

State Action to Oversee Consolidation of Health Care Providers

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Policy Points

- > **Well-designed state merger review authority can prevent further health provider consolidation and offer better oversight of approved transactions.**
- > **State health care antitrust enforcement demands a robust merger review process, including pretransaction notice and review and approval authority, as well as posttransaction monitoring and oversight.**

ABSTRACT

While federal oversight over health care provider transactions is crucial, state officials—working independently or alongside federal antitrust enforcers—must work to protect competition in health care markets across the country. Currently, significant variation exists among state legal and administrative frameworks that can be used to review proposed health care transactions for potential anticompetitive harm. Based on an analysis of state merger review practices in all 50 states, this brief describes the variation among state review practices to identify the key elements of a comprehensive state merger review framework. To protect competition and consumers from the anticompetitive effects of consolidation, state regulators need broad pretransaction notice; sufficient time to review transactions using substantive review criteria; the ability to approve, conditionally approve, or block transactions administratively; and the means to oversee conditionally approved transactions.

INTRODUCTION

Health care markets have become increasingly concentrated as health care providers pursue mergers and other forms of strategic agreements to gain market power. Unfortunately, this consolidation has led to highly concentrated markets and has generated higher prices for insurers, which are passed on to consumers through higher premiums.¹ Although many health care provider markets are already considered highly concentrated,² states and federal antitrust enforcement agencies must remain vigilant to protect the remaining competitive health care markets and minimize further consolidation. This brief is the second in a three-part series looking at health care consolidation. The first brief argues that both state and federal antitrust enforcement is critical to address the rising costs that result from consolidation. This second brief

examines the importance of well-designed state merger review authority in preventing further consolidation and better oversight of approved transactions.

While federal oversight over health care provider transactions is crucial, state oversight is also needed to protect competition in health care markets across the country. For example, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) receive notice only of transactions over \$92 million as required by the 2021 Hart-Scott-Rodino Antitrust Improvements Act (HSR).³ Therefore, smaller health care provider transactions, such as acquisitions of physician groups by hospitals, are rarely reported and ultimately escape federal review. As a result, these smaller transactions and other forms of consolidation not challenged by federal antitrust enforcers have increased substantially.^{4,5} Second, federal antitrust enforcers have limited resources and have struggled to analyze the ever-increasing number of reported mergers.^{6,7} In sum, few health care transactions rise to federal attention, and those that do are often met with limited resources to challenge them.

States must therefore work independently or alongside federal antitrust enforcers to protect health care provider markets. Under their *parens patriae* authority, state attorneys general (AGs) can bring suit under state or federal antitrust laws. State AGs can also join the FTC or DOJ in lawsuits to enjoin a transaction under Section 7 of the Clayton Act.⁸ Unlike federal enforcers, state enforcers and regulators may have additional legal and administrative frameworks that they can use to review proposed health care transactions for potential anticompetitive harm. Beyond filing suit under antitrust laws, common state oversight mechanisms include AG review of nonprofit health care transactions to enforce charitable trust and other related laws, certificate of need (CON) programs, and mandated review by another state agency.⁸ However, these frameworks for merger review vary widely across the country—in scope and efficacy. Although a few states have more comprehensive processes than most, no state has a perfect system.

For state regulators to efficiently and effectively monitor and challenge potentially anticompetitive health care transactions, they need sufficient resources and ample statutory authority, which many states currently lack. Based on an analysis of state merger review practices in all 50 states, this brief identifies the key elements of a comprehensive state merger review framework and analyzes how state regulators and enforcers can use and augment their existing authority to address health care consolidation. It then describes the variation in authority throughout the United States and concludes with an overview of developments in the 2021 state legislatures to improve health care merger review processes.

COMPONENTS OF COMPREHENSIVE MERGER REVIEW

Since health care transactions are infamously challenging to unwind once finalized,⁹ effective health care antitrust enforcement demands a robust merger review process, including pretransaction notice of a broad range of transactions to state agencies, strong pretransaction review and approval authority, and posttransaction monitoring and oversight of transactions allowed to proceed with conditions. States looking to expand an existing merger review mechanism can choose to focus on any of these four areas of merger review (notice, pretransaction review, approval authority, post-transaction oversight) and determine which area would go the farthest in empowering state entities to protect competition.

1. Notice of Impending Transactions

States must monitor consolidation in their health care markets to prevent and address any potential harms to competition. To do this, states should require transacting parties to provide notice of all impending health care provider transactions to at least one state entity. Notice requirements allow states to address transactions and their potential anticompetitive effects prophylactically. For instance, a broad notice requirement enables states to analyze transactions too small to trigger the federal \$92 million HSR threshold and track

“stealth consolidation,” where markets end up highly concentrated after a series of smaller, unreported and unchallenged transactions.¹⁰ Furthermore, a broad notice requirement enables states to track patterns of consolidation through non-horizontal transactions, such as vertical mergers, affiliations, cross-market mergers, and private equity acquisitions. Comprehensive notice of all health care provider transactions helps states exercise their existing enforcement capabilities to their fullest extent—whether they have an administrative pretransaction approval process or must bring suit under antitrust laws to challenge potentially anticompetitive transactions.

States looking to implement or improve existing notice requirements should consider two foundational questions: (1) which transactions should require advance notice, and (2) who should receive that notice.

Scope of Notice

States considering implementing or expanding notice requirements should compel notice from a wide array of health care providers and a broader range of transaction types to ensure that they have the information they need to oversee health care markets.

Range of health provider types. Currently, only five states—Connecticut, Massachusetts, Nevada, Oregon, and Washington—require notice of transactions involving health care providers beyond just hospitals. (See Table 1.) Oregon and Nevada passed laws in the 2021 legislative session that have not yet taken effect. As many health care providers now take on many complex organizational forms,¹¹ states must have broad notice statutes for states to have a full view of consolidation within their health care markets.

For- and nonprofit providers. In addition to the type of health care provider organization that must give notice, it is also important to include both for- and nonprofit providers in notice requirements. Many states limit notice requirements to transactions involving nonprofit hospitals.¹² This limitation stems from an extensive history of requiring the AG to protect the charitable purpose and assets of nonprofits and other charitable organizations.¹³ Yet, for-profit health systems have experienced the most growth from mergers and acquisitions over the past few years.⁴ Additionally, private equity and hedge funds have increasingly sought to acquire or affiliate with hospitals and physician groups.¹⁴ Unless these firms acquire a nonprofit hospital, most states will not receive notice of these potentially anticompetitive transactions.

Table 1. State Recipients of Pretransaction Notice for Non-Hospital Health Providers

Type of Provider in Addition to Hospitals	Connecticut	Massachusetts	Nevada	Oregon	Washington
All providers & provider organizations (broadest)	—	AG, Health Policy Commission	—	Oregon Health Authority*	AG
All group practices	AG	—	AG**	—	—
Only large group practices (8 or more physicians)	CON	—	—	—	—

Abbreviations: AG, attorney general; CON, certificate of need program.

*Only transactions where one party had an average revenue of at least \$25 million in the preceding three years and another party had an average revenue of at least \$10 million, or if the new entity is projected to have at least \$10 million in revenue.

**AG receives notice of a group practice transaction only if the transaction meets two conditions: (1) the transaction results in a material change to the business, and (2) the group practice will subsequently provide more than 50% of the health care services in the market.

Range of transaction types. Notice should also extend to a wide range of transaction types. While many notice statutes cover mergers and acquisitions that result in a change in control or involve a certain amount of interest in the business, a few states have expanded notice requirements to include transactions beyond these traditional forms of consolidation. Connecticut,¹⁵ Massachusetts,¹⁶ and Washington¹⁷ have the most inclusive language and require notice of any transaction that would result in a “material change” to provider organizations’ operations or governance structure, including for-profit and nonprofit hospitals and physician groups.⁸ “Material change” provisions can encompass a wide variety of emerging forms of consolidation that include contractual affiliations, hiring of independent physician groups, and other smaller transactions that can result in stealth consolidation.⁸ Although states with “material change” provisions often list the types of transactions covered, Massachusetts has expanded what is included under “material change” by not limiting the statute to the listed examples.¹⁶

Recipients of Notice

In addition to broadening notice requirements, states should consider which state entities can best review the application. State AGs are a strong first choice because they can file suit under antitrust law to enjoin transactions that may harm citizens even if they do not have additional statutory authority to block transactions. However, requiring notice to both the AG and another state agency has several benefits.

First, requiring notice to multiple state agencies allows a state to distribute the labor and resources needed to review proposed transactions and benefit from different agencies’ expertise. For example, in Massachusetts, both the AG and the Health Policy Commission (HPC)—a specialized independent state agency—receive notice of proposed transactions. The HPC reviews the transaction and submits a market impact report to the AG.¹⁶ The AG can then utilize the HPC’s market impact analysis, which would have been time- and resource-intensive for the AG’s office to produce on its own, to assess

whether to challenge a proposed transaction through litigation.

Second, dual notice can also allow different state entities to focus their review on different concerns. Currently, 10 states require transacting health care entities to provide notice to multiple agencies.¹⁸ Both the AG and either the CON program or another state health agency, like the health department, receive notice in all of these states. However, in most of these states, different transaction types must report to different state offices, resulting in different review priorities. For example, in Rhode Island, the AG receives notice of nonprofit hospital transactions only, while the Rhode Island Department of Health receives notice of all hospital transactions.¹⁹ This differentiated notice in Rhode Island reflects each entity’s review process: the AG considers whether the nonprofit’s charitable assets and purpose are adequately protected, and the Department of Health considers the impact of the transaction on health care access and quality. In a different approach, in Hawaii, both the AG and the state health planning and development agency receive notice of acquisitions of all hospitals, but only the agency conducts a substantive review.²⁰ Although the Hawaii AG does not review transactions, the notice requirement can still help the AG stay informed of any potentially harmful transactions that warrant challenge under antitrust laws.

Notice is the cornerstone of any effective state merger review as it alerts state agencies to impending transactions, providing them with the necessary foresight to exercise their existing enforcement capabilities fully.

2. Pretransaction Review

Although notice is the critical first step in alerting state entities of impending transactions, these entities also need sufficient time and authority to properly assess whether the proposed transaction serves the public, preserves access to affordable health care, and does not significantly harm competition. To achieve those goals, some states have implemented waiting periods; given state entities the ability to compel additional information; provided well-articulated review criteria;

and permitted the use of independent agencies or consultants to conduct more in-depth reviews if needed.

Waiting Periods

States differ in the length of time transacting parties must give to state entities before consummating the transaction. Across the country, these waiting periods generally range from 30 days to 90 days, with some states allowing for extensions. For example, the California AG must issue his or her decision within 90 days of receiving notice and can extend that period an additional 45 days under certain conditions.²¹ In Colorado, transacting parties must submit notice to the AG 60 days before the transaction closes.²² In a different approach, Massachusetts and Connecticut impose de facto waiting periods by preventing certain transactions from closing until a cost and market impact review (CMIR) has been completed, which can extend the waiting period to over 200 days.^{16,23} State agencies must have enough time and resources to review transactions thoroughly and substantively before issuing a decision.

Compelling Additional Information

Information contained in the required notice is not always sufficient for state agencies to complete their review. To gather any necessary additional information, state regulators and enforcers should have the ability to collect supplemental information from the parties. Many state agencies already have the power to request or more formally subpoena information to inform their review. Public hearings also allow states to garner additional information and hear from stakeholders about community impact.²⁴

Review Criteria

Once state entities gather information, having clear, substantive review criteria helps ensure consistent and comprehensive assessments of each transaction. Review criteria may also guide state entities and transacting parties in identifying potentially anticompetitive transactions and assist courts in reviewing transactions if challenged via antitrust laws.

Review criteria often differ depending on which state entity is conducting the review and which

transactions they are responsible for assessing—either solely nonprofit transactions or non- and for-profit transactions. State reviews limited to nonprofit hospital transactions are typically housed within the AG's office and consider whether the transaction complies with charitable trust and other related laws. These laws aim to protect the charitable assets and purpose of the organization, not protect competition, so they often do not allow the reviewing entity leeway to address competition concerns.

CON programs instilled with merger review authority are commonly responsible for reviewing both non- and for-profit transactions. While CON programs have long been criticized for stifling competition by requiring approval for building new facilities, adding beds, or purchasing new equipment and generally creating barriers to new competition, they have the potential to be a viable mechanism for merger review.^{9,25} However, CON reviews are often limited to considering the health care needs of the affected community and whether the transaction will lead to inappropriate increases in service utilization or duplication. Like the reviews of nonprofit transactions, these criteria address significant concerns but are not directly related to competition and often do not lead to substantive reviews for anticompetitive transactions.

Although the review criteria in many states were not created to protect competition, some states have explicit competition-based criteria in their review or have review criteria that are broad enough to encompass competition concerns. For example, in Rhode Island, one of the review criteria for the AG in reviewing nonprofit transactions is whether the transaction is proper under Rhode Island antitrust laws.²⁶ Similarly, in New Hampshire, one of the review criteria for nonprofit transactions is whether the transaction is appropriate under other laws generally, including antitrust laws.²⁷ Oregon passed a new merger review law during the 2021 legislative session that requires the Oregon Health Authority (OHA) to consider whether a material change transaction will lead to substantial anticompetitive effects that are not outweighed by public benefits.²⁸ Additionally, a number of CON programs

and other various state entities also review transactions under criteria such as how the transaction will impact the cost of and access to health care services, both of which could be impacted if the consolidated entity gains substantial market power. Ideally, review of all transactions would include antitrust or competition-based criteria, such as whether the consolidating transaction will harm health care markets and competition, as these are intimately related to access and affordability.

Based on our analysis of the merger review criteria in all 50 states, we offer three options for best practices in crafting merger review criteria:

- 1. Uniform baseline criteria.** Because states lack consistent competition-based review criteria, we developed uniform baseline criteria that can be used for all consolidating health care provider transactions.⁸ These criteria include examining whether the transaction will: (1) harm health care markets and competition; (2) increase prices; (3) limit access to health care services; and (4) harm the public interest. Implementing uniform baseline criteria for all transactions would direct state regulators to consider the impact on access to care and whether the transaction would harm competition or anticompetitively raise prices.
- 2. More discretion in statute.** Alternatively, if passing legislation requiring analysis of uniform baseline review criteria is not politically feasible, states can include statutory language to provide the reviewing entity more discretion. For example, California's AG reviews nonprofit health care transactions based on the review standard for nonprofit organizations; however, the statute also states that the AG "shall consider any factors the [AG] deems relevant."²⁹ In addition to this language, the statute requires that the AG consider broadly whether the transaction is in the public interest.²⁹ The California AG recently used this statute and accompanying regulations to examine the effect a cross-market merger would have on competition and health care prices. In his review, the AG found cause for concern that the affiliated entities could leverage their

connection in negotiations with insurers and raise prices.³⁰ To address this concern, the AG imposed conditions intended to protect competition, such as a price cap and requiring the health system and hospital to negotiate separately with insurers.³¹ While uniform review criteria are ideal, broad discretion can empower the AG to consider competition concerns.

- 3. Subregulatory review.** Pennsylvania's sub-regulatory merger review protocol also provides a viable model for states that cannot pass merger review legislation. The Pennsylvania AG's office instituted the *Review Protocol for Fundamental Change Transactions Affecting Health Care Nonprofits (Review Protocol)*, which sets out the criteria the AG uses to review nonprofit transactions that fall under the AG's purview.³² Specifically, the *Review Protocol* institutes a public interest review to evaluate the transaction's potential impact on the availability and accessibility of health care in the affected community, which includes an antitrust review. The *Review Protocol* is not statutory but rather guidelines published on the AG's website.

Regardless of the approach, reviews analyzing the full economic and health care implications of proposed health care transactions are resource and time-intensive for state entities, especially those with responsibilities beyond merger review. States have tried to ease this burden by either permitting state entities to employ independent consultants to conduct the review or by creating an independent public entity, like the Massachusetts HPC, to review the potential impact of impending transactions on health care access, price, and competition.^{8,16}

As will be discussed in the following section, establishing comprehensive review criteria is crucial because they set the parameters for the review process and dictate the boundaries of a state's authority to approve or disapprove a transaction. Having uniform baseline criteria would also clarify these boundaries and empower agencies to block anticompetitive transactions. Furthermore, in states where the AG must go to court to challenge a transaction, having a comprehensive review provides insight into the details of the transaction,

informing the decision to challenge the transaction in court.

3. Pretransaction Approval Authority

Although many states have pretransaction approval authority—the authority to administratively approve or block a transaction without going to court—the strength of that authority varies dramatically across the country. In some states, the state regulators must approve a transaction if the transaction terms meet basic criteria, such as whether corporate officers of a nonprofit hospital fulfilled their fiduciary duties when entering into the transaction.³³ These types of approvals essentially serve as a rubber stamp, and state regulators do not have the power to substantively address transactions that raise concerns outside of the limited criteria. Other states are similarly limited in their approval authority, where the state regulator’s decision to approve or disapprove a transaction must be based on narrow nonprofit or CON criteria. However, some states, like Connecticut and Rhode Island, have meaningful approval authority through broad or explicitly competition-based review criteria coupled with the power to approve, approve with conditions, or block proposed transactions.

Alternatively, Massachusetts and Pennsylvania are two examples of states that have successfully utilized *parens patriae* power under state and federal antitrust laws to challenge anticompetitive health care transactions to protect the public interest.^{32,34} Under this authority, the Pennsylvania AG challenged transactions under the Clayton Act and Pennsylvania common law³⁵ and the Massachusetts AG under Massachusetts antitrust law.³⁶ However, attempting to block a transaction in court takes time and resources, and it is not always successful, as evidenced by the recent loss of the Pennsylvania AG and the FTC in their challenge of Thomas Jefferson University’s acquisition of Einstein Healthcare Network.³⁷

When considering pretransaction approval authority, states should be mindful of the limits of existing criteria that state regulators and enforcers must use when reviewing mergers. Furthermore, state policymakers should give state regulators and enforcers pretransaction approval authority to

approve, block, or impose conditions on a transaction based on competition-related concerns.

4. Conditional Approvals/Consent Decrees and Posttransaction Oversight

In weighing salient policy considerations against potential anticompetitive harms, state entities may sometimes allow a potentially harmful merger to proceed with conditions rather than block it entirely. Although the ability to conditionally approve transactions is an important tool for state entities to have, this path should be used more sparingly than it currently is by most states.³⁸ If a state regulator or enforcer feels that conditional approval is necessary, the agency should carefully select conditions to minimize harm and achieve the desired benefits. The merged entity must also be closely monitored either by a state entity or an outside monitor to ensure compliance and that the conditions deliver their intended effects.

States have imposed conditions in two different ways. First, many state entities with pre-transaction approval authority can approve transactions subject to specific conditions. Second, state AGs without prior approval authority, like the Massachusetts and Pennsylvania AGs, can seek court approval to impose conditions through negotiated consent decrees. There are benefits and drawbacks to each method. For states with prior approval authority, the process is more streamlined and efficient. However, political pressures may influence state entity decisions. Furthermore, transacting parties may also challenge the decision in court. Conversely, negotiating consent decrees can be arduous and more resource intensive. But, once a consent decree is in place, the parties cannot alter it without a formal modification request approved by the court.

Imposed conditions tend to reflect the underlying review criteria. Conditions arising from conditional approvals from state regulators with pre-transaction approval authority are often required to be directly related to the statutory review criteria. As a result, the conditions imposed in most states reflect concerns relating to health care access and need rather than competition. Common conditions arising from conditional approvals include

maintaining the current health care services (such as emergency room services and women’s health services), providing certain amounts of charity care, and maintaining community benefit programs. However, Connecticut, where the CON program has competition-based review criteria, has imposed price-related conditions, such as a cost growth cap for certain transactions.³⁹

Conditions imposed through consent decrees are generally more likely to reflect competition concerns because the challenges often arise from antitrust laws. For example, Massachusetts’s HPC’s review of the transaction between Beth Israel Deaconess Medical Center and Lahey Health found that the transaction would likely result in increased market power and potentially give the providers enough leverage to raise prices.⁴⁰ The Massachusetts AG heeded these warnings and negotiated a set of conditions with the merging parties under Massachusetts’s Antitrust Act.³⁶ The consent decree imposed conditions devised to mitigate harm to competition and the public, including a seven-year price cap to ensure that price increases remained below the state’s annual health care cost growth cap. While a success, the price cap only holds for seven years.

Regardless of the method, conditions have typically been time-limited. Conditions imposed either by conditional approvals or consent decrees generally last anywhere from three to ten years. Although these conditions may be effective for that period, after they expire, health care providers are free to proceed as they wish—leaving the market largely unprotected from price increases and other market power abuses of the consolidated entity.

Conditions also require extended time and resources on behalf of the regulator to monitor the transacting parties’ adherence and ensure the conditions have their intended effect. Some states have addressed this need by either requiring the transacting parties to provide compliance reports to the state entity or utilizing independent monitors to oversee compliance with the conditions of the transaction. Ideally, the transacting parties would pay the costs of the state regulators to review compliance reports and monitor the transaction, as

Rhode Island requires, or pay the costs of the independent monitors, as Connecticut and California require.⁸ However, not all states with authority to conditionally approve transactions also have the statutory authority to conduct posttransaction oversight. This gap leaves state entities without sufficient means to monitor the conditions once imposed.

Lastly, the frequent use of conditional approvals and consent decrees suggests that state entities may be subject to political and other pressures to let transactions go through and that conditions may be the only means available to alleviate potential concerns. States must consider priorities beyond competition, such as access to care, when analyzing an impending transaction. For example, in instances where the transaction is necessary to save a failing hospital that provides essential services to a community, a conditional approval would allow the hospital-saving transaction to go through but with restrictions on the parties’ conduct moving forward. Transacting providers may also promise the state valuable community benefits such as a certain amount of charity care or new facilities in exchange for the state permitting the transaction. Additionally, in many states, health care providers are one of the biggest employers and wield substantial financial and political power that may impact the decisions of reviewing agencies.⁴¹ The widespread use of conditional approvals and consent decrees is an area for further research to understand how they work in practice and what types of conditions can help alleviate anticompetitive effects of transactions.

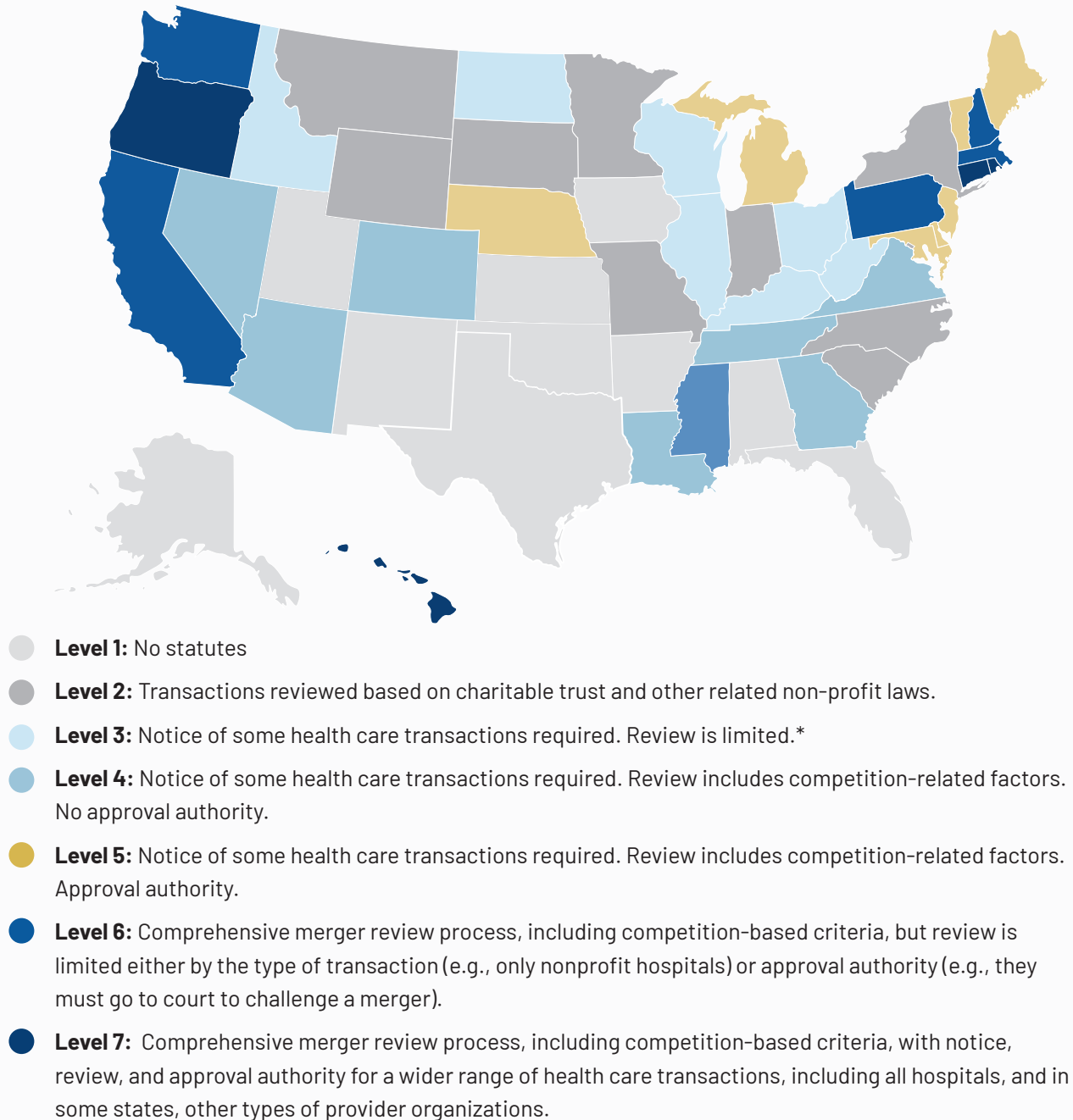
MERGER REVIEW AUTHORITY VARIES BY STATE

Our comprehensive analysis of state merger review statutes across the country found that states’ merger review processes vary widely, with states differing considerably in the scope of required notice, review criteria, and approval authority. While states like Connecticut, Massachusetts, and Rhode Island have relatively comprehensive merger review authority, 11 states have no statutory process for tracking or challenging health care provider

differing considerably in the scope of required notice, review criteria, and approval authority. While states like Connecticut, Massachusetts, and Rhode Island have relatively comprehensive merger review authority, 11 states have no statutory process for

tracking or challenging health care provider transactions outside of state or federal antitrust laws. In the middle are many states with statutes focusing solely on a narrow review of nonprofits or review through CON programs. (See Figure 1.)

Figure 1. Current State of Merger Review Statutes Across the United States



* These states are limited in their review and approval either because only a narrow subsection of health care entities must provide notice or because there is a lack of substantive review beyond nonprofit laws or CON laws. No specific competition or competition-related factors are included.

For more information on merger review in specific states, see <https://sourceonhealthcare.org/market-consolidation/>.

RECENT LEGISLATIVE APPROACHES TO MERGER REVIEW

In the 2021 legislative session, California, Florida, Nevada, Oregon, and New York introduced bills to expand merger review authority; however, only Oregon and Nevada passed new legislation implementing health care merger review processes. Oregon passed a comprehensive merger review process, and Nevada passed two new notice requirements.

Oregon's HB 2362 creates one of the most comprehensive health care merger review processes in the country. It grants the Oregon Health Authority (OHA) the power to analyze and approve, conditionally approve, or disapprove material change health care transactions involving at least one party with revenue over \$25 million and another with revenue over \$10 million over the preceding three years. HB 2362 creates a dual-level process for review: preliminary and comprehensive.²⁸ During the preliminary review, the OHA will approve or conditionally approve a transaction if it finds that the transaction is necessary to maintain the solvency of a party to the transaction *or* if the transaction does not have the potential to negatively impact access to affordable care and likely meets the comprehensive review criteria. The comprehensive review utilizes criteria such as whether there is a substantial likelihood of anticompetitive effects from the transaction that outweigh the benefits. If the transaction does not meet the criteria for approval or conditional approval under the preliminary review, the OHA must conduct a comprehensive review and may appoint a review board of outside stakeholders to make recommendations to the OHA. The law also permits the OHA to implement additional criteria for both the preliminary and comprehensive reviews. Although the qualifying monetary thresholds may still ignore smaller transactions, this law is a significant step in addressing consolidation concerns in the state.

In a less comprehensive approach, Nevada's new laws require only that transacting parties provide notice to either the Nevada Department of Health and Human Services (HHS) or the Nevada AG and do not endow either

agency with any additional review or approval authority. The first law, SB 329, requires hospitals and physician groups engaging in a variety of transactions to give notice to the HHS 60 days *after* the transaction has been finalized.⁴² Still, the data gathered can provide crucial information to monitor consolidation in the state. Notably, HHS is required to publicly publish this information, allowing other state agencies as well as outside organizations, policymakers, and the public access to this information.

The other Nevada bill, AB 47, requires parties to a transaction involving group practices to notify the AG, but only if the transaction will result in a material change *and* if the group practice will provide more than 50% of the health care services within a market.⁴³ However, unlike the public publication requirements in SB 329, AB 47 requires the AG to keep all notices confidential, meaning that the AG cannot disclose group practice transactions to the public. AB 47 initially required notice of all transactions (not just those in health care) involving parties with \$5 million in sales of services or transactions over \$25 million to provide notice to the AG. These thresholds would have included most health care provider transactions. However, during the legislative process, the bill was whittled down to just the limited group practice notice requirement.

The other bills introduced in 2021 contained either comprehensive merger review processes or proposals with novel elements, but unfortunately failed to pass. California's AB 1132 would have significantly expanded the AG's merger review authority beyond its current nonprofit review.⁴⁴ Another Oregon bill, HB 2079, would have created a new merger review process within the OHA similar to HB 2362.²⁸ However, the bill would have also required the OHA to provide its analysis to the AG so the AG could also investigate whether the parties had previously engaged in unfair competition or anticompetitive conduct.

Lastly, New York considered a bill that would have automatically imposed a five-year price cap on all CON-approved transactions.⁴⁵ This automatic price cap would have sent a strong message that consolidation cannot lead to higher prices; however, the

price cap was time-limited and, problematically, did not account for the potential need to raise prices in critical access hospitals to keep them open or other public interest considerations. Overall, the failure of these bills and the limitations of Nevada's new notice requirements illustrate the political challenges in implementing or expanding merger review.

CONCLUSION

States without existing merger review should begin by instituting a notice requirement because it alerts state entities to consolidating activity and can also help inform policymakers what type of merger review process would most benefit the state. Notice also informs the AG about larger and potentially more anticompetitive transactions that they can challenge under state or federal antitrust laws.

As health care markets become increasingly consolidated, state regulators should be equipped with tools to protect competition and consumers from the anticompetitive effects of consolidating transactions. To do this, state regulators and enforcers need broad pretransaction notice; sufficient time to review transactions using substantive review criteria; the ability to administratively approve, conditionally approve, or block transactions; and the means to oversee conditionally approved transactions. Although the federal antitrust enforcers at the FTC and DOJ play an essential role in overseeing large transactions, states also have an important role in addressing the smaller and stealthier forms of consolidation happening in markets across the country.

NOTES

1. Schwartz K, et al. *What We Know About Provider Consolidation*. Washington, DC: Kaiser Family Foundation, 2020. <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/>. Accessed August 2, 2021.
2. Medpac. *Report to the Congress: Medicare Payment Policy*. Washington, DC: Medicare Payment Advisory Committee, 2020. http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf. Accessed August 2, 2021.
3. HSR threshold adjustments and reportability for 2021. Federal Trade Commission website. <https://www.ftc.gov/news-events/blogs/competition-matters/2021/02/hsr-threshold-adjustments-reportability-2021>. Published February 17, 2021. Accessed May 28, 2021.
4. Furukawa MF, Kimmey L, Jones DJ, Machta RM, Guo J, Rich EC. Consolidation of providers into health systems increased substantially, 2016–18. *Health Aff (Millwood)*. 2020;39(8):1321-1325. doi:10.1377/hlthaff.2020.00017.
5. Nikpay S, et al. Hospital-physician consolidation accelerated in the past decade in cardiology, oncology. *Health Aff (Millwood)*. 2018;37(7):1123-1127.
6. Federal Trade Commission. *Fiscal Year 2021 Congressional Budget Justification*. Washington, DC: Federal Trade Commission; 2021:81. https://www.ftc.gov/system/files/documents/reports/fy-2021-congressional-budget-justification/fy_2021_cbj_final.pdf. Accessed August 2, 2021.
7. Competition and Antitrust Law Enforcement Reform Act of 2021, S. 225, 117th Cong. (2021).
8. King J, Chang S, Montague A. *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States*. San Francisco, CA: 2020: The Source on Healthcare Price and Competition and The Petris Center; 1-41. <https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/>. Accessed August 2, 2021.
9. Greaney TL. Coping with concentration. *Health Aff (Millwood)*. 2017;36(9):1564-1571. doi:10.1377/hlthaff.2017.0558
10. Ip G. How ‘stealth consolidation’ is undermining competition; big tech gets the attention but the monopoly problem lies beneath. *Wall Street Journal*. June 19, 2019. <https://www.wsj.com/articles/how-stealth-consolidation-is-undermining-competition-11560954936>.
11. Heeringa J, Mutti A, Furukawa MF, Lechner A, Maurer KA, Rich E. Horizontal and vertical integration of health care providers: A framework for understanding various provider organizational structures. *Int J Integr Care*. 2020;20(1):2. doi:10.5334/ijic.4635.
12. Market consolidation. The Source on HealthCare Price and Competition. <https://sourceonhealthcare.org/market-consolidation/>. Accessed May 28, 2021.
13. Lott C, Morris ET, Goldman KK, et al. *State Regulation and Enforcement in the Charitable Sector*. Washington, DC: Urban Institute; 2016. <https://www.urban.org/sites/default/files/publication/84161/2000925-State-Regulation-and-Enforcement-in-the-Charitable-Sector.pdf>. Accessed August 2, 2021.
14. Gustaffsson L, Seervai S, Blumenthal D. The role of private equity in driving up health care prices. *Harvard Business Review*. October 29, 2019. <https://hbr.org/2019/10/the-role-of-private-equity-in-driving-up-health-care-prices>. Accessed August 2, 2021.
15. Conn. Gen. Stat. § 19a-486i.

16. Mass. Gen. Laws Ch. 6D § 13.
17. Wash. Rev. Code Ann. § 19.390.030.
18. The 10 states include Connecticut, Georgia, Hawaii, Massachusetts, Nebraska, New Jersey, Rhode Island, Vermont, Washington, and Wisconsin.
19. 23 R.I. Gen. Laws Ann. § 23-17.14-7; 23 R.I. Gen. Laws Ann. § 23-17.14-9; 23 R.I. Gen. Laws Ann. § 23-17.14-9 to 12.
20. Haw. Rev. Stat. Ann. § 323D-71; Haw. Rev. Stat. Ann. § 323D-77.
21. Cal. Corp. Code § 5915; Cal. Corp. Code § 5920.
22. Colo. Rev. Stat. Ann. § 6-19-103.
23. Conn. Gen. Stat. § 19a-639f.
24. Sixteen states and the District of Columbia: Arizona, Colorado, Georgia, Hawaii, Idaho, Louisiana, Massachusetts, Maine, Nebraska, New Hampshire, North Dakota, Oregon, Vermont, Virginia, Washington, and Wisconsin.
25. Lerner K, Geyer M. A perfect storm: Health care consolidation and the lack of antitrust enforcement. *Antitrust*. 2020;34:43-44.
26. 23 R.I. Gen. Laws Ann. § 23-17.14-7; 23 R.I. Gen. Laws Ann. § 23-17.14-10.
27. N.H. Rev. Stat. Ann. § 7:19-b.
28. H.B. 2362, 2021 Reg. Sess. (Or. 2021).
29. Cal. Corp. Code § 5917; Cal. Corp. Code § 5923.
30. Vistnes G. *Competitive Effects Analysis of the Proposed Cedars-Sinai Health System/Huntington Memorial Hospital Affiliation*. Los Angeles: Office of the California Attorney General; 2020:281-322. <https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/ag-decision-huntington-121020.pdf>. Accessed August 2, 2021.
31. Attorney General Becerra Conditionally Approves Affiliation Agreement Between Cedars-Sinai and Huntington Memorial Hospital. Office of the California Attorney General. <https://oag.ca.gov/news/press-releases/attorney-general-becerra-conditionally-approves-affiliation-agreement-between>. Published December 10, 2020. Accessed May 28, 2021.
32. Review protocol for fundamental change transactions affecting health care nonprofits. Office of Attorney General Josh Shapiro (Pennsylvania) website. <https://www.attorneygeneral.gov/protect-yourself/charitable-giving/review-protocol-for-fundamental-change-transactions-affecting-health-care-nonprofits/>. Accessed May 28, 2021.
33. See, e.g., Wis. Stat. Ann. § 165.40.
34. Mass Gen. Laws Ch. 93 § 9.
35. Final Order, Commonwealth of Pennsylvania v. Geisinger Health System Foundation, Bloomsburg Health System and Bloomsburg Hospital (No. 4:12-Cv-01081, June 27, 2012).
36. Assurance of Discontinuance, Commonwealth of Massachusetts v. Beth Israel Lahey Health, Inc. (No. 2018-3703, November 29, 2018). <https://www.mass.gov/files/documents/2018/11/29/BILH%20AOD%20Filed%202018.11.29.pdf>. Accessed August 2, 2021.

37. Pennsylvania's AG drops challenge to Jefferson-Einstein deal. Modern Healthcare. <https://www.modernhealthcare.com/mergers-acquisitions/pennsylvanias-ag-drops-challenge-jefferson-einstein-deal>. Published January 12, 2021. Accessed May 28, 2021.
38. Based on the authors' research of the outcome of transaction reviews in all 50 states, the majority of reviewed and challenged transactions result in a conditional approval or consent decree.
39. See Settlement Agreement: Transfer of Ownership of St. Vincent's Medical Center to SVMC Holdings Inc., Connecticut Office of Health Strategy 5, 7-8 (2019). <https://portal.ct.gov/-/media/OHS/CONfolder/1832271-HHC-St-Vincents-Final-executed.pdf?la=en>. Accessed August 2, 2021.
40. Massachusetts Health Policy Commission. *The Proposed Merger of Lahey Health System; Caregroup and Its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; And Each of Their Corporate Subsidiaries into Beth Israel Lahey Health*. Boston: Massachusetts Health Policy Commission; 2018. <https://www.mass.gov/files/documents/2018/09/27/Final%20CMIR%20Report%20-%20Beth%20Israel%20Lahey%20Health.pdf>. Accessed August 2, 2021.
41. Bureau UC. Health Care Still Largest U.S. Employer. The United States Census Bureau. Accessed May 28, 2021. <https://www.census.gov/library/stories/2020/10/health-care-still-largest-united-states-employer.html>
42. S.B. 329, 2021 Leg., 81st Sess. (Nev. 2021).
43. A.B. 47, 2021 Leg., 81st Sess. (Nev. 2021).
44. A.B. 1132, 2021-2022 Reg. Sess. (Cal. 2021).
45. A.B. 3583, Gen. Assem., 2021-2022 Reg. Sess. (N.Y. 2021).

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