CENTER ON HEALTH AND FAMILIES

RESTRICTING ANTICOMPETITIVE CONTRACTING IN HEALTHCARE IN TEXAS

An Antitrust Approach to Patient-Centered Policy

WRITTEN BY **Noah Torres**

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KEY POINTS

- **61% of Texans reside** in "highly" or "very highly" consolidated healthcare markets, wherein they have decreased access to affordable and quality care. Tying, exclusive dealing, and non-compete agreements support consolidation.
- **Tying, exclusive dealing, and non-compete contractual arrangements** directly contribute to the construction of healthcare monopolies, monopsonies, and oligopolies at the expense of patient health and access to care.
- **Tying clauses between providers and insurers** require that if one provider is covered, others must be, enabling providers to leverage market power, capture purchasers, manipulate prices, and foreclose rivals.
- **Exclusive dealing clauses** between providers and insurers or other general contracting entities require that the entities not contract with the provider's competitors, foreclosing other providers or insurers from the market.

INTRODUCTION

In Texas, unsustainable and rising healthcare costs pose an existential threat to widespread patient access to affordable and quality healthcare. Since the early 1990s, per capita healthcare expenditure in Texas has steadily risen each year, with an average per capita expenditure of $8,406 in 2020 (Texas 2036, 2020). Similarly, average employer sponsored health insurance (ESI) spending is firmly set on an upward trajectory, with average ESI spending at $6,475. While per capita healthcare expenditures in Texas may not be as high as expenditures in peer states such as New York or California, ESI expenditures in Texas are higher than the ten peer states, including New York and California. Further, Texans express anxiety about healthcare costs. Per a 2023 survey by Altarum Healthcare Value Hub, 70% of respondents indicated they experienced one or more healthcare affordability burdens, including delaying or forgoing care (Altarum, 2024). Furthermore, healthcare expenditure in Texas consumes approximately 31.8% of the state budget or $102 million, second only to educational expenses, which account for 38.2% of the state budget (Texas 2036, 2024). Healthcare spending at the federal level occupies a comparable portion of the federal budget. Notably, the United States spends more per capita on healthcare than any comparable, high-income peer nation (Wager et al., 2024). In fact, as Brot-Goldberg et al. (2024) suggest, price increases in the hospital sector—including inpatient and outpatient services hospitals—has outpaced price increases in all other industries and economic sectors since 2000.

Despite extraordinarily high healthcare expenditures in Texas and the United States, both Texas and the United States consistently rank lower than peer states and nations, respectively, in metrics that are suggestive of healthcare quality. For example, according

to a 2023 study by the Commonwealth Fund, Texas ranks 48th of all 50 states and the District of Columbia in "health system performance" (Commonwealth Fund, 2023). Per the Commonwealth Fund, in Texas, 18.4% of adults forgot care due to costs, while only 74.6% of adults possess access to a regular source of care; notably, Texas underperforms in these areas, among others, when compared to national data (Commonwealth Fund, 2023). At the national level, the United States consistently ranks lower than peer countries in metrics that are suggestive of healthcare quality (Wager et al., 2023). As evinced by these numbers then, higher healthcare expenditures and costs do not necessarily result in improvements in healthcare outcomes. Higher healthcare expenditures, therefore, do not necessarily conduce to superior healthcare outcomes (Roberts et al., 2017).

If higher costs do not correlate with superior quality, then under the current state of healthcare in the United States, Americans may be unnecessarily afflicted by equally unjustifiable healthcare costs, which may amount to reckless rent-seeking behavior by healthcare actors. A question arises then concerning the genesis of the trend of increasing healthcare expenditures and prices in Texas since these increases have yielded neither perceptible benefits for patients nor improvements to quality of care. While the causes of increased healthcare costs are several, one principal cause is unchecked consolidation of healthcare and insurance markets and the reinforcement of consolidated markets via anticompetitive, private law contracting behavior among healthcare providers and insurers in Texas and the United States. Signifying the conjoining of healthcare-related entities under the common ownership of corporation via merger and acquisition, consolidation typically assumes three forms. Per Levinson et al. (2024), consolidation may occur as vertical integration, wherein entities offering distinct services within the same supply chain merge, horizontal integration, wherein entities offering identical services merge, or cross-market integration, wherein two entities in different geographic markets merge. In Texas, healthcare markets are especially concentrated. According to Gupta and Miller (2023), 61% of Texans live in "highly" or "very highly" concentrated healthcare markets, well above the percentages in peer states such as Florida (40%), New York (14%), and California (2%). The reality that over half of Texans reside in concentrated healthcare markets is a concerning fact, as studies indicate that as hospitals and other healthcare entities consolidate and competition decreases in a market, patient experience and quality of care indicators decline (Beaulieu et al., 2020) and prices for services rise (Arnold et al., 2024). Furthermore, Brot-Goldberg et al. (2024) find that healthcare price increases as the result of merger consummation produce negative cascading effects on patients. For example, for every 1% increase in healthcare prices, employers external to the healthcare industry cut payroll by 0.37% correlative to decreases in total worker counts likely to counteract the average $40.09 increase in spending per ESI plan member, for every $1 in hospital revenue secured by price increase, labor income external to the healthcare industry fell anywhere between $1.33 to $1.69, and for every 1% increase in healthcare prices leads to approximately one additional death from suicide or overdose per 100,000 people. Not only does consolidation raise the cost of healthcare services for patients, consolidation results in peripheral consequences that further handicap the economic and financial viability of individual patients.

While the perceptible consequences of consolidation are often associated with the incipience or foundation of a consolidated healthcare entity, *i.e.,* the act of merger or acquisition, the maintenance of a consolidated healthcare entity is supported by other private-law, contractual methodologies that, like the mere act of consolidation, produces a cascade of consequences that restrain and reduce patient access to affordable and quality healthcare. These contracting practices that serve to maintain or conserve a consolidated healthcare entity may be subsumed under six significations: most-favored nation clauses, exclusive dealing arrangements, tying arrangements, anti-tiering/

Table 1

Contractual Clause	Description
Most-Favored Nation (MFN) Agreement	A contractual agreement wherein a healthcare provider agrees to not give a lower payment rate to any other insurer or to give an insurer the best or lowest rate notwithstanding rates given to other insurers.
Tying Arrangement	A contractual agreement wherein two distinct products are bundled together and the sale of one product is conditioned on the sale of the other product. Includes "all-or-nothing" agreements.
Exclusive Dealing Arrangement	A contractual agreement wherein a seller conditions the sale, rent, or transfer of any rights concerning one or more products or services on the buyer's agreement to not purchase, rent, or seek any rights relating to a competitor's products or services.
Anti-Tiering/Anti-Steering Clause	A contractual agreement between a healthcare provider and an insurer which prohibits an insurer from placing healthcare providers in value tiers based on quality or price criteria.
Gag Clause	A contractual agreement between a healthcare provider and an insurer that prohibits healthcare providers from informing patients, employers, and other third parties from knowing negotiated payment rates of services.
Non-Compete Agreement	A contractual agreement between a healthcare entity and an individual healthcare practitioner that prevents a departing healthcare practitioner from continuing the practice of medicine or a medical specialty for a defined temporal period in a specified geographic locus.

***Note**: Red shading: prohibited in Texas. Green shading: permitted in Texas.*

anti-steering clauses, gag clauses, and non-compete agreements. For the sake of brevity, readability, and reference, these six clauses and their possible anticompetitive consequences in healthcare are described in tabular format in **Table 1** above.

While the utilization of these six clauses is not necessarily anticompetitive, they are frequently used to engage in practices that violate the Sherman Antitrust Act of 1890 (15 U.S.C. 1-7) and Clayton Antitrust Act of 1914 (15 U.S.C. 12-17), which both provide broad statutory prescriptions and proscriptions for combatting private law anticompetitive behavior in the United States (Angerhofer et al., 2023). The Sherman Act has two provisions that address anticompetitive behavior. Section 1 prohibits conspiracy among competitors to restrain trade, while Section 2 prohibits conduct by a singular entity that monopolizes or is conducive to monopoly (Angerhofer et al., 2023). Across several sections, the Clayton Act prohibits a multitude of practices, including conditional sales that reduce competition (15 U.S.C. 3), mergers and acquisitions that significantly inhibit competition (15 U.S.C. 7) price discrimination (15 U.S.C. 13), exclusive dealing and product tying (15 U.S.C. 14). Additionally, Section 4, in the spirit of commutative justice, permits persons to be compensated for an antitrust violation that has caused injury to his property (15 U.S.C. 4).

Animating both Sherman Antitrust and Clayton Antitrust is the principle that the American people, as sovereign, delegate to state and federal governments the authority to regulate the activities of private corporations for the sake of preserving market competition, preventing consumer harm, and ensuring consumer access to goods and benefits arising therefrom. Therefore, healthcare, like other industries and markets, ought to be "participated in by an exhaustible number of persons in an exhaustible variety of ways or on an inexhaustible variety of occasions" (Brown, 2025, p. 29). Anticompetitive contracting in healthcare, however, prevents such participation to the detriment of patient health.

In Texas, Section 1458 of the Texas Insurance Code has restricted the use of most-favored nation clauses, anti-tiering or anti-steering clauses, and gag clauses since the enactment of House Bill 711 on June 12, 2023. Those that remain permissible in Texas, namely tying arrangements, exclusive dealing arrangements, and non-compete agreements, may have anticompetitive effects within the domain of healthcare that restrain or restrict patient access to affordable and quality healthcare.

Tying arrangements are characterized by the conditioning of the sale, rent, or transfer of rights of some product or service on the sale, rent, or transfer of rights of another product. As Sagi (2014, p. 1) notes, tying arrangements "coerce consumers to buy additional products or services beyond what they intend to purchase… this pressure can be applied because a consumer in a monopolistic market does not have the alternative to buy the product or service from a competing firm." In other words, in consolidated healthcare markets, healthcare providers who occupy a monopolistic or dominant position may utilize tying arrangements to compel consumers—patients, insurers, or other third parties—to purchase products or services they may not have otherwise purchased, thereby driving up costs for consumers and limiting choice. Tying arrangements may occur in several strata of healthcare. For example, as Gudiksen et al. (2020) note, the most pervasive—and perhaps the most harmful and injurious—mode of tying is an "all-or-nothing" tying arrangement wherein a healthcare provider requires a "health plan that wants to contract with a particular provider or affiliate in a provider system to contract with all other providers in that system" (Gudiksen et al. 2020, p. 22). Other modes of tying may occur when hospitals and healthcare provider systems bind a specific medical service to a specific group of medical practitioners. For example, a hospital or healthcare provider may tie the delivery of aortic dissection surgery to a specific group of cardiothoracic surgeons, thereby not only restraining patient choice of service provider based on cost or quality metrics, but also constraining the number of cardiothoracic surgeons operating in a particular market and thereby creating artificial scarcity conducive to higher prices of services. Other products and services may be bundled in healthcare, including the delivery of a specific medicine with a specific trade name or name brand.

Exclusive dealing arrangements, which condition the sale, rent, or transfer of rights of an item on the agreement that the buyer, lessor, assignee, or beneficiary of rights do not seek to purchase, rent, or acquire the rights of an item or service from any competitor of the seller. As Gudiksen et al. (2020) note, exclusive dealing most commonly occurs between healthcare providers and insurers in two forms. On one hand, exclusive dealing arrangements may be utilized by a hospital or healthcare provider system to condition the coverage of that hospital or healthcare provider's services by an insurer on the agreement that the insurer will not extend coverage to the hospital's competing providers. On the other hand, insurers may initiate exclusive dealing arrangements with hospitals and condition the coverage of medical services on the agreement that the hospital or healthcare provider will not contract with any other insurer for coverage of identical or similar services. Functionally, exclusive dealing arrangements may resemble tying arrangements.

Non-compete agreements in healthcare are especially anticompetitive and harmful for patients. Imposed on physicians by their employer—usually a

healthcare provider or hospital system--non-compete agreements stipulate that if a physician terminates employment with the contracting healthcare provider, then the physician may not continue the practice of medicine or a specific medical specialty in a specific geographic locus for a specified period. Non-compete agreements may also stipulate that departing physicians may not continue the practice of medicine with any of the contracting healthcare provider's competitors, including those competitors both interior and exterior to the defined geographic radius. As for the anticompetitive nature of non-compete agreements, non-competes are conducive to the cotemporaneous construction of labor monopsonies in healthcare. Monopsony is the "negative image of monopoly… it is the structural condition in which a well-specified good or service has only one buyer" (Lopatka, 2015, p. 72). In employment and labor contexts, monopsony describes the phenomenon wherein healthcare provider system operates as the dominant or "single buyer" of physicians and their services. Labor monopsony is often concurrent with monopoly, for "monopolist in the manufacture of a particular good would also be a monopsonist in the types of labor used only in the production of that good" (Ashenfelter et al., 2010, p. 204). In healthcare contexts, non-competes contribute to the construction of labor monopsony insofar as they impose restrictions backed by threat of pecuniary or legal punishment that effectively disincentivize physicians to terminate employment or contractual relations with a given hospital. Moreover, even if a physician elects to terminate a contractual relationship supplemented by a non-compete agreement with healthcare provider, physicians in Texas must pay a buyout fee. While statute indicates that fees must be reasonable and while an arbiter may determine a reasonable fee in the event of discordance between contracting parties, fees may nevertheless disincentivize physician departure from a medical practice, further solidifying monopsony power. In a consolidated healthcare market wherein a healthcare provider system possesses dominance or monopoly power, non-competes are thus all the more powerful for establishing monopsony power. In other words, both monopoly power and non-compete agreements enable health systems to function as the singular, major employer of physicians in a given market. As a consequence of non-competes and monopsony power, patient access to affordable and quality healthcare is significantly restrained, a troubling reality in light of not only rising medical costs, but also physician shortages in Texas. As indicated by the Texas Department of Health and Human Services, Texas has 224.8 physicians for 100,000 population, below the national average of 277.8 per 100,000 population, placing the state at 41 out of 50 states ranked by number of practicing physicians (DSHS, 2022). Restraining access *per se*, non-compete agreements disincentivize physician labor mobility, barring physicians from making career decisions that may result in their relocation to one of 224 counties in Texas lacking a primary care physician, or from simply establishing or joining a medical practice that offers services at a lower price than their previous employer. Further, in the event a physician departs a practice and adheres to the terms of a non-compete agreement, patients with chronic illnesses or patients separated from their doctor by significant difference may find themselves unable to continue care with their previous physician. On one hand, Texas statute currently only provides that physicians bound by non-competes cannot be denied access to former patients with acute illnesses (Texas Business & Commerce Code, 15.50(b)). On the other hand, research indicates that upon geographical separation of a patient and their primary care physician that results in travel time of 40 minutes or more, only 45% patients continue seeing their physician, while 23% elect a new primary care physician (Sabety, 2022). Finally, by restricting the movement of physicians, non-competes not only increase geographic scarcity of physicians, thereby raising prices, but also stifle innovation in medical care that may benefit patients. As Barak Richman (2023) notes, "noncompete clauses don't just stifle competition across physicians, they stifle innovation in the delivery system altogether." Stifled innovation, restricted access to physicians, increased prices, and non-compete agreements pose a serious threat to the health and well-being of Texans.

Ultimately, the continued permissibility of tying arrangements, exclusive dealing arrangements, and non-compete agreements in healthcare presents a serious threat to not only to the health and well-being of Texas patients insofar as it hinders their access affordable and quality care, but also the labor mobility of Texas physicians that is all but necessary for facilitating patient access, especially in rural communities. As fixtures of the healthcare landscape of Texas, these agreements portend nothing but continued aggravation of extant problems in the state, including physician shortage, physician maldistribution, high costs of healthcare, restricted access to affordable and quality healthcare, and ultimately poor health outcomes.

It is imperative that Texas enact legislation that restricts the use of tying arrangements (especially in their "all-or-nothing" permutations), exclusive dealing arrangements, and non-compete agreements. In the absence of these agreements, not only will physicians have greater labor mobility that will permit them to establish new, independent, and affordable medical practices, relocate to practice in rural and medically underserved communities, foster healthcare and healthcare business innovation, but patients will have greater access to affordable and quality healthcare. Artificial and needless barriers to healthcare access in the form of anticompetitive contracting or business practices not only inhibits individuals from accessing necessary medical intervention, but also—by the very act of inhibiting access—stifles and inhibits every individual unfairly prevented from accessing care the ability to pursue their own personal flourishing in conjunction with the pursuit of the common good of all Texans, which is paramount. Thus, not only is the health of Texans at stake, but also the health of Texas.

Reforming healthcare contracting practices in Texas is a herculean task that requires navigation of arcana of public health policy, healthcare law, and antitrust and anticompetition economics. At the convergence of these categories are quandaries relating to patient access to care, patient outcomes, the minutiae of private-law agreements, and economic measurements of anticompetition. To this end, this paper will endeavor to provide a policy prescription for ameliorating the current anticompetitive landscape in Texas healthcare, beginning first with a brief exposition on antitrust and anticompetition paradigms that have dominated academia, agencies, and courts at both the state and federal levels. Subsequently, this paper will investigate the nature of tying, exclusive dealing, and non-compete arrangements and their potential anticompetitive consequences in healthcare. Third, this paper will investigate the legal history of each anticompetitive contracting practice in the United States, later turning attention to the legal history of each anticompetitive contracting practice in Texas. Finally, this paper will conclude with policy prescriptions.

A not so small portion of this paper is dedicated to economic and legal analyses. On the one hand, interlaced economic analysis reveals quantifiable harm exacted upon a given healthcare market that in some part is the consequence of anticompetitive contracting. Said harm upon a market, *e.g.* the construction of a monopoly or monopsony, the exclusion of rivals, the artificial raising of prices, is inextricable from questions of healthcare service access and affordability insofar as barriers to healthcare for the individual patient resulting from the economic behavior of hospitals or insurers are, *inter alia*, financial, geographic, or institutional. In other words, the economic behavior of hospitals and insurers and their distinctly economic consequences that concern concepts such as price, scarcity, monopoly, and monopsony exert mediated influence on patient access and outcomes via idiosyncratic hospital policy. On the other hand, caselaw—especially in the State of Texas—reveals the juridical confusion resulting from the historical discordance between the judiciary, legislature, and statute on anticompetitive contracting, particularly with respect to non-competes, as the decisions of courts on the enforcement of non-competes in at-will employment is frequently at odds with statute. Since public health is of utmost importance and is sometimes hindered by economic activity and since a concordance of discordances between the judiciary, the legislature,

and statute is preferrable to mere discordance, then legal and economic questions are germane for any future policy relating to anticompetitive contracting in Texas.

PARADIGMS OF ANTITRUST AND ANTICOMPETITION THOUGHT AND THE DYNAMICS OF ENFORCEMENT

Policy and Paradigms: Making Legal Theory and History Relevant to Policy

Anticompetition policy in healthcare is undergirded by an expansive history of both legal and economic ideas defining the relevant scope of antitrust and anticompetition law enforcement, the economic consequences of anticompetitive activity, and both the injury and harm said activity may inflict upon patients as consumers and physicians as market actors. Understanding these competing theories aids not only in understanding how both Texas and the United States arrived at its current state in antitrust and anticompetition law and policy but also aids in coherently identifying how anticompetitive contracting harms Texas patients and physicians via the unique nexus of law, policy, and economics.

Four main schools of thought or "paradigms" are relevant, namely the Chicago School of Antitrust, the Harvard School, the Post-Chicago School, and the Neo-Brandeisian School. These schools of antitrust have exerted significant influence on the Federal Trade Commission, the Antitrust Division of the United States Department of Justice, and federal and state courts. The framework of "paradigm shifts" articulated by Thomas Kuhn provides a useful analytic for understanding the schools of antitrust thought. For Kuhn, a paradigm indicates a "shared constellation of group commitments from analogies to metaphors, to shared exemplars, to heuristics, to ontological models, or to shared models of the law of nature" (Gopesh et al., 2020). In their incipiency, these paradigms are proposed only by the most precocious thinkers and therefore represent a "Copernican moment" in the history of a given body of thought. Eventually gaining widespread acceptance amongst members of these disciplines, paradigms become those very shared constellations of commitments defining a discipline. However, these normative commitments may eventually be challenged by "anomalies, or violations of expectations, and the "emergence of crises that may be induced by failure to make an anomaly conform" (Kuhn, 1982, p. ix). Eventually frustrated by these failures, members of a given discipline rearticulate their constellation of commitments, and eventually establish a new paradigm, marking yet another "Copernican moment" within their discipline. This process is cyclical. Herbert Hovenkamp, perhaps the foremost theorist of antitrust jurisprudence, has already made this astute observation when accounting for the rise of the post-Chicago school in the 1990s (Hovenkamp, 1985). Some thirty years later, both Kuhn and Hovenkamp were vindicated once more, as the nascent Neo-Brandeisian movement marks yet another paradigm shift in antitrust legal theory that informs policy.

Bearing in mind this framework for understanding the dual legal and economic ideas of antitrust law and how these laws have shaped policy is important for conceptualizing any future anticompetition policy in healthcare. While a one-off anomaly in either the market or in antitrust enforcement does not eviscerate a theory or approach to antitrust law, repeated anomalies in the real world invite reexamination of antitrust and anticompetition policies. Both antitrust law and enforcement in Texas and the United States have struggled to adequately address the unique consequences of anticompetitive practices in healthcare on both markets and consumers. Pointedly, healthcare market actors have long eluded minimalist antitrust enforcement in their effort to achieve market dominance while both competition and consumers suffer. Thus, since, "anomalous experiences may not necessarily be identified with falsifying ones" yet since anomalies (*i.e.*, elusive consolidation) at the nexus of antitrust law and healthcare economics are numerous, the paradigm framework necessitates reflection on the future of both antitrust theory and law and how nascent paradigms may evolve to redress previously unresolvable quandaries (Kuhn, 1982, p. 146). Since transitions between paradigms are characterized by an

"overlap between the problems that can be solved by the old and by the new paradigm" and identifiably different approaches, new paradigms thus cannot be dismissed in their infancy or even considered incompatible with a broader set of commitments (Kuhn, 1982, p. 85). The effort to restrain anticompetitive contracting in healthcare should not be inhibited by conceptual stagnation of another paradigm or fears that a nascent paradigm is unsatisfactory. For example, in present contexts, one should not dismiss the notion that greater restriction of certain anticompetitive contracting practices in healthcare such as non-compete agreements is unreasonable or far-fetched, or even compatible with Texan or American frameworks merely because the Federal Trade Commission's 2024 effort to enact a total ban on non-compete agreements failed to pass muster in the courts. While one may have criticisms of the FTC's effort to ban non-competes from the standpoint of administrative jurisprudence, the disputed question of the effectiveness of the policy is wholly distinct.

Paradigms of Antitrust and Anticompetition: Sources of Legislative, Judicial, and Administrative Decisions

Since the question of anticompetitive contracting and past legislation, judicial decisions, and administrative enforcement has been shaped paradigms in antitrust thought, which are simultaneously legal, political, and economic theories, they are necessary to understand in order to craft policy surrounding antitrust and anticompetition. In **Table 2**, the characteristics of each school that are contextually relevant and germane for understanding the course of antitrust and anticompetition law in Texas and the United States are indicated.

Operating with the assumption that trends in academic and enforcement are closely linked and have influenced decisions in Texas, these dynamics allow Texas to keep a finger on the pulse of possible avenues for antitrust and anticompetition legislation and regulation. Further, since the antitrust schools make both normative economic and legal claims and since these claims have shaped policy, law, and enforcement, they are necessary for interpreting both the consequences of anticompetitive contracting and enforcement responses to anticompetitive contracting in healthcare.

TYING, EXCLUSIVE DEALING, AND NON-COMPETE CLAUSES: ANTICOMPETITIVE CONSEQUENCES IN HEALTHCARE AND BEYOND

In healthcare contexts, anticompetitive contracting practices such as tying, exclusive dealing, and non-compete agreements are utilized to aid in the unrestricted growth and market consolidation of healthcare actors such as provider systems and insurers. The act of consolidation itself generally assumes one of three modes, namely, horizontal mergers, vertical mergers, and cross-market mergers, as explicated in **Table 3** (Levinson et al., 2024).

Notably, cross-market mergers have increased significantly in the United States. From 2000 to 2012, more than half of the 528 general acute care hospital mergers were between entities in different geographic areas (Dafny et al., 2018). Moreover, in 1970 only 10% of American hospitals were part of provider systems extending over multiple geographic areas, while in 2019 nearly 67% of American hospitals were part of these pan-regional provider systems (Fulton et al., 2022). A recent study indicates that nearly 90% of American metropolitan statistical areas (MSAs) have concentrated hospital markets, 65% of MSAs have concentrated specialist markets, and 39% of MSAs have concentrated primary care physician markets (Fulton, 2017).

As Havighurst and Richman (2011, p. 850) rightly assert, consolidated healthcare markets and the monopolies that dot their landscape are "in fact more, not just equally, harmful to both consumers and the general welfare than monopolies of other kinds." If these contractual clauses were restricted, hospitals and insurers alike would lose the very means by which they unfairly gained market dominance. In the

Table 2

Paradigm/ School	Flourished	Key Ideas	Enforcement Approach

Harvard	Mid-1930s – Early 1970s	• **"Structure-Conduct-Performance" (SCP)**
		  • The number of firms in a market and their relative sizes (i.e., market structure) influences how those firms will compete in a market (Piraino, 2007).
		  • Market structures influence prices and output (Panhans, 2023).
		  • "Certain types of anticompetitive behaviors were more or less inevitable given a particular market structure" (Hovenkamp, 2007, p.2).
		  • Certain conduct, such as tying and exclusive dealing, tended towards market foreclosure and anticompetition (Hovenkamp, 2007).
		• **Dominant single-firm exclusionary conduct**
		  • Large, dominant firms in a market tended toward anticompetitive behavior, even if there is no quantifiable harm (Panhans, 2023; Hovenkamp, 2010).
			• **Casuistry**
			  • Some market structures have "predictable, proximate effects… though their general tendency is to create and preserve more concentrated market structures than would otherwise exist and to elevate the barrier of entry of new sellers" (Bain & Qualls, 1987, 265).
			  • Yet, anticompetitive harm is not necessarily guaranteed by a structure.
			  • Case-by-case analysis of market structures and firm conduct not necessarily requiring quantifiable demonstration of harm (Bain & Qualls, 1987)
			• **Maintenance of market balance**
			  • Enforcement should preserve unconsolidated markets.
			  • Even if a firm has market dominance by legitimate means, antitrust enforcement may be necessary to preserve a market (Piraino, 2007).
			• **Suspicion of large firms**
			  • Preemption of anticompetitive behavior by large firms, even if there is no quantifiable harm and if dominance was attained legitimately.
			  • Major cases against IBM, AT&T, and Xerox during this period (Baker, 2016).

Chicago	Mid-1970s – Late 1980s	• ***Laissez-faire* economics**
		  • Markets will naturally reach equilibrium without interference.
		• **Consumer Welfare principle**
		  • Antitrust laws were designed to promote allocative and productive efficiency, which benefited consumers.
		  • Allocative efficiency: "[T]he placement of resources in the economy, the question of whether resources are employed in tasks where consumers value their output the most" (Bork, 1978, p. 91).
		  • Productive efficiency: "[A]ny activity by a business firm that creates wealth… productive efficiency consists in offering anything, whether products or services, that consumers are willing to pay for… efficiency is therefore measure by their relative success in a market" (Bork, 1978, p. 105).
			• **Minimalism and abstentionism**
			  • "Size achieved by normal means, thought to reflect superior efficiency, and size gained by unfair practice that prevented competition… the latter were unfair" (Bork, 1978, p. 68).
			  • "[T]he existence of these two elements [allocative and productive efficiency] and their respective amounts are the real issues in every properly decided antitrust case" (Bork, 1978, p. 108).
			  • Antitrust and anticompetition laws are enforced only if there is quantifiable harm to consumer welfare (Glick & Bush, 2022).
			  • Relaxed scrutiny toward mergers, noticeable in FTC and DOJ enforcement trends during the height of the Chicago School (Lancieri et al., 2022).
			  • The only legitimate domain for antitrust regulation is in the restraint of certain monopolistic arrangements and price-fixing cartels because of how they might disrupt market efficiency.
			• **Rejection of casuistic enforcement approach of Harvard school in favor of scientific-economic approach (Crane, 2014).**
			• **Despite insistence that tying was not anticompetitive, courts maintained aggressive posture toward the practice (Baker, 2003).**

Post-Chicago	Late 1980s - Late 2000s	• **Consumer welfare remains the sole focus of antitrust (Yoo, 2020).** • **Inherited but increased reliance on game theory to understand firm behavior (Kobayashi & Muris, 2012).**	• **Unclear if post-Chicago exerted appreciable influence on antitrust litigation (Springman, 2009)** • **Increased, but not significant suspicion of horizontal mergers and unilateral strategic behavior (Yoo, 2020; Hovenkamp, 2001).**

Neo-Brandeisian	2010s-Present	• **Protection of economic competition and opportunity**
		  • Antitrust laws "safeguard against concentration of private power and… protect market structures that distributed individual opportunity and prosperity." (Khan, 2018, 132).
		  • "Antimonopoly is a key tool and philosophical underpinning for structuring society on a democratic foundation" (Khan, 2018, p. 131).
		  • "Antimonopoly does not mean 'big is bad'," rather the principal goal of anticompetition law is to ensure executives do not aggrandize power and that executives are compelled to "provide the best service possible to everyone who relies," on their business (Khan, 2018, p. 132).
		• **Rejection of consumer welfare as the singular and paramount concern of antitrust and anticompetition law.**
		  • Chicago School's focus on efficiency has led to higher prices and market concentration. (Khan, 2018).
		  • Narrow social concerns about group-specific inequality are irrelevant.
		• **Law, policy, and economics exist in a triadic relationship (Khan, 2018).**
		  • Changes in policy can positively transform market economics to promote opportunity and competition.
		  • Unrestrained firms may retard the reasonable and rational enjoyment of rights and liberties afforded to Americans by nature and the political community.
		  • Markets are not amphitheaters filled with automatons engaged in a perpetual atavistic Darwinian spectacle of agonism and cannibalism.
			• **Aggressive posture towards consolidation and mergers**
			  • Under Lina Khan's leadership, the FTC pursued legal challenges against mergers between larger firms such as Kroger's, Albertson's, Activision-Blizzard, Microsoft, Google, and Meta Platforms.
			• **Heightened suspicion of contractual practices, such as exclusive dealing and tying.**
			  • In 2022, the FTC modified its definitions of "unfair methods of competition" (UMC) to include contracts that may be anticompetitive, aggressive merger activity, and non-quantifiable harm to markets. (FTC, 2022).
			  • 2022 UMC indicates that FTC will stop monopolies in their "incipiency," rather than wait to observe quantifiable harm (FTC, 2022, p. 10).
			• **Antitrust and anticompetition laws preemptively correct market structures.**

Table 3

Merger Type	Characteristics
Horizontal	Consolidation of entities that offer the same or similar service, as when a large hospital system acquires a smaller hospital system.
Vertical	Consolidation between entities that offer distinct services within the same industry supply chain, as when a hospital system acquires a clearinghouse or other intermediary.
Cross-Market	Consolidation between two healthcare providers operating in different geographic areas.

absence of these contracts, physician mobility would increase, cost of medical services would decrease, and patient access to affordable and quality care would increase. Precisely, prohibition of anticompetitive contracts might function both as a remedy for "for earlier mergers found unlawful after the fact" and "significantly reduce the extraordinary pricing freedom that hospital and other monopolists enjoy by virtue of U.S.-style health insurance" (Havinghurst & Richman, 2011, p. 882).

Tying Arrangements

Consider then the clauses that uphold hospital consolidation and monopoly. Alongside exclusive dealing and non-compete agreements, tying arrangements are considered especially anticompetitive and are ubiquitous in healthcare. Tying agreements are defined as an "agreement by a party to sell one product but only on the condition that the buyer purchases a different (or tied) product" (*Northern Pacific Railway Co. v. United States*, 1958). In other words, in tying, there is both a "tying" product to which a "tied" product is bundled. In healthcare, tying arrangements commonly feature in relationships between hospitals and insurers, wherein an insurer, seeking to contract with an individual physician or group of physicians, is required to contract with all or some providers in that provider group if the insurer is to contract with any provider in the system. Provider systems who have one or several "must have" providers within their system are astutely aware of relative necessity for health insurers to contract with those "must have" providers and thus utilize those providers as leverage to compel insurers into contracting with all providers in the system (Hulver & Levinson, 2023). Of particular note are "all-or-nothing" (AON) tying arrangements, which specifically condition the contracting with one physician on the contracting with all physicians unlike other tying arrangements that may only condition the contracting with one physician on the contracting with some physicians in a provider group. Since all-or-nothing agreements are tying arrangements and since, as the International Competition Network suggests, "for an arrangement to be considered tying, customers of the tying product must be denied the choice of suppliers for the tied product," all-or-nothing arrangements must be considered a particularly severe form of tying conspiracies and arrangements (The Unilateral Conduct Working Group, 2015, p. 3). Pointedly, since all-or-nothing agreements in healthcare capture a provider group's total population of physicians, anticompetitive effects such as market foreclosure or price discrimination may intensify with all-or-nothing tying agreements. In turn, these agreements may lead to higher prices for patients and decreased care options, especially if all-or-nothing agreements are paired with exclusive contracts between provider groups and hospitals that result in either physicians only being covered by one insurer or insurers only working with one physician group in a given market. As Havighurst and Richman (2011) note, tying by hospitals "makes for efficient negotiating" with insurers and at the time of writing had not faced significant scrutiny, though the tying practices are "vulnerable to antitrust attack" because of their easy application to exclude competition and raise prices.

Three modes of tying exist notwithstanding the number of items bundled: contractual tying, technical tying, and tying through economic coercion. Contractual tying involves the creation of a private law agreement between parties conditioning the contracting for one item on the contracting of another item or items. Technical tying, an agreement much more prevalent in transactions for moveable, tangible goods and not necessarily services, occurs when a firm "technically links the tying product with the tied product together" (Sagi, 2019, p. 2). In other words, technical tying considers the tied product functionally or materially inextricable from the tying product. Economic coercion, on the other hand, occurs when a firm offers the tied products at a discount so attractive that consumers are all but compelled to not engage with competitors (Sagi, 2019). As Hovenkamp and Hovenkamp note, tying may also occur when a seller simply refuses to engage with prospective buyers who do not seek

to purchase the *de facto* bundle (Hovenkamp & Hovenkamp, 2015). Notably, economic coercion may be a viable means to reinforce either a contractual or technical tying arrangement.

Tying arrangements may have negative economic consequences in a market. In healthcare contexts, these consequences may needlessly restrain consumer choice of physician or care provider or render care more expensive due to the consequences of bundling. Tying provides a "mechanism whereby a firm with monopoly power in one market can use the leverage by this power to foreclose sales in, and thereby monopolize a second market," and thus should be treated as *per se* illegal (Whinston, 1990, p. 837). Consider the leverage model described by Whinston (1990) transposed onto healthcare contexts: There exist two markets for distinct goods, *O* (ophthalmologists) and *G* (general practitioners). Market *O* is served by Hospital System 1 and its "must-have" ophthalmologist, Dr. Forlenza and his staff at a "must have" ophthalmology practice in the system. Of note, a system-affiliated provider or practice may be coined "must-have" if its "geographic proximity, referrals, legal obligations, reputation, specialized services" renders the only accessible location for patients or the most desirable source of care for patients (Gudiksen et al., 2020, p. 22). Market *G* is served by Hospital System 1, 2, and 3, wherein each System has a plurality of general practitioners. In both markets there exist three consumers, *X, Y,* and *Z,* insurance companies representing their policyholders. Each insurer desires one unit of *O* and several units of *G* and is willing to pay some specific value, *v,* for each good. Recognizing its dominance over Market *O,* Hospital System 1 bundles *O* and *G*, requiring insurers who wish to cover either *O* or *G* to cover the other good ($O \leftrightarrow G$)[1]. If $O \leftrightarrow G$ and not exclusively $O \rightarrow G$[2] or $G \rightarrow O$[3] or selling each product independently, Hospital System 1 "pre-commits" to the tie, meaning that neither product is available without the purchase of the other. Per Whinston (1990) and Garcés (2012), "pre-committed" tying is especially anticompetitive, as Hospital System 1 will periodically lower the cost ($>v$) of the tied product *G* to foreclose Hospital Systems 2, 3, *etc.* from Market *G*, as lower costs will incentivize insurers *X, Y,* and *Z* to contract only with Hospital System 1. Moreover, since Hospital Systems 2, 3, *etc.* lack market power in Market *O,* they thus lack the means to effectively combat Hospital System 1's leveraging of its "must-have" physician. If the market for *G* is neither perfectly competitive nor monopolistic, but rather oligopolistic wherein a small number of firms—but not one—have market dominance (61% of Texans reside in consolidated healthcare markets, and thus necessarily reside in a healthcare market characterized by monopoly or oligopoly), then the anticompetitive foreclosure is amplified. Ultimately, if Hospital System 1's tying strategy succeeds, "the tied market becomes unprofitable," and competitors are compelled to exit the market (Garcés, 2012, p. 153). If tying is especially successful, this "exit" may occur in the form of acquisition of participants in Market *G* from Hospital Systems 2, 3, *etc.* by Hospital System 1, thus enlarging the size of Hospital System 1. With competition effectively removed, Hospital System 1's bargaining power with insurers is greatly increased, and System 1 may demand higher prices ($v<$) not only for services *O,* but also for services *G*. If the same conditions hold as the scenario described yet Market *G* is replaced with Market *P*, signifying *all* practitioners in a given hospital system notwithstanding specialty, Hospital System 1, utilizing a pre-committed tie where $O \leftrightarrow P$, may leverage its "must-have" ophthalmologist and accompanying practice to require the coverage of all physicians in its system. The same consequences may follow only if oligopoly exists in the tied market. As Nalebuff (2003, p. 25) notes, the described manner of tying and bundling will put rivals or potential entrants into a market at a disadvantage, rendering their entry either prohibitively impossible or unusually expensive.

1 "An insurer may contract with O if and only if it contracts with G"

2 "An insurer may contract with O only if it contracts with G"

3 "An insurer may contract with G only if it contracts with O"

Exclusive Dealing Arrangements

Another type of anticompetitive contracting practice is exclusive dealing, otherwise known as "exclusive contracting," or "exclusivity agreement," is a mode of non-price vertical restraint. Precisely, it is an arrangement where "one party's willingness to deal with another is contingent upon that other party (1) dealing with it exclusively or (2) purchasing a large share of its requirements from it" (DOJ, 2022). Exclusive dealing arrangements, like tying arrangements, exist on a spectrum. They may be strict, requiring "dealers or distributors wishing to distribute a supplier's products agree [to] not handle competing products," or relatively benign, requiring a dealer to accord a "supplier's product preferential treatment," in vending arrangements, *i.e.*, affording preferential treatment in digital or physical displays of products (Hovenkamp & Hovenkamp, 2015).

In healthcare, exclusive dealing agreements are commonly utilized by provider networks to prevent insurers from contracting with other providers if they already maintain a private law agreement with one provider or are attempting to contract with one provider. Additionally, a provider system may enter into exclusive contracts with physicians or physician groups, precluding physicians from other groups from providing any services within the system (Behinfar, 1996), purchase or handle the goods of any competitor (Marvel, 1982). In healthcare, exclusive dealing agreements may feature in scenarios where providers prohibit insurers from offering specific insurance plans to other provider groups in a market. Additionally, exclusive dealing arrangements may arise between group-purchasing organizations (GPO), which represent hospitals seeking the purchase of medical devices, and medical device manufacturers, wherein physicians at a hospital represented by the GPO may be bound to comply with commitment agreements with device manufacturers (Elhauge, 2002). Pharmacy benefit managers (PBM) may also engage in exclusive dealing arrangements with pharmaceutical corporations, requiring hospitals and physicians to only prescribe certain brands of medication (Moss, 2012). The most contentious type of exclusive dealing, however, is that between providers and physicians or physician groups, a private law arrangement that is ubiquitous in hospital administration (Portman, 2007). Notably, these types of private law arrangements between providers and physicians are frequently paired with clean-sweep agreements, which require contracting physicians to waive any rights enumerated in physician bylaws (Portman, 2007). Moreover, in some private-law agreements, exclusive-dealing arrangements are paired with tying arrangements, establishing a Janus-faced mechanism that not only bundles the sale of two or more products together but restricts buyers from engaging with other sellers.

Consider, for example, a one-sided exclusivity agreement wherein hospitals may enter exclusive dealing arrangements with physicians, wherein a designated group of physicians are the only practitioners with rights to deliver specific services in the hospital, thus binding the hospital, but not the physicians. However, if a specific group of physicians agrees to only practice at that hospital and if the hospital agrees to only grant rights to a specific group of physicians to deliver a specific service, then bidirectional exclusivity exists. As Haas-Wilson (2003) exclusive dealing arrangements in healthcare may foreclose rivals from the market, decrease competition, and increase prices. On one hand, one-sided exclusivity agreements may "decrease competition in the market for physician services," while bidirectional exclusivity agreements may limit the "ability of competing hospitals to obtain sufficient numbers of patient admissions" (Haas-Wilson, 2003, p. 164). Further, if an exclusive dealing contract has increased "duration of the contract, penalties for breach of the contract, and proportion of the local hospital and physician services markets involved in the contract," then the greater likelihood the agreement will have the effect of stifling competition, decreasing supply of medical services, and raising prices for patients.

Despite their harm, exclusivity contracts are not *per se* violations of either the Sherman Act or the Clayton Antitrust Act, though they may be casually

Exclusivity agreements may limit the "ability of competing hospitals to obtain sufficient numbers of patient admissions."

contributive to anticompetitive effects in healthcare markets, either by their effects or by arrangements facilitating their execution. After all, as Hylton (2003) notes, exclusive dealing is a vertical relationship is fundamentally a contractual relationship between two vertically-related entities, such as retailers and suppliers. By definition, a contractual relationship between two vertically-related entities are "exclusive," insofar as the contract affords exclusive rights and privileges to both parties, so "every exclusive vertical relationship, forecloses someone from the same relationship" (Hylton, 2003). However, two possible anticompetitive effects may result from exclusive dealing: unreasonable foreclosure and manipulation of costs of competitors by forcing them to go elsewhere to meet input requirements. Therefore, courts and regulatory enforcers casuistically infer the rectitude of exclusive dealing arrangements via empirical analysis of either direct or indirect evidence (*United States* v. *Dentsply International, Inc.*, 2005). According to the Federal Trade Commission, direct evidence includes noticeable price increases coupled with output reductions relative to "but-for world" counterfactuals where the exclusivity agreements do not exist, while indirect evidence includes observable market phenomena that allow regulators to infer that anticompetitive effects have occurred (Abbot, 2018). Furthermore, in the interpretation of both direct and indirect evidence, foreclosure is another nearly necessary—but not categorically necessary—anticompetitive effect of exclusive dealing arrangements. Per the Federal Trade Commission, "foreclosure" is defined as those as those potential transactions that a person engaging in exclusive dealing has made unavailable to its rivals (Brief for FTC as Amicus curiae, *Applied Medical Resources Corp.* v. *Medtronic, Inc.*, 2023). Similarly, the United States Department of Justice notes that exclusivity agreements tend towards foreclosure, and may be anticompetitive because it permits one seller to "monopolize the efficient distribution services and thereby prevent [foreclose] its rivals from competing effectively," or, in other words, stifle the efforts of rivals to effectively enter the market, especially when they would have been able to under but-for world circumstances (DOJ, 2022). However, as seemingly inextricable foreclosure may be in the execution of exclusivity agreements, it is only one of several possible anti-competitive effects of exclusivity agreements and thus is not necessary for anticompetitive harm to be sufficiently demonstrated, as other direct or indirect markets of anticompetitive effects can occur in the absence of market foreclosure (Brief for FTC as Amicus curiae, *Applied Medical Resources Corp.* v. *Medtronic, Inc.*, 2023). Additionally, the United States Department of Justice has suggested that there are other variables operative when considering the anticompetitive nature of an exclusive-dealing agreement, namely the duration of the private law arrangement, an approximate quantification of market foreclosure, and the substantive nature of the product and the arrangement (DOJ, 2022).

Taken together, these points evince that while exclusive dealing agreements are not necessarily harmful, they tend to contribute to market foreclosure and may have especially harmful consequences in healthcare because of the nature of healthcare markets, the good functioning of which patients are dependent upon for positive health outcomes.

Non-Compete Agreements

In addition to tying arrangements and exclusive dealings, non-compete agreements, covenants, clauses, and obligations represent another form of private law contracting that may have anticompetitive effects, especially within the domain of healthcare. The Federal Trade Commission defines non-compete clauses as a type of restrictive covenant that is characterized by a "term or condition of employment that prohibits a worker from, penalizes a worker for, or functions to prevent a worker from (1) seeking or accepting work in the United States

with a different person where such work would begin after the conclusion of the employment that includes the term or condition; or (2) operating a business in the United States after the conclusion of the employment that includes the term or condition" (FTC, 2024, p. 38342). According to O'Shea and Balat (2022), non-compete clauses may impose ancillary restrictions to enforce restrictions, including geographic restrictions on where a departing employee may work or the ability of the departing employee to solicit the employer's customers or employees (O'Shea & Balat, 2022).

As a private-law agreement, non-compete covenants have had a pervasive and long-standing presence within the common law tradition, with both their lawfulness and possible anticompetitive effects at the center of debate. The debate surrounding non-compete agreements is bifurcated into two opposing arguments concerning labor mobility and human capital investment (Posner et al., 2004). On one hand, proponents of non-compete agreements argue that the agreements, generally considered are relatively necessary protections of human capital investment and trade secrets, preventing departing employees both from appropriating sufficiently general knowledge obtained from job training for use as an employee of a competitor and from disseminating non-training knowledge that may be insufficiently protected by the legal infrastructure of intellectual property and trade secret law. On the other hand, opponents of non-competes argue that the agreements, generally considered, are needlessly restrictive of labor mobility, and thus competition.

Proponents of non-competes argue that, while they may restrain trade and conduce toward consolidation of monopoly power, non-compete agreements are "justified by other interests," namely securing and protecting corporate investments into human capital (Rubin & Shedd, 1981, p. 93). According to Rubin and Shedd (1981, p. 96), it would be "inefficient to enforce all restrictive covenants," yet they contend that binding employees by non-compete agreements is appropriate, if not necessary, when employees are the recipients of sufficiently general training that may be utilized in the context of other employment contracts facilitated by competitors and when he value of information received or encountered in the sufficiently general training is "so great that the worker cannot pay for it by accepting reduced wages." Per Rubin and Shedd (1981),

> Some types of employment relationships will involve both types of general training—general training for which the worker will pay in the normal manner, by accepting reduced wages, and general training for which the worker cannot pay because of its high value. If the worker signs a covenant [to not compete], he would be unable to use any of the training in other jobs. Presumably, the employer would then be forced to finance all of the investment, since it would all be specific. If the worker then left this place of employment, some of his training would be valuable to many firms and its use would not cost the original employer anything. Yet the worker would be constrained from using his training. Not using general training (absent trade secrets) thus imposes a cost. The covenant not to compete should therefore ideally apply only to those types of training involving trade secrets of the employer.

Furthermore, Rubin and Shedd (1981) contend that non-competes may also positively impact wages, noting that if non-competes are utilized by an employer—and especially if they are ubiquitous in that employer's industry—"he will reduce the supply of potential employees and thus pay a higher wage to those persons who nonetheless choose to work for him," principally because any human capital investment in the employer is protected from risk by the noncompete agreement. As it seems then, non-compete agreements, at least in some industries, may function to "secure trade secrets, reduce employee turnover, or improve leverage in future employment negotiations," insofar as they discourage or prohibit an employee from joining a competitor (Fox, 2023, p. 609). On this point, consider that employers may demonstrate reticence to devote resources to employees or employee benefits in the

absence of non-competes, for if no other barriers to employee departure exist, employers find themselves assuming a risk that might be significantly mitigated by non-competes.

Moreover, opponents of non-competes rightly contend that proponents of the agreements are in error about supposed positive consequences of the agreements on employee benefits, which goes hand-in-hand with the restriction of labor mobility. Precisely, according to Lobel (2020), non-competes may induce monopsonies and decrease wages in one stroke. Consider that "employers calibrate compensation largely based on competing external offers," and that since non-competes effectively reduce the number of offers a given employee may receive "employers face less pressure to increase wages" (Lobel, 2020, p. 939). Indeed, while one may argue that the additional amelioration of risk brought about by non-competes may very well render a state of affairs where an employer would offer higher pay, nothing about the private-law arrangement arising from a non-compete agreement sufficiently induces an employer to offer higher pay. That is to say, the decision to alter pay within a non-compete arrangement is wholly contingent upon the decisional calculus exercised by employer that is not necessarily altered by an agreement to not compete. Since no increase in pay is guaranteed by the use of non-competes and since non-compete agreements would make more burdensome—and expensive, considering that states like Texas require an option to buy out of a non-compete—the job search process that is characterized by expenses of employee time and effort, non-compete agreements may conduce toward monopsony power (Lobel, 2020, p. 939). As Manning (2003) notes, "job-switching" itself is already conducive to monopsony, insofar as it is inextricable from the criteria he identifies as sources of monopsony power, namely "ignorance among workers about labor market opportunities, individual heterogeneity in preferences over jobs, [and] mobility costs." Non-competes, which may require a buy-out, thus raise the expenditures borne by a departing employee, and therefore may coerce one to simply remain with their employer (thereby decreasing labor mobility in an industry) or may lead one to incur additional costs that render it more difficult for a departing employee to secure employment. Precisely, non-competes aid in "monopsonistic exploitation" insofar as their effects are that "the elasticity of supply is restricted, that is, reduced, when labor mobility is limited" (Alderman & Blair, 2024, p. 125). Additionally, even when non-competes are paired with higher wages—seemingly a benefit for an employee—the agreements may conduce toward monopsony and its injurious consequences for employees and consumers alike. Consider while that monopsony power may competitively attained by "foresight or natural attrition," monopsony may be anticompetitive when monopsonistic power is utilized to leverage control over jobs in a given industry or market by "increasing the amount of an input purchased and hence the price paid for it either to reduce competition in the input market or to impose costs on competitors in the input market and thereby raise price in the output market" (Lopatka, 2014, p. 72). In labor markets, this may mean that firms hire more workers and increase wages to reduce competition for labor or impose higher labor costs on competing employers, ultimately increasing prices of goods and services in the firm's given market. Further, as Alderman and Blair (2024) suggest, non-compete agreements make it significantly more difficult for "new entry and/or growth" of competing firms" that results in "less output and higher prices for consumers."

While the anticompetitive, injurious, or harmful consequences of non-competes may be spectral insofar as they are marked by idiosyncrasies particular to each industry contingent upon their ubiquity and stringency of enforcement, the anticompetitive, injurious, and harmful consequences of non-competes are most especially felt in the healthcare industry, wherein approximately 45% of American physicians are currently bound by non-competes (Robeznieks, 2023). While the supposed benefits of non-compete agreements may seem especially valuable—if not necessary—private law arrangements for healthcare actors considering that patient lists, clinical data, and medical research are considered trade

secrets (Vinti, 2024), the injury and harm to both doctors and patients that arises from the utilization of non-compete agreements outweighs any benefits that may otherwise be provided by the agreements. As O'Shea and Balat (2022) suggests, since the "bond developed in the patient-doctor relationship is often stronger than that found in the general labor market," any artificial interruption to the patient-doctor relationship because of enforcement of a non-compete agreement may not only lead to anticompetitive effects but may also lead to negative health outcomes for patients. Pointedly, non-compete agreements may first produce anticompetitive effects within the physician labor market by establishing an employment monopsony, which in turn, by way of functioning as an efficient cause, contributes to reduction in movement of physicians, and therefore a reduction in services available to patients and higher prices, especially if physicians receive greater compensation because of the supposed risk-mitigation offered by non-competes for hospitals. Non-competes, therefore, exacerbate the already pressing problem of physician distribution and physician shortage in Texas, where 214 out 254 counties lack a primary care physician (DSHS, 2024). While increasing the number of physicians will ameliorate this shortage, if a significant portion of those physicians are restrained by non-competes, the problem of physician distribution will remain. Unsurprisingly then, research indicates that in the absence of non-compete agreements, healthcare monopsonies are extinguished, thereby increasing labor mobility, lowering the cost of healthcare services, and increasing access to quality and affordable healthcare for patients.

Furthermore, non-competes may disrupt patient care by artificially severing the relationship between physicians and patients (Sherman et al., 2022). Disruption to patient care, especially disruption to the relationship between a patient and a general practitioner, may impart negative consequences on patient health. For example, in a study by Sabety (2022) that analyzes how 20% of Medicare patients from 2002-2019 valued their relationship with their primary care physician (PCP) and responded to

Non-competes, therefore, exacerbate the already pressing problem of physician distribution and physician shortage in Texas, where 214 out 254 counties lack a primary care physician.

disruption to care, 65% of adult patients saw their PCP for at least three years and 68% of adult patients tried to follow a departing physician. Unfortunately, once one-way travel time exceeded 40 minutes, less than 40% of patients attempted to follow their PCP. For those patients who could not follow their physicians, only 25% resumed seeing a PCP. Those patients who did not resume PCP care were 4% more likely to die, 4% more likely to visit the emergency room, and 3% more likely to be admitted to the hospital (Sabety, 2022).

Moreover, physicians recognize the harm posed by non-compete agreements for patients and practitioners alike. According to Sherman et al. (2022), 85% of surveyed orthopedic surgeons indicate that non-competes are not important for surgeon recruitment, 90% indicated that non-competes were not necessary for hospital groups to recruit surgeons, 77.5% indicated that they would be dissuaded from accepting a new position if it contained a non-compete agreement, and 97.5% indicated that non-competes contributed to consolidation. Further, 82.1% of surveyed surgeons bound by non-competes indicated that the agreement would require them to abandon patients if they switched careers and 71% indicated that their patients would have to drive significant distances to continue care (Sherman et al. 2022). Additionally, in Texas, 71% of Texans indicate that they oppose non-compete agreements, especially if they severe the physician-patient relationship (Phillips, 2025).

As for the question of general labor mobility and the potential of non-compete agreements to form monopsonies, a study by Balasubramanian et al.

Restricting non-compete agreements disrupted the monopsony power of providers, improved labor mobility (reflected in the growth of practices and the ability of practices to sustain themselves for longer periods), and ultimately improved patient access to healthcare services.

(2020) indicates that following a ban of non-compete agreements in Hawaii for tech workers, labor mobility increased by 11% and new hire wages increased by 4%. Gilson (1999) indicates that the proscription of non-compete agreements in California and resulting increased labor mobility may explain the relative success of the region compared to other technology corridors, such as Massachusetts' Route 128. These findings concerning mobility in Silicon Valley are further supported by Fallick et al. (2006), who find that not only in Silicon Valley, but in other localities throughout California, the proscription of non-compete agreements resulted in a 40% higher than average rate of employee mobility.

In healthcare, additional research by Balasubramanian et al. (2021) evinces the benefits of any type of legal restraint on the use of non-competes both for labor mobility of physicians, but also patient access to quality and affordable healthcare. As the study posits, at the county-level, in states where non-compete agreements were restricted, the average difference in the measure of healthcare access in the year of proscription increased by 3.7%, suggesting increased accessibility to healthcare (Balasubramanian et al., 2021). Furthermore, at the practice-level, employment increased following proscription by 1% each year, while practice closure and probability of practice closure decreased (Balasubramanian et al., 2021). In other words, restricting non-compete agreements disrupted the monopsony power of providers, improved labor mobility (reflected in the growth of practices and the ability of practices to sustain themselves for longer periods), and ultimately improved patient access to healthcare services. However, while the reality of their possible anticompetitive effects have illumined the minds of antitrust enforcers in the judiciary and administrative state in recent years, the history of adjudication and regulation of non-competes is marked by a certain dynamism, variability, and nuance, which only recently evolved—at least for federal agencies such as the Federal Trade Commission—exacting efforts to enact a categorical prohibition of non-compete agreements.

ANTITRUST AND ANTICOMPETITION LAW ENFORCEMENT AGAINST TYING, EXCLUSIVE DEALING, AND NON-COMPETE AGREEMENTS: A LEGAL HISTORY

Any discussion of the anticompetitive effects of tying, exclusive dealing, and non-compete agreements not only warrants an economic analysis that reveals the foreclosure and stifling of free markets that harms patients as both consumers and as individuals requiring fulfillment of their health needs to enable full participation in political life, but also a legal and administrative analysis that reveals how courts and agencies have responded to anticompetitive contracting. Legal and administrative analysis thus reveals the nexus between law and policy, including the legal harm that may result from anticompetitive contracting practices and how policy may respond to such harm. Further, legal and administrative analysis aids legislators in anticipating how courts and agencies may respond to any future policy.

Antitrust Enforcement against Tying Arrangements

All-or-nothing arrangements and other tying arrangements that approximate their severity (*i.e.*, arrangements that tie most, but not all, physicians in a provider group) have been routinely subject to the scrutiny of antitrust enforcers in agencies and courts despite the Sherman Act not explicitly identifying tying as a statutorily proscribed practice, however Section 1, which proscribes agreements that restrain trade, may be interpreted to prohibit tying arrangements. After *Henry v. A.B. Dick Co* (1912) wherein the

Supreme Court did not invalidate a tying arrangement artificed by a mimeograph manufacturer, Congress inserted an anti-tying provision in the Clayton Act (15 U.S.C. 14; Hovenkamp & Hovenkamp, 2015). Furthermore, Section 5 of the Federal Trade Commission has been interpreted to proscribe tying as an unfair method of competition.

In 1947 in *International Salt Co. v. United States* (1947), the Supreme Court adjudicated an appeal concerning a tying arrangement that required lessees of patented machinery that dissolved rock salt into brine to use only the lessor's salt. Ruling that the arrangement was illegal, the Court found that the tying of the two products rendered it prohibitively impossible for other firms to compete against International Salt Co.'s salt distribution, even though salt from other distributors would have been sufficient for use in machinery produced by International Salt Co. (Peterman, 1979).

In the 1949 case, *Standard Oil Co. of California v. United States*, the Court invalidated Standard Oil Co.'s tying arrangement, which contractually bound independent dealers in petroleum products and automobile accessories to purchase products from Standard Oil Co. According to the Court, tying arrangements "serve hardly any purpose beyond the suppression of competition," and that typical justifications such as "protection of the goodwill of the manufacturer of the tying device… fails" because prescription that two products must be used together is superfluous if the tied product sufficiently attracts the attention of consumers (*Standard Oil v. U.S.*, 1949). If that is the case, then tying is useless. If it is not the case that the tied product sufficiently attracts the attention of consumers, then the arrangement unreasonably restrains both consumers from access to other potentially superior goods and forecloses competitors possibly offering superior goods.

Later in 1958 in *Northern Pacific Railway v. United States,* the Court ultimately indicated that tying arrangements, such as all-or-nothing clauses, were *per se* illegal if "a party has sufficient economic power with respect to the tying product to appreciably restrain free competition in the market for the tied product and a 'not insubstantial' amount of interstate commerce is affected" (*Northern Pacific Railway v. United States*, 1958). In fact, the Court went so far as to suggest that the "existence of a host of tying arrangements in itself" was sufficient evidence that a firm possessed outsized market power according to the criteria laid down by the Court (*Northern Pacific Railway v. United States*, 1958, p. 8). By suggesting that sufficient economic power to impose a restraint on trade is all that is required to demonstrate a *per se* violation—and that a demonstration of monopoly power is not required—the Court effectively lightened the burden placed upon plaintiffs to prove that tying arrangements were *per se* illegal (Hylton, 2003, p. 291).

Up until the mid-1950s, the Federal Trade Commission followed the courts in their application of the Sherman and Clayton acts against tying arrangements, looking only at "the volume of the defendant's business and his position in the market" to ascertain the legal rectitude of any given bundle (Columbia Law Review Association, Inc., 1955). However, in *In re Maico*, the FTC lessened the severity of its scrutiny of tying arrangements, "vigorously reject[ing] the contention that they [tying arrangements] are illegal *per se*," instead requiring an explication of the relevant market landscape, the condition of competitors, the total volume of business increased, and evidence of market share decrease, thereby indicating that the Commission held that if no clear and discernible effects were imposed upon competition, then mere demonstration of "market power" was not sufficient to render an agreement a *per se* violation (CLR Assoc, 1955).

In *Times-Picayune Publishing Co. v. United States* (1953, p. 605), the Court reinforced the judgment in *Standard Oil*, remarking that tying arrangements "flout the Sherman Act's policy that competition rule the marts of trade." Further, the Court asserted that by implementing a tying arrangement, a "seller coerces the abdication of buyers' independent judgement as to the tied product's merits and insulates it from the competitive stresses of the open

market (*Times-Picayune Publishing Co.* v. *United States*, 1953, p. 345). In other words, tying contravenes the very operation of free trade, binding consumers to purchase goods they may or may not have otherwise purchased. In *United States v. Lowe's Inc.* (1962), the Court echoed the ruling of *Standard Oil* and *Times-Picayune*¸ reasserting that tying arrangements serve to stifle competition. Moreover, in *Lowe's*, the Court indicated that if a tying product is sufficiently "unique," then sufficient power exists on part of the seller to impose an unfair tying arrangement. In *Fortner Enterprises Inc. v. United States Steel Corp*. (1969), the Court asserted that tying arrangements serve "no legitimate business purpose that cannot be achieved in some less restrictive way," and that tying constituted a *per se* violation of the Sherman Act. Further, in *Fortner*, the Court explicitly indicated that the leverage achieved by a tying arrangement contributed to foreclosure of rivals within the tied product market, noting that tying arrangements "deny competitors free access to the market for the tied product not because the party imposing the tying requirements has a better product or a lower price, but because of his power or leverage" (*Fortner Enterprises, Inc. v. United States Steel Corp.,* 1969, p. 393). Foreclosure and leverage go hand-in-hand in tying arrangements, as extension of leverage into the market of the tied product may prevent rivals from entering that market. Thus, at the very heart of mid-century injunctions against tying was the leverage theory, which Hovenkamp and Morton (2020) suggest was at the time "influential and largely accounts for the development of the *per se* rule against tying," which persisted well into the latter half of the twentieth century.

In 1977, the Court heard further arguments surrounding the *Fortner* case, as it was remanded to a bench trial and the plaintiffs succeeded in litigating the case to the Supreme Court. In *Fortner II*, the Court displayed a decidedly different mood toward tying arrangements (Evans, 2006). Whereas in *Fortner I* the Court affirmed that tying arrangements were all but anticompetitive and *per se* illegal, in *Fortner II*, the Court asserted that tying arrangements, including the arrangement at hand, were not *per se* illegal because such characterization required sufficient demonstrate of market power, unless one could prove that a product was characterized by "uniqueness" (*United States Steel Corp* v. *Fortner Enterprises, Inc.*, 1977). *Fortner II*'s introduction of the "unique" criterion is significant, for as a given feature of an individual product, it renders it difficult for consumers to switch to a purported alternative. Furthermore, the Court suggested that "uniqueness" may extend to several qualities, including patents, physical advantage, or cost advantage of a product (1977).

Continued movement away from the *per se* rule is evinced in *Jefferson Parish Hospital District v. Hyde* (1984). In *Jefferson Parish*, an anesthesiologist challenged an all-or-nothing contract requiring all anesthesiologic services in a hospital to be performed by a single firm by whom he was not employed. Per the petitioner, the agreement both unfairly restricted anesthesiologists exterior to the contracted firm from performing services in the hospital and restricted patient choice of anesthesiologists. The Court broached the central question of *Jefferson Parish* via the *per se* analysis, however it found that the *per se* analysis was insufficient insofar as the hospital only possessed 30% share of the geographic market of anesthesia services, a number "insufficient as a basis to infer market power" (*Jefferson Parish*, 1984, p. 466). Recognizing that the petitioners' claims did not meet a certain quantitative substantiality threshold—a criterion previously established by judiciary in *Northern Pacific*—and therefore did not demonstrate that either patients or physicians were unfairly foreclosed from either utilizing or participating in anesthetic services as consumers or employees, respectively, the Court introduced several criteria to determine a *per se* violation. In articulating these criteria, the Court loosened its aggressive posturing toward tying arrangements that it had adopted in *Standard Oil* and *International Salt*. By introducing a plurality of necessary conditions for a *per se* violation, the Court in *Jefferson Parish* effectively rendered it more difficult for tying arrangements to be invalidated. Whereas in previous rulings the Court asserted that mere *ex ante* cognizance of market power was sufficient to consider a tying arrangement a *per*

se violation, the analysis imposed by the Court in *Jefferson Parish* inserts several criteria to constitute a *per se* violation, including distinction between the tying and tied products, sufficient market power, lack of choice, and substantial foreclosure. Per the Court, the anesthesia group did not meet these necessary criteria for a *per se* violation of the Sherman Act. Moreover, the Court decided that there was "no showing here the kind of restraint on competition that is prohibited by the Sherman Act," thus ruling for the petitioners (*Jefferson Parish*, 1984, p. 466).

As it stands, the "partial *per se*" analytic from *Jefferson Parish* remains the standard rule to the present (Hodgson, 2019). The influence of *Jefferson Parish* is discernible in several of its 'progeny' in the decades thereafter. Consider, *Ezpeleta* v. *Sisters of Mercy Health Corp* (1985), wherein a terminated anesthesiologist challenged a hospital's tying of surgical services to anesthetics dispensed by a singular group possessing practice privileges. In *Ezpeleta*, the Court found that since the hospital had only 30% market share, the tying arrangement was not illegal, and that the plaintiff wrongly focused on the effects of the arrangement on doctors and not patients (Classen, 1987). Rather than showing that a "patient was not able to go to a different hospital in order to obtain the services of an anesthesiologist" outside of the contracted group or that "competing anesthesiologists" were impacted, the plaintiff's complaint centered on the "individual effect" of a contract (*Ezpeleta*, 1985) Once more, in *McMorris v. Williamsport Hospital* (1984), a radiologist who was removed as the director the hospital's radiology department challenged the hospital's tying arrangement that required all nuclear medicine procedures to use the services of another radiologist, Dr. Gouldin, excluding Dr. McMorris from practicing radiology and nuclear medicine (*McMorris*, 1984). In its analysis of the arrangement, the Court applied the *Jefferson Parish* "partial *per se*" rule, finding that the hospital possessed 55-60% market share in nuclear medicine and that only certain procedures within a geographic area could be performed at the hospital. Therefore, the Court insisted that there was a "genuine issue of fact concerning the hospital's market power," and the tying arrangement that helped support this power (*McMorris*, 1984). As these cases show, *Jefferson Parish* marks the incipience of an antitrust regime that made it more difficult to successfully challenge certain physician-hospital contracts, as the "partial *per se*" analytic framework imposed greater burdens upon plaintiffs to evince certain criteria indicative of anticompetitive behavior and harm.

Since *Jefferson Parish,* a flurry of cases has been brought against tying arrangements within the domain of healthcare, including *UFCE & Employers Benefit Trust v. Sutter Health*, *People of the State of California ex rel Xavier Becerra v. Sutter Health*, and *Shaw et al. v. Advocate Aurora Health Inc. et al.* Of note are both *Sutter* cases, which contended that that the Sutter Health provider system was dominant in Northern California and utilized its market power to engage in all-or-nothing tying arrangements, alongside other practices such as gag clauses and anti-tiering and anti-steering (Bird & Varanini, 2022). According to the plaintiffs, Sutter Health utilized its "must-have" status to force health plans to include all their providers at rates determined by Sutter, a classic instance of tying to exert leverage and foreclosure (Gudiksen et al., 2020). However, litigation surrounding tying was not identical in both cases. In *UEBT*, the plaintiffs alleged that Sutter utilized systemwide contracting to enforce all-or-nothing tying, while in *Becerra* the plaintiffs demonstrated how Sutter utilized all-or-nothing arrangements to exert leverage over markets where Sutter's market power was lacking (Bird & Varanini, 2022). Despite contentious litigation and the kaleidoscope of claims brought against Sutter Health, both cases were closed by way of settlement. Notably, the settlement imposed restrictions on Sutter's future use of tying arrangements, enjoining the provider system from utilizing "must have" providers to compel insurers to cover other Sutter providers, suggesting continued awareness the anticompetitive harm of tying.

Since neither Sutter case resulted in a judgment by a court, no precedent derives from either case despite the prohibition of using "must have" providers as leverage. However, ongoing litigation elsewhere

concerning tying arrangements may yield more substantive and lasting results. Of note, two cases filed in 2024, *Uriel Pharmacy Health and Welfare Plan* v. *Advocate Aurora Health Inc.* (2024) and *Shaw et al.* v. *Advocate Aurora Health Inc. et al.* (2024) challenge the use of all-or-nothing tying arrangements by hospitals. In *Uriel*, plaintiffs contend that Advocate Aurora unconditionally requires that if a network vendor seeks to include any of Advocate Aurora's providers in its plan, it must include all Advocate Aurora providers in every plan it offers. Notably, Advocate Aurora is not merely coercing plans into all-or-nothing tying agreements, but they are also conditioning any contracts with Advocate Aurora providers on the inclusion of these providers in all plans offered by the insurer (Complaint, *Uriel Pharmacy Health and Welfare Plan* v. *Advocate Aurora Health Inc.,* 2022). In *Shaw*, plaintiffs contend that Advocate Aurora engages in anticompetitive behavior that drives up the costs of care for patients, including all-or-nothing tying that coerces commercial health plans to include "overpriced facilities" (Honart, 2024).

As it stands, both *Uriel* and *Shaw et al.* are pending in Wisconsin district courts. Both cases are invitations to judicial antitrust enforcement to reemphasize its commitment to restricting tying arrangements that are anticompetitive and harm the consumer. Moreover, they may offer an opportunity to further refine the analytical criteria laid forth in *Jefferson Parish*. Nevertheless, legal history reveals that real harm can arise from tying, especially in healthcare contexts and that while legal analysis of tying arrangements has gradually departed a "pure" *per se* character, there remains the question if specific permutations of tying arrangements are *per se* illegal while other arrangements are only analyzed via a "rule of reason" if they do not sufficiently meet the criteria for those arrangements that may be *per se* violations of antitrust law. Policymakers and legislators, therefore, should not be concerned that the introduction of "rule of reason" style analysis suggests that tying arrangements cannot be broadly regulated by law.

Antitrust Enforcement against Exclusive Dealing Arrangements

Enforcement against exclusive dealing arrangements is not so different from enforcement against tying arrangements, as the two arrangements possess similar mechanisms and produce similar effects. Moreover, since the language of the Clayton Act, Section 3 "applies equally to tying and exclusive dealing arrangements," articulating no distinction between the two arrangements, enforcement decisions involving either tying or exclusive dealing arrangements have been treated as applicable to both types of private-law arrangements (Hylton, 2003). Precisely, Congress identified exclusive dealing as a "specific contractual provision requiring scrutiny to check whether its effect was to significantly lessen competition" in a manner like treatment of tying arrangements (Marvel, 2019). Even though the same section of the Clayton Act concerns exclusive dealing and tying arrangements, courts have treated them distinctly since the 1947 *International Salt* case already referenced herein. Prior to *International Salt*, both tying and exclusive dealing arrangements were afforded identical treatment via analysis that assumed both types of arrangements were likely anticompetitive, *per se* violations of the Sherman and Clayton Acts. Prior to *International Salt*, in *Standard Fashion Co. v. Magrane-Houston Co.* (1922), the Court ruled that since the Clayton Act was conceived to "prevent agreements," that would, "lessen competition and [tend] to create monopoly," and since the exclusive dealing arrangement in question "substantially lessened competition and tended to create monopoly" by allowing Standard Fashion to dominate the pattern business, the Court asserted that there is "no doubt" that the arrangement violated the Clayton Act (*Standard Fashion Co,* 1922, p. 258). Strikingly, the Court's analysis in *Standard Fashion* was devoid of any casuistic, rule of reason analysis. In fact, the Court in *Standard Fashion* demonstrated a willingness to prohibit exclusive dealing or tying arrangements merely on the basis of an *ex ante* recognition that an arrangement that not merely was probable to be anticompetitive, but could be anticompetitive (*Standard Fashion Co.,* 1922). In the same year in *United Shoe Machinery Corp. v. United*

States (1922), the Court emphasized that not only actual contractual language that creates an exclusive dealing arrangement may be prohibited, but any substantive provision of a contract that materially create an arrangement that would prevent a party to the contract to using, leasing, or purchasing any good from a competitor may also be prohibited.

In *Standard Oil Co.* v. *United States* (1949), the Court revisited the question of whether exclusive dealing arrangements constituted a *per se* violation and if these arrangements ought to be treated in the same manner as tying arrangements. In *Standard Oil*, the Court explicitly distinguished between the tying arrangements and the exclusive dealing arrangements characterizing the several thousand contracts facilitated by Standard. In some contracts, Standard conditioned the purchase of petroleum on the purchase of all relevant infrastructure and instruments for the maintenance of a gas station from Standard *and* required dealers to not purchase any and all of those elements of infrastructure or instruments from any other competitor (*Standard Oil Co.,* 1949). Other contracts required dealers who sought to purchase any good besides petroleum from to either purchase all other non-petroleum goods from Standard *or* in the event of purchase of any future good, purchase the good only from Standard Oil (*Standard Oil Co.,* 1949). Among the central concerns of the Court in *Standard Oil,* one concerned ascertaining whether any inquiry beyond proving that a substantial portion of commerce is affected or may be affected was necessary for finding an arrangement in contrivance of antitrust laws. While the Court reinforced its strict opposition to tying arrangements, it noted that "economic differences may be noted" between tying and exclusive dealing arrangements, and the court posited that exclusive dealing or "requirement" contracts "may well be of economic advantage" to both buyers and sellers, and thus ought to be subject to greater scrutiny before invalidating an exclusive dealing arrangement (*Standard Oil Co.,* 1949). Let the reader consider the fact that the swelling of criteria to define a *per se* violation may raise questions if an act is truly *per se* unlawful or if only some specific permutation of an act is *per se* lawful while others are not.

In *Tampa Electric Co. v. Nashville Coal Co*. (1961), the Court further modified the analytic framework for exclusive dealing arrangements. In this case, Tampa Electric Co., a public utilities corporation in Florida, entered an exclusive dealing contract with Nashville Coal Co. that required Tampa Electric to purchase all the coal needed for its coal power plant from Nashville Coal. Nashville Coal eventually disengaged from the contract, claiming it was illegal, and Tampa Electric sued to have the contract enforced. Whereas *Standard Oil* conditioned the description of an exclusive dealing arrangement as anti-competitive on a percentage-based "quantitative substantiality" test, *Tampa Electric* imposed a "qualitative substantiality" test. Per the Court, "a mere showing that the contract itself involves a substantial *number* of dollars is ordinarily of little consequence" and what is more significant is "weigh[ing] the probable effect of the contract on the relevant area of effective competition" (*Tampa Electric Co.,* 1961, p. 329). The probability of effects is weighed according to "duration, purpose and effect of the agreement" and not according to any quantitative, economic metric (Rosch, 2006, p. 52). Ultimately, using these criteria, the Court in *Tampa Electric* ruled that the contract did not violate antitrust laws and that since the contract involved a public utility, and thus a public good, Nashville Coal must abide by the contract's terms (George, 1961). The significance of *Tampa Electric* lies in its modification of the "rule of reason" test, representing a rejection of the "mechanical rule" that depended wholly on pure economic considerations (Weston, 1961). In freeing judges from having to perform the minutiae of economic calculus to demonstrate "actual adverse effect on competition," *Tampa Electric* prescribes that they only conjure a "reasonable forecast for an automatic response," that is, they are tasked with determining if an arrangement may become anti-competitive and when or if it may satisfy the conditions for a violation of the Sherman or Clayton acts (Weston, 1961). In the period following *Tampa Electric*, antitrust enforcement in lower courts followed

the qualitative substantiality "rule of reason" methodology quite faithfully. Consider further some of the following cases identified by the ABA as having been decided in the spirit of *Tampa Electric* (ABA, 1992).

In *Jefferson Parish*, already mentioned herein, the Court explicitly asserted that "exclusive dealing is an unreasonable restraint on trade only when a significant fraction of buyers or sellers are frozen out of a market by the exclusive deal" (*Jefferson Parish,* 1984, p. 45). While not providing a universally applicable threshold quantification to distinguish between exclusive dealing that is "unreasonable" or "not unreasonable," the Court asserted that the 30% of the market dominated by the hospital in question was not a sufficient percentage to be considered a "significant fraction" (*Jefferson Parish,* 1984, p. 45).

As a brief aside, consider the manner the Court in *Jefferson Parish* treated tying arrangements. Because the question in *Jefferson Parish* centered on a contractual agreement containing provisions that 1) required only anesthesiologists from a specific physician group perform anesthesiologic services and 2) bound the performance of anesthesiologic services to the anesthesiologists from a specific physician group, the boundaries between tying and exclusive dealing are muddied. The arrangement is thus best described as "exclusive tying," an all but common contractual chimera. However, this chimera would be treated as a tying arrangement. Recall the two-product test in *Jefferson Parish*, which the Court considered necessary for determining whether a tying arrangement exists, noting that "a tying arrangement cannot exist unless two separate product markets have been linked" (*Jefferson Parish,* 1984, p. 21). Consider further the application of the logic of the Court. Per Steuer (1985), "if a shoe store is required to purchase all its lace shoes and loafers from a single manufacturer, this would constitute exclusive dealing if all 'shoes' are the same product but tying if lace shoes and loafers are considered separate products." Therefore, "the test for determining whether there is more than one "product" being sold will often become the test for distinguishing exclusive dealing from tying" (Steuer, 1985). Policymakers, therefore, must ensure that both tying and exclusive dealing are regulated.

Beyond *Jefferson Parish*, other cases utilized and developed the *Tampa Electric* test. For example, in *Collins v. Associated Pathologists, Ltd.* (1987), the District Court adjudicated over whether an exclusive dealing and tying hybrid arrangement between a hospital and a pathology group substantially foreclosed competition in pathological services. In assessing the arrangement, the Court refused to engage with any "peripheral" effects of the arrangement, including its impact on patients' capacity to select a physician, thereby denying the contention of the plaintiff that the arrangement unfairly restrained trade between patients and pathologists, and instead focused on the immediate effects of the agreement on foreclosed pathologists. Citing *Dos Santos v. Columbus* (1982), the Court contended that like anesthesiologists, the "patient generally takes no part in the selection of a particular anesthesiologist," who is instead selected by the surgeon, pathologists are also not usually the object of a patient's choice. Echoing the ruling of *Tampa Electric*, the Court in *Collins* asserted that the evidence brought by the plaintiff not only failed to demonstrate the quantitative substantiality of the effects of the arrangement but also failed to demonstrate the relevant marketplace. Ultimately, the Court considered the contract to be valid and enforceable. Curiously, in *Collins*, the Court eviscerated any claims by the petitioner that the market was foreclosed, asserting that since the petitioner successfully sought work in another state, the market at hand must have been nationwide, and therefore impossible for a single pathology group to foreclose competitors in any appreciable manner.

During the post-*Tampa Electric* period, extending from the 1980s to 1990s, courts were particularly amenable to maintaining exclusive dealing contracts in healthcare. However, in *Oltz v. St. Peter's Community Hospital* (1988), wherein the petitioner claimed that an exclusive dealing arrangement between the respondents and anesthesia providers injured competition and was unlawful, the Ninth Circuit affirmed lower court's findings in

favor of the petitioner's claims about the agreement. While the court in *Oltz* adhered to the *Tampa Electric* framework in analyzing the hospital-anesthesiologist private law arrangement, it did not adhere to the strange logic of the court in *Collins* wherein the relevant market considered was either national or local, but not both; notably, the respondents proffered this exclusive either-or market characterization, which the circuit court considered "entirely unnecessary" (1988, p. 30). Moreover, *Oltz* entertained the question of the anticompetitive effects in the market between physicians and patients. Per the Court, the contract in question "potentially affected two different segments of the economy… the market in which anesthesia service providers compete for staff privileges… [and] the other was the patient market for anesthesia services" (*Oltz,* 1988, p. 33), and to render a contract unlawful and void, only demonstration of injury for *one* locus of competition is necessary. Further distinguishing between the immediate question in *Oltz* and prior adjudication in *Collins*, the circuit court highlights that the only reason that rule of reason analysis was confined to merely pathologists and not pathology *services* is because in *Collins*, the plaintiff failed to demonstrate any cause to suspect the exclusive dealing arrangement injured the pathology service market and that there was no evidence that demonstrated a "demand for such [pathology] services that was separate from the demand for hospital services in general" (*Oltz,* 1988, p. 34). *Oltz*, however, the circuit court affirmed that the mere existence of a preference among physicians for "individual anesthesia service providers" was sufficient to consider anesthesiologic services as a relevant product market (*Oltz,* 1988, p. 35). In analyzing both markets, the circuit court reaffirmed the *Tampa Electric* principle that precise, quantitative demonstrations of foreclosure are not necessary to invalidate an exclusive dealing arrangement and instead reaffirms the qualitative analysis of the lower court, which found that St. Peter's exclusive contract had "actual detrimental effects on competition," since "some patients and surgeons…preferred the services of Oltz and were hindered from obtaining them," and since "the price of anesthesia services and the incomes

This observation by the circuit court broaches a maxim ubiquitous in healthcare: "hospitals don't compete for patients, they compete for doctors," implying, therefore, that patients pick doctors rather than hospitals. Policymakers, therefore, ought to be guided by this maxim.

of [contracted] anesthesiologists rose dramatically because of the challenged restraint" (*Oltz,* 1988, p. 38). This observation by the circuit court broaches a maxim ubiquitous in healthcare: "hospitals don't compete for patients, they compete for doctors," implying, therefore, that patients pick doctors rather than hospitals (Lynk, 2018, pp. 344-345). Policymakers, therefore, ought to be guided by this maxim.

To justify their affirmation of the lower court's decision concerning the exclusive dealing arrangement between the hospital and the anesthesiologists, the circuit court in *Oltz* delivered a critical assertion about the possibility for conspiracy between hospitals and physician groups. The respondents contended that conspiracy between the hospital and anesthesiologists was *ipso facto* and *de iure* impossible, as the Supreme Court previously determined that "officers of a single firm are not separate economic actors pursuing separate economic interests," but rather representatives of a single, legal person, a *persona ficta* to whom their wills are conformed (*Copperweld Corp.* v. *Independence Tube Corp,* 1984, p. 769). However, in *Oltz*, the anesthesiologists are not empowered to act for the corporate person of St. Peter's Hospital. In fact, as the circuit court rightly points out, the anesthesiologists are "independent contractors pursuing their personal economic interests" that are not necessarily coextensive with the interests of St. Peter's (*Oltz,* 1988, p. 46). In other words, since St. Peter's and the anesthesiologists are wholly distinct legal entities, they can enter a conspiracy to restrain or inhibit competition. Per the circuit court, hospital administrative records indicate

that administrators and the anesthesiology group conspired together.

While the "rule of reason" methodology utilized in *Oltz* represents no discernible evolution from *Tampa Electric*, *Oltz* is a significant watershed moment in enforcement of exclusive dealing contracts in healthcare contexts. Prior to *Oltz*, courts rarely found that exclusive dealing contracts for healthcare services violated either the Sherman or Clayton Acts. However, with *Oltz*, the circuit court demonstrated that not only is it possible for hospital and physician groups to conspire to restrain trade, but also that when they do successfully conspire to restrain trade, they may adversely affect competition relating to physicians and physician services, considered distinctly.

Perhaps the most important exclusive dealing case after *Jefferson Parish* and *Tampa Electric* is *United States v. Dentsply Int'l Inc*. In *Dentsply*, the Third Circuit adjudicated over an exclusive dealing arrangement between Dentsply and dealers of Dentsply products that required dealers who sought to stock Dentsply's new "premium teeth" dentures to not stock any rival "premium teeth" products, however, they could distribute non-premium products from other distributors (Marvel, 2019). According to the fact finding of the court in *Dentsply,* despite dealer dissatisfaction with Dentsply exclusive dealing arrangements, dealers nevertheless adhered to the terms of these contracts from 1993 to 2005 (*United States* v. *Dentsply Int'l Inc.,* 2005). Notably, as Kulick (2013) notes, the fact that the dealers relented to Dentsply's exclusive dealing contracts despite the absence of any benefits strikes at a fundamental assumption of the Chicago School, namely that firms do not engage in exclusive dealing that do not make economic sense or incite intense dissatisfaction, especially considering that all parties to the contracts were empowered to cease the agreement at any time.

Per Dentsply, the animating impetus of the exclusive dealing was to buttress its own operations against those of its rivals, whom Dentsply believed had superior and more efficient distribution processes (Marvel, 2019). While the district court found that Dentsply's contracts did not preclude rivals, particularly Vident and Ivoclar, and that Dentsply's market power was insufficient to exert anticompetitive influence, the Third Circuit asserted otherwise. Without undergoing a rigorous economic analysis of Dentsply's market share, the Third Circuit found that the "long duration of [Dentsply's] exclusionary tactics and anecdotal evidence of their efficacy [made] it clear that power exited and was used effectively" (*Dentsply Int'l Inc,* 3d Cir., 2005). Further, Dentsply actively and successfully conspired to foreclose a significant number of rivals from the market. Per the court, since the benefits of purchasing artificial teeth via a dealer outweigh benefits of purchasing from a manufacturer directly, laboratories were all but coerced by the "long-entrenched Dentsply dealer network" to purchase from Dentsply's dealers (*Dentsply Int'l Inc,* 3d Cir., 2005). Ultimately, the Third Circuit asserts that Dentsply's practices, no matter what justification may be offered, were intentionally exclusionary and the effects of this exclusion were amplified by the structure of the artificial teeth market. *Per se* violations, by the mere fact of their commission, are unlawful, and to probe for intent and condition the lawfulness of an action generally considered a *per se* violation on intent would "reopen the very questions of reasonableness which the *per se* rule is designed to avoid" (Stucke, 2012, p. 811). However, when considering practices such as exclusionary dealing that are not *per se* lawful or unlawful, analysis of intent is relevant. The consideration of intent in *Dentsply* therefore represents a departure from the *per se* violation characterization *in toto* . Further, entertainment of intent suggests that while courts may be sufficiently satisfied with a given justification for an exclusive dealing arrangement, they may also find a given justification grounded on intent to be pretextual and unsatisfactory. Intent, therefore, is hardly a sufficient justification for an exclusive dealing arrangement, instead rendering the defendant vulnerable to greater judicial scrutiny.

As it stands, *Dentsply* remains a watershed case in exclusive dealing jurisprudence, rendering it even more complex to determine how an exclusive dealing arrangement may be lawful or unlawful.

Antitrust Enforcement against Non-Compete Agreements

As a matter of law considered within the cognizance of judicial and regulatory organs, the enforceability of non-compete agreements has been evaluated under the "rule of reason" framework. While ostensibly a restraint of trade, the utilization of non-compete agreements has not been considered a *per se* violation, in part because neither the Sherman nor Clayton acts identify as such and jurists have not (at least until lately) attempted to render it so and in part because non-compete agreements feature as a time-honored private law agreement dating from medieval arrangements established by guilds (Fisk, 2001). The lack of serious antitrust engagement with non-compete agreements is curious, for as Blake (1960, p. 628) suggests, "unreasonable postemployment restraints would seem to clearly violate the Sherman Act, with the usual consequences, including possible actions by the attorney general and treble-damage liability to the injured party;" however, this sort of enforcement likely never realized because most suits concerning non-compete agreements regard injunctive relief.

Among the earliest common law cases involving non-competes are *Dyer's Case* (1414) and *Mitchel v. Reynolds* (1711). In *Dyer*, the court held that non-competes are enforceable insofar as they do not restrict trade, generally, but only trade when considered in the context of specific places and persons (Beck, 2021). Some 300 years later, *Mitchel,* however, represented a watershed moment in non-compete litigation, as it introduced the 'rule of reason' criteria into the legal calculus utilized in the Anglo-American common law tradition. In *Mitchel*, the court "presumes restrictive covenants invalid, but the party seeking enforcement may prove that, in the particular circumstances, it is a 'just and honest contract'" (Fisk, 2001, p. 457). Notwithstanding the exceptional circumstances permitted by *Mitchel*, the case is salient for admitting that ordinarily, non-competes, as restraints of trade, are unjust and invalid.

Within explicitly American contexts, judicial decisions concerning non-compete agreements follow the rule of reasonableness framework that had been established in the Anglo-American common law tradition since *Mitchel*. Blake (1960) provides a history of non-compete cases relevant to Anglo-American jurisprudence from the sixteenth century to the middle of the twentieth century. For example, in the 1874 case *Oregon Steam Navigation Co. v. Winsor* (1873) heartily endorsed the "rule of reason" framework when analyzing restrictive covenants concerning employment. Per the Court, "questions about contracts in restraint of trade must be judged according to the circumstances on which they rise and in subservience to the general rule that there must be no injury to the public by its being deprived of the restricted party's industry, " and further that "the party himself must not be precluded from pursuing his occupation" (*Oregon Steam Navigation Co.*, 1873, p. 64). In *Oregon Steam*, the court ultimately upheld the arrangement, contending that the agreement was necessary to protect the use of an individual steam ship in the transfer of its employment from one firm to another (*Oregon Steam Navigation Co.,* 1873). Blake (1960) notes that following this decision, other states, including New York, Rhode Island, and Massachusetts, adopted the "rule of reason" standard for analyzing the validity of non-compete agreements. As Lee (2019, p. 11) suggests, the rapid adoption of the "rule of reason" standard during the late nineteenth century was not merely the consequence of jurists revisiting older Anglo-American jurisprudence, but also a consequence of the "advancing ideologies of economic liberalism" that would inevitably come into conflict with public policy considerations.

At the turn of the twentieth century, judicial treatment of restrictive covenants to not compete post-employment continued to receive treatment under the "rule of reason" framework. So pervasive was this framework that in the twentieth century, only two states, California and North Dakota, had any categorical statutory restrictions on non-compete agreements, which remain in place as of writing (Lee, 2019). In fact, California's ban on non-compete agreements predates the twentieth century. While in 1868 California state courts held that the "reasonableness" standard applied, in 1872, the state legislature promulgated

The judicial landscape of non-compete agreements in the twenty-first century, therefore, is marked by a greater quantity of challenges against the agreements, with increased scrutiny by courts.

statute that banned the use of non-compete agreements unless certain criteria and circumstances were met for their use (*Edwards v. Arthur Andersen LLP*, 2008). In North Dakota, non-compete agreements have been proscribed since the 1865 promulgation of the Dakota Territory Civil Code, which prohibits "a contract by which anyone is retrained from exercising a lawful profession, trade, or business" (N.D. Cent. Code. 09-08-06). Since 1865, courts in North Dakota have considered this prohibition of restraint of trade applicable to non-compete agreements (Griffin, 2020). Elsewhere in the twentieth century, however, the "reasonableness" test governed the use of non-competes, having been forged in the crucible of litigation. Three criteria arose in the twentieth century that defined the "reasonableness" test for non-compete agreements, namely that there are identifiable and protectable business interests, that restraint is no more than necessary, and that it does not violate public policy (Lee, 2019).

In the twenty-first century, non-competes have faced significantly greater scrutiny than in the past, in no little part due to the ascendancy of the Neo-Brandeisian school of thought among jurists and the population of antitrust agencies with professed Neo-Brandeisians such as Lina Khan. Interestingly, the surge of case law surrounding non-competes in the twenty-first century corresponds to the increased use of non-compete agreements throughout the 1990s and 2000s, especially for executive positions. In 2013, for example, there was a 60% rise of cases concerning non-compete agreements compared to the number of cases during the 2000s (Simon & Loten, 2013). The proceedings of some of these cases are illustrative of the cotemporaneous Neo-Brandeisian "Copernican moment" in antitrust enforcement. Grisham (2017) has surveyed the state of non-compete legislation in the twenty-first century. In *Golden Road Motor Inn, Inc. v. Islam*, the Nevada Supreme Court wrestled with the question of whether courts could modify "overbroad" non-compete agreements to maintain the structural skeleton of the agreements while casuistically tempering any excessive or unreasonable elements of the agreements. According to the Court, the non-compete agreement between Golden Road (operator of Atlantis Casino Resort) and Sumona Islam (a former Atlantis casino employee) was grossly unreasonable, prohibiting Islam from working in any gaming establishment within a 150 miles radius for one year after her employment (Grisham, 2017; *Golden Road Motor Inn, Inc. v. Islam*, 2016). Further, the Nevada Supreme Court upheld longstanding Nevada state law that courts may not "blue-pencil" or modify otherwise unreasonable non-compete agreements to make them permissible, as it fundamentally generates a new private-law contract, an authority not afforded to the courts (Caliguire, 2016). Similarly, in North Carolina, the state Supreme Court held that courts did not possess the authority to execute judicial emendation of non-compete contracts, as it would assign to the court the role of scrivener, which would lead to "nothing but mischief" (Grisham, 2017; *Beverage Systems of the Carolinas v. Associated Beverage Repair*, 2016). However, as Grisham (2017) notes, courts in other states such as New Mexico permit judicial emendation, provided both parties of a contract agree that emendation is acceptable. As for the matter of trade secret, intellectual property, and corporate interests, Grisham (2017) indicates that courts have closely scrutinized the nature of employee training, confidential knowledge, and client relationships during employment tenure to determine whether they sufficiently justify the use of a non-compete agreement and if general knowledge and skill appertain exclusively to the employee or any training intervention by his employer. The judicial landscape of non-compete agreements in the twenty-first century, therefore, is marked by a greater quantity of challenges against the agreements, with increased scrutiny by courts regarding duration and circumstantial fittingness.

As for administrative enforcement of antitrust and anticompetition laws, the Federal Trade Commission has centered the sights of its administrative prowess squarely on non-compete agreements, seeking to eventually categorically restrict the use of non-compete agreements, save for few exceptions. On May 7, 2024, the Federal Trade Commission announced its "Non-Compete Rule", which would have proscribed non-compete agreements save for those applying to senior executives who meet certain necessary criteria (FTC, 2024). Per the FTC, the rule, justified by sections 5 and 6 of the Federal Trade Commission Act, would have classified non-compete agreements as an "unfair method of competition" (FTC, 2024). According to the terms of the rule, no person, natural or legal, could attempt to enter, attempt to enter, enforce, or attempt to enforce a non-compete agreement (FTC 2024). A decidedly herculean task, the FTC sought to proscribe non-competes in an effort to overcome the inconsistencies and insufficiencies of state-level regulation of non-compete agreements and ultimately provide regulatory uniformity (O'Shea & Balat, 2022). The ultimate *raison d'etre* of the Commission's rule, however, beyond uniformity, was to combat anticompetitive practices in the labor market. As O'Shea and Balat (2022) note, both the Trump and Biden administrations indicated via the executive orders 13813 and 14036, respectively, indicated that non-compete agreements may aggravate unfair conditions in labor, especially in the healthcare industry.

Notwithstanding the intentions of the Federal Trade Commission to combat the anticompetitive effects of non-compete agreements, the Non-Compete Rule faced several challenges in the judiciary that questioned the Commission's authority to promulgate a rule concerning non-competes. Three cases from 2024 evince this conflict. In *Properties of the Villages Inc. v. Federal Trade Commission*, the Middle District of Florida ruled on the basis of the major questions doctrine, contending that while the FTC has substantive rulemaking authority, there is no clear evidence that Congress delegated substantive rulemaking authority to the FTC to promulgate a rule on non-compete agreements (*Properties of the Villages, Inc.* v. *Federal Trade Commission*, 2024). Per the major questions doctrine, at least as it is presently interpreted, a court "will not sustain a major regulatory action unless the statute contains a clear statement that the action is authorized" (Sohoni, 2022). However, in *ATS Tree Services Inc. v. Federal Trade Commission*, the court for the Eastern District of Pennsylvania refused to enjoin the Commission's Non-Compete Rule. In its decision on ATS's motion to stay and enjoin the Non-Compete Rule, among several points, the court contended that ATS incorrectly assumed the necessity of non-compete agreements to protect proprietary information, highlighting that intellectual property law provides for other modes of protection that would ameliorate ATS's anxiety (*ATS Tree Services LLC* v. *Federal Trade Commission*, 2024, pp. 21-22). Further, the court indicated that section 6 of the FTC Act, which engenders the Commission with the authority to make rules to carry out its directive of preventing unfair methods of competition and that non-competes could be considered unfair methods of competition (*ATS Tree Services*, 2024, p. 25). The upshot of this claim is that the major questions doctrine does not preclude the Commission's rule-making authority as it relates to non-compete agreements.

The most decisive 2024 non-compete case was *Ryan LLC v. Federal Trade Commission*, wherein Ryan LLC, a tax firm utilizing non-competes, sued the Commission contending that the rule was capricious and unlawfully sought to proscribe a private-law agreement that Ryan LLC believed was eminently useful for protecting corporate interests. Heard in the Northern District of Texas, the court initially issued a preliminary injunction for the plaintiffs on July 3, 2024, claiming that the plaintiffs were likely to eventually succeed in demonstrating that the Commission lacked the necessary rule-making authority according to the major questions doctrine and that the plaintiffs would likely succeed in demonstrating the rule is unlawful under the Administrative Procedure Act (Dvoretzky et al., 2024). Ultimately, on August 20, 2024, the same court granted the plaintiff's appeal for summary judgement and issued a universal injunction of the

Future swelling of support for restriction of non-compete agreements may not occur in spite of the universal injunction against the Commission's Non-Compete Rule, but rather because of the injunction.

Commission's Non-Compete Rule. Agreeing with the contentions of the plaintiffs, the court ultimately held that the rule was arbitrary and capricious as the FTC Act, when plainly read, "does not grant the Commission authority to promulgate substantive rules regarding unfair methods of competition," but rather only unfair or deceptive practices (*Ryan LLC v. Federal Trade Commission*, 2024, p. 16). However, the court admits that the FTC Act affords some authority to the FTC to make rules concerning unfair practices, though those rules cannot be substantive rules, but only rules relating to "housekeeping" (*Ryan LLC*, 2024). Ultimately, as it stands as of writing, the district court's decision in Ryan rendered the Non-Compete Rule unenforceable. However, the Commission has appealed both the decisions rendered in *Ryan* and *Villages*. As of writing, both appeals remain pending (Fisher Phillips, 2024).

Ultimately, assessment of the landscape of antitrust and anticompetition law enforcement against non-compete agreements evinces a blossoming cognizance of the injurious and harmful effects of non-competes for both employers and consumers. Notwithstanding the injunction of the FTC's non-compete rule, both public opinion and the professional inclinations of regulators, judges, and legislators is marked by heightened suspicion and scrutiny of non-compete agreements. As a 2024 Ipsos poll demonstrates, 59% of surveyed Americans support restrictions on non-compete agreements (Jackson et al., 2024). Further, despite some legislative failures, several bills restraining non-compete agreements have been introduced into state legislatures (EIG, 2024). Under the aegis of Lina Khan, one of the foremost representatives of the Neo-Brandeisian school of antitrust, federal regulators have unquestionably assumed a bellicose stance toward non-compete agreements. Parallel to these developments, as previously indicated by Grisham (2017), recent history is marked by a noticeable uptick in legal contests surrounding the enforceability and rectitude of non-compete agreements. If anything, the movement of public and professional opinion toward increased restriction of non-compete agreements portends future legislative and regulatory effort to that end. Moreover, future swelling of support for restriction of non-compete agreements may not occur in spite of the universal injunction against the Commission's Non-Compete Rule, but rather because of the injunction, which reignited public consideration and debate on the careful balance between the free market and liberty of contract, labor mobility, human capital investment, and the destination of healthcare goods and services.

ANTICOMPETITIVE CONTRACTING IN TEXAS: A LEGAL AND LEGISLATIVE HISTORY

Having considered the possible anticompetitive effects of tying arrangements, exclusive dealing arrangements, and non-compete agreements and how these anticompetitive effects may bring injury and harm to physicians and patients, it is imperative that Texas ensure that it has sufficient regulatory and legislative mechanisms to restrict anticompetitive behavior in healthcare. After all, judicial proceedings are especially costly and time-consuming, resulting in both physicians and patients yearning for comprehensive and effective statutory intervention instead of an ersatz enforcement regime characterized by a patchwork of judicial decisions and inchoate legislation. However, before considering any policy solutions or statutory intervention, consider first the landscape of Texas legislative and regulatory rules concerning the identified anticompetitive contracting practices.

In **Table 4**, legislation and regulation directly or indirectly concerning the three identified anticompetitive practices are identified. A brief inquiry into case law relating to non-competes in Texas will follow thereafter.

Table 4

Texas Legislation Relating to Non-Compete Agreements, Tying Arrangements, and Exclusive Dealing Arrangements			
Bill Name	**Bill Number**	**Status**	**Remarks**
AN ACT Relating to certain contract provisions and conduct affecting healthcare provider networks.	H.B. 711	Passed. Effective 2023 June 12	(Modifying Section 1458.001, Texas Insurance Code) H.B. 711 prohibits any general contracting entity in healthcare from utilizing most-favored nation clauses, anti-steering/anti-tiering clauses, and gag clauses in any direct contract entered into with a provider for the delivery of health care services. Early drafts of H.B. 711 contained provisions that would have also restricted tying arrangements (all-or-nothing agreements).
AN ACT Relating to covenants not to compete by physicians	H.B. 3623	Passed. Effective 2009 September 09	(Modifying Chapter 15.50(b), Texas Business & Commerce Code) H.B. 3623 amended sections of the Business & Commerce Code to include the following prescriptions and proscriptions relating to the enforcement of physician non-compete agreements: 1) Non-competes must not deny physician a list of patients he has seen within one year from termination, 2) Must allow physician continued access to patient records, 3) Must offer a "reasonable" buyout, 4) Must not prohibit a physician from providing care to a patient with an acute condition. Also provides for a "saving clause" that allows for judicial emendation of non-compete agreements.
AN ACT Relating to the criteria for enforceability of covenants not to compete and to certain procedures and remedies in actions to enforce those covenants.	H.B. 7	Passed. Effective 1993 September 01	(Modifying Chapter 15.50, Texas Business & Commerce Code) H.B. 7 moved to modify the 1989 Covenants Not to Compete Act in light of Texas Supreme Court rulings that aggressively restrained the use of non-compete covenants in employment-at-will relationships and ignored the retroactivity clause in the 1989 Act. Included provisions that rendered non-competes, as ancillary agreements, enforceable in employment-at-will relationships, purged need for independent consideration, and explicitly preempts over the common law.
AN ACT Relating to the criteria for enforceability of covenants not to compete and to certain procedures and remedies in actions to enforce those covenants ("Covenants Not to Compete Act")	S.B. 946	Passed. Effective 1989 August 28	(Modifying Chapter 15, Texas Business & Commerce Code) S.B 946 attempts to resolve some disputed questions surrounding the rectitude and lawfulness of non-compete agreements following S.B 397. Under the modifications of the Business Code imparted by S.B. 397, non-compete agreements seemed *prima facie* unlawful. S.B 397 establishes an exception in the code for non-compete agreements, rendering them permissible only if they both are "ancillary or part of" an otherwise enforceable agreement and contain reasonable geographic and temporal limitations. Construction of the statute indicates that non-competes are exceptional and not ordinary or primary in employment-related private law agreements.
AN ACT Relating to the regulation of monopolies, contracts, combinations, and conspiracies in the restraint of trade or commerce; containing enforcement provisions. ("Texas Free Enterprise and Antitrust Act")	S.B. 397	Passed. Effective 1983 August 29	(Modifying Chapter 15.01-.05,.12-.13,.16,.20-.22, repealing 15.06,.14,.15, .17-.19,.28-.34, Texas Business & Commerce Code) Among other actions, generally proscribed restraints of trade in the state of Texas for the purpose of maintaining trade and competition. While no explicit mention was made of non-compete agreements, the language utilized suggests a categorical ban of all restraints on trade, which would ordinarily include non-compete agreements. No mention is made of tying arrangements or exclusive dealing arrangements.

As it presently stands, the legislation included in the table above displays all legislation that is presently enforced in the state of Texas relating to non-compete agreements, tying arrangements, and exclusive dealing arrangements. However, some statutes concerning anticompetitive contracting—specifically non-compete arrangements—have been subject to a difficult and complex history in the courts. As Vethan (2013) suggests, the history of non-competes in Texas might even be called "torturous." Tracing several Texas Supreme Court cases ruled prior to the 1989 Covenants

to Not Compete Act, Vethan highlights how the Court assumed a decidedly hostile stance toward non-compete agreements. For instance, in *Hill v. Mobile Auto Trim Inc.* in 1987, the Court interpreted statute and the common law tradition to categorically prohibit non-compete agreements. Per the Court, non-compete agreements are ordinarily unenforceable and are enforceable "only if they are, in other respects, reasonable" (*Hill v. Mobile Auto Trim Inc*, 1987). The necessary criteria for enforceability, and thus reasonableness are that 1) the covenant must be necessary for the protection of the promisee, 2) the covenant is not oppressive to the promisor, 3) the covenant must not be injurious to the public and to not "deprive the community of needed goods," and 4) the covenant must give consideration for something of value, (Hill *v.* Mobile Auto *Trim Inc.,* 1987, pp. 170-172). For the Court, Mobile Auto's noncompete failed to satisfy any of the criteria. Hill obtained most of his practical knowledge prior to his employment with Mobile Auto Trim, Mobile Auto Trim did not provide him any specialized training, and Mobile Auto Trim insufficiently demonstrated that the knowledge Hill possessed of their services were trade secrets. Ultimately, the Court ruled that "covenants not to compete which are primarily designed to limit competition or restrain the right to engage in a common calling are not enforceable" (*Hill v. Mobile Auto Trim Inc.,* 1987, p. 172). Implicitly then, the Court asserted that limitation of competition is unreasonable. In *Martin v. Credit Protection Association, Inc.* in 1988, the Court further restricted the use of non-compete agreements when utilized to protect customer information. Per the Court in *Martin*, customer information is not considered special knowledge that could be protected by a non-compete (Vethan, 2013). Since customer information is not protected, *Martin* effectively permitted the stealing of customers without any repercussions.

Following the 1989 Covenants Not to Compete Act, the Texas Supreme Court revisited several cases, including *Martin*. In its 1990 reconsideration of *Martin*, the Court held that the Covenant Not to Compete Act, though written to be retroactive, would not alter its conclusions and insisted that for a non-compete to be enforceable, there must be an "independent valuable consideration" which could not be satisfied by customer information or specialized training, (Vethan, 2013). In *Travel Masters v. Star Tours, Inc.*, the Court offered one of its most severe rulings on non-compete agreements, restricting non-compete agreements in employment-at-will contracts. Per the Court, since employment at will contracts are "not binding upon either the employee or the employer and is not an otherwise enforceable agreement," where one could demand specific performance , "we conclude that a covenant not to compete executed either at the inception or during an employment-at-will relationship cannot be ancillary to an otherwise enforceable agreement and is unenforceable as a matter of law" (*Travel Masters v. Star Tours Inc.*, 1992). In other words, the Court circumvented much of the content of the 1989 Covenants Not to Compete Act.

Following *Travel Masters*, a flurry of cases surrounding non-compete agreements filled the dockets of several court of appeals throughout Texas, with most cases centered on the question of the definition of employment-at-will and the relationship between employment-at-will and non-compete agreements (Tayon, 1995). In response, the Legislature moved to amend the 1989 Covenants Not to Act, operating with the explicit goal of harkening a triumph of statute over the common law (Tayon, 1995). While the 1993 revisions of the Covenants to Not Compete Act made non-competes enforceable in employment-at-will arrangements and preempted the common law, the Texas Supreme Court nevertheless refused to treat employment-at-will as an independent agreement to render non-competes enforceable. In the 1993 case *Light v. Centel Cellular Co.*, the Court cited both *Martin* and *Travel Masters* to justify its decision (Tayon, 1995). However, in 1994, the Court revisited *Light* once more. In *Light* 1994, the Court did not arrive at a novel conclusion, maintaining its decision that the non-compete in question was unenforceable (Tayon, 1995). Nevertheless, the Court arrived at its conclusion via a different line of argument. According to the Court, the agreement between Light and Centel concerning at-will employment

was characterized by non-illusory agreements, thus constituting an "otherwise enforceable contract " (Tayon, 1995; Vethan, 2013). However, the contract also contained illusory agreements. Illusory agreements are those that are conditioned upon an act or deed that is exclusively within the control of the promisor. In this respect, illusory agreements, upon their performance, constitute a unilateral contract. As Vethan notes, in these agreements "only the performance [of the promised action] completes the contract and makes it enforceable" (Vethan, 2013, p. 180).

As for the question of the enforceability of a non-compete agreement, the Court identified two necessary criteria for determining the enforceability of non-compete agreements: 1) the consideration given by the employer in the otherwise enforceable agreement must give rise to the employer's interest in restraining the employee, and 2) the covenant must be designed to enforce the employee's consideration or return promise in the otherwise enforceable agreement (*Light v. Centel Co*, 1994). On these points, the Court found that the agreement was not enforceable, as the covenant to not compete was not ancillary to an otherwise enforceable agreement. Centel promised to provide Light with confidential information and Light promised not to compete because she had received confidential information. However, the employer merely promised information, and per the Court in *Light*, promises cannot make unilateral contracts that depend on performance for their actual creation enforceable (Vethan, 2013; *Light v. Centel*, 1994, pp. 647-648). Further, as Tayon (1995) notes, an at-will relationship cannot be productive of any real obligation.

In the 1998 case *Alex Sheshunoff Management Services, L.P. v. Johnson*, the Texas Supreme Court revisited the 1994 *Light* decision. In *Sheshunoff,* the Court slightly backtracked from the strict interpretations of *Light* and contended that unilateral contracts were sufficient to fulfill the 1993 Covenants Not to Compete Act's requirements (Vethan, 2013). Later, in 2011 in *Marsh USA Inc. v. Cook*, the Texas Supreme Court further departed from some elements of *Light*, most notably relocating the salience of consideration. Whereas in *Light* the Court held that consideration given by the employer must "give rise" to the employer's interest in restraining the employee from competing, in *Marsh*, the Court held that consideration given by the employer must only "reasonably relate" to the interest protected by the non-compete agreement. In other words, the consideration itself need not be productive of the interest.

Under the common law of Texas, non-compete agreements, to be considered ancillary, must be designed to enforce the employee's consideration or return in an otherwise enforceable agreement and the consideration of the employer must be reasonably related to a business interest worthy of protection.

Marsh ultimately remains the common law standard for judicial treatment of non-compete agreements in Texas. Thus, as it stands under the common law of Texas, non-compete agreements, to be considered ancillary, must be designed to enforce the employee's consideration or return in an otherwise enforceable agreement *and* the consideration of the employer must be reasonably related to a business interest worthy of protection (Vethan, 2013). Further, any agreement made can include at-will employment defined by a unilateral agreement, which becomes enforceable when employees engage in specific performance (Vethan, 2013). Finally, non-competes are necessarily ancillary to "otherwise enforceable agreements," that can include a promise to provide confidential information that the employer may deem necessary to protect with a non-compete agreement (Vethan, 2013).

As for lawsuits involving exclusive dealing or tying arrangements in Texas, perhaps the most notable is the 2011 suit *United States and Texas v. United*

Regional Healthcare System of Wichita Falls. In *United Regional*, the state of Texas sued United Regional for its use of exclusive dealing arrangements, claiming that United Regional had "effectively bought exclusivity with commercial insurers by offering a substantial discount to insurers if United Regional was the only local hospital or outpatient surgical provider in the insurer's network" (Gudiksen et al., 2020, p. 34). According to Texas, the exclusive dealing arrangements and the consequent exclusion of other hospitals "reduced competition and enabled United Regional to maintain its monopoly power," thereby resulting in higher insurance premiums, higher healthcare costs, limiting price competition, restraining healthcare access, and reducing competition without any reasonable justification (Complaint, *United States and Texas v. United Regional Healthcare System of Wichita Falls*, 2011, p. 2). In its decision, the district court of the Northern District of Texas determined that United Regional's discounting was below cost and would exclude an equally efficient competitor, however the Court forbade United Regional from engaging in any exclusive dealing arrangements (Gudiksen et al., 2020).

Table 5

Tying Arrangements, including All-or-Nothing Tying				
State	**Bill or Statute Name**	**Bill Number/ Statute Citation**	**Status**	**Remarks**
Massachusetts	Mass. Gen. Laws ch. 176O, § 9A. Agreements or contracts between carrier and health care provider prohibited if containing certain provisions: Health Insurance Consumer Protections	Mass. Gen. Laws ch. 176O, § 9A	Enacted 2010, amended 2012.	Prohibits agreements or contracts that limit the ability of the insurer to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; prohibits all-or-nothing in provider contracts (also prohibits gag clauses, most favored nation, anti-steering/anti-tiering).
Connecticut	§ 38a-477i. Contract provisions containing all-or-nothing clauses, anti-steering clauses, anti-tiering clauses or gag clauses prohibited.	Conn. Gen. Stat. § 38a-477i	Added by P.A. 23-0171, S. 19 of the Connecticut Acts of the 2023 Regular Session, effective 2024 July 01.	Prohibits contract provisions containing all-or-nothing clauses, anti-steering clauses, anti-tiering clauses and/or gag clauses. Defines "all-or-nothing clause" as any health care contract that 1) requires the health carrier/health plan administrator to include all members of a health care provider in a network plan or 2) requires the health carrier or health plan administrator to enter into any additional contract with an affiliate of the health care provider as a condition to entering into a contract with such health care provider.
Nevada	Nevada Rev Stat §§ 598A.010-440: Nevada Unfair Trade Practice Act CHAPTER 598A - UNFAIR TRADE PRACTICES	Section 598A.440 - Provider of health care prohibited from entering into certain contracts; violation constitutes contract in restraint of trade; authorized provisions of contract; subcontracting or delegating performance of obligations under contract; penalty	Enacted 1975, amended 2024.	Prohibits from requiring third party to place all providers of health care affiliated with a business entity on the same tier, contracting with affiliated provider as a necessary condition, banning third party from contract with non-party or penalizes the third party from entering in contracts with others.

As evinced by legal history, Texas is in dire need of comprehensive legislation concerning tying arrangements, exclusive dealing, and non-compete arrangements. Current legislation, regulation, and common law is insufficient for curtailing the potentially anticompetitive effects of any future contractual arrangement that may arise within the context of healthcare.

ANTICOMPETITIVE CONTRACTING IN OTHER STATES: LEGISLATIVE HISTORY

Alongside Texas, other states have statutory prohibitions concerning non-compete agreements, tying arrangements, and exclusive dealing arrangements. **Tables 5 and 6** explicate legislation as of writing.

Table 6

Exclusive Dealing Arrangements				
State	**Bill or Statute Name**	**Bill Number/ Statute Citation**	**Status**	**Remarks**
Louisiana	Title 51- Competitor, agreements discriminating against; manuals	LA Rev § 51:124	Effective, 1970. Amended by Acts 1970, No. 669, 51.	Categorically prohibits conditioning the sale, lease, or contract for any good on the condition, agreement, or understanding that the purchaser or lessee shall not use or deal in the goods of a competitor where the effect is the substantial lessening of competition.
Massachusetts	Regulation of Trade and Certain Enterprises, Discouraging Competition (Part of Massachusetts Antitrust Act of 1978)	Mass. Gen. I, Title XV, 93.6	Effective 1978 August 17.	Explicitly proscribes conditioning the sale or contract of any good for use, consumption, or resale upon any agreement that the purchaser or lessee shall not use or deal in the goods of any other competitor when the sale or lease may substantially lessen competition.
Missouri	Restraint of Trade Prohibited	S.B. 424, L. 1975/MO Rev. Stat. 416.031	Effective 1974 August 29.	Proscribes any person engaged in commerce from making a sale or contract for any commodity on the condition that the lessee or purchaser shall not use or deal in the commodities of competitors of the lessor or seller.
Rhode Island	Commercial Law-General Regulatory Provisions-Certain Contracts Unlawful	R.I. Gen 6-36-6	P.L. 1979, ch. 98, § 1; P.L. 2014, ch. 528, § 26. Effective 1979.	Prohibits contracts for supplying commodities or furnishing of services; or for the fixing or prices charged for commodities or services, or for the giving or selling of a discount or rebate, on the condition that one party shall not deal in the commodities or services of a competitor where the effect of the contract is to lessen competition or create a monopoly.

Table 7

Non-Compete Agreements/Covenants Not to Compete				
State	Bill or Statute Name	Bill Number or Statute Citation	Status	Remarks
California	AN ACT to Amend Section 15500 of, and to add Section 16600.1 to, the Business and Professions Coe, relating to business	A.B. 1076/ Cal. Bus. & Prof Code. 16600.1	Passed. Effective 2024 January 1.	Full ban on non-compete agreements. Employers prohibited from asking employees to sign non-competes. Employees may pursue civil action against employers asking for employee to sign non-compete agreement. Out-of-state non-compete agreements rendered unenforceable in California.
Colorado	AN ACT concerning restrictive employment agreements	C.R.S. 8-2-113, 5(a) / H.B. 22-1317	Passed. Effective 2022 August 10.	Non-compete agreements for physicians are void and unenforceable. Provisions of a non-compete that require payment of damages that is reasonably related to injury suffered by reason of termination are enforceable. Damages not applicable when physician discloses his continuing practice of medicine and new professional contact information to a patient with a rare disorder.
Delaware	AN ACT to Amend Title 6, Chapter 27. of the Delaware Code by Prohibiting Physicians from Entering into Agreements Not to Compete	64 Del Laws c. 175 § 1. / S.B. 294	Passed. Effective 1983 June 13.	Prohibits physicians from entering into non-compete agreements. Renders void any agreement that restricts physician labor mobility for a period of time.
Illinois	Illinois Freedom to Work Act	Public Act 103-0915/ S.B. 2737	Passed. Effective 2025 January 01.	Prohibits the use of non-compete agreements categorically with respect to mental health services to veterans and first responders. Additional prohibitions for non-compete agreements for individuals earning under certain income thresholds.
Iowa	AN ACT Relating to and making appropriations for veterans and health and human services.	HF2698	Passed. Effective 2024 May 09.	Prohibits the use of non-compete agreements by healthcare employment agencies in any contract with an agency worker or healthcare entity. Prohibits the use of non-compete agreements by a healthcare technology platform in any contract with an independent nursing services professional or healthcare entity.
Maryland	AN ACT Concerning Labor and Employment-Noncompete and Conflicts of Interest Clauses for Veterinary and Health Care Professionals and Study of the Health Care Market	HB 1388	Passed. Effective 2024 June 01.	Voids non-compete agreements for veterinarians and healthcare professionals in direct patient care and earning less than $350,000 annually. For those earning above $350,000 and not in direct patient care, but who satisfy other criteria, non-competes are limited to one year from termination and a ten-mile radius from primary locus of employment.
Massachusetts	Restrictive covenants upon physicians rendered unenforceable.	Mass. Gen. l. XVI, Ch. 112, Sec. 12X	Effective since 1977	Any contract or agreement with a physician that restricts the practice of medicine in any geographic area for any time is void and unenforceable.

Minnesota	A BILL FOR AN ACT relating to employment; providing that covenants not to compete are void and unenforceable; providing for the protection of substantive provisions of Minnesota law to apply to matters rising in Minnesota; proposing coding new law in Minnesota Statutes, chapter 181.	Minnesota Statutes § 181.988 / SF 405	Effective 2023 July 01.	Any covenant not to compete contained in a contract or agreement is void and unenforceable, unless agreed upon to in the sale or dissolution of a business.
New Hampshire	AN ACT relative to employment contract restrictions upon physicians	N.H. Rev. Stat. § 329:31-a/ S.B. 417	Effective 2016 August 05.	Any contract or agreement with a physician licensed to practice in New Hampshire that restricts the right of the physician to practice in any area for a period of time after termination of a partnership is void and unenforceable.
North Dakota	North Dakota Century Code, Title 9.	N.D. Cent. Code. 09-08-06	Effective since the 19th century.	Any contract by which anyone is restrained from exercising a lawful profession, trade, or business is void.
Oklahoma	Oklahoma Statutes, Title 15: Contracts	15 Okl. Stat. § 219A.	Effective since the 19th century.	General restrictions on contracts that prohibit a person from exercising a lawful profession, or trade, or business. Non-compete agreements are not permitted unless for non-solicitation purposes.
Pennsylvania	AN ACT Prohibiting the enforcement of certain non-compete covenants entered into by health care practitioners and employers and providing for a study by the Health Care Cost Containment Council	HB 1633	Passed. Effective 2025 January 01.	Proscribes the use of non-competes in healthcare are limited to one year in duration unless involved in the sale of a business. Non-competes are unenforceable if employee was terminated by employer. Requires that patient receive notification of physician departure, that timely transfer of patient health records occurs if applicable, that patients may be permitted to see another physician within departing physician's practice, that departing physician's employer must inform patients within 90 days of physician's departure.
Rhode Island	AN ACT relating to business and professions- Board of Medical Licensure and Discipline	R.I. Gen. Laws § 5-37-33/ H. 7586	Passed. Effective 2016 July 12.	Any contract or agreement that establishes terms of partnership or employment, or any other professional relationship with a licensed physician that includes any restriction of the right of such physician to practice medicine is void and unenforceable. Restrictions void and unenforceable include those contracts restricting the practice of medicine by geography or time, or by restricting physicians from providing treatment or solicitating a patient.
South Dakota	AN ACT to prohibit certain restrictions in employment contracts	H.B. 1185/ SD.53-9-11.1-2	Passed. Effective 2023 March 27.	Voids non-compete agreements entered into on or after July 1, 2023, that restrict a practitioner from practicing or providing professional services within scope of practice after termination of employment or dissolution of partnership. Does not apply to the sale of a practice or interest in a practice or to restrictions on solicitation.
New Mexico	AN ACT Relating to Health Care; Making Certain Provisions in Health Care Practitioner Agreements Void, Unenforceable and Against Public Policy, Including Certified Nurse Practitioners and Certified Nurse-Midwives in the Definition of "Health Care Practitioners"	SB 82 & 128/ N.M Stat 24-11-2	Passed. Effective 2017 April 6.	Proscribes the use of non-compete agreements for some categories of healthcare providers in the state.

POLICY RECOMMENDATIONS FOR TEXAS: RESTRICTING ANTICOMPETITIVE CONTRACTING FOR THE SAKE OF PATIENT-CENTERED HEALTHCARE

Legal and economic theory, analysis, and history reveal that the presence of anticompetitive contracting is bad for patients in Texas. On one hand, economic analysis of the consequences of anticompetitive contracting demonstrates that tying, exclusive dealing, and non-compete agreement may foreclose competitors from a market and contribute to the establishment of monopoly and monopsony in healthcare markets. As a consequence of dominance by either healthcare providers or insurers won by drawn out and tortuous contractual negotiations, Texas patients are left to bear the fruits of these conflicts in high prices, reduced access to quality care, and in some circumstances, reduced health outcomes. On the other hand, the legal history of anticompetitive contracting and the legal theory that shaped that very history reveals that courts and agencies have been astute observers of the deleterious consequences of tying, exclusive dealing, and non-compete agreements in healthcare markets. The decisions of courts and agencies therefore provide a useful framework for understanding not only the several permutations of these consequences, their severity, but also how they conflict with the very foundational juristic and constitutional principles of American society. At the core of these legal and administrative decisions is the awareness that not only competition in a market must be protected, but that protection of this competition is for the very purpose of ensuring the freedom of markets, the liberty of individuals, and their very flourishing in political life.

Attaining the common good and proper individual flourishing of all Texans is the paramount concern of the state. While healthcare is neither the ultimate common good of all Texans nor the totality of individual, personal flourishing, healthcare is a subaltern common good and is an inextricable element of man's natural communal and political existence, insofar as it is a potent and necessary means to improve man's health to allow for his full participation in society (Cochran, 1999). Precisely, if Texans have access to quality and affordable healthcare that functions to alleviate illness and improve personal physical and mental well-being, one can more freely pursue his own personal good in tandem with participation in the broader good of the whole political community. Indeed, healthcare may be divisible in that each person experiences it differently and according to a particular transactional relationship between a provider and a patient, and thus is not a public good like national defense, but quality and affordable healthcare is so necessary for the flourishing of both the individual and the community that it is imperative that public authorities and private actors in healthcare in healthcare act to balance the interests of physicians and patients (Cochran, 1999). Artificial and needless barriers to healthcare access in the form of anticompetitive contracting or business practices thus not only inhibits individuals from accessing necessary medical intervention, but also—by the very act of inhibiting access—stifles and inhibits every individual unfairly inhibited from accessing care the ability to pursue their own personal flourishing in conjunction with the pursuit of the common good of all Texans.

To this end then, several policy proposals concerning anticompetitive contracting practices are in order. These proposals aim to appropriately address the needs of patients and physicians alike; however, these proposals are articulated with an astute awareness that healthcare is an idiosyncratic discipline that individuals are necessarily reliant upon for their own wellbeing. Therefore, these proposals are proffered with an understanding that the relationship between a patient and a physician—perhaps not so unlike the relationship between a client and attorney—are personal and the maintenance of incumbent patient relationships is critical to patient health (Malloy, 2006). The three anticompetitive contracting practices identified herein—tying, exclusive dealing, and non-compete agreements—each possess the potential not only to produce anticompetitive consequences that stifle competition,

establish monopsonies or monopolies, but also possess the potential to disrupt incumbent patient care and foreclose non-incumbent patients from access to care. To prevent the stifling of competition, the creation of monopolies and monopsonies, the meteoric skyrocketing of prices, and to ensure patient access to quality and affordable, consider the following proposals.

First, the state of Texas ought to consider restraining the use of tying arrangements in healthcare. As a contractual practice that binds the sale of two distinct products together, tying arrangements may needlessly and anticompetitively restrict consumer choice, conserve monopolistic or monopsonistic market power of healthcare providers or insurers, limit competition among healthcare providers, and ultimately lead to higher prices and lower quality of care for patients. Specifically, statutory prohibitions of tying arrangements ought to forbid the creation or enforcement of any agreement by general contracting entities in healthcare that conditions the purchase of one product on the additional purchase of one or more product. By categorically restricting the conditioning of the purchase of any product on the tied purchased of any other product, not only will statute proscribe "all-or-nothing" tying arrangements, but statute will also proscribe "some-or-nothing" or "most-or-nothing" tying arrangements, thereby preventing general contracting entities from leveraging market power *in toto*. Precisely, if statute were to only proscribe "all-or-nothing" arrangements wherein the purchase of one product is dependent upon the purchase of all other products offered by a seller, sellers could still coerce buyers to purchase a bundle most or some products with the primary product subject of their desire. Simply put, if a provider has 100 physicians in its network and if only all-or-nothing tying is proscribed, then that provider could still demand that the person with which it is contracted still purchase the services of 99, 50, 25, or 1 of those physicians within its network. Therefore, merely prohibiting all-or-nothing agreements all but invites general contracting in entities to simply find a work-around to nevertheless approximate the desired consequences of an all-or-nothing agreement.

Second, the state of Texas ought to consider restraining the use of exclusive dealing arrangements in healthcare. Not so unlike tying arrangements, exclusive dealing arrangements condition the sale of a product. While tying conditions the purchase of two distinct products on the inclusion of one or more products, exclusive dealing arrangements condition the purchase of one or more products on the agreement that the purchaser will not contract with any of the seller's competitors. Exclusive dealing arrangements, as already treated herein, may be unreasonable and produce anticompetitive consequences, such as foreclosure of competition via creation of barriers of entry into a market, elimination of consumer choice, the artificial creation of monopolies or monopsonies, and or price manipulation. Therefore, the state of Texas ought to introduce legislation that prohibits the use of exclusive dealing contracting between general healthcare entities.

Finally, the state of Texas ought to consider proscribing the use of non-compete agreements in healthcare. While tying arrangements and exclusive dealing may produce several anticompetitive effects, non-compete agreements are especially insidious. Via non-compete agreements, healthcare employers such as provider networks can quickly construct artificial employment monopsonies that restrain individual physicians from either establishing their own practice or seeking employment with a competitor-provider. Under an employment monopsony, physician labor mobility is restrained, resulting in reduced access to care for those patients who are unable to utilize the services of the monopsonistic provider and higher costs result for healthcare services across a market. Non-competes are particularly egregious in Texas, which faces the dyadic problem in resolving not only a physician shortage, but an uneven physician distribution across the state, as 214 out of 254 counties in the state are lacking a primary care physician.

While an increase in physician numbers is desirable, if non-compete agreements in healthcare remain broadly enforceable, those new quantities of physicians may be restrained by non-compete agreements that disincentive or coerce said physicians from departing a provider group, establishing their own practice, or working in a medically underserved area. Further, non-competes threaten to disrupt patient care, which may lead to poor health outcomes, especially for those with chronic illnesses or the elderly (Leibowitz & Blacklock, 2024). To ensure even physician distribution that necessarily requires labor mobility, Texas ought to severely restrict the use of non-compete agreements, eliminating the use of unreasonable geographic and temporal restraints and require providers both to notify patients within 90-days that their physician is departing the provider network and to ensure timely transfer of health records to the departing physician's new employer or the patient's elected new physician.

Enacting legislation that more severely regulates the use of tying, exclusive dealing, and non-compete arrangements will ultimately strike at the heel of hospital consolidation, which is associated with decreased patient access to quality and affordable healthcare (Gudiksen et al., 2020). While upshot of novel prohibitions and restrictions of certain anticompetitive contracting practices such as tying, exclusive dealing, and non-compete arrangements is that patients may have superior opportunities for access to quality and affordable healthcare services insofar as anticompetitive hospital consolidation efforts are stifled, other second and third-order benefits may arise as well. Specifically, enacting legislation against anticompetitive contracting practices that stifles the easy path to hospital consolidation that presently exists may disincentivize ongoing provider abuse of government programs such as the 340B Drug Discounting Program ("340B"). Under 340B, providers that subsist under designations such as critical access hospitals, sole community hospitals, rural referral hospitals, and disproportionate share hospitals (DSH) that offer care for low-income, indigent, or otherwise needy populations may purchase drugs from pharmaceutical manufacturers at a discounted rate (AHA, 2023). However, 340B is oft abused by providers, as the program lacks transparency and does not incentivize providers to direct financial savings to providing care for low-income patients (Desai & McWilliams, 2018). Furthermore, abuse of the 340B program may go hand-in-hand with anticompetitive consolidation efforts, as provider groups are incentivized to acquire physicians and providers that frequently utilize drugs subject to steep reimbursement (Desai & McWilliams 2018). Acquired practices that meet certain 340B criteria may be categorized as "child sites" of the provider and thus expand the provider's eligibility for 340B discounts (Sullivan et al., 2024). If 340B discounts are abused by a provider, then provider consolidation—which is dependent upon anticompetitive contracting practices—may only further and expand the scope of 340B abuse.

Anticompetitive contracting is linchpin of hospital consolidation, and thus inextricable from the deleterious consequences of consolidation that bear down upon physicians and patients alike. It is thus imperative that the Legislature act to restrict these anticompetitive practices. The common good of Texas and the lives and flourishing of Texans depend on their action. ■

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ABOUT THE AUTHOR

Noah Torres is a policy scholar for the Center for Health and Families at the Texas Public Policy Foundation, where he focuses on marriage and family formation policy and healthcare antitrust regulation and enforcement.

Born in Fort Worth, TX to a family actively involved in the local Hispanic, Catholic, and political circles, Noah was raised with an astute awareness of the value of civic virtue for securing the common good and flourishing of individuals in a community.

Noah later attended the University of Dallas, where he earned his B.A. ('21) in Politics and Theology and his M.A. ('23) in Political Theory.

While in graduate school, Noah executed research and authored a thesis on the early modern political, juristic, and ecclesiological thought of Francisco de Vitoria, Robert Bellarmine, Giovanni Botero, Paolo Sarpi, and Niccolò Machiavelli and their respective influences on the relationship between law and conscience as mediated by interpretations of the concepts of sovereignty and 'reason of state' articulated by the Papacy and Roman Curia. Related to these studies, Noah is an active participant in conversations surrounding the influence of the classical and Salamancan-Scholastic legal traditions on American jurisprudence. Additionally, he has presented on Francsico de Vitoria and Giovanni Botero at academic conferences in the United States and Europe and has published on Vitoria's theory of subjective right in academic journals.

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