Examining the Authority of California's Attorney General in Health Care Mergers

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Introduction

The health care industry has recently experienced horizontal, vertical, and cross-market consolidation unprecedented in scale and scope. While certain types of industry consolidation[1] have been associated with marginal increases in the adoption of evidence-based care processes and health information technology, it has not been linked to conclusive increases in clinical integration, better patient experience, or improvements in patient outcomes.[2] In short, consolidation in the health care industry has not improved the quality of care.

However, consolidation within and across the industry has been found to generate market power and to drive price growth.[3] For example, economic research demonstrates that both horizontal consolidation of hospitals and vertical consolidation of physician practices with hospitals contribute to health care price increases throughout the nation, especially in California.[4] Recent evidence finds an association between hospital mergers and price increases even when the merger occurs across geographic markets.[5] Despite this evidence, many consolidation efforts, in particular vertical and cross-market mergers, continue to proceed unchallenged.[6]

Consolidation in the health care industry has not improved the quality of care, yet it has been found to generate market power and drive price growth.

State antitrust enforcement can provide a robust alternative to federal antitrust enforcement agencies. However, as described below, current constraints limit the ability of California's attorney general (AG) both to pursue all possible antitrust violations in California and to address the escalating scope and negative impacts of health care industry consolidation. As a result, some policymakers have begun considering expanding the AG's oversight of health care mergers.

This report examines the California AG's existing merger oversight authority, compares that to the authority held by other state AGs, and then offers a series of considerations for policymakers interested in ensuring that California's health care markets operate in a more consumer-friendly manner.

Existing Oversight Authority in California

Three California state agencies have the legal authority to oversee mergers and acquisitions involving health care entities.[7] For this report, the use of the word "merger" includes both mergers and acquisitions. "Consolidation" is used to include mergers and acquisitions as well as affiliations, joint negotiating agreements, joint ventures, and other exclusive contracting arrangements. Specifically, the California AG (i.e., the California Department of Justice) must approve most mergers[8] of *nonprofit* hospitals and may file suit to challenge *any* potentially anticompetitive mergers for violation of Section 7 of the federal Clayton Act in its *parens patriae* capacity. The doctrine of *parens patriae* allows the state, specifically its attorney general, to represent the interests of its constituents for claims of harm based on state or federal law.[9] In addition, the California Department of Insurance (CDI) must approve any mergers involving domestic insurers, while the California Department of Managed Health Care (DMHC) must approve of any mergers involving health plans.

Attorney General Oversight of Health Care Provider Transactions

The scope of AG review of a transaction depends on the types of entities that attempt to merge. Mergers involving only for-profit organizations, which often include physician practices and for-profit hospitals, do not require notice or AG approval. Mergers involving a nonprofit corporation require written notice to the AG for any sale or for a transaction that leads to the disposition of "substantially all of [a nonprofit corporation's] assets."[10]

Most important, mergers involving nonprofit health facilities, like nonprofit hospitals, require consolidating entities to provide written notice to — and obtain the approval of — the AG for any transaction involving a "material amount of assets."[11] When reviewing these transactions, the AG must examine whether the terms are fair and reasonable, including whether the transaction improperly benefits any private entity, is at fair market value, and is consistent with the purposes of the charitable trust in which the assets are held.[12] Additionally, the AG reviews the merger based on a variety of factors, such as whether the transaction will affect access to health care services, raise antitrust concerns, or is in the public interest.[13] After review, the AG may choose to approve, conditionally approve, or disapprove the merger.[14]

In a conditional approval, the AG may demand conditions related to the public's interest, including requiring that the merged system maintain adequate charity care and preserve access. For example, in 2018, when the AG conditionally approved the Dignity Health merger with Catholic Healthcare Initiatives, the AG required the new health system to offer discounts to uninsured patients earning up to 250% of the federal poverty level and to maintain emergency and women's health care services for 10 years.[15] Similarly, in 2015, when the AG conditionally approved the acquisition of the Daughters of Charity Health System by Prime Healthcare Foundation, the AG required Prime Healthcare to maintain certain medical centers as acute care hospitals and to preserve emergency and reproductive health care services.[16]

Regardless of the level of notice and approval required, the AG retains the authority to review and challenge *any* merger and acquisition in court, even if another state agency already approved the merger.[17] Specifically, the AG can use federal antitrust law to challenge any anticompetitive merger or acquisition, on its own behalf as a purchaser of health services or as *parens patriae* on behalf of the interests of its citizens, to prevent or repair harm from actions like anticompetitive mergers.[18]

For example, in 1999, the California attorney general filed a challenge, "in its *parens patriae* capacity for injunctive relief under Section 7 of the Clayton Act," [19] to the merger of Sutter Health's Alta Bates Medical Center with Summit Medical Center.[20] The merger made Sutter the largest provider of hospital services in the East Bay.[21] The court found that Summit Medical Center had successfully established the "failing company defense" because it faced a "grave risk of business failure" and lacked "any alternative purchaser."[22] Additionally, the court noted that, despite the merger, health plans could "discipline" hospitals by steering patients to lower-cost health providers.[23] The court also observed that if anticompetitive price increases did occur because of the merger, patients could choose to join Kaiser.[24] Finally, the court noted that the AG's claim that "patients are unwilling to travel to hospitals located in San Francisco or Contra Costa County for acute inpatient services" seemed to come mostly from "pure conjecture," which allowed the court to broaden the geographic market sufficiently to permit the merger.[25]

Over a decade later, a Federal Trade Commission (FTC) retrospective study found that Summit's post-merger price increase was among the largest of any comparable hospital in California, being between the 95th and 99th percentile of price changes.[26] Summit's prices before the merger were significantly lower than those of Sutter Alta Bates, but increased to align with Alta Bates' within a few years of the merger.[27] Steven Tenn, the author of this FTC study, concluded that the presence of other hospitals, which patients and health plans can turn to, was an "insufficient constraint" to prevent an anticompetitive price increase.[28]

By 2018, growing evidence of Sutter Health's higher prices led the AG to sue the health system for violation of the Cartwright Act, alleging that its contracting practices, such as "all-or-nothing" contracting, anti-tiering/anti-steering prohibitions, high out-of-network prices, and restrictions on price transparency harmed competition in Northern California.[29] In December 2019, the AG and Sutter Health reached a settlement agreement that requires Sutter Health to, among other

things, pay $575 million to compensate those covered under the class action and legal fees, limit out-of-network pricing, and stop all-or-nothing contracting.[30] As of publication time of this paper, court approval for the settlement remains pending.

CDI and DMHC Oversight of Transactions Involving Domestic Health Insurers and Health Care Service Plans

Mergers involving domestic[31] insurers[32] must receive prior approval from CDI, while mergers involving health care service plans[33] must receive prior approval from DMHC.[34] After receiving the required notice from the entities seeking to merge, CDI or DMHC examines whether the transaction may "substantially lessen competition" or "create a monopoly."[35] While the standard for review parallels federal antitrust review, the specific review at each agency differs. For mergers involving domestic insurers, CDI must consider competition in addition to other factors including financial solvency, fair and reasonable terms, and adverse effects on policyholders' interests.[36] Similarly, for mergers involving a health care service plan, DMHC must determine whether the resulting entity would still meet all requirements of the Knox-Keene Act,[37] such as whether the transaction will result in a "stable health care delivery system."[38] A new law, effective January 1, 2019, granted DMHC the authority to review whether the transaction may "substantially lessen competition" or "create a monopoly."[39] DMHC has not yet reviewed any transaction for competitive concerns under the new law, but in some recent approvals, DMHC successfully conditioned approval of the mergers with terms related to pricing and competition.

For example, in the three approvals DMHC conditionally granted in 2018 (CVS-Aetna, Cigna-Express Scripts, and Optum-DaVita), it required all three insurers to not increase premiums due to the acquisition and to keep premiums at a minimum.[40] When approving these mergers, DMHC also demanded other terms to preserve competition, including divestiture or firewalls.[41] Specifically, DMHC aligned with the United States Department of Justice (DOJ) and California AG settlement with CVS and Aetna [42] in requiring Aetna to divest its Medicare Part D business in California when merging with CVS.[43] When conditionally approving the Cigna-Express Scripts merger, DMHC also required Express Scripts to contract with unaffiliated health plans at arm's length (i.e., contracting as if Express Scripts were not merged with Cigna) for at least five years.[44] Express Scripts additionally agreed to maintain firewalls to insure that Cigna would not have access to Express Scripts' competitively sensitive information.[45] Finally, when conditionally approving the Optum-DaVita merger, DMHC required that Optum's medical groups, risk-bearing organizations, and individual providers must continue to contract at arm's length with unaffiliated California health plans for at least three years.[46] In requiring arm's-length contracting and firewall protection for competitively sensitive information, DMHC has tried, for a limited time, to preserve competition and mitigate the effects of potential monopolization.

In sum, three California agencies have a role in reviewing proposed mergers in the health care industry as summarized in Table 1 (see page 6). The type of entity merging or being acquired (e.g., nonprofit health facilities, domestic insurers, or health care service plans) determines which agency receives the notice and/or administers the review. Nonetheless, the AG must be notified of all mergers involving a nonprofit entity to ensure compliance with the mission of the organization. While the AG cannot require prior approval for some nonprofit entity mergers, the AG, after deeming any transaction to be anticompetitive under federal antitrust laws, can sue to block or unwind a transaction.

Table 1. Current Oversight Authority over Health Care Transactions in California

STATE AGENCY	STATUTORY AUTHORITY	TYPE OF ENTITY REGULATED	PREMERGER NOTICE AND APPROVAL	CONDITIONAL APPROVAL ALLOWED	REVIEW OF COMPETITION
AG	Cal. Corp. Code § 5914 et seq.	Nonprofit hospitals	✔	✔	—
AG	Clayton Act, Section 7 (15 U.S.C. § 18)	All mergers and acquisitions	—	—†	—†
CDI	Cal. Ins. Code §§ 1215.1 et seq.	Domestic insurers	✔	✔	✔
DMHC	Cal. Health & Safety Code §§ 1399.70 et seq.; 1339.70 et seq.*	Health care service plans	✔	✔	✔

*This section of the Knox-Keene Act regulates conversions and restricting of nonprofit health plans, which may include mergers and acquisitions.

†The AG can sue to enjoin (i.e., prevent) or unwind a merger only after such a merger is proposed or completed, respectively. (See, for example, *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1117 [N.D. Cal. 2001] [suing to enjoin a proposed merger]; and *California v. Am. Stores Co.*, 495 U.S. 271, 276 [1990] [California filing in federal court to prevent merger after FTC-approved merger].) However, after filing suit, an AG may conditionally approve such a merger via a court-approved settlement. Since the primary cusp of the Clayton Act is to prohibit any mergers or acquisitions that may substantially lessen competition or tend to create a monopoly, the AG's review of the merger must include competition.

Note: The state agency does (✔) or does not (—) have explicit statutory authority for the action described to the entity it regulates.

Potential Shortcomings of Existing Oversight

The potential shortcomings of existing oversight in California stem from (1) the absence of notice and approval procedures encompassing all health care consolidation activities, (2) the absence of a state law governing all forms of consolidation, and (3) limited personnel and financial resources available to conduct effective post-merger review. The difficulties caused by these shortcomings are discussed below.

Lack of Notification Requirements

While the AG retains the authority to challenge any anticompetitive health care merger, stronger and more effective antitrust enforcement authority would require that the AG receive prior notice of all relevant health care mergers with sufficient time to review and approve them. While nonprofit entities must notify the AG prior to a sale or transfer of their assets, the AG must rely on news reports and other sources to track consolidation of for-profit hospitals and physician practices. As a result, the AG may be unaware of a transaction, and therefore unable to challenge it, until after its completion. The historical reluctance of courts to unwind health care mergers that have already occurred increases the importance of premerger review by the AG.[47] Furthermore, the lack of oversight may inhibit the AG's ability to become aware of and thus challenge small, but potentially anticompetitive, transactions.

The AG must rely on news reports and other sources to track consolidation of for-profit hospitals and physician practices. As a result, the AG may be unaware of a transaction, and therefore unable to challenge it, until after its completion.

For example, mergers involving ambulatory surgery centers, which are typically for-profit entities; physician practices; and outpatient clinics rarely reach the Hart-Scott-Rodino minimum threshold for review by federal regulators,[48] so consolidation of similar entities may occur without federal or state oversight. As a result, this "stealth consolidation" can escape regulatory scrutiny while still affecting market power and health care prices.[49] Finally, some forms of consolidation,

such as cross-market mergers and contractual affiliations, also avoid regulatory scrutiny because they escape reporting requirements specified in the statute (see Table 1) despite potentially having similar anticompetitive effects as other mergers.

Difficulty of Challenging a Transaction

Another potential shortcoming of existing oversight is the difficulty the AG faces in opposing a potentially anticompetitive transaction. Specifically, even when the AG learns of a proposed transaction, other than one involving nonprofit health facilities,[50] the AG cannot demand a waiting period to allow time for review or additional documentation to inform its decisionmaking. Additionally, unlike mergers involving nonprofit health facilities, the AG cannot require premerger approval and unilaterally impose conditions for mergers that may involve only for-profit entities, like physician practices. As such, to prevent a potentially anticompetitive transaction involving, for example, physician practices, the AG can only challenge the merger in court.

However, unlike some other state competition laws, California's Cartwright Act does not allow the AG to challenge a potentially anticompetitive merger transaction under state law, so California merger challenges are subject to federal law precedents under the Clayton Act.[51] In addition, although the AG, as parens patriae, retains the authority to challenge any anticompetitive merger for violation of Section 7 of the federal Clayton Act or other antitrust laws, the AG may be hesitant to challenge some transactions, especially smaller ones, because such challenges can be resource intensive and time-consuming.

Post-Transaction Review and Compliance

A third potential shortcoming of existing oversight is the substantial time and resources required to conduct effective post-merger review and to ensure compliance with the terms of any conditional approvals. Specifically, when a transaction is approved with conditions, the AG and the merged entity agree to specific terms in a consent decree. Oversight of that consent decree, however, can require substantial time and resources to monitor consistently for many years. Further, post-transaction oversight lasts only for a limited time, while the market power obtained from a transaction will remain.[52]

Additionally, post-transaction oversight can easily be undone by other events such as hospital closure or sale to public entities. For example, the US Bankruptcy Court for the Central District of California, Los Angeles Division held, in one case, that the AG could not review a sale after the closure of a hospital and, in another case, that a consent decree negotiated by the AG regarding an acute care facility no longer applied after that facility was sold to a public entity.[53] These decisions demonstrate the need to amend California Corporation Code to include closed facilities in the definition of health care facilities and to allow the AG to review sales to any entities to prevent such entities from skirting enforcement of consent decrees through bankruptcy proceedings.

Consent decrees require substantial resources to oversee and are only effective with proper monitoring.

These three potential shortcomings in the California merger review process inhibit the ability of the AG to effectively oversee mergers and other forms of consolidation in the state, especially stealth vertical or cross-market consolidation. Hence, California could benefit from an enhanced consolidation review process that allows the AG to (1) systematically prioritize the review of proposed transactions with appropriate time for that review, (2) block or conditionally approve consolidation with likely anticompetitive effects without a lengthy and expensive court challenge, and (3) streamline the monitoring of consent decree compliance.

Consolidation Review in Other States: Three Approaches

To bolster their ability to ensure that health care consolidation serves the public interest, other states have taken a number of steps to increase consolidation oversight, including (1) required notification and/or approval of health care provider consolidation, (2) required review of a proposed transaction's impact on competition or an outright prohibition of certain anticompetitive transactions, and (3) mandated post-transaction monitoring and approval before a reduction or elimination of medical services. These approaches, described below, offer some potential avenues for enhancing California's consolidation oversight.

APPROACH 1

Notification and Approval of Provider Consolidation

To better understand and control health care consolidation, some states have expanded notice and approval requirements to include consolidation activity involving both for-profit and nonprofit hospitals and provider organizations (Table 2). Furthermore, Rhode Island and Hawaii require state agencies to approve all mergers involving hospitals over a certain threshold, which may be based on percentage of assets or control interest.[54]

Connecticut, Washington, and Massachusetts also require notice of proposed mergers involving all provider organizations, including dentists and other licensed health professionals (Washington and Massachusetts) or physician group practices (Connecticut). Including all provider organizations in the consolidation review process allows these states to more effectively review all forms of consolidation. Additionally, these three states require notice for any transaction that will result in a "material change" for a provider organization (Washington and Massachusetts) or a physician group practice, which includes two or more physicians (Connecticut).[55] In all three states, the definition of "material change" includes a merger, acquisition, and contracting affiliation between hospitals or group practices or a combination of the two.[56] Defining "material change" broadly allows these states to review transactions that do not qualify as a traditional merger but can have similar anticompetitive effects.

Table 2. State Requirements for Notice or Approval of Provider Consolidation*

	HOSPITAL M&As		NOTICE OF CONSOLIDATION	
	NOTICE OF	APPROVAL OF	PHYSICIAN GROUP	PROVIDER
Colorado	✔			
Rhode Island	✔	✔		
Hawaii	✔	✔		
Connecticut	✔	†	✔	
Washington	✔		✔	✔
Massachusetts	✔		✔	✔

*This table includes all state agency notice and approvals, including the state's departments of health and the state's department of justice (AG). Additionally, states like Colorado, Rhode Island, and Hawaii require notice and approval for all mergers that exceed a certain threshold of a specified percentage of assets or control interest.

†Connecticut approves all hospital mergers and acquisitions via its certificate of need program.

Post-transaction oversight lasts only for a limited time, while the market power obtained from a transaction will remain.

Further, Washington and Massachusetts define the term "provider organization" to encompass not only hospitals and physician organizations, but also organizations of other health care professionals, such as dentists and midwives.[57] This broad scope provides a comprehensive overview of health care consolidation. While Connecticut does not have the same scope as Washington and Massachusetts, it reviews mergers and acquisitions involving large physician organizations and/or hospitals as part of its certificate of need review.[58]

Considerations for California

To adopt a level of oversight similar to that of these six states, California could consider including for-profit hospitals and provider organizations in the list of entities that must provide notice and get approval from the AG before a merger or acquisition. The state could additionally adopt a "material change" notice standard, similar to Washington, Connecticut, and Massachusetts, so that the California AG can monitor *all* forms of health care consolidation. This definition could include affiliation agreements for joint negotiation, whole-firm acquisitions, and activities by a wider array of providers, such as dentists, air ambulance providers, pharmacies, and dialysis clinics. To minimize the burden of this approval on the AG, policymakers could design a tiered notification and approval framework that aligns the level of AG involvement with the level of market concentration, market power, and potential competitive harm. Such a framework is described in the box "Categories of Risk and AG Oversight: A Three-Tier Architecture" on page 12.

APPROACH 2

Adoption of Specific Standards Relating to Competition and/or Adoption of State Clayton Act Analog

While consolidation review currently allows the state AGs to consider the effect of competition, some states have articulated specific and explicit considerations regarding competition for inclusion in the review. Furthermore, some states have enhanced merger review by passing an analog to the federal Clayton Act that allows the state AG to challenge potentially anticompetitive consolidation in court. These two policy options, described below, are complementary and can be done in conjunction or separately.

Requirement to assess competitive effects. Some states specify what the AG must consider when reviewing competitive effects by adopting consolidation review criteria spelling out conditions potentially harmful to competition. Specifically, in Maryland, the AG can find that a nonprofit health entity has not properly exercised due diligence in considering the impact of consolidation, thus violating its fiduciary duty. The AG can prevent a merger if "the nonprofit health entity [has not] considered the risks of an acquisition, including whether an acquisition: (i) would result in diseconomies of scale; or (ii) would violate federal or state antitrust laws."[59] On the other hand, both Connecticut and Massachusetts mandate completion of a cost and market-impact review, which examines how the transaction would affect health care prices and the health care market.[60]

Adoption of state analog of Clayton Act. At least 10 states allow the AG to challenge a potentially anticompetitive merger or acquisition in state court by adopting a state analog of the federal Clayton Act.[61] These state statutes make unlawful any merger or acquisition that may "substantially . . . lessen competition or . . . tend to create a monopoly." While state AGs can sue under the federal Clayton Act, those with state analogs of the Clayton Act have effectively used these laws to challenge mergers in federal or state

court.[62] Further, cases brought under a state analog of the Clayton Act are not bound by federal court decisions interpreting the federal Clayton Act as long as the state's analog does not have a harmonization provision that requires that the state's antitrust laws be read in harmony with federal antitrust laws.

Considerations for California

California policymakers have two options to increase consolidation oversight by the state AG: (1) explicitly require review of competition during approval of a transaction, and/or (2) implement a state analog of the Clayton Act by amending the Cartwright Act or by passing new legislation.

First, California policymakers could consider requiring the AG to weigh any transaction's impact on competition, market power, price, and quality when considering approval for a transaction. This authority would mirror that granted to DMHC in AB 595 that allows DMHC to disapprove a transaction if it would "substantially lessen competition in health care service plan products or create a monopoly in this state." Currently, the state's AG may consider any factors it deems relevant, but the statutes only require consideration of factors related to charitable trust doctrine, and whether the transaction would affect health care access, be in the public interest, and affect cultural interests in the community.[63]

"Stealth consolidation" can escape regulatory scrutiny while still affecting market power and health care prices.

Expanding the list of factors would explicitly require the AG to consider the impact of a particular transaction on market-based factors like price, quality, and competition. These factors could enable the AG to more effectively oversee and oppose anticompetitive vertical and cross-market consolidation that federal antitrust enforcement officials have neglected.

Alternatively, California's policymakers could amend the state's antitrust law — the Cartwright Act — or pass new legislation to include language similar to the Clayton Act that would allow the AG to challenge *all* anticompetitive transactions, including affiliations and mergers. By empowering the AG to challenge an anticompetitive merger in a state court, the state could develop its own jurisprudence governing health care consolidation.[64] As a result, the California AG could file suit to block problematic cross-market and vertical consolidation that may not be fully addressed by federal antitrust law.[65]

Implementation of both options would ensure that the AG can stop a proposed transaction due to competitive concerns and also sue to enjoin or unwind a merger later on if the transaction proves anticompetitive.

APPROACH 3

Comprehensive Post-Consolidation Oversight Authority

In many states, including California, the AG can condition approval of a transaction through use of consent decrees that aim to mitigate competitive harm and, sometimes, retain or promote community benefits. However, oversight of consent decrees requires substantial resources and consistent monitoring.[66] Because limited post-consolidation enforcement may cause significant harm that cannot be easily remedied, some states enacted statutes to strengthen or standardize consent decrees by (1) requiring post-transaction disclosures by the merged entity (Colorado);[67] (2) allowing the AG to appoint an independent monitor, paid for by the merging entities, to assess whether the merged entity complies with the consent decree and the impact of the merger on competition, price, and access (Massachusetts and New Jersey);[68] and (3) prohibiting a reduction or elimination of health care services without prior approval (Rhode Island and Hawaii).[69] Additionally, Massachusetts has a Health Policy Commission (HPC), an independent agency that engages in many activities related to health care consolidation, including commenting on proposed consent decrees like the one between

Partners Healthcare System and the Massachusetts AG and assisting in consent decree oversight.[70]

Considerations for California

Despite the AG's ability to implement a wide array of conditions in consent decrees and the necessity of case-specific conditions, policymakers in California could aim to establish norms and guidelines around certain consent decree conditions to help promote consumer welfare and to limit administrative burdens and expenses. For instance, policymakers could consider adopting express statutory authority, similar to Corporation Code section 5917 and 5923, to require the AG to consider consent decree conditions that may include requiring the consolidated entity to (1) take on the burden of reporting compliance with the consent decree, (2) hire an independent monitor to conduct periodic compliance reviews, (3) maintain access to certain health care services post-consolidation, and/or (4) establish limits on prices, costs, or margins.[71] Alternatively, the AG could promulgate publicly available guidelines or policies regarding consent decrees and include similar provisions. Normalization of certain consent decree conditions could help maintain important consumer protections despite any changes in attorneys general ideologies or enforcement priorities.

Additionally, if California successfully implements the proposed Office of Health Care Affordability, that office, like the Massachusetts's HPC, could provide further oversight over compliance with consent decrees and report on consent decree effectiveness. Furthermore, policymakers could consider incorporating strict conflict of interest laws for the proposed Office of Health Care Affordability and any other entity providing reports to the AG, mirroring those of Massachusetts's HPC,[72] to best ensure the effectiveness of those agencies and the impartiality of their reports.

Together, these three approaches, properly and thoughtfully implemented, could provide a foundation for California to promote competition in its health care market by serving as the basis for important improvements to the AG's existing consolidation oversight.

A Framework for Improving the California AG's Oversight

Building on other states' oversight of health care consolidation with consideration of California's unique health care market conditions, a framework for potential policymaker actions is described below. The goal of this framework is to minimize anticompetitive consolidation through enhanced oversight in three areas: (1) increased pre-consolidation notification and approval requirements, (2) a tiered review process that allows the AG to challenge anticompetitive consolidation in state courts, and (3) strong post-transaction authority. In proposing this framework, structural remedies, such as blocking or unwinding an anticompetitive transaction, remain the preferred approach to potentially anticompetitive mergers, as post-transaction oversight, such as consent decrees and conduct remedies, only targets the effects of an anticompetitive merger for a limited period of time and require continuing, resource-intensive oversight.

AREA 1

Require AG Notification/Approval of All Health Care Consolidation Activity

California could consider requiring consolidating entities to notify the attorney general 90 days before making any "material change" to the operation of a health insurance company, health care service plan, or health care provider; this definition would apply to all licensed health care professionals and facilities, including hospitals, physicians, dentists, and pharmacists. All entities would be required to provide the AG with, at a minimum, justification of the consolidation (e.g., improving health care access or necessity for clinical integration); size of the transaction (e.g., number of providers in the consolidation entities, number of patients affected, or a dollar amount of the assets involved in the transaction); proposed market definition; and market share (or sufficient data to allow the AG to determine market share). Such requirements could enable the AG to more accurately track

consolidation in the state and more effectively challenge consolidation before it occurs.

AREA 2

Implement Tiered Levels of Notice and Approval

California could institute tiers for approval based on the size, scope, and potential impact of the transaction. Such an approach could help the AG focus time and resources on transactions that have a higher risk of impacting competition, market power, price, or quality. Policymakers could create specific, distinct criteria for each tier to allow categorization of health care transactions (see an example three-tier architecture in the box below). The categorization process should be as minimally burdensome as possible to limit the resources required for transactions with minimal impact on consolidation. Pre-consolidation notification could include a suggested tier placement, market share, and market definition, but the AG should thoroughly review the notification to ensure proper tier placement to identify potentially anticompetitive consolidation. Criteria for determining the tier placement could include the Herfindahl-Hirschman Index (HHI),[73] other indicia of the creation or exercise of market power in key markets, and the size of the transaction. These criteria should extend beyond traditional

Categories of Risk and AG Oversight: A Three-Tier Architecture

Tier I — De Minimis Risk. Transactions are likely to have a low impact on competition, market power, price, or quality. They may occur in unconcentrated markets (e.g., HHI < 1,500), in cases where the merged entity will not have significant market share in any health care market, or when the acquisition is too small to have a significant impact. For example, a small primary physician practice group acquiring a solo practitioner or a hospital contracting exclusively with specialists in an unconcentrated market would come within this category. For Tier I determinations, the AG must decide within 30 days whether to approve the merger or request additional information. If the AG takes no action during that time, the transaction is automatically approved.

Tier II — Moderate Risk. Transactions are likely to have a moderate impact on competition, market power, price, or quality. Inclusion in this category may be demonstrated by evidence showing that the transaction occurs in product or geographic markets with moderate concentration (e.g., an HHI between 1,500 and 3,600*); the merged entity would have a market share in any health care market that exceeds 40%; or the transaction would increase the market power of the resulting entity by a significant amount. Tier II would likely include a transaction between two intermediate physician practice groups, a hospital merger in a moderately concentrated county, or a large hospital system acquiring an important specialty group in a different geographic area with a competitive market. For Tier II determinations, the AG must affirmatively waive or approve the transaction within 60 days, subject to stays related to information requests.

Tier III — High Risk. Transactions are likely to have a considerable impact on competition, market power, price, or quality. Inclusion in this category may be demonstrated by evidence showing the transaction occurs in product or geographic markets that are highly concentrated (e.g., HHI > 3,600); the merged entity would have a market share that exceeds 60% in any health care market; or that the addition of the acquired or merged entity would increase the market power of the resulting entity by a significant amount. A transaction involving a major health system would likely be Tier III, even if the system were acquiring a small physician practice or a hospital in another geographic area. Transactions involving "must have" facilities or the only hospital in a region could also require Tier III review. For Tier III determinations, the AG would have 90 days, subject to stays related to information requests, to review the transaction and approve or deny the transaction. Tier III transactions carry a presumption of illegality. While the AG maintains the ability to challenge any merger or conditionally approve any merger with a consent decree, approval of Tier III transactions should, in nearly all cases, include a consent decree with post-market oversight.

*This number acknowledges many health care markets already exceed HHI of 2,500. This range is a suggestion, and policymakers should adjust this range as needed.

factors used in evaluating horizontal mergers to incorporate factors relevant to potentially anticompetitive vertical or cross-market consolidation as well. Upon determining the appropriate tier placement, the AG would notify the parties of the tier determination and the facts relevant to that decision.

In determining whether to approve a particular transaction at any tier, the AG would weigh the potential impact of the material change on competition, market power, price, and quality. Any applicable waiting period for approval could be stayed pending receipt of the requested information. To further facilitate the review, the AG could be empowered to request reports from the proposed Office of Health Care Affordability, or alternatively or additionally, the California Department of Public Health (CDPH) and Office of Statewide Health Planning and Development (OSHPD) to assist in providing an in-depth analysis on potential impacts and relevant data.

In addition to a new statute that would implement the tiered framework described above, policymakers could also consider supplementing, but not substituting, the tiered framework by increasing the AG's ability to challenge anticompetitive consolidation in state court, thereby creating an additional backstop should new information or changes in the market lead to the transaction resulting in being anticompetitive. Specifically, California could pass new legislation or amend the state's antitrust law, the Cartwright Act (California Business and Professions Code § 16720 et seq.) to resolve the issue in *State of California ex rel. Van de Kamp v. Texaco, Inc*, which prevents the AG from using the Cartwright Act to challenge mergers or acquisitions in state court. This new legislation or amendment would provide an additional cause of action outside of the federal Clayton Act to review all forms of consolidation, including affiliations and joint ventures. Policymakers should be sure to exclude a harmonization provision to allow state jurisprudence to develop outside of federal jurisprudence and antitrust laws. Amending the Cartwright Act in this manner could allow a statutory basis for broadened review of anticompetitive health care consolidation, including vertical and cross-market consolidation as well as affiliations that federal antitrust regulators have not typically enforced.

AREA 3

Strengthen Post-Transaction Review Authority

The AG's post-transaction review authority could be strengthened to improve the monitoring of consolidation's impact. To ensure the efficacy of conditional approvals, policymakers could consider standardizing and strengthening the AG's post-transaction review authority by enacting a statute that requires the AG to consider the use of certain specific, effective consent decree conditions. Alternatively, the AG could consider releasing publicly available guidelines or policies to ensure transparency and standardization of post-transaction authority.

Additionally, to ensure effective post-transaction monitoring, policymakers could grant the AG authority to request assistance from agencies that either collect data or monitor some aspect of health care, such as the proposed Office of Health Care Affordability, OSHPD, or CDPH. Additional levels of monitoring or review could help ensure compliance with consent decrees, consumer-friendly practices, health access, and competitive markets.

Finally, policymakers could consider expanding the California Corporations Code § 5914 et seq. to grant the AG the ability to approve of the sale of assets of *any* nonprofit health facility, regardless of its operating status, and require AG approval of any proposed modification to a consent decree resulting from a sale of nonprofit health facility assets to *any* entity, including a public entity. Such an amendment would fully resolve the challenges created by prior court decisions holding that existing law did not require AG consent for the sale of closed nonprofit hospitals and that previously imposed consent decrees did not apply to the sale of nonprofit hospitals to a public entity. Should policymakers seek to implement the tiered framework suggested above, they should include the provisions

described in this paragraph to ensure that any consent decrees imposed remain in effect regardless of any events or the status of the organization (public, nonprofit, operating, etc.) unless otherwise indicated or waived in writing by the AG.

Conclusion

Rampant consolidation in California's health care provider markets over the past two decades has proceeded without significant intervention or enforcement by federal antitrust authorities. Consolidation of various kinds — vertical, horizontal, and cross-market — and among various sectors of the health care supply chain — including hospitals and physician groups — have resulted in higher health care prices.

Robust oversight authority at the state level could limit potentially harmful transactions both before and after the fact. A number of states have undertaken such efforts to protect the competitiveness of their health care markets and the public interest. In California, constraints on the AG's ability to pursue antitrust violations and to address the negative impacts of consolidation — including higher prices and curtailed access to care — could be remedied through policy initiatives to enhance the AG's oversight authority.

Policymakers could accomplish this by (1) expanding the scope of AG review to include *all* providers and provider organizations, including sole physician practices; (2) creating a tiered notice and approval framework that aligns the level of AG involvement with the level of market concentration, market power, and potential competitive harm; and (3) enhancing its post-consolidation review process. Vesting prior approval authority in the AG would constitute a major change in the way transactions are reviewed and could lay the groundwork for effective competition in the multiple, diverse markets around the state. In the end, because consolidation leads to higher health care prices, an AG with a broader scope and clear holistic process of review could help improve the affordability of health care in California.

Endnotes

1. The word "consolidation" is used here to acknowledge that today's health care markets reduce competition not simply via traditional mergers and acquisitions but also through affiliations, such as joint negotiating agreements. Here, "merger review" is used to acknowledge that California's existing oversight is limited to traditional forms of consolidation, such as mergers and acquisitions. To enhance California's oversight on health care market consolidation, policymakers should consider "consolidation review" to encompass all forms. As such, "consolidation review" is used when discussing other states' approaches and California's framework to improving state oversight over market consolidation.
2. *See* Nancy D. Beaulieu et al., "Changes in Quality of Care After Hospital Mergers and Acquisitions," *New England Journal of Medicine* 382, no. 1 (2020); Marah Noel Short and Vivian Ho, "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality," *Medical Care Research and Review* (Feb. 9, 2019), doi:10.1177/1077558719828938; and Thomas Koch, Brett Wendling, and Nathan E. Wilson, "Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries," *Health Services Research* 53, no. 5 (Oct. 2018): 3549–68, doi:10.1111/1475-6773.12825.
3. *See, for example*, Richard M. Scheffler, Daniel R. Arnold, and Christopher M. Whaley, "Consolidation Trends in California's Health Care System: Impacts on ACA Premiums and Outpatient Visit Prices," *Health Affairs* 37, no. 9 (Sept. 2018): 1409–16, doi:10.1377/hlthaff.2018.0472; and Claire E. O'Hanlon, "What Can State Regulators and Lawmakers Do When Federal Antitrust Enforcement Fails to Prevent Health Care Consolidation?," *Health Affairs Blog*, March 26, 2019, www.healthaffairs.org. Hanlon writes that consolidation can also "reduce . . . the number of outside options for employers that purchase insurance, patients who seek care, and employees who work in these health systems. Furthermore, consolidated health entities have increased leverage over the communities in which they operate."
4. Richard M. Scheffler, Daniel R. Arnold, and Brent D. Fulton, "The Sky's the Limit: Health Care Prices and Market Consolidation in California," California Health Care Foundation, October 2019, www.chcf.org. See also *Consolidation in California's Health Care Market 2010–2016: Impact on Prices and ACA Premiums*, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, March 26, 2018, petris.org (PDF); and Scheffler, Arnold, and Whaley, "Consolidation Trends," 1409, 1411, and 1414.
5. Leemore Dafny, Kate Ho, and Robin S. Lee, "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *RAND Journal of Economics* 50, no. 2 (Summer 2019): 286–325, doi:10.1111/1756-2171.12270.
6. *See* Thomas L. Greaney, "The New Health Care Merger Wave: Does the 'Vertical, Good' Maxim Apply?," *Journal of Law, Medicine & Ethics* 46, no. 4 (Dec. 1, 2018): 918–26, doi:10.1177/1073110518821990.
7. Here, the use of "mergers" for current oversight authority in California would include both mergers and acquisitions. The later use of "consolidation" would include joint ventures and contracting affiliation, unless otherwise indicated.
8. The AG's review of a transaction is limited to assets transferred, sold, or otherwise disposed to a for-profit, mutual benefit, or another nonprofit corporation or entity. This scope does not include public entities as discussed in the federal bankruptcy case *In re Verity Heath System of California, Inc.*, which is referenced later in this paper.
9. *See Alfred L. Snapp & Son, Inc. v. Puerto Rico*, 458 U.S. 592, 607 (1982) (noting that to exercise *parens patriae* powers, the state has a "quasi-sovereign interest in the health and wellbeing — both physical and economic — of its residents in general").
10. *See* Cal. Corp. Code § 5913 (for nonprofit public benefit corporations), Cal. Corp. Code § 7913 (for nonprofit mutual benefit corporations).
11. Specifically, the scope of the statute covers all nonprofit public benefit corporations, nonprofit mutual benefit corporations, and nonprofit religious corporations either (a) operating or controlling a health facility such as general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, intermediate care facilities, and others described in Cal. Health & Safety Code § 1250 or (b) operating or controlling a facility that provides similar health care currently or with a suspended license. Cal. Corp. Code §§ 5914, 5920.
12. *See* Cal. Corp. Code §§ 5917, 5923.
13. *See* Cal. Corp. Code §§ 5917, 5923 and *Questions for Kathleen Foote, Senior Asst. Attorney General at the California Dept. of Justice*, AHLA PG Spotlight: Antitrust Practice Group Interview Series, March 2016 (discussing that the attorney general reviews for antitrust).
14. Cal. Corp. Code §§ 5917, 5923 (listing factors the attorney general should consider). This list does not include antitrust concerns, but the attorney general may review any relevant factors.
15. *Attorney General's Conditions to Change in Control and Governance of California Hospital Medical Center and Approval of Ministry Alignment Agreement by and between Dignity Health and Catholic Health Initiatives*, California Office of the Attorney General, November 21, 2018: 6, oag.ca.gov (PDF).

16. *Conditions to Change in Control and Governance of St. Francis Medical Center and Approval of the Definitive Agreement by and Among Daughters of Charity Ministry Services Corporation, Daughters of Charity Health System, Prime Healthcare Services, Inc.*, and Prime Healthcare Foundation, Inc., California Office of the Attorney General, February 20, 2015, oag.ca.gov (PDF).
17. This review and challenge authority is *separate* and *distinct* from the prior approval requirements listed above.
18. *Hawaii v. Standard Oil Co. of Cal.*, 405 U.S. 251, 258 (1972).
19. *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1117 (N.D. Cal. 2001).
20. The recent 2018 lawsuit and pending settlement involving Sutter Health (i.e., *UFCW & Employers Benefit Trust v. Sutter Health*) is an example of the attorney general acting in a *parens patriae* capacity. However, the 2018 lawsuit is not an example of challenging mergers but challenging anticompetitive behavior.
21. *See* "Attorney General Lockyer Files Antitrust Suit to Block Merger of Summit-Sutter/Alta Bates Medical Centers," press release, California Office of the Attorney General, August 10, 1999, oag.ca.gov; and Tom Abate, Ken Hoover, and *Chronicle* staff writers, "Alta Bates, Summit Merge / East Bay Hospitals Close Deal Within Hours of Judge's Ruling," *San Francisco Chronicle*, December 28, 1999, www.sfgate.com.
22. *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1137 (N.D. Cal. 2001).
23. *Id.* at 1130. But, as evidenced in the 2018 lawsuit filed by the California AG (i.e., *UFCW & Employers Benefit Trust v. Sutter Health*, No. CGC 14-538451 [consolidated with No. CGC-18-565398]), Sutter Health allegedly prohibited any steering for plans contracting with the health system.
24. *Id.* at 1119. This claim was contrary to a 1999 *San Francisco Chronicle* article reporting that "Kaiser has proposed shutting down its Oakland hospital and diverting Kaiser patients to Summit." Tom Abate et al., "Alta Bates."
25. *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1131 (N.D. Cal. 2001).
26. Steven Tenn, "The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction," *Intl. Journal of the Economics of Business* 18, no. 1 (2011): 76. The post-merger period was between January 2001 and December 2001.
27. Tenn, "Price Effects," 75.
28. Tenn, "Price Effects," 79.
29. People of the State of California, ex. rel. Xavier Becerra, No. CGC 18-565398 (Cal. Super. Ct. S.F. City and Cnty. 2018) (consolidated with. Case No. CGC 14-538451).
30. Notice of Motion and Motion for Preliminary Approval of Settlement; Memorandum of Points and Authorities (Redacted), *UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al.*, No. CGC 14-538451 (consolidated with. Case No. CGC-18-565398) (Cal. Super. Ct. S.F. City and Cnty.), California Office of the Attorney General, February 25, 2020, oag.ca.gov (PDF).
31. "Domestic insurer" is not defined for this section of the statute. However, Cal. Ins. Code § 739(c), the only statute that defines domestic insurer, defines it as "any . . . health insurer . . . organized in this state." While this definition is not applicable to the statute relating to domestic mergers, such definition may be persuasive. Additionally, 22 states defined a domestic insurer as an insurer formed under the laws of that particular state. As such, the authors assume this definition holds here. *Cf.* Cal. Const. art. XIII, § 28 (repealing in 1976 the definition of "domestic insurer," which would have defined a domestic insurer as an "insurer organized under the laws of this state and licensed to transact insurance in this state on or before December 31, 1966").
32. Cal. Ins. Code §§ 826, 1215. An "insurer" for this section of the statute is defined as "an organization organized for the purpose of assuming the risk of loss under contracts of insurance or reinsurance."
33. Cal. Health & Safety Code §§ 1345(f)(1–2). A "health care service plan," as regulated by DMHC, is defined as either "(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees" or "(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee."
34. Cal. Health & Safety Code § 1399.65(a)(1) (merger, purchase, or acquisition of a health care service plan requires "prior approval from the director"); and Cal. Ins. Code § 1215.2(d) (acquisition cannot be made "until the [insurance] commissioner approves").
35. Cal. Health & Safety Code § 1399.65(b); and Cal. Ins. Code § 1215.2(d)(2). DMHC has clarified that the scope of review is limited to "transactions where a California-licensed health plan is being purchased or where the plan is merging or consolidating with another California-licensed health plan or insurer." *See Delta Dental Purchase of Interest in Moda*, California Dept. of Managed Health Care (DMHC), January 3, 2019, www.dmhc.ca.gov (PDF).
36. Cal. Ins. Code § 1215.2(d)(1–5) (providing the criteria for which the insurance commissioner can disapprove a merger or acquisition).

37. Cal. Health & Safety Code § 1341. The Knox-Keene Health Care Service Plan Act of 1975 (Cal. Health & Safety Code § 1340 et seq.) regulates health care service plans, including health maintenance organizations (HMOs), within California. DMHC is charged with enforcing the Knox-Keene Act.

38. Cal. Health & Safety Code §§ 1399.65(a)(3), (a)(4).

39. Cal. Health & Safety Code § 1399.65.

40. *CVS-Aetna Acquisition Undertakings*, DMHC, 2018: 6, 8, www.dmhc.ca.gov (PDF); *Optum-DaVita Undertakings*, DMHC, 2018: 4, www.dmhc.ca.gov (PDF); *Cigna-Express Scripts Undertakings*, DMHC, 2018: 5, www.dmhc.ca.gov (PDF); and "DMHC Approves Optum's Acquisition of DaVita," press release, DMHC, November 28, 2018, www.dmhc.ca.gov.

41. *See CVS-Aetna*, DMHC; *Optum-DaVita*, DMHC; and *Cigna-Express Scripts*, DMHC.

42. *United States of America, et. al. v. CVS Health Corporation and Aetna Inc.*, Civil Case No. 18-2340 (RJL) (D.C. Cir. 2019) (ordering Aetna to divest from its individual standalone prescription drug plan, available to Medicare beneficiaries under Medicare Part D).

43. *CVS-Aetna*, DMHC, 10–11.

44. *Cigna-Express Scripts*, DMHC, 7.

45. *Cigna-Express Scripts*, DMHC, 8.

46. *Optum-DaVita*, DMHC, 6.

47. Robert A. Berenson et al., *Addressing Health Care Market Consolidation and High Prices: The Role of the States*, Urban Institute, January 2020: 30, www.urban.org (PDF); and *Opinion of the Commission by Deborah Platt Majoras, In the Matter of Evanston Northwestern Healthcare Corporation, Docket No. 9315*, Federal Trade Commission (FTC), n.d.,: 90, www.ftc.gov (PDF) ("Divesting Highland Park after seven years of integration would be a complex, lengthy, and expensive process").

48. "HSR Threshold Adjustments and Reportability for 2019," FTC, March 7, 2019, www.ftc.gov. For 2019, the HSR threshold requires reporting for deals valued over $90 million.

49. *See also* Thomas G. Wollmann, "Stealth Consolidation: Evidence from an Amendment to the Hart-Scott-Rodino Act," *American Economic Review: Insights* 1, no. 1 (June 2019): 90–91, doi:10.1257/aeri.20180137; and Reed Abelson, "Small, Piecemeal Mergers in Health Care Fly Under Regulators' Radars," *New York Times*, April 8, 2016, www.nytimes.com (one official called it "creeping consolidation").

50. *See* Cal. Corp. Code §§ 5915; 5921 (allowing 90 days for the AG to review, with an option to increase by another 45-day period. *See also* Cal. Corp. Code §§ 5917(g); 5923(g) (requiring that the AG has been provided with "sufficient information"); and 5250 (stating that a "corporation is subject at all times to examination by the Attorney General").

51. The Cartwright Act cannot be used to challenge mergers or acquisitions because of a California Supreme Court case, *State of California ex rel. Van de Kamp v. Texaco, Inc.*, where the court held that "the Attorney General's view that the Cartwright Act applies to mergers is not supported." 46 Cal. 3d 1147, 1168 (1988).

52. *See* Berenson, "Addressing Health Care," 31.

53. Memorandum of Decision Finding That the Debtor Is Not Required to Obtain the Consent of the California Attorney General to Sell the Assets of a Closed Hospital, In re Gardens Regional Hospital and Medical Center, Inc., Debtor, No. 2:16-bk-17463-ER at *1 (Bankr. C.D. Cal. May 15, 2017), www.govinfo.gov (PDF); Memorandum of Decision Overruling Objections of the California Attorney General to the Debtors' Sale Motion, No. 2:18-bk-20151-ER (Bankr. C.D. Cal. Dec. 26, 2018), www.leagle.com. Policymakers have made some piecemeal. But note, in 2017, AB 651 and SB 687 amended the code to include "a facility that provides similar health care, regardless of whether it is currently operating or providing health care services or has a suspended license" (emphasis added). It's unclear if the court in *In re Gardens* would have differed in its analysis, as the court's analysis hinged on the definition of "health facilities" as defined in Section 1250 of California Health & Safety Code rather than "a facility that provides similar health care." Furthermore, the bill analyses for either bill do not indicate the Gardens case as a reason for the amendment. However, it may be possible the inclusion of this language, which came in bill amendments after the Gardens decision, was in response to the Gardens court's decision. Additionally, as of publication, AB 2036 (2019), as introduced, seeks to ensure the longevity of the AG's consent decree by requiring that the "condition shall remain in effect for the entire period of time specified by the Attorney General" and that "an additional or subsequent sale, transfer [. . .], or other disposition of assets" would not affect the longevity of the conditions. In doing so, AB 2036 would directly answer the court's reasoning in *In re Verity*, which stated that there was no statute that allowed the AG to continually enforce.

54. Colo. Rev. Stat. Ann. § 6-19-102; R.I. Health and Safety § 23-17.14-4; and Haw. Rev. Stat. Ann. § 323D-71. For Colorado, the threshold for notice is "any transaction that would result in the sale, transfer, lease, exchange, or other disposition of *fifty percent or more of the assets* of a hospital," which would also include a "series of transactions taking place in any five-year period, which would result in the aggregate of the transfer of fifty percent or more of a hospital's assets" (emphasis added). For Rhode Island, the threshold for notice or approval is "any transfer by a person or persons of an ownership or membership interest or authority in a hospital, or the assets of a hospital [including joint venture] [. . .] which results in a change of ownership or control or possession of twenty percent (20%) or greater of the members or voting rights or interests of the hospital or of the assets of the hospital or pursuant to which, by virtue of the transfer, a person, together with all persons affiliated with the person, *holds or owns, in the aggregate, twenty*

percent (20%) or greater of the membership or voting rights or interests of the hospital or of the assets of the hospital" (emphasis added). Finally, for Hawaii, the threshold for notice or approval is an acquisition that "results in a change of ownership or control of twenty per cent or greater or which results in the acquiring person or persons holding a fifty per cent or greater interest in the ownership or control of that hospital."

55. *See* Conn. Gen. Stat. Ann. § 19a-486i; Wash. Rev. Code Ann. § 19.390.030; and Mass. Gen. Laws Ann. ch. 6D, § 13.

56. Conn. Gen. Stat. Ann. § 19a-486i(c); Wash. Rev. Code Ann. § 19.390.030(2); and Mass. Gen. Laws Ann. ch. 6D, § 13(a).

57. *See* Wash. Rev. Code Ann. § 19.390.020(12); and Mass. Gen. Laws Ann. ch. 6D, § 13(a). Washington defines "provider" as any licensed health care professional under Wash. Rev. Code Ann. § 18.130.040, which ranges from midwives and dental hygienists to veterinarians and physical therapists. Wash. Rev. Code Ann. § 19.390.020(11) (defining provider as "a natural person who practices a profession identified in RCW 18.130.040"). Similarly, Massachusetts defines a provider as any entity "qualified . . . to perform or provide health care services." Mass. Gen. Laws Ann. ch. 6D, § 1.

58. Conn. Gen. Stat. Ann. § 19a-486i. Connecticut supplements its notice requirements by also requiring notice of (a) a Hart-Scott-Rodino Act filing where a hospital, hospital system, or other health care provider is a party to the merger or acquisition or (b) a transaction that results in an affiliation between hospitals, hospital systems, or a combination thereof. Conn. Gen. Stat. Ann. § 19a-630(9); and Conn. Gen. Stat. Ann. § 19a-638(a)(2); (a)(3). On top of the notices required, Connecticut also requires a certificate of need for (a) any transfer of health facility ownership or (b) any transfer of large group practice, defined as having eight or more full-time physicians, ownership to an entity that is not a physician group.

59. Md. Code Ann., State Gov't § 6.5-301(e)(2).

60. Mass. Gen. Laws Ann. ch. 6D, § 13; and Conn. Gen. Stat. Ann. § 19a-639f.

61. Alaska Stat. Ann. § 45.50.568; Colo. Rev. Stat. Ann. § 6-4-107; Haw. Rev. Stat. Ann. § 480-7; Idaho Code Ann. § 48-106; La. Stat. Ann. § 51:125; Me. Rev. Stat. tit. 10, § 1102-A; Neb. Rev. Stat. Ann. § 59-1606; N.J. Stat. Ann. § 14:3-10; N.J. Stat. Ann. § 56:9-4; Okla. Stat. Ann. tit. 79, § 208; and Wash. Rev. Code Ann. § 19.86.060.

62. Examples in state court include *Maine v. Connors Bros* and in federal court include *Saint Alphonsus Med. Ctr. – Nampa, Inc. v. St. Luke's Health Sys., Ltd.*, where the Idaho AG alleged both a violation of the Clayton Act and the Idaho Competition Act, and *Washington v. Franciscan Health Sys.*, where the Washington AG alleged a violation of both the Clayton Act and the state analog of the Clayton Act (Wash. Rev. Code § 19.86.060).

63. *See* Cal. Corp. Code §§ 5917, 5923.

64. The current iteration of the Cartwright Act cannot be used to challenge mergers or acquisitions because of a California Supreme Court case, *State of California ex rel. Van de Kamp v. Texaco, Inc.*, where the court held that "the Attorney General's view that the Cartwright Act applies to mergers is not supported." 46 Cal. 3d 1147, 1168 (1988). *See also* David A. Upah, "State Anti-Merger Policy: Divesting the Federal Government of Exclusive Regulation," *Loyola Univ. Chicago Law Journal* 12 (1981): 531 (pointing out that an "effective state antitrust statute incorporating a provision similar to section 7 of the Clayton Act would be a means of assuring national policy at the state level"); Thomas M. Wilson et al., *State Merger Enforcement*, ABA Antitrust Section, Monograph 21, 1995: 42 (explaining how state law can designate a merger to be anticompetitive even if federal law does not without being preempted); and Thomas M. Wilson, *Antitrust Federalism: The Role of State Law*, ABA Antitrust Section, Monograph 15, 1988: 64 (noting that "purely intrastate" conduct may push the "jurisdictional limits of the federal court").

65. *See also* Clark C. Havighurst and Barak D. Richman, "The Provider Monopoly Problem in Health Care," *Oregon Law Review* 89, no. 3 (2011): 854, http://scholarship.law.duke.edu/faculty_scholarship/2281 (noting that "too many judges and commentators have chosen to deem competition as inappropriate in health care or to view nonprofit hospitals as benign servers of the public interest rather than as potential monopolists against whom consumers need antitrust protection").

66. *See* Berenson, "Addressing Health Care," 31.

67. Colo. Rev. Stat. Ann. § 6-19-405. In Colorado, for any nonprofit to for-profit transaction, the parties must annually report "grant-making and other charitable activities related to its use of the proceeds of the covered transaction received" and detail activities to show the merged entity complied with the merger review criteria for five years.

68. Mass. Gen. Laws Ann. ch. 180, § 8A(d)(5); and N.J. Stat. Ann. § 26:2H-7.11(i)(1). For more in-depth monitoring, Massachusetts and New Jersey allow the hiring of an "independent health care access monitor," funded by the acquiring entity, to monitor and report quarterly on community health care access for three years.

69. 23 R.I. Gen. Laws Ann. § 23-17.14-18; and Haw. Rev. Stat. Ann. § 323D-82. In Rhode Island, a hospital cannot eliminate or significantly reduce emergency or primary care services without the department of health's approval. Similarly, in Hawaii, an acquirer would need agency approval to "substantially reduce or eliminate direct patient care services at the hospital below the levels at" the time of acquisition.

70. *See* Berenson "Addressing Health Care" 52; and *Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgment by Consent, Commonwealth v. Partners Healthcare System, Inc. & Others*, SUCV 2014-02033-BLS2 (Mass. Super. Ct. 2015)

71. *See* Thomas L. Greaney, "Coping with Consolidation," *Health Affairs* 36, no. 9 (September 2017): 1564–71, doi:10.1377/hlthaff.2017.0558.

72. Mass. Gen. Laws ch. 6D § 2(c).

73. In developing this criterion, policymakers should not substantially rely on, but could consider, the Herfindahl-Hirschman Index (HHI) as the federal antitrust regulators do. HHI, as an indication for market concentration, does not account for a variety of health care consolidation including cross-market consolidation, vertical consolidation, or affiliation.