIAG or federal enforcers of small, non-hospital transactions, acquisitions or other significant changes in ownership or control. It is near-impossible to investigate potentially anti-competitive combinations and behavior without the RIAG first knowing that a transaction will take place because plans for these types of transactions are generally closely-held confidential commercial information. Moreover, challenging anticompetitive transactions before they are consummated is crucial, as "unwinding" those transactions—or, as it's frequently described, "unscrambling the egg"—is notoriously difficult, as well as costly.[15] That is why a pre-merger notification rule is essential for effectuating the RIAG's antitrust power to investigate combinations that threaten to restrain or monopolize trade, and which pose a high risk of raising costs for patients and payers. This rule therefore

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[7] R.I. GEN. LAWS § 6-36-2(a)(2).
[8] R.I. GEN. LAWS § 23-17.14-32(b).
[9] R.I. GEN. LAWS § 23-17.14-3(1)–(3).
[10] R.I. GEN. LAWS § 23-17.14-6.
[11] *See generally* Thomas G. Wollman, *Stealth Consolidation: Evidence from an Amendment to the Hart-Scott-Rodino Act*, AMERICAN ECONOMIC REVIEW: INSIGHTS 77, 81 (2019), https://pubs.aeaweb.org/doi/pdfplus/10.1257/aeri.20180137.
[12] Cory Capps et al., *Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene*, 36 HEALTH AFFAIRS 1556, 1560 (2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0054 .
[13] Richard M. Scheffler et al., *Monetizing Medicine: Private Equity and Competition in Physician Practice Markets*, AM. ANTITRUST INST. at 4 (2023), https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf
[14] *See* Paul J. Eliason et al., *How Acquisitions Affect Firm Behavior and Performance: Evidence from the Dialysis Industry*, 135 THE QUARTERLY JOURNAL OF ECONOMICS 221, 1 (2020), https://www.ftc.gov/system/files/documents/public_events/1349883/eliasonheebshmcdevittroberts.pdf .
[15] *See, e.g., F.T.C. v. Univ. Health, Inc.*, 938 F.2d 1206, 1217 n.23 (11th Cir. 1991) (stating that "once an anticompetitive acquisition is consummated, it is difficult to 'unscramble the egg'").

serves to narrow the gap by ensuring that the RIAG has notice of potentially anticompetitive mergers with sufficient lead time to intervene before consolidation is consummated.

II. Regulatory Action in Response to Problem

The proposed rule requires medical-practice groups[16] to notify the RI Office of Attorney General of certain "material changes" at least 60 days prior to closing. A material change is deemed to occur under specific conditions, including when:

1. A medical-practice group merges, consolidates, is acquired, or otherwise combines with another medical-practice group, and the transaction results in a group of 8 or more physicians, physician assistants, and / or nurse practitioners;
2. A medical-practice group merges, consolidates, is acquired, or otherwise combines with a hospital or hospital system;
3. There is a formation of a partnership, joint venture, accountable care organization, parent corporation, management services organization, or other organization created for administering contracts with health insurance carriers or third-party administrators or current or future contracting on behalf of one or more medical-practice groups; or
4. There is a transaction involving a significant equity investor which results in a change of ownership or control of a medical-practice group.

The parties to a material change can comply with the rule by submitting a form provided by the Attorney General that discloses the following information:

1. The parties to the transaction and their contact information,
2. A description of the nature and purpose of the transaction,
3. An identification of the services and locations where each party currently provides health care services,
4. An identification of any new locations or services contemplated as a result of the transaction, and
5. Anticipated effective data for the transaction.

The penalty for non-compliance with the rule is $200 per day starting on the 59th day prior to the closing of a material change and $100,000 if notice is not given prior to closing. The Attorney General may also pursue injunctive relief to stop a material change until the parties to the transaction have been compliant with the rule for 60 days.

III. Cost-Benefit Analysis

The proposed rule is an effective and minimally-burdensome means to enable the Attorney General to investigate anticompetitive health care transactions prior to consummation; it will achieve the objectives of R.I. GEN. LAWS § 6-36-9 and the HCA more cost-effectively, and with greater net benefits to the state of Rhode Island, than alternatives.

[16] Defined in the proposed rule as a "single legal entity formed primarily for the purpose of being a physician group practice in any organizational form recognized by the state in which the group practice achieves its legal status, including, but not limited to, a partnership, professional corporation, limited-liability company, limited-liability partnership, foundation, not-for-profit corporation, faculty practice plan, or similar association."

a. Stakeholders and Scope of Analysis

While the rule is likely to reduce the cost of health care in Rhode Island, which would benefit most individuals and businesses that purchase health care , there are relatively few classes of direct stakeholders to consider in the cost-benefit analysis. Direct stakeholders include the regulated businesses and the Office of the Attorney General. Indirect stakeholders include consumers of health care and—one step further removed—purchasers of health insurance, such as employers and employees.

The benefits of the rule should endure indefinitely. For the purposes of analysis, however, benefits and costs are projected over five years because market behavior is likely to change over that time frame.

b. Concentration in the health care market will continue to rise

Concentration in the health care market is steadily increasing.[17] This trend includes an increasing prevalence of private equity investment in medical groups.[18] Effective antitrust enforcement is a key means for restraining increases in market concentration.[19] Because antitrust intervention depends upon RIAG notification, without the proposed rule, the health care services market will likely continue to consolidate in accordance with recent trends.

i. Trends show steady increases in health care market concentration

The U.S. health care industry is "more consolidated than at any point in history," and rising steadily.[20] Concentration is starkest in the hospital market (with almost 95% of hospital markets considered highly concentrated in 2018), followed by specialist physicians (77.5%), insurers (58.1%), and primary care providers (42.1%).[21] *See* Exhibit 1. The primary measure of competition used by state and federal regulators to measure market concentration is the Herfindahl-Hirschman Index ("HHI").[22] Highly concentrated markets are markets with an HHI above 1,800 and an increase in HHI of 100 points is considered a "significant increase" in concentration.[23]

[17] *See* King et al., *supra* note 4, at 8; *see also* Sam Hughes & Natasha Murphy, *Empowering State Attorneys General To Fight Health Care Consolidation*, CTR. FOR AM. PROGRESS (Feb. 16, 2023), https://www.americanprogress.org/article/empowering- state-attorneys-general-to-fight-health-care-consolidation/ (last visited May 6, 2025).

[18] Ola Abdelhadi et al., *Private Equity–Acquired Physician Practices and Market Penetration Increased Substantially, 2012–21*, 43 HEALTH AFF. 354 (2024).

[19] *See, e.g.*, Hughes & Murphy, *supra* note 17 ("As health care markets become more concentrated, strong antitrust enforcement becomes increasingly important to reining in rising health care costs.").

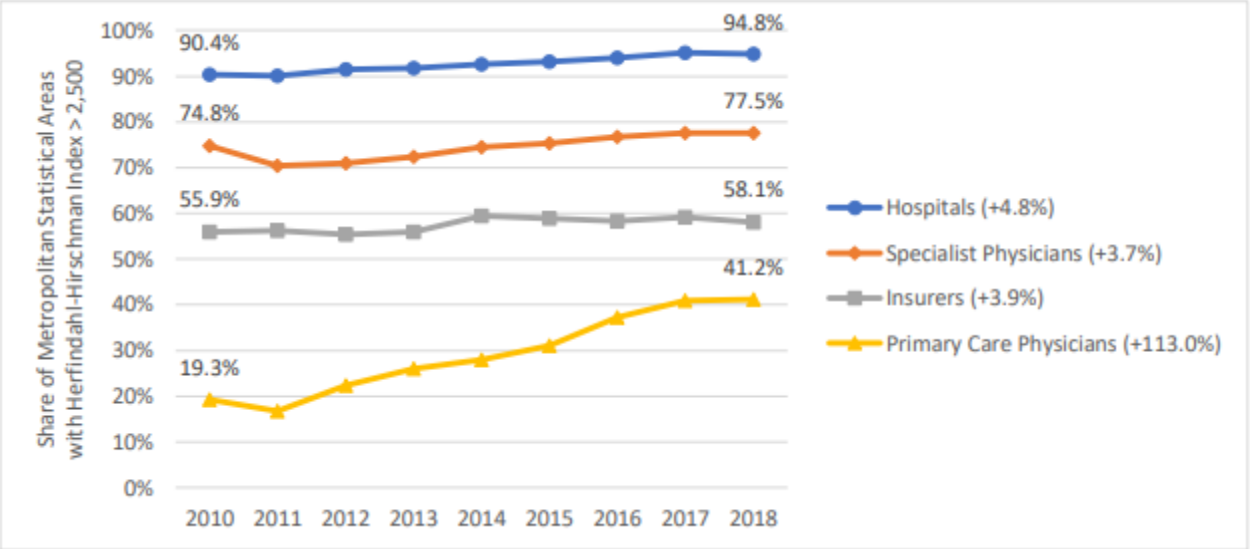
[20] King et al., *supra* note 4, at 6-8.

[21] *Id*. at 6.

[22] Hughes & Murphy, *supra* note 17.

[23] *Merger Guidelines,* DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION (2023), 5-6; *see also* Capps et al., *supra* note 12, at 1557.

Exhibit 1: Share of MSA with HHI > 2,500



Source: Nicholas C. Petris Center on Health Care Markets and Consumer Welfare (petris.org), University of California, Berkeley, analysis of data from the American Hospital Association Annual Survey, SK&A Office Based Physicians Database from IQVIA, and Managed Market Surveyor File from HealthLenders InterStudy (Decision Resources Group.)[24]

While the R.I. HCA addresses hospital transaction, where concentration is most pronounced, from 2010 to 2016 larger increases in concentration were found in the primary care physician market than the hospital market.[25] Two sources of concentration in health care services are hospital-physician integration (when hospitals acquire physicians or physician groups), as well as acquisition of small group physician practices or individual physicians by larger physician groups. And the market share for large physician groups (100+ physicians) in Rhode Island grew by 4.4% from 2013 to 2015, with an accompanying sharp decrease in small physician groups (<10 physicians) – from 33.9% percent of the market to just 26.3% – in the short span of two years. [26]

In addition to hospital-physician integration and mergers and acquisitions directly involving medical-practice groups, studies have reported significant increases in the frequency of private equity investment and consolidation among medical groups. For example, Scheffler et al. reported a five-fold increase in the number of private equity deals involving outpatient clinics – including physician practices – from 2012 to 2021, and while there was a decrease in capital invested through such deals during the pandemic, the authors reported a 37 percent increase in capital investment from 2020 to 2021 alone.[27]

Health care services consolidation can significantly harm consumer welfare. When physician groups are acquired by hospitals, their prices may increase without a corresponding increase in quality

[24] King et al., *supra* note 4, at 7.
[25] Brent D. Fulton, *Health Care Market Concentration Trends In The United States: Evidence And Policy Responses*, 36 HEALTH AFFAIRS 1530, 1533 (2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556 .
[26] David B. Muhlstein, *Physician Consolidation: Rapid Movement From Small To Large Group Practices, 2013–15: Appendix*, 35 HEALTH AFFAIRS 1638, 4 (2016).
[27] *See* Scheffler et al. *supra* note 13, at 10.

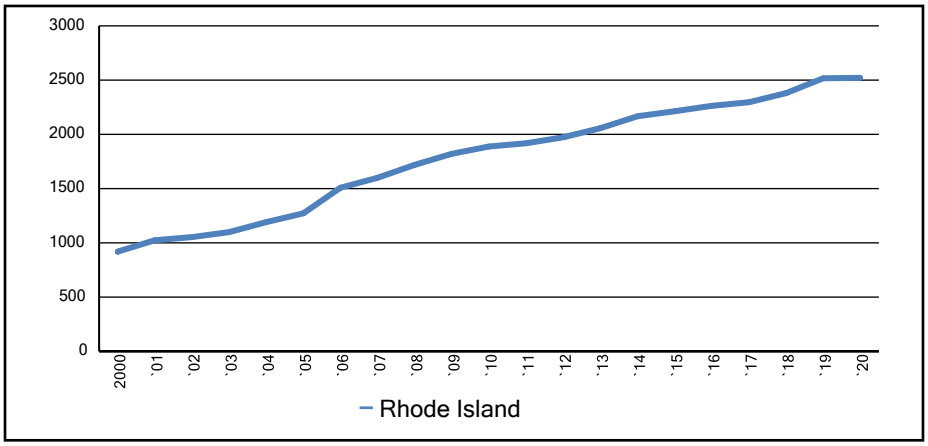
of care.[28] Similarly, physician group investments and buyouts by private equity investors have been associated with increasing costs of care and deterioration in quality of care. For example, Singh and colleagues reported a statistically significant mean increase of $71 in charges per claim (equating to a 20.2% increase) and $23 increase in allowed amount per claim (11% increase) among practices acquired by private equity.[29] In some markets, a single private equity firm can ultimately acquire significant market share; one report found that in 108 markets, a single private equity firm's holdings exceeded 30% market share, and in 50 of those markets, a single private equity firm's holdings exceeded 50% market share.[30] Vertical integrations among physician groups and specialists can similarly lead to higher costs, and can result in "significantly" altered physician care practices.[31] In the dialysis industry, for example, care practices are altered to "increase [Medicare] reimbursements and decrease costs," including by replacing high-skill nurses with lower-skill technicians and increasing the patient-load of each employee by more than 10%.[32] These changes appear to have serious consequences: in one study patients at acquired dialysis facilities were 6.1% more likely to be hospitalized in a given month, and survival rates for new patients fell by 1.3%-3.0%.[33] These are not outlier results. Similar trends have been found in gastroenterology, where patients' post-procedures complications increased "substantially" after vertical integration,[34] as well as cardiology, where mortality rates – after falling 22% in the previous 12 years – rose 4% from 2011-2017.[35] Researchers have also found that private equity investment can result in higher rates of physician turnover, with findings suggesting that physicians may be over 16% less likely to continue working with a practice acquired by private equity after two years.[36] These concerning trends can substantially and negatively affect the health care system's ability to ensure access to needed care.

And while the quality of patient care may decline, consumers may also bear the burden of higher prices following integration.[37] In cardiology, for example, more and more cardiologists are

[28] Eliason at al., *supra* note 14, at 1.
[29] Yashaswini Singh et al., *Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization*, JAMA HEALTH FORUM 6 (2022).
[30] Ola Abdelhadi et al., *supra* note 18 at 354.
[31] Soroush Saghafian et al., *The Impact of Vertical Integration on Physician Behavior and Healthcare Delivery: Evidence from Gastroenterology Practices*, NBER WORKING PAPER SERIES 1 (2023), https://www.nber.org/papers/w30928 (last visited May 8, 2025).
[32] Eliason et al., *supra* note 14, at 2.
[33] *Id.*
[34] Saghafian et al., *supra* note 31.
[35] Larry Sobal, *Has Employment of Cardiologists Been a Successful Strategy? – Part 2*, AMERICAN COLLEGE OF CARDIOLOGY (Nov. 14, 2019), available at https://www.acc.org/Membership/Sections-and-Councils/Cardiovascular-Management-Section/Section-Updates/2019/11/06/09/49/Has-Employment-of-Cardiologists-Been-a-Successful-Strategy-Part-2 (last visited May 8, 2025).
[36] Victoria Berquist et al., *Sale of Private Equity–Owned Physician Practices and Physician Turnover,* 6 JAMA HEALTH FORUM e245376 (2025).
[37] *See* Alison Evans Cuellar & Paul J. Gertler, *Strategic integration of hospitals and physicians*, 25 JOURNAL OF HEALTH ECONOMICS 1, 1 (2006), available at https://www.sciencedirect.com/science/article/pii/S0167629605001098 (finding integrated hospitals have higher prices than stand-alone hospitals but are no more efficient); *see also* Daniel R. Austin & Laurence C. Baker, *Less Physician Practice Competition is Associated with Higher Prices Paid for Common Procedures*, 34 HEALTH AFFAIRS 1753, 1753 (2015), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.0412 (finding physician practices in counties with higher concentration had prices 8% to 26% higher than counties with lowest concentration); *see also* Thomas Koch &

employed by hospitals and health systems – more than 70% in 2019.[38] The same stress test that one would have received in a private cardiology practice can cost "two to three times as much" in the hospital.[39] Such price increases are accompanied by increases in Medicare costs up to 27%, and consumer out-of-pocket costs up to 21% higher for certain cardiology services.[40] Health care market integrations can also have negative financial impacts not only on consumers but also on taxpayers: Rhode Island's Medicare spending has increased from $919 million in 2000 to $2.521 million in 2020 — a per capita increase of $1,412 per person, from $877 in 2000 to $2,289 in 2020.[41] *See* Exhibit 2. Moreover, employers are shown to "pass through higher health-care costs dollar for dollar to workers, either by reducing wages or fringe benefits, or even dropping health insurance coverage entirely."[42] Health care consolidation can also harm Rhode Island employers and employees, and industries that would benefit from additional spending that follow from increased employee wages.

Exhibit 2: R.I. Medicare Spending (in Millions of Dollars)



Source: Centers for Medicare and Medicaid Services.[43]

Shawn W. Ulrick, *Price Effects of a Merger: Evidence from a Physicians' Market*, 59 ECONOMIC INQUIRY 790, 790 (2020), available at https://onlinelibrary.wiley.com/doi/full/10.1111/ecin.12954 (finding orthopaedic practices that were part of a merger increased prices 10% to 20% for two of three payers relative to control geographies without mergers).

[38] Larry Sobal, *Has Employment of Cardiologists Been a Successful Strategy? – Part 1*, AMERICAN COLLEGE OF CARDIOLOGY (Nov. 6, 2019), available at https://www.acc.org/membership/sections-and-councils/cardiovascular-management-section/section-updates/2019/11/06/09/49/has-employment-of-cardiologists-been-a-successful-strategy-part-1 (last visited May 9, 2025).

[39] Sobal *supra* note 35.

[40] *Id*.

[41] *See Rhode Island City & Town Population Estimates,* U.S. CENSUS BUREAU, available at https://dlt.ri.gov/sites/g/files/xkgbur571/files/2024-05/townest.pdf (last visited May 9, 2025). Calculation based on a population of 1,048,319 in 2000 and 1,097,379 in 2020.

[42] Martin Gaynor et al., *The Industrial Organization of Health-Care Markets*, 53 JOURNAL OF ECONOMIC LITERATURE 235, 236 (2015), available at https://www.aeaweb.org/articles?id=10.1257/jel.53.2.235.

[43] CENTERS FOR MEDICARE & MEDICAID SERVICES, *Health Expenditures by State of Residence, 1991-2020*, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence (last visited May 9, 2025).

Antitrust enforcement is a key mechanism for preventing anticompetitive concentration.[44] Given that most large physician groups result not from horizontal mergers, but from "piecemeal acquisitions of small group practices,"[45] enforcement against even small mergers or private equity transactions can be essential for preventing anticompetitive concentration. And yet, current Rhode Island law does not require notification of physician acquisitions, mergers, or private equity investments below the HSR threshold, which renders antitrust enforcement against those transactions nearly impossible.[46] For these reasons, failure to implement the proposed rule is likely to result in concentration continuing to rise,[47] and resultantly, in increased prices and decreased quality of health care for Rhode Island residents.

c. Cost-Benefit Analysis: The Benefits of the Proposed Rule Outweigh its Costs

The proposed action entails a variety of costs and benefits distributed across different stakeholders. By enabling the OAG to investigate potentially anticompetitive transactions, acquisitions, and private equity transactions, the rule will prevent excessive market consolidation, slow the growth of health care prices, prevent degradation in quality of care, and ultimately save lives. Because the administrative costs of complying with the rule are low, the benefits of the rule significantly outweigh the costs.

ii. Benefit #1: Safeguarding access to affordable care.

The proposed rule will allow the RIAG to receive notice of transaction and determine what, if any, impact they may have on Rhode Islanders' access to quality, affordable health care. There is a demonstrated positive correlation between market consolidation and health care prices – in other words, as market concentration goes up, so do prices. This trend holds across various types of transaction activity and health care services. Researchers observed a 12% increase in Affordable Care Act Marketplace premiums in California after the percentage of physicians in hospital-owned practices increased from 25% to 40%.[48] Similarly, researchers found 32-47% higher prices in clinical systems acquired by larger integrated delivery systems compared to expectations in the absence of any

[44] *See, e.g.*, Hughes & Murphy, *supra* note 17 ("As health care markets become more concentrated, strong antitrust enforcement becomes increasingly important to reining in rising health care costs."); *see also* King et al., *supra* note 4, at 10 ("Since mergers are notoriously difficult to unwind once consummated, successful healthcare antitrust enforcement demands comprehensive notice, strong premerger review and approval policies to prevent further anticompetitive concentration, as well as effective, long-term post-merger monitoring and oversight."); *see also* Thomas L. Greaney & Barak D. Richman, *Consolidation in Provider and Insurer Markets: Enforcement Issues and Priorities – Part 1*, AMERICAN ANTITRUST INSTITUTE, 1 (2018), available at https://www.antitrustinstitute.org/wp-content/uploads/2018/09/AAI_Healthcare-WP-Part-I_6.12.18.pdf ("Unfortunately, the current policy environment has inherited healthcare markets that for many years suffered from inadequate antitrust attention.").

[45] Capps et al., *supra* note 12, at 1556.

[46] *See, e.g.,* Wollman, *supra* note 11, at 80 (arguing that discovering mergers is difficult in the absence of a notification requirement).

[47] *Id.* at 77 ("I find that among newly-exempt deals, antitrust investigations fall to almost zero while mergers between competitors rise sharply. Effectively all of the rise reflects an endogenous response of firms to reduced premerger scrutiny, consistent with large deterrent effects of antitrust enforcement.").

[48] Richard M. Scheffler et al., *Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices*, 37 HEALTH AFFAIRS 1409, 1409 (2018), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0472 .

acquisitions.[49] Similar trends are seen after private equity investments in medical practices. For example, in a study of gastroenterology markets, researchers found a 78.1% increase in professional fees after PE acquisition.[50] And, in a robust nationwide study, Stanford researchers found that prices paid by PPO plans to physician practices for 15 common medical procedures were up to 26% higher in the least competitive counties as compared to the most competitive counties.[51] *See* Exhibit 3.

[49] Caroline S. Carlin et al., *The Impact of Provider Consolidation on Physician Prices*, 26 HEALTH ECONOMICS 1789, 1789 (2017), available at https://onlinelibrary.wiley.com/doi/10.1002/hec.3502 .

[50] Yashaswini Singh et al., *Increases in Physician Professional Fees In Private Equity-Owned Gastroenterology Practices,* 44 HEALTH AFF. 215 (2025).

[51] Austin & Baker, *supra* note 37, at 1753.

Exhibit 3: Prices for common procedures increase as competition decreases

	HHI quartile				
Procedure (specialty)	**1** (most competitive)	**2**	**3**	**4** (least competitive)	**Δ Price, Least vs. Most Competitive**
Laparoscopic cholecystectomy with imaging (general surgery)	$972	$1,086	$1,079	$1,225	26.0%
Insertion of intracoronary stent (cardiology)	$1,163	$1,193	$1,318	$1,454	25.0%
Inguinal hernia repair (general surgery)	$612	$668	$660	$765	25.0%
Laparoscopic cholecystectomy (general surgery)	$946	$992	$1,025	$1,175	24.2%
Colonoscopy with lesion removal (gastroenterology)	$539	$548	$602	$656	21.7%
Cataract removal and prosthetic lens (ophthalmology)	$856	$863	$919	$1,031	20.4%
Knee arthroscopy and surgery (orthopedics)	$887	$849	$970	$1,036	16.8%
Laparoscopic appendectomy (general surgery)	$779	$785	$797	$904	16.0%
Mohs surgery for skin tumor (dermatology)	$702	$659	$737	$797	13.5%
Repair of nasal septum (otolaryngology)	$723	$746	$732	$817	13.0%
Fragmenting of kidney stone (urology)	$1,041	$954	$1,067	$1,139	9.4%
Total knee replacement (orthopedics)	$2,259	$2,078	$2,428	$2,440	8.0%
Shoulder arthroscopy and surgery (orthopedics)	$760	$700	$816	$756	-0.5%
Intensity-modulated radiation therapy (radiation oncology)	$932	$813	$859	$916	-1.7%
Vasectomy (urology)	$578	$554	$605	$567	-1.9%

Source: Daniel R. Austin & Laurence C. Baker. [52]

[52] Austin & Baker, *supra* note 37, at 1758.

iii. Benefit #2: Safeguarding access to quality care

The proposed rule will allow the RIAG to review transactions to ensure they will not lead to a degradation in care quality. A study by FTC economists found that increases in consolidation can lead to statistically and economically significant increases in negative health outcomes.[53] For example, in one study of the dialysis industry, post-consolidation care practices are altered to "increase [Medicaid] reimbursements and decrease costs"; for example, large chains have been found to replace high-skill nurses with lower-skill technicians and increasing the patient-load of each employee by more than 10%.[54] The study noted that patients at acquired dialysis facilities were 6.1% more likely to be hospitalized in a given month.[55]

iv. Cost #1: Compliance with the rule

Health care providers and/or transacting parties seeking to engage in material changes under the rule will have to comply with its provisions. Because compliance solely involves filling out a simple form, however, the costs of compliance are minimal. The notification form is designed to be completed by a non-attorney, and only requires the following fields of information:

1. The parties to the transaction, their locations, and their contact information,
2. A brief description of the nature and purpose of the proposed transaction,
3. The anticipated effective date of the transaction, and
4. Any new locations and services planned following the transaction.

Additionally, the parties to the transaction are encouraged to submit any voluntary documentation that might help the Attorney General review it (e.g., contracts, memoranda of understanding, etc.). All-in, filling out the form should take no longer than 30 minutes for a non-attorney employee.

a. Cost-Benefit Analysis of Alternatives: There Are No Alternatives As Effective and Less Burdensome Compared to the Proposed Rule

We have considered several alternative regulatory actions as part of the analysis,[56] and there is no alternative "which would be as effective and less burdensome to affected parties."[57] The alternatives considered are:

i. Post-merger notification rule for health care entities

This option would require medical-practice groups who transact resulting in a material change (using the same definition of material change as the proposed rule) to notify the Office of Attorney General within 30 days of closing the transaction. The Attorney General would promulgate this rule under the same authority as the Proposed Action, namely R.I. GEN. LAWS § 6-36-1 *et seq.*

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[53] Thomas Koch et al., *Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries*, 53 HEALTH SERVICES RESEARCH 3549, 3549 (2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6153168/#hesr12825-note-1005.

[54] Eliason et al., *supra* note 14, at 2.

[55] *Id.*

[56] R.I. GEN. LAWS § 42-35-2.9(b)(1).

[57] R.I. GEN. LAWS § 42-35-2.9(b)(2).

A post-merger notification rule for health care entities would be significantly less effective at controlling market consolidation as compared to a pre-merger rule, and thus the benefits to price of care and patient outcomes would pale in comparison to a pre-merger rule. The primary reason why a post-merger rule would be less effective is the difficulty of "unscrambling" the proverbial egg – that is, the costs to a combined entity of undoing a consummated transaction. A post-merger notification rule is likely to result in significantly more expense to the transacting parties, particularly the buyer.[58] Post-merger reviews that result in anticompetitive findings may result in a forced divesture, "including a fire-sale price if no buyer will pay more."[59]

ii. Pre-merger notification rule for health care entities with a revenue-based materiality definition

This option would mirror the Proposed Action in its entirety except it would replace the employee headcount-based materiality threshold with a revenue-based materiality threshold.

The proposed rule, with its headcount-based materiality threshold for transactions between medical-practice groups or between a hospital and medical-practice group, would be less costly and more effective than a revenue-based materiality threshold because (1) it would be more costly for transacting parties to comply with a revenue-based threshold, and (2) it would be more costly for the Attorney General to review and verify a revenue-based threshold. For transacting parties, a revenue-based materiality threshold would entail numerous forecasting exercises, requiring analyses of the parties' finances and assumptions about how business dynamics would change post-merger. In contrast, a headcount-based threshold requires a single arithmetic equation: summing the parties' employed physicians, nurse practitioners and physician's assistants. A revenue-based model would also be more resource intensive for the Attorney General – state employees would have to spend a substantial amount of time reviewing the various assumptions behind financials provided by the transacting entities to ensure accurate reporting.

For the same reasons, use of a 10 percent investment threshold when defining what constitutes a significant equity investor (other than a private equity company) would be less costly for private parties to comply with, and less costly for the Attorney General to review, than a capital-based materiality threshold.

iii. Pre-merger notification rule for health care entitles, triggered by physician headcount, excluding nurse practitioners and physician assistants

This option would mirror the Proposed Action in its entirety except it would omit nurse practitioners and physician assistants from the employee headcount-based materiality threshold calculation.

The primary cost of a physician-only headcount threshold relative to the proposed rule, which includes physician assistants and nurse practitioners in the headcount threshold, is that the former

[58] Perkins Coie, *Unscrambling the Eggs: FTC and DoJ Challenges to Non-HSR-Reportable Deals* (Aug. 12, 2013), available at https://www.jdsupra.com/legalnews/unscrambling- the-eggs-ftc-and-doj-chall-22841/ (last visited May 9, 2025).
[59] *Id.*

would disincentivize health care entities interested in transacting from employing physicians. This has potentially negative impacts on patient care as well as overall employment for trained physicians.

iv. No regulation; rely on federal enforcement of Hart-Scott-Rodino Act and state enforcement under R.I. GEN. LAWS § 6-36-1 *et seq.* and the Hospital Conversions Act

This option would forgo the rulemaking process and would instead approach health care antitrust in Rhode Island through traditional avenues. The primary enforcement mechanisms would be (1) traditional antitrust enforcement by the Attorney General via Rhode Island state law and (2) federal antitrust enforcement.

The cost and benefits of this alternative are quite similar to the counterfactuals presented in section III(c) of this memo.

v. Proposed rule, but with formal approval required before completing transaction

This option would mirror the proposed Rule, but would require explicit authorization by the Attorney General prior to consummating a material change.

This option would be substantially more burdensome on both health care entities and the Attorney General. The Proposed Rule grants the Attorney General the opportunity to review material changes but imposes a discrete timeline on how long they may take to do so, thus balancing law enforcement priorities with private business interests in moving quickly.

IV. Small Business Impact Analysis

The rule is likely to impact small businesses. Per R.I. GEN. LAWS § 42-35.1-2, "small business" is defined by the federal Small Business Administration ("SBA") standard articulated in 13 C.F.R. § 121.101 and § 121.201, which lists the business size (in annual receipts) under which an NAICS-coded business is considered "small."[60] A sample of health care businesses considered "small" include: Offices of Physicians (except Mental Health Specialists) under $16 million; Offices of Dentists under $9 million; General Medical and Surgical Hospitals under $47 million; and Nursing Care Facilities under $34 million.[61] The rule will have a negligible impact on small businesses in Rhode Island because (1) the notification requirement is triggered only when a business engages in a material change, and therefore does not impose a recurring compliance obligation, and (2) material changes are likely to include large businesses and/or attorneys whose involvement will mitigate any disproportionate impact of the rule on small businesses.

i. The Rule will have minimal administrative costs for affected small businesses

As stated in section III(c)(iv), administrative compliance costs for all health care entities should be minimal, and small businesses are no exception. Small health care providers seeking to engage in material changes under the rule will have to comply with its provisions. Because compliance solely involves filling out a simple form, however, the costs of compliance are minimal. The notification form is designed to be completed by a non-attorney with basic knowledge of the business, and only requires the following fields of information:

[60] *See* R.I. GEN. LAWS § 42-35.1-2; *see also* 13 C.F.R. § 121.201.
[61] *See* 13 C.F.R. § 121.201

1. The parties to the transaction, their locations, and their contact information,
2. A brief description of the nature and purpose of the proposed transaction,
3. The anticipated effective date of the transaction, and
4. Any new locations and services planned following the transaction.

Additionally, the parties to the transaction are encouraged to submit any voluntary documentation that might help the Attorney General in the review (e.g., contracts, memoranda of understanding, etc.). Finally, there is likely to be a notable deterrence effect whereby the pre-merger notification rule will reduce attempts at facially anticompetitive transactions, thereby limiting compliance costs.[62]

[62] *See* Thomas G. Wollman, *How to Get Away with Merger: Stealth Consolidation and its Effects on US Healthcare*, NBER WORKING PAPER SERIES, 27-8 (2021), available at https://www.nber.org/system/files/working_papers/w27274/w27274.pdf .