

Models for Enhanced Health Care Market Oversight – State Attorneys General, Health Departments, and Independent Oversight Entities

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EXECUTIVE SUMMARY

State policymakers are urgently seeking tools to address rampant health care market consolidation, which drives health care costs higher and can threaten health care access and quality for patients. Traditional antitrust tools are often inadequate to address novel forms of health care consolidation, including vertical consolidation of health systems and physician practices, cross-market acquisitions across state lines, and the rapid entry of private equity, retail giants, and health insurers into health care provider markets.

In response, some states have strengthened and expanded the authority of their attorney general, along with the health department or an independent state entity, to provide greater oversight over health care transactions. This report describes how states have expanded oversight over health care transactions in two primary ways:

(1) Expanding the Review Authority of the Attorney General or Other State Agency: by requiring prior notice of a broader scope of transactions and/or establishing the ability to block or impose conditions upon the transaction without a court order; and

(2) Giving Authority to Review Transactions to Additional Oversight Entities: by vesting another state entity (in addition to the state attorney general) with the authority to review and report on a proposed transaction's broader health care market impact.

To assist state policymakers seeking to increase health care market oversight, we reviewed state statutes and regulations regarding health care transactions and interviewed state officials and staff members in eight states with expanded authority to review health care transactions. This report synthesizes this legal analysis and lessons from state conversations to present recommendations and policy considerations for state policymakers to strengthen oversight authority of health care transactions.

STATE ACTIONS TO STRENGTHEN OVERSIGHT OF HEALTH CARE TRANSACTIONS

Recommendations	Considerations
<p>1. Require prior notice to state officials of proposed health care transactions.</p>	<ul style="list-style-type: none"> • What data should be made public? • What threshold level, if any, should exempt transactions from notice? • Which health care entities and which transactions should be covered?
<p>2. Require concurrent notification and review by both the attorney general and the health department or other health care market oversight body.</p>	<ul style="list-style-type: none"> • What are best practices for collaboration between the agency and the attorney general? • What is the risk of the attorney general and other reviewing agency reaching different conclusions?
<p>3. Authorize the attorney general or state agency to block or impose conditions upon harmful transactions without a court order.</p>	<ul style="list-style-type: none"> • Which agency or agencies should have the authority to block a transaction?
<p>4. Establish health care transaction review criteria to assess whether the transaction is in the public interest.</p>	<ul style="list-style-type: none"> • How should a state define what it means for a transaction to be “in the public interest”?
<p>5. Have robust mechanisms for monitoring compliance with conditions, including significant penalties for noncompliance.</p>	<ul style="list-style-type: none"> • Can the conditions be imposed, monitored, and enforced, for the entire length of time of concern? • Should the attorney general or market oversight program monitor transactions and their impact on market conditions after closing?
<p>6. Allocate sufficient time and resources for implementation of health care market oversight programs.</p>	<ul style="list-style-type: none"> • How long should states have to review a transaction?
<p>7. Authorize the health department or health care market oversight entity to review and approve or place conditions upon significant health facility or service line closures.</p>	

INTRODUCTION

State policymakers are urgently seeking tools to address the harms of rampant health care market consolidation. Health care consolidation drives health care prices higher, and the price increases are passed on to patients in the form of higher premiums and out-of-pocket spending.^{1,2} In addition, soaring health care costs from consolidation ripple through the economy, squeezing households', employers', and governments' budgets and crowding out spending on other worthy investments.³

The health care market is consolidating in new ways and among novel market players – including vertical consolidation of health systems and physician practices, cross-market purchases that grow health systems across state lines, and the rapid entry of private equity, retail giants, and health insurers into health care provider markets.^{4,5,6} Beyond mergers or acquisitions, these transactions may take the form of joint ventures, affiliations, or management services contracts.

While vigilant federal and state antitrust enforcement remains critical, current antitrust doctrine may be insufficient to oversee the full scope of health care market consolidation. Traditional antitrust tools and precedent are ill-equipped to address non-horizontal transactions involving different product markets (e.g., hospitals, physicians, or payers) or geographic markets (e.g., Kaiser acquiring Geisinger Health).⁷ Moreover, consolidation resulting from smaller transactions, such as private equity roll-ups of physician practices, are too small to trigger notification under the Hart-Scott-Rodino Act.^{8,9} The 2023 Merger Guidelines established by the federal antitrust enforcers more broadly address non-horizontal and smaller, serial transactions, but federal authorities lack the resources to police the full scope of health care consolidation across the country. States can supplement these efforts with their parallel and supplemental enforcement authority over health care transactions. However, many states only require review of nonprofit hospital acquisitions and may overlook transactions involving for-profit entities, such as Amazon, Optum, CVS, or Walmart. Further, challenging a transaction typically requires a state attorney general (AG) to obtain a court order, which is so resource-intensive that it limits enforcement to the biggest transactions.¹⁰

As a result, some states have strengthened and expanded the authority of their AG, along with the health department^a or an independent state entity, to provide greater oversight over health care transactions.¹¹ This issue brief describes how states have expanded oversight over health care transactions in two primary ways: (1) by expanding the scope of transactions for review, requiring prior notice, and/or establishing the ability to block or impose conditions upon the transaction without a court order; and (2) by vesting another state entity with the authority to review and report on a proposed transaction's broader health care market impact on factors such as health care costs, access, quality, equity, or workforce.

To assist state policymakers seeking to increase health care market oversight, we reviewed the statutes and regulations regarding health care transactions in all 50 states.¹² In addition, we interviewed staff members in AGs' offices, health departments, and health care market oversight agencies in eight states with additional authority to review health care transactions: California, Massachusetts, Minnesota, New Hampshire, Oregon, Pennsylvania, Rhode Island, and Washington.^b This issue brief synthesizes our legal review and those conversations to

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^aThe name of the health agency may vary from state to state, such as the Department of Health Services (Arizona), Department of Public Health (Georgia), or the Office of Health Strategy (Connecticut), or the authority may be divided among multiple divisions or agencies.

^b All of the views, observations, conclusions, and recommendations in this brief are those of the authors, and not those of any particular state, office, or official.

glean lessons and present options for state policymakers to strengthen oversight authority of health care transactions.

EXISTING AUTHORITY OF STATE ATTORNEYS

GENERAL

State AGs possess authority as *parens patriae*, which is the power of the state to bring a suit to protect the interests, health, and well-being of the state’s residents.¹³ Nearly all state AGs have existing legal authority to supervise and enforce antitrust and unfair competition laws, state consumer protection laws, and laws governing nonprofit charitable organizations, applicable beyond health care to a broad swath of state economic activities.¹⁴ Though this report focuses on how states have expanded the authority of state AGs to oversee health care transactions, it is helpful to understand AGs’ existing authority as a backdrop for the evaluation of models for increasing state supervision of health care transactions.

Antitrust/Unfair Competition Laws

State AGs have authority under both federal and state antitrust laws to address anticompetitive mergers and acquisitions “whose effect may be substantially to lessen competition, or to tend to create a monopoly.”¹⁵ Four primary federal statutes govern antitrust and unfair competition matters: sections 1 and 2 of the Sherman Act, section 7 of the Clayton Act, and section 5 of the Federal Trade Commission Act.^{16,17} Most states also have their own antitrust laws, many of which follow the Sherman Act and some of which are also analogous to the Clayton Act.¹⁸ These laws address transactions and conduct by resulting entities that have the market power to profitably raise prices, reduce quality or services, or harm rivals’ ability to compete.

State antitrust laws that govern health entities vary widely. The Maryland Antitrust Act, for example, provides an exception to hospital mergers and acquisitions approved by the Maryland Health Care Commission.¹⁹ However, the Connecticut Antitrust Act makes no such exception, and in fact, Connecticut requires notice of all transactions between two or more health entities and specifically gives the AG review and approval authority over such transactions involving nonprofit hospitals.²⁰ As discussed below, states such as New York and Minnesota have recently proposed bills that would broaden current state antitrust law to address monopolization by dominant actors by requiring more stringent reporting requirements for mergers and imposing more substantial criminal and civil penalties.²¹

Consumer Protection: Unfair and Deceptive Acts and Practices Laws

Under state Unfair and Deceptive Acts and Practices (UDAP) laws, AGs have authority to investigate unfair and deceptive trade practices and seek monetary and injunctive relief.²² While these laws typically apply only after harm has been done, UDAP laws can be used to deter future harms. For instance, Connecticut, in response to rising costs caused by vertical integration, passed a law that prohibits hospitals from charging facility fees for outpatient office visits at an off-campus, hospital-based facility and has made a provider’s violation of the facility fee prohibition an unfair trade practice under the state’s UDAP law.²³ While this

model of enforcement may cause acquiring entities to more carefully weigh the benefits and drawbacks of a vertical integration acquisition, it is unlikely to deter such acquisitions altogether.

Nonprofit/Charitable Trust Authority

The authority of state AGs over nonprofit organizations, including nonprofit hospitals, and charitable trusts is governed by state law that varies in some respects. All states have nonprofit corporation and charitable trust laws; most states have nonprofit conversion statutes that specifically address sales of nonprofit hospitals or their assets to for-profit entities.²⁴ As a general rule, state AGs have supervisory power over charitable assets such as trusts and nonprofit organizations to ensure that fiduciary duties and charitable purposes are being met. Unlike for-profit corporations, nonprofits lack shareholders, so the AG represents the interests of the community in the protection of the charitable assets and purposes of the organization. These supervisory powers include the authority to investigate and prosecute violations of the state's nonprofit corporation and charitable trust laws. For the states that have nonprofit hospital conversion statutes, AGs also have the authority to review proposed transactions, hold public hearings, and in some cases deny a nonprofit hospital acquisition by a for-profit corporation or challenge such a conversion in court.^{25, 26}

LIMITATIONS OF EXISTING AUTHORITY

While state AGs' authority under antitrust, consumer protection, and nonprofit charitable trust laws are broad, this authority has significant limits particularly as it relates to health care transactions.

Unreported Transactions

First, AGs may not receive prior notice of transactions, or they may only be notified of transactions that are reportable under the federal Hart-Scott-Rodino Act (with a minimum deal value of \$111.4 million in 2023) or transactions that involve the sale of a nonprofit hospital to a for-profit company.²⁷ Smaller transactions (such as those involving physician practices), transactions among for-profit entities (such as private equity), and contractual changes of control may go unreported and therefore unreviewed by state AGs. Without prior notice, AGs must rely on consumer complaints, press releases, and active monitoring to know of pending transactions, which may not provide enough time or information for review.

Court Order Required to Oppose Mergers

Second, the AG must go to court to oppose a merger, which requires resource-intensive litigation to prove to the court that the transaction would be anticompetitive under relevant antitrust laws. As a result, smaller transactions – such as vertical hospital-physician acquisitions – typically go unchallenged even if they pose risks to the market through their cumulative impact.²⁸ Existing law and precedent tend to focus on horizontal mergers, and it may be difficult to convince a court to stop a non-horizontal transaction or consider non-price effects of a merger, such as health equity, access, quality, or broader public interest concerns.

Gaps in Oversight of Nonprofit Hospital Conversions

The legal bases to challenge nonprofit hospital conversions typically are limited to concerns about the nonprofit’s charitable purposes, conflicts of interest, and fiduciary obligations, and may not encompass a broader assessment of the impact of the transaction on public welfare. Moreover, the authority to supervise nonprofit conversions does not apply to health care transactions among for-profit entities, such as physician groups, private equity, or for-profit health care companies, such as CVS, Amazon, or Optum.

The limits of state AG authority to provide full oversight of health care markets has led some states to enhance that authority – by increasing the scope of transactions subject to notice and review, authorizing state officials to block or place conditions on transactions without having to obtain a court order, or vesting the Department of Health (DOH) or an independent oversight entity with the ability to conduct market-impact reviews of transactions and to report on or oversee the actions of health market participants.

MODELS OF EXPANDED OVERSIGHT OVER HEALTH CARE TRANSACTIONS

States vary widely in both the statutory authority and processes for review. While acknowledging that every state is unique, it is useful to organize state models for enhanced health care oversight along two dimensions: (1) who is given health care market oversight authority (the AG, the DOH, or an independent health care market oversight entity), and (2) what authority is given: (a) pre-transaction notice and review, or (b) notice plus the authority to approve transactions, impose conditions, or disapprove a transaction without seeking a court order (see Table 1).^c

Table 1. State Health Care Market Oversight Authority

		Attorney General	+ Department of Health	+ Health Care Market Oversight Entity
Notice and review (must go to court to challenge transaction under existing authority)	Nonprofit only	AZ, GA, ID, MI, ND, NH, NJ, PA, TN, VA	AZ, NJ	
	Nonprofit and for-profit	CO, HI, IL*, MA, MN, WA*	HI, MN, NY*	MA*, CA*
Approve, approve with conditions, or disapprove (includes notice and review authority)	Nonprofit only	CA, LA, MD, NE, OH, OR, VT, WI	MA, NE, VT	
	Nonprofit and for-profit	CT, NY*, RI	CT, RI, WA, WI	OR*

*Authority includes some nonhospital transactions, including provider groups and/or private equity transactions. The authority in states without the asterisk is specific to hospitals or health facilities.

^cIn most states, mergers of health insurers are reviewed by a state’s Department of Insurance. In this report, we exclude transactions that are reviewed exclusively by the Department of Insurance, typically transactions involving only insurers. We also exclude review by state certificate-of-need programs as the purpose of those reviews are typically to avoid duplicative services and to determine whether new capital expenditures meet a community need. Nonetheless, transactions involving an insurer and a provider are often reviewed by multiple state agencies, and we include the process of reviewing these complex transactions in this report.

Several of the states requiring pre-transaction notification specify review criteria for the AG's evaluation of health care transactions, which generally assess the impact on competition under antitrust or charitable trust law. Four states – Oregon,²⁹ Pennsylvania,³⁰ New Hampshire,³¹ and Minnesota³² – also require the AG to determine whether the health care transaction is in the public interest^d or that the hospital's governing board exercised due diligence in determining that the transaction is in the best interest of the community it serves. This "public interest" factor allows the AG to challenge transactions that will result in harms that can be difficult to address using antitrust law, like health care access, quality, and equity concerns.

Technically, the AG in the states discussed in this section must go to court to obtain a court order to block a transaction, but if the AG decides to challenge a transaction, the transacting parties may negotiate a settlement with the AG to agree to conditions that address the AG's concerns, or they may abandon the transaction altogether.³³ Consequently, merely requiring transacting parties to notify the AG before consummating a transaction can provide significant oversight of health care markets.

States Granting the Attorney General the Authority to Disapprove of or Condition Transactions

Recognizing the difficulty and expense of obtaining a court order to block a transaction, states may authorize the AG to block or impose conditions on health care transactions administratively. Ten states require the AG to approve transactions for a change in control of a nonprofit hospital (see Figure 1). While some of these states only give the AG the authority to review the use of the charitable assets, others, including California,³⁴ Maryland,³⁵ Louisiana,³⁶ Tennessee,³⁷ and Rhode Island,³⁸ allow the AG to consider whether the transaction is in the public interest or other broad impacts on the affected communities, including continued access to affordable health care services. In states where the AG has the authority to disapprove of a merger, a harmful transaction can be blocked, or conditions can be imposed, without expending the time and resources required for a court order. As a result, the AG may be able to provide broader oversight of more transactions than if a court order was required. Parties can still challenge the AG's decision in court as arbitrary or capricious,³⁹ but the courts generally give deference to the AG in these cases.

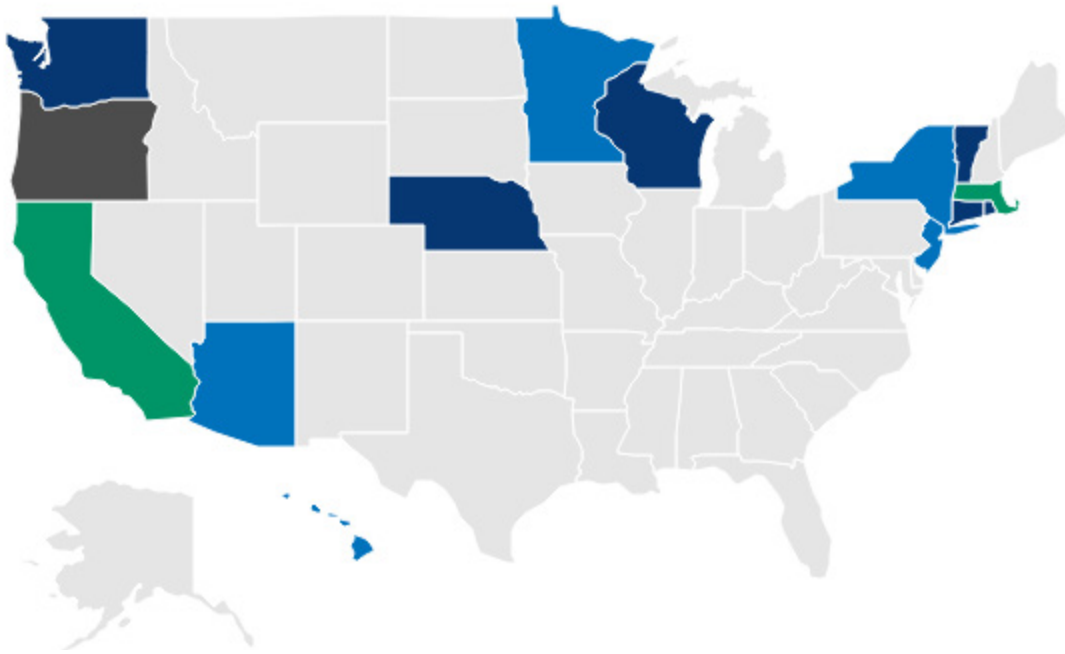
States with Additional Authority Vested in Another Agency

In addition to expanding the AG's oversight of health care transactions, many states require notification of significant health care transactions to another state agency, such as the DOH (see Figure 2). Massachusetts⁴⁰ created an independent health care market oversight body that must be notified before a material change transaction. Additionally, California⁴¹ and Oregon⁴² created market oversight programs within the state agency that licenses and collects data on hospitals and health care costs. Even though these programs are technically operated by the state DOH, the review of proposed mergers by these programs is significantly different than the review conducted by other state DOHs. These three states – Massachusetts, California, and Oregon – have similar notification and review processes, so we discuss them together.

^dIn this section, we exclude states where AG has the authority to block transactions that are not in the public interest, but where "public interest" is narrowly defined in the statute to only include consideration of how the nonprofit hospital assets are transferred and used for charitable purposes (see, e.g., Colo. Rev. Stat. § 6-19-403(a)).

Figure 2. State Agency or Health Care Market Oversight Entity Authority in Health Care Transactions

- Department of Health Notice and Review Authority
- Department of Health Approval Authority
- Independent Health Oversight Entity Notice and Review Authority
- Independent Health Oversight Entity Approval Authority



Notification to the Department of Health

In all states, the DOH is responsible for hospital licensure. The DOH often collects health care data on hospital discharges and all-payer claims. State certificate-of-need (CON) or health planning programs are frequently run through a division of the DOH. Thus, the DOH is the agency in many states with the most complete view of the state’s health care delivery system.

In 12 states (see column 2 of Table 1), health care entities must give pre-transaction notice to the state DOH, which then conducts a review of the transaction. In states where pre-transaction notice goes to both the AG and DOH, the parties are typically required to submit a single set of documents to both offices, and the AG and DOH conduct concurrent reviews. Seven states give the DOH the authority to block or place conditions on transactions, so, in these states, a transaction may be stopped by an adverse determination by either the DOH or the AG.

States that vest independent review authority in the DOH and the AG task each agency with reviewing different aspects of the transaction, with review criteria specific to their complementary authority and expertise. While some criteria, like cost and affordability, are typically reviewed by both agencies, the DOH is often better positioned to review the likely impact of a transaction on health care access, equity, and quality. In many states, like California, Massachusetts, and Minnesota, the DOH collects payment, encounter, and

discharge data from hospitals and other health care entities and has the expertise to review and analyze that data. Furthermore, the DOH typically oversees licensing bodies that routinely review quality data. States that have developed economic and market oversight expertise in the DOH may consider this model of transaction review authority shared between the AG and the DOH.

Health Care Market Oversight Body

Three states – Massachusetts, California, and Oregon – have gone further to create a dedicated state agency, program, or independent commission to review proposed health care transactions. In Massachusetts, the Health Policy Commission (HPC) is an independent commission funded through assessments on health care entities. In Oregon and California, the health care market oversight body is an office or program within the DOH and funded through the state budget with fees charged to transacting parties to conduct the merger review. In all three of these states, the emphasis of the oversight body is on transparency and public engagement. All three states publish transaction notices and solicit public comment. While the HPC in Massachusetts and the Office of Health Care Affordability in California do not have the authority to block or place conditions on mergers, the Oregon Health Authority, through the Health Care Market Oversight program, does.⁴³ In Massachusetts and California, the health care market oversight body publishes the findings of its review, which can be referred to or inform the state AG’s own review and enforcement actions regarding the transaction.⁴⁴

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LESSONS FROM STATES WITH EXPANDED MARKET OVERSIGHT AUTHORITY

Our review of state laws and conversations with state officials with enhanced health care market oversight authority yielded several lessons for other states that are interested in pursuing similar policies. Although the substantive statutory authority and division of authority varied, several areas of relative consensus emerged, which we label “recommendations.” Other insights about these models suggest there may be policy trade-offs involved, so the policy recommendation would vary with state preferences; we label these points “considerations.”

Recommendation 1: States should require prior notice to state officials of proposed health care transactions.

A common theme in our interviews was a strong recommendation for states to require parties to notify state officials or the AG before consummating a transaction. All of the states represented in our interviews required pre-transaction notification of some health care transactions. The interviewees unanimously agreed that relying on the thresholds established by the Hart-Scott-Rodino Act would miss some harmful transactions of health care providers. Given the difficulty of unwinding a merger, the interviewees emphasized the importance of assessing the implications of a transaction before consummation.

Consideration 1a: What data should be made public? States may want to require public notification and an opportunity to comment on proposed transactions. Informing the public about proposed transactions by posting notices allows the AG or other state officials to get input from the public about the potential impact of the transaction. In addition, states may require transacting parties to explain the reasons for the transaction and the intended changes to the delivery of health care services to their communities. These notifications can serve as a public accountability mechanism if the transacting parties indicated they would not close service lines, reduce essential services, or reduce access for Medicaid enrollees. A few states also acknowledged the potential risk of disclosing transactions and their terms before they are implemented. For example, if specific purchase terms of an agreement are publicized, there is at least the possibility that a competitor could come in and offer a higher or otherwise more attractive deal in an effort to disadvantage a rival. All states keep some financial information confidential on request, and none of the interviewees identified a situation in which public knowledge that a particular transaction was proposed caused competitive harms.

Consideration 1b: What threshold level, if any, should exempt transactions from notice? Many states exempt transactions below a threshold dollar amount, revenue threshold, or number of physicians. For example, Massachusetts only requires transaction notification between two nonhospital providers if the transaction “would result in an increase in annual Net Patient Service Revenue of the Provider ... of ten million dollars or more, or in the Provider or Provider Organization having a near-majority of market share in a given service or region.”⁴⁵ Minnesota requires transactions involving an entity with over \$80 million in annual revenue to be reported to the AG and DOH,⁴⁶ while transactions involving entities with annual revenue between \$10 million and \$80 million are only required to notify the DOH.⁴⁷ When we asked state officials about their perceptions on the existing thresholds, many responded that they would like lower dollar thresholds and notice of partial acquisitions as they thought they were missing some transactions that could negatively impact health care delivery and affordability. When asked about whether additional resources were needed to review a broader scope of transactions, the state officials expressed that the smaller transactions that were unlikely to harm competition could be identified and approved relatively quickly and did not require significant resources. State officials advised against requiring public reports assessing each transaction because significant staff time is typically required to write reports, even for insignificant transactions.

Importantly, even if individual transactions do not exceed a state’s reporting threshold, states can require notice of smaller transactions involving a common party (e.g., a buyer) over a period of time that cumulatively exceed the reporting threshold. For example, Minnesota defines a transaction as “a single action, or a series of actions within a five-year period.”⁴⁸ This approach follows the Federal Trade Commission and U.S. Department of Justice’s 2023 merger guidelines, which would require entities to notify authorities of serial transactions that collectively may affect the market.⁴⁹

Consideration 1c: Which health care entities and which transactions should be covered? Because health care transactions are becoming more common among entities at different places in the health care delivery space (e.g., consolidated payer-provider entities) or with institutional investors (e.g., private equity roll-ups), the state officials generally emphasized that the scope of authority should not be limited to nonprofit entities and should extend equally to for-profit entities, nonprofit organizations, physician groups, private equity, retailers, payers, or any other transaction in which one of the parties is a health care provider.

States should further consider whether and how to include transactions involving management services organizations (MSOs). MSOs are business entities that provide nonclinical services to physician groups, including administrative support. MSOs may negotiate payer contracts on behalf of physicians, and provide the scale and resources (like electronic health records) necessary to do risk-based contracting, but they do not typically own the physician practices; rather, they exert operational control via contract. The MSO model allows private equity firms and other corporate investors, such as Optum, to acquire control of physician practices without violating state bans on the corporate practice of medicine.⁵⁰ As a result, some states have sought to include MSOs in their health care market oversight programs. The state may accomplish this by specifically defining MSOs to be a “health care entity” subject to oversight or by broadly defining material change transactions to include MSO contracts or agreements that convey controlling interests to an MSO. For example, New York law specifically defines MSOs as a health care entity subject to the review of material changes by the DOH,⁵¹ and Massachusetts reviews any MSOs created for administering contracts with carriers.⁵²

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The MSO model allows private equity firms and other corporate investors, such as Optum, to acquire control of physician practices without violating state bans on the corporate practice of medicine.⁵⁰

Recommendation 2: States should require concurrent notification and review by both the attorney general and the health department or other health care market oversight body.

The primary advantage of joint review authority is that it leverages different agencies’ complementary goals and expertise to provide oversight over the broader health care market. State AGs have broad existing authority to investigate and enforce compliance with antitrust laws and consumer protections, with expertise in evaluating the economic market impacts of specific transactions on competition, prices, and consumers. Confidentiality is often a key element of the AG’s enforcement authority, and the ability to obtain and maintain confidential information through subpoena or civil investigative demands grants the AG access to financial and competitively sensitive information to assess market impacts of transactions and parties’ market conduct.

On the other hand, the DOH or other health care agency focused on transparency exists to protect and inform the public and often has greater expertise than the AG in evaluating non-price effects of transactions, including health care quality, access, health needs, workforce concerns, and health equity. These broader public interest considerations may also make it easier for the DOH to block or place conditions on non-horizontal transactions that would be difficult to challenge on pure antitrust grounds. Additionally, having the DOH review transactions allows the agency to step up if the AG is resource constrained or is focused on markets other than health care.

Consideration 2a: What are best practices for collaboration between the agency and the attorney general? In states where the AG and either the DOH or health care market oversight body shares authority for review, the interviewees emphasized that open lines of communication were critical, even when they were not reviewing a particular transaction. For example, Massachusetts’ HPC routinely writes policy and research reports on the status of particular aspects of the health care industry, such as the workforce⁵³ and consolidation in the pediatric market,⁵⁴ that are likely to be helpful to the AG, state policymakers, and the public. The interviewees also emphasized the need to share documents freely and for the agencies to share the same confidentiality requirements.

Consideration 2b: What is the risk of the attorney general and other reviewing agency reaching different conclusions? In all of the states with joint approval authority, either the DOH or the AG could disapprove of a transaction. Officials in one state voiced a concern that the AG might have difficulty challenging a merger in court if the DOH or health care market oversight body issued a public report in support of the merger. Conversely, Massachusetts has successfully used a shared review process, in which the HPC issues a public report and the AG or DOH must act to block a merger, for over a decade, and judges have often found the HPC reports to be persuasive. For example, in 2015 when Partners Healthcare System proposed acquiring additional hospitals in the Boston area, the court found the AG’s proposed conduct remedy to be insufficient to address the harms of increased health care costs that the HPC estimated would result from the acquisitions.⁵⁵ Specifically, the court held that the remedies proposed in the consent decree negotiated by the AG were “temporary and limited in scope – like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off.”⁵⁶ While having concurrent review risks reaching different conclusions, public reporting of both the decisions and the data underlying the decisions should allow courts to come to decisions that best serve the public interest.

Recommendation 3: States should authorize the attorney general or state agency to block or impose conditions upon harmful transactions without a court order.

The most powerful models of oversight pair prior notice and review with the authority to administratively stop or place conditions upon transactions deemed to be harmful or contrary to public interest. With such authority, the AG does not need to convince a court that a transaction would harm competition or resort to protracted litigation to obtain a court order to stop a transaction or a court-approved settlement to impose conditions upon a transaction.

Consideration 3a: Which agency or agencies should have the authority to block a transaction? One possible concern is that authorizing the AG to block health care transactions administratively could be seen as straying from the AG’s law enforcement role across other industries. States reluctant to grant an AG administrative authority over health care markets may want to vest that regulatory oversight function in the DOH or independent health care market entity, while vesting the AG’s office with the primary responsibility for enforcement.

Recommendation 4: States should establish health care transaction review criteria to assess whether the transaction is in the public interest.

Many state officials and staff in the AG’s office expressed the desire to consider factors beyond traditional antitrust or charitable trust doctrine to evaluate health care market transactions. Over the past few decades, antitrust enforcement has been insufficient to address vertical consolidation and other types of non-horizontal transactions, as well as transactions involving for-profit entities and corporate investors. Allowing officials to assess whether a transaction is in the public interest allows considerations of equity, access, quality, and workforce that are not generally contemplated under existing antitrust doctrine.

A common theme among interviewees was either an appreciation of a public interest standard (allowing consideration of the broader impact of the transaction on the affected community or public welfare) that they or another state agency had, or a desire to have such

a standard. Many also expressed a desire to expand their state’s review criteria to include impacts on equity and population health.

Consideration 4a: How should a state define what it means for a transaction to be “in the public interest”? Most states that have a public interest standard for reviewing health care transactions do not statutorily define what it means to serve (or harm) the public interest, or the statute defines the public interest standard in broad and flexible terms, including assessing the impact on health care access, quality, equity, the workforce, or the community as a whole. To preserve flexibility, states may want to authorize the reviewing officials to define the public interest in regulation or leave it to case-by-case determination.

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To preserve flexibility, states may want to authorize the reviewing officials to define the public interest in regulation or leave it to case-by-case determination.

Recommendation 5: States should have robust mechanisms for monitoring compliance with conditions, including significant penalties for noncompliance.

State interviewees acknowledged that it was easier for the parties if there was a single set of conditions with one monitor, but in some instances more than one monitor may be needed to oversee different conditions of the transaction. For example, in states where multiple divisions within the AG’s office share review authority, the charitable trust division and the antitrust division may impose conditions specific to their own review criteria. In these situations, the staff said the AG typically negotiated one consent decree or conditional approval, and the number of monitors would depend on the conditions imposed and the monitors’ expertise.

Conversely, in some states where the AG and DOH have independent authority to impose conditions, distinct sets of conditions flow from the agencies’ independent authority to block a transaction and separate review criteria. Interviewees in these states described the need to collaborate on any areas of overlap, but also described how access and equity conditions often require different expertise to monitor than contractual or economic conditions. Consequently, these states often had separate sets of conditions and separate mechanisms to monitor compliance with the conditions. Even so, if transacting entities were found to be noncompliant, the agencies typically relied on the AG for enforcement.

States need robust data collection or discovery authority to assess and monitor compliance with conditions and should have significant penalties for noncompliance. Existing laws often have minimal financial penalties, and some entities may see them as the cost of doing business. States should consider strengthening financial penalties for noncompliance and grant the AG the authority to unwind transactions or seek divestiture where the parties did not comply with the imposed conditions or where the transactions were consummated without the requisite review and approval.

Consideration 5a: Can the conditions be imposed, monitored, and enforced, for the entire length of time of concern? In most states, the oversight of conditions sunsets after a period of time (e.g., 5-10 years). Since the market power arising from the merger does not end after that time, states should consider ways to extend oversight over market behavior (prices, contracting, further acquisitions, service line closures) if the concerns about market power persist.

Consideration 5b: Should the attorney general or market oversight program monitor transactions and their impact on market conditions after closing?

Even approved transactions that appear procompetitive and in the public interest when they close may have unexpected consequences when other market conditions change. For example, if other facilities that are not involved in the transaction shut down, the merged entity may have significantly more market power than was expected when the transaction was reviewed. States should consider requiring the DOH or state market oversight agency to release an annual report assessing market conditions in that state that identifies geographic areas or types of providers (e.g., pediatric specialists or skilled nursing facilities) of concern and evaluates the impact of transactions that have occurred over the past 5-10 years. The findings of such an annual report could inform the market impact review process for future transactions.

Recommendation 6: States should allocate sufficient time and resources for implementation of health care market oversight programs.

The state should provide a sufficient period to implement an enhanced market oversight program, especially if the program requires coordination among state offices. This time is needed to hire staff, adopt systems and policies, and provide the public with guidance about how the program will work. Although there is no one best time frame for implementation, legislation might provide for six months to one year of lead time prior to the start of the program. While a longer implementation period may allow for promulgation of regulations, this consideration should be balanced against the possibility that longer lead times will incentivize market participants to hurry to close their transactions before the oversight program begins. Relatedly, state legislators may want to authorize the use of emergency or interim final rulemaking during the initial period of implementation. This gives the regulatory agencies or officials the flexibility to develop thoughtful rules to govern the oversight program but may also allow for quicker times to implementation, by condensing typical notice-and-comment procedures.

States need additional full-time personnel and the ability to contract with outside experts to operate an effective health care market oversight program. States need full-time staff with in-house expertise (including health economists, actuaries, accountants, data analysts, and attorneys) to conduct initial reviews, assess smaller transactions, and engage in the day-to-day operations of the program. These in-house personnel are in addition to, not in lieu of, the ability to hire outside experts and consultants to assist with comprehensive market impact reviews and serve as independent monitors/auditors for ongoing oversight of consummated transactions. Typically, the costs of third-party consultants can be charged to the parties to the transaction, whereas in-house staff time is covered through state budgeting and/or industry fees.

Consideration 6a: How long should states have to review a transaction? State AGs and other officials need sufficient time after notice to conduct market impact reviews. In general, our conversations reflected that 90 to 120 days' notice would allow such time to conduct reviews. Legislation authorizing the review should prohibit transactions from closing before the review is complete. The reviewing authority should also have the authority to stop the clock, or not start the clock, until all the necessary and requested information has been received from the transacting parties. Similarly, states can implement a process for expedited reviews of certain transactions, such as those involving distressed health care entities or transactions unlikely to pose significant market impacts.

Recommendation 7: States should consider authorizing the health department or health care market oversight entity to review and approve or place conditions upon significant health facility or service line closures.

Many states expressed concern that closures or reduction in service lines (e.g., labor and delivery or emergency services) do not require prior notice or approval by the state. Because facility or service line closures are not typically included in transactions reviewed by the AG, these changes in service lines often go unreviewed, particularly outside the context of a pending transaction. Maintaining service lines is a common condition in consent decrees/ conditions of approval of a particular transaction, but those are time-limited and difficult to enforce. In some states, a health care entity has to notify the DOH before a change in essential service lines and the DOH can hold a public meeting, but the DOH typically has no authority to require that a hospital keep service lines open. States should consider defining significant health facility or service line closures as “material change transactions” subject to prior notice, review, and approval (or conditional approval) by the state’s health care market oversight bodies. State officials may also want to consider including a requirement for transacting parties to notify the state and submit plans for review and approval of any planned reductions in services over a period of oversight (e.g., 10 years) as a standard condition in any transaction approvals.

States with an active certificate-of-need (CON) program could also pass a law requiring all significant reductions in services to be reviewed by the CON program. For example, New York passed a law in 2021 requiring a health equity assessment to be filed with the CON program for any merger, acquisition, closure, or substantial reduction, expansion, or addition of a hospital service, including a demonstration how a project will improve or affect access to hospital services by members of medically underserved groups.⁵⁷ Many states, however, have repealed CON laws due to the perception that they were anticompetitive,⁵⁸ so states without CON programs may consider granting the DOH or health care market oversight body the authority to review closures, as described above.

CONCLUSION

Over the past decades, rounds of consolidation in health care markets have led to market failure in many regions, resulting in inadequate and expensive health care for many Americans. The federal government has increased efforts to improve market oversight,⁵⁹ but state AGs play a key role in monitoring transactions and challenging anticompetitive mergers by health care entities through enforcement of antitrust and charitable trust laws. Recognizing the limitations of these laws, many states have passed laws requiring transacting health care entities to give notice to the AG or DOH prior to consummation of transactions. Other states have given the AG or DOH the authority to disapprove or place conditions on transacting parties in an administrative process, allowing state officials to consider the effects of the transaction along dimensions like access, quality, and equity. Collectively, these forerunner states provide an array of options for states seeking to strengthen health care market oversight to reinvigorate competition. Effective review of proposed mergers is one step toward reinvigorating competition and ensuring that all Americans have access to affordable, high-quality health care.

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