Suggested reading to prepare for Dr. Katherine Gudiksen's health care market competition presentation to the Oregon Health Policy Board on September 10, 2024

1) New evidence on the impacts of cross-market hospital mergers on commercial prices and measures of quality, showing price increases among hospital mergers in different markets (i.e. non-horizontal mergers)

2) Considerations for state-imposed conditions on healthcare provider transactions discussing the conditions that states have placed on mergers between 2012 and 2022.

3) Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities

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RESEARCH ARTICLE

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New evidence on the impacts of cross-market hospital mergers on commercial prices and measures of quality

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Abstract

Objective: To examine the impact of "cross-market" hospital mergers on prices and quality and the extent to which serial acquisitions contribute to any measured effects.

Data Sources: 2009–2017 commercial claims from the Health Care Cost Institute (HCCI) and quality measures from Hospital Compare.

Study Design: Event study models in which the treated group consisted of hospitals that acquired hospitals further than 50 miles, and the control group was hospitals that were not part of any merger activity (as a target or acquirer) during the study period.

Data Extraction Methods: We extracted data for 214 treated hospitals and 955 control hospitals.

Principal Findings: Six years after acquisition, cross-market hospital mergers had increased acquirer prices by 12.9% (CI: 0.6%–26.6%) relative to control hospitals, but had no discernible impact on mortality and readmission rates for heart failure, heart attacks and pneumonia.

For serial acquirers, the price effect increased to 16.3% (CI: 4.8%–29.1%). For all acquisitions, the price effect was 21.8% (CI: 4.6%–41.7%) when the target's market share was greater than the acquirer's market share versus 9.7% (CI: −0.5% to 20.9%) when the opposite was true. The magnitude of the price effect was similar for out-of-state and in-state cross-market mergers.

Conclusions: Additional evidence on the price and quality effects of cross-market mergers is needed at a time when over half of recent hospital mergers have been cross-market. To date, no hospital mergers have been challenged by the Federal Trade Commission on cross-market grounds. Our study is the third to find a positive price effect associated with cross-market mergers and the first to show no quality

effect and how serial acquisitions contribute to the price effect. More research is needed to identify the mechanism behind the price effects we observe and analyze price effect heterogeneity.

KEYWORDS
cross-market, health care competition, hospitals, price, quality, serial acquisitions

What is known on this topic

- Over half of the hospital mergers in the last decade have been cross-market.
- Cross-market hospital mergers lead to higher hospital prices.

What this study adds

- Serial acquirers are significant contributors to estimated cross-market price effects.
- We find no discernible impact of cross-market mergers on mortality and readmission rates for heart failure, heart attacks and pneumonia.
- Overall, this study provides further evidence that cross-market hospital mergers lead to price increases and novel findings of no quality effect and the impact of serial acquirers on the price effect. More antitrust scrutiny of these mergers—particularly those of serial acquirers—appears prudent given the current state of highly concentrated hospital markets in the United States.

1 | INTRODUCTION

U.S. hospitals have been consolidating for decades. Between 1998 and 2017 there were 1577 hospital mergers with 456 occurring from 2013 to 2017.[1] By 2016, 90% of Metropolitan Statistical Areas (MSAs) were highly concentrated according to the U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC)'s Horizontal Merger Guidelines.[2] Hospitals joining systems is a primary driver of this increase in concentration. From 1970 to 2019, the percentage of hospitals in multi-hospital systems increased substantially from 10% to 67%.[3]

As hospital systems have expanded, they've extended into regions where they previously had no presence.[4] A recent study found 55% of the 1500 hospitals targeted for a merger or acquisition from 2009 to 2019 operated in a commuting zone that the acquirer did not previously operate in.[3] The price and quality effects of these "cross-market" hospital mergers and acquisitions (M&A) are the focus of this paper.

Two previous empirical studies examine the price impacts of cross-market hospital mergers – Lewis and Plum (2017) and Dafny, Ho, and Lee (2019).[5,6] Lewis and Pflum (2017) found that prices at target hospitals involved in cross-market mergers increased by about 17% more than unacquired, stand-alone hospitals, with these increases reaching 29% for targets acquired by large systems and 33% for small targets being acquired. The authors additionally showed that out-of-market mergers lead to a relaxation of competition; that is, the prices of nearby competitors to acquired hospitals increase by around 8%.[5]

Dafny, Ho, and Lee (2019) found that hospitals involved in cross-market mergers had price increases of 7% to 10% relative to control hospitals if the acquisition was in-state, but did not find relative price increases when the acquisition was out-of-state. The price effect persisted when the target hospitals were excluded from the model, meaning the acquiring system's hospitals also had relative price increases. The price increase of the acquiring system's hospitals climbed to 31% when the acquirer had a below-median market share and the target had an above-median market share, and the price increase was 18% in the opposite situation, when the acquirer had an above-median market share and the target had a below-median market share.[6]

The contribution of our paper is threefold. First, we add to the empirical evidence of the price effects of cross-market hospital mergers by providing the first evidence using the actual prices paid by commercial insurers (and consumers through out-of-pocket payments). The two previous empirical papers on the price effects of cross-market mergers calculated prices by adjusting revenue data collected at the hospital level. Second, we provide the first evidence of the quality effects of cross-market mergers. Compared with the empirical evidence on the price and quality effects of horizontal hospital mergers, the empirical evidence on the effects of cross-market hospital mergers is sparse.

Finally, we are the first to present evidence of the price effects generated by serial cross-market acquirers. We do this by utilizing a new difference-in-differences estimator that allows treated units to receive multiple changes in their treatment dose by redefining the "event" as the first time a group's treatment changes.[7] Accounting for increases in treatment dose is particularly important in our setting as it was very common for the acquiring systems in our sample to acquire a cross-market hospital in more than 1 year during our study period. Importantly, this allows our work to complement Dafny, Ho,

and Lee (2019), which limited its treatment sample to hospitals experiencing a treatment only once during the five-year period spanning the transaction generating that treatment. The authors noted that this means the transactions included in their final analysis sample "involve smaller acquirers (as measured by the number of facilities), as larger acquirers tend to engage in multiple closely timed acquisitions."[6] The new estimator allows us to estimate the impact of cross-market mergers on the prices of hospitals that are part of the large systems that serially acquire cross-market hospitals.[7]

We focus on the cross-market price effect at acquiring hospitals as opposed to target hospitals. Lewis and Pflum (2017) convincingly show that cross-market mergers lead to higher prices at target hospitals.[5] But from an antitrust perspective, challenging cross-market mergers is less of an uphill battle if the evidence is clear that cross-market mergers allow acquirers to increase their prices, because prices at the acquirer are not likely to increase due to a "change in control" or better quality. Change in control theory in the context of cross-market mergers boils down to the acquirer being able to increase prices at the target because the target wasn't maximizing profit; either because it was nonprofit and maximizing profit wasn't its objective, or because it didn't have the bargaining skill to negotiate high prices.[8] Acquirers by definition do not experience a change of control and thus this explanation for higher prices after a cross-market merger is ruled out. It also seems unlikely that an increase in quality could explain acquirer price increases after a cross-market merger. Acquirers are often large health systems whereas targets are frequently independent hospitals.[3] It seems unlikely that a large health system's quality would improve by merging with an independent hospital. However, despite acquirer quality improvements being a priori unlikely, we test this empirically to confirm our intuition.

1.1 | Potential mechanisms

To date economists have proposed five mechanisms for cross-market price increases: (1) common customers, (2) tying, (3) change in control, (4) hospital quality improvements, and (5) multimarket contact. As noted in the previous paragraph, our focus on acquirer prices is meant to make it unlikely that (3) and (4) are the mechanisms driving our result. We discuss (1), (2), and (5) briefly for the remainder of this section (see King et al. 2023 for a more detailed review of these mechanisms).[8]

The common customer theory states that cross-market price increases can arise from the market linkages created by the existence of a common customer. The common customer could be an employer or insurer. Employers (or the insurers who sell to them) need provider networks that span multiple patient markets if they have employees in multiple markets. For instance, a large national employer like Wal-Mart needs a health plan that has provider networks in all parts of the country. Wal-Mart could contract with a different local health plan in all parts of the U.S., but it's easy to see how contracting with one insurer that has created a provider network that covers the whole country could be desirable.

Tying deals with how a firm with market power in one market (the tying market) can tie its sales in that market with its sales in a second market (the tied market). Tying by a monopolist can reduce the sales of its competitors in the tied market and lower their profits below a level that would justify continuing operations.[9] Bundling across markets can also increase the bargaining strength of firms and lead to higher prices without disadvantaging rivals.[10,11]

Multimarket contact is the notion that as hospital systems grow they will increasingly come into contact with each other in more and more markets throughout the U.S. Bernheim and Whinston[12] show how multimarket contact can lead to collusive behavior. For example, if systems A and B know they are going to compete against each other several times for inclusion in insurers' networks, it may make sense for them to not compete as much on price as they would have in a one-off situation for fear of retaliation.[13,14]

2 | DATA

2.1 | Hospital prices

We utilized 2009–2017 commercial claims from the Health Care Cost Institute (HCCI)'s 1.0 database to construct our measure of hospital price. HCCI 1.0 pools medical claims data from three large U.S. health insurers—Aetna, Humana, and UnitedHealth. The HCCI data covers on average 45 million under age 65 individuals with commercial insurance per year from 2009 to 2017 and includes observations from every U.S. state and metropolitan statistical area. Our price measure is the amount paid to a hospital for a standardized inpatient admission. The amount paid is the amount paid by the health insurer plus the out-of-pocket amount paid by the patient, including deductibles, copayments, and coinsurance. We standardized prices by dividing the total amount paid for admissions to a hospital by the number of standardized admissions. A standardized admission is an admission of average intensity, with a relative weight equal to one, but admissions that deviate from the average intensity receive a relative weight that reflects their intensity. We used MS-DRG relative weights, which assign relative weights based on the clinical characteristics of the inpatient stay and the expected resource requirements. For example, a kidney transplant is more complicated and requires more clinical resources than an uncomplicated childbirth. In 2017, a kidney transplant had a relative weight of 3.2, and, therefore, accounted for 3.2 standardized admissions, whereas an uncomplicated childbirth, which had a relative weight of 0.6, accounted for 0.6 standardized admissions. This data has been used in several studies that have analyzed the impact of health care consolidation on prices, but has never been used in the context of cross-market hospital mergers.[15–17]

2.2 | Hospital quality

Our measures of hospital quality were extracted from CMS' Hospital Compare. We extracted six measures of quality for which data was

consistently reported during from 2009 to 2017: 30-day mortality and readmissions rates for heart failure, heart attacks, and pneumonia. All six measures can range from 0 to 100 with lower values indicating better quality. This data has been used in several studies to analyze the impact of hospital consolidation on quality.[16,18]

2.3 | Cross-market hospital mergers

We began by constructing a panel of the short-term community hospitals using Fiscal Years 2009–2017 of the American Hospital Association (AHA)'s Annual Survey. We then used hospital ownership information from AHA to determine whether a hospital was involved in M&A activity during a given year. We identified hospitals that were M&A targets as those whose system identifiers changed between years in the AHA data. We identified acquirers as hospitals in systems containing hospital targets, but whose system identifiers did not change. In the case when a merger led to all hospitals in the merged system obtaining a new system identifier, we categorized the hospitals in the system that had more hospitals pre-merger as acquirer hospitals and the hospitals in the system with fewer hospitals pre-merger as target hospitals.

2.4 | Control variables

We included a set of time-varying hospital- and county-level control variables in our models. The hospital-level control variables were extracted from AHA and included a hospital's number of beds, indicator variables for the hospital's for-profit, government, or teaching hospital status, and the hospital's share of inpatient days from Medicare and Medicaid enrollees (to control for potential cost-shifting) as well as its number of technologies. The county-level control variables included number of hospitals, uninsured rate, median household income, population, and unemployment rate.

3 | EMPIRICAL STRATEGY

We used the event study estimator developed by de Chaisemartin and D'Haultfoeuille (Forthcoming) (hereafter, dCDH estimator) to quantify the impact of cross-market hospital mergers on the price and quality of acquiring hospitals.[7] To the best of our knowledge, the dCDH estimator is the first estimator that both (1) incorporates the recent developments in the difference-in-differences event study literature[19] (e.g., accounting for staggered interventions with heterogeneous treatment effects) and (2) enables an estimate of multiple treatments, which is critical for our serial acquisition analysis. The estimator allows treated units to receive multiple changes in their treatment dose by redefining the "event" as the first time a group's treatment changes. Accounting for increases in treatment dose is particularly important in our setting as it was very common for the acquiring systems in our sample to acquire a cross-market hospital in more than 1 year between 2011 and 2017. Of the 214 acquiring hospitals that met our treatment requirements, only 32 of them acquired a cross-market hospital in only 1 year from 2011 to 2017. Among the remaining 182 treated hospitals, 96 hospitals were part of systems that acquired a cross-market hospital in four or more years from 2011 to 2017. These 96 hospitals were spread across 12 systems (see Table A1 in the appendix for the full distribution).

Before presenting the regression model we estimated, we first detail how we constructed our sample of treated and control hospitals. Treated hospitals met the following criteria: (1) they, independently or as part of a system, acquired a hospital (or system) that was further than 50 miles away between 2011 and 2017, with the first acquisition occurring from 2011 to 2015; and (2) they were never a target of an acquisition from 2009 to 2017. The 50-mile requirement was to ensure that the mergers were safely "cross-market." While treated hospitals needed to be more than 50 miles from any target hospital, it could be the case that other hospitals in the acquiring system were within 50 miles. For instance, if a two-hospital system (hospitals A1 and A2) acquired independent hospital B, and A1 was 100 miles from B and A2 was 25 miles from B, we would consider just A1 to be treated. Other studies use similar distance cutoffs for defining cross-market. Lewis and Pflum (2017) used 45 miles and Dafny, Ho, and Lee (2019) used 30 min' drive.

The requirement that the first acquisition needed to occur during 2011–2015 means the treated hospitals did not participate in a merger or acquisition transaction for at least 2 years prior to treatment, providing a "clean" pre-treatment period to assess relative difference-in-differences in prices between the treatment and control hospitals prior to the treated period. This requirement also ensures at least 3 years of price data post-acquisition (including the acquisition year) was available for treated hospitals. Hospitals that were not involved in M&A (either as targets or acquirers) from 2009 to 2017 served as our control hospitals.

The idea behind the dCDH estimator is to take the perspective of a social planner seeking to conduct a cost–benefit analysis comparing hospitals' actual treatments (i.e., acquiring a cross-market hospital) to the counterfactual "status-quo" scenario where every hospital would have kept the same treatment as in period 1 (i.e., no cross-market acquisitions). In our context, the planner wants to know if the cross-market mergers that took place over the entire duration of the study period led prices and quality to be higher or lower. This means we can account for a common scenario in our data of a treated hospital receiving multiple "doses" in the form of acquiring multiple cross-market hospitals over our study period. For instance, if a hospital acquired a cross-market hospital in 2011, 2015, and 2017 we would consider it to have been treated three times. See Appendix A for the technical details and identifying assumptions of the dCDH estimator in our context.

4 | RESULTS

Table 1 shows descriptive statistics for the 214 treated hospitals and 955 control hospitals in our sample. Treated hospitals were more

TABLE 1 Attributes of treated and control hospitals.

	Treated hospitals mean (SD)	Control hospitals mean (SD)	*p*-Value differences in means
Dependent price variable			
ln(Price)	9.35 (0.46)	9.17 (0.54)	<0.01
Price ($)	12,661 (5552)	11,079 (6344)	<0.01
Hospital characteristics			
Beds	187 (192)	206 (216)	<0.01
For-Profit	0.21 (0.41)	0.02 (0.15)	<0.01
Government	0.06 (0.23)	0.34 (0.47)	<0.01
Teaching	0.05 (0.22)	0.09 (0.29)	<0.01
Medicare Share of IP Days	0.53 (0.14)	0.50 (0.17)	<0.01
Medicaid Share of IP Days	0.19 (0.11)	0.21 (0.15)	<0.01
Technologies	50 (31)	49 (33)	0.65
County characteristics			
Population	486,317 (1,303,104)	713,857 (1,637,878)	<0.01
Median Income ($)	49,863 (12,301)	51,986 (13,923)	<0.01
Uninsured	0.15 (0.06)	0.15 (0.06)	0.02
Unemployed	0.07 (0.03)	0.07 (0.03)	0.13
Rural	0.31 (0.26)	0.31 (0.28)	0.85
Hospitals	4.3 (9.2)	5.8 (11.9)	<0.01
Census region			
Northeast	0.06 (0.23)	0.15 (0.36)	<0.01
Midwest	0.24 (0.43)	0.26 (0.44)	
South	0.41 (0.49)	0.35 (0.48)	
West	0.29 (0.46)	0.24 (0.43)	
Observations	1926	8595	
Unique Hospitals	214	955	

Note: Statistics in the table are pooled across years. Treatment hospitals included hospitals (or hospitals within systems) that met the following criteria: (1) hospitals that made an acquisition from 2009 to 2017 of a hospital (or system) that was further than 50 miles away, with the first acquisition occurring from 2011 to 2015; and (2) hospitals that were never a target of an acquisition from 2009 to 2017. Control hospitals were never part of merger activity (either as a target or acquirer) from 2009 to 2017.
Abbreviations: IP, inpatient; ln, natural log; SD, standard deviation.

likely to be for-profit and have a higher share of Medicare inpatient days than control hospitals. They also had fewer beds, a lower share of Medicaid inpatient days, and were less likely to be government or teaching hospitals than control hospitals. In terms of county characteristics, treated hospitals were in counties with a lower population, lower income, and fewer hospitals than control hospitals. They were also more likely to be in the South and West Census Regions than control hospitals.

Figure A1 in the appendix shows the raw price trends for treated and control hospitals. As a reminder, our group of treated hospitals was constructed so that they were first treated during the 2011–2015 time period. The breakdown by treatment year for the 214 treated hospitals in our sample is 80 in 2011, 31 in 2012, 49 in 2013, 37 in 2014, and 17 in 2015. The average price at treated hospitals started higher than that of control hospitals and remained higher throughout our 2009–2017 study period. The average price for treated hospitals grew by 40% over the period (from $10,479 in 2009 to $14,640 in 2017) whereas the average price for control hospitals grew by 39% over the period (from $9184 in 2009 to $12,758 in 2017).

Figure A2 in the appendix splits the treated group of hospitals by whether the hospital was part of a system that acquired cross-market hospitals in four or more years from 2011 to 2017. The control hospital price trend lines in Figure A2 are the same as the control price line shown in Figure A1. Panel A shows the average price of the 118 treated hospitals whose systems acquired cross-market hospitals in three or fewer years from 2011 to 2017 grew by 33% (from $11,299 to $15,059). Panel B shows the average price of the 96 treated hospitals whose systems acquired cross-market hospitals in four or more years from 2011 to 2017 grew by 49% (from $9471 to $14,125).

Figure 1 graphically depicts the results of our regression analysis (see Table A2 in the appendix for the regression coefficients underlying the figure). The placebo estimates $(t = -4 \ldots -2)$ all hover around zero and are not statistically significant. The DID_t estimates start out

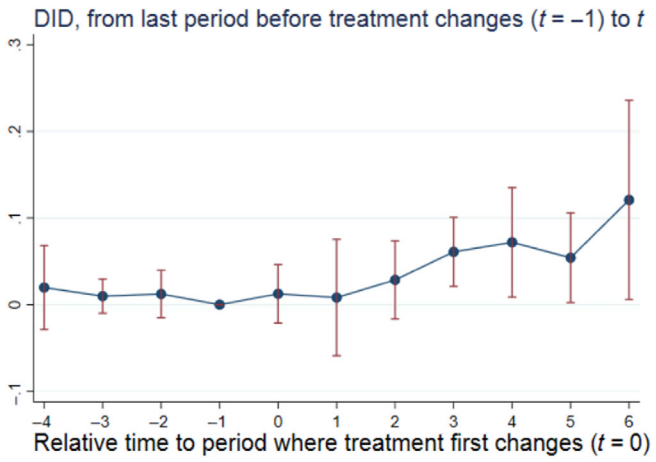

FIGURE 1 Effect of cross-market M&A on acquirers' prices. Standard errors were estimated using 100 bootstrap replications clustered at the hospital level. The regression underlying this figure included hospital and year fixed effects as well as time-varying hospital- and county-level control variables. The hospital-level control variables included number of beds, indicator variables for the hospital's for-profit, government, or teaching hospital status, and the hospital's share of inpatient days from Medicare and Medicaid enrollees as well as its number of technologies. The county-level control variables included number of hospitals, uninsured rate, median household income, population, and unemployment rate. The coefficient estimates corresponding to this figure are available in Table A2 of the appendix. DID, difference-in-differences; M&A, mergers and acquisitions; *t*, time since treatment first changes.

around zero and begin trending up at $t = 2$. By $t = 3$ the coefficient estimate is 0.061 and is statistically significant ($p = 0.003$). By $t = 6$ the coefficient estimate is 0.121 ($p = 0.039$) indicating that prices at hospitals treated for the first time six periods ago are 12.9% (=(exp (0.121)-1)*100) higher relative to prices at control hospitals.

In Figure 2 we attempt to disentangle the 12.9% price effect. Panel A shows the event study where we keep the control hospitals the same, but the treated group is now the 118 treated hospitals whose systems acquired cross-market hospitals in three or fewer years from 2011 to 2017. Panel B shows the event study where the control hospitals are the same, but the treated group is the 96 treated hospitals whose systems acquired cross-market hospitals in four or more years from 2011 to 2017. Panel A again shows no sign of a pre-trend and the $t = 4$ coefficient of 0.069 is statistically significant ($p = 0.065$), indicating there is still a price effect when the cross-market acquisition isn't part of an extended string of cross-market acquisitions in successive years. However, the price effect appears more transitory in this case as the coefficient estimates are directionally negative and not statistically significant in $t = 5, 6$.

Panel B, on the other hand, shows a steady and persistent price effect. The $t = 4$ coefficient is 0.075 ($p = 0.096$), and by the time $t = 6$ comes around the coefficient is 0.151 ($p = 0.004$), indicating prices are 16.3% (CI: 4.8%–29.1%) higher at treated hospitals that are part of systems serially acquiring cross-market hospitals relative to prices at control hospitals.

In Figure 3 we show how the price effect differs by whether the acquiring hospital had a higher or lower market share than the target system. Each hospital's market share was measured as its share of admissions among general acute care hospitals located in its county. Next, we compared each treated hospital's market share to the market share of the target it was acquiring. If the target was more than one hospital we calculated the target's market share as the weighted average (using admissions) of the county market shares of its system members. Panel A includes treated hospitals whose market shares were below the market shares of the first cross-market targets they acquired during the study period. Panel B shows the opposite situation – it includes treated hospitals whose market shares were above the market shares of the first cross-market targets they acquired during the study period. The average market shares of the targets and acquirers in Panel A were 76% and 56%, respectively. The average market shares of the targets and acquirers in Panel B were 24% and 59%, respectively. Comparing the two event studies plots indicates that the price effect is twice as large when the target's market share is greater than the acquirer's (the $t = 6$ coefficient is a positive and statistically significant 0.197 ($p = 0.011$) indicating prices 21.8% (CI: 4.6%–41.7%) higher than those at control hospitals, see Panel A) than it is in the reverse situation (the $t = 6$ coefficient is a positive and statistically significant 0.092 ($p = 0.063$) indicating prices 9.7% (CI: −0.5% to 20.9%) higher than those at control hospitals, see Panel B).

Figure A3 in the appendix delves deeper into the acquirer price effect of cross-market mergers by assessing whether there is a difference between the price effect of cross-market mergers that occur within a state and those that cross-state lines. Among the 214 treated hospitals in our sample, 68 hospitals only experienced out-of-state cross-market mergers during our study period. Our sample also included 60 hospitals that only experienced within state cross-market mergers during our study period. The remaining 86 treated hospitals experienced some combination of out-of-state and within state cross-market mergers during our study period.

Panel A in Figure A3 shows the event study after removing all treated hospitals in the sample except the 68 hospitals that only experienced out-of-state cross-market mergers during our study period. The figure is very similar to that shown for the full sample, indicating that the price effect for out-of-state cross-market mergers is no different to than it is for other types of cross-market mergers. Specifically, the $t = 6$ coefficient is identical magnitude to that of the $t = 6$ coefficient in full sample version (0.121 and 0.121), so they are not statistically different. Panel B repeats the analysis using the 60 hospitals that only experienced in-state cross-market mergers as the treated hospitals. It's $t = 6$ coefficient (0.130) is not statistically different than the $t = 6$ coefficients in the full sample and Panel A.

Figure 4 shows the quality effect of cross-market hospital mergers. Panel A shows the event studies when heart failure mortality and heart failure readmission rate are the dependent variables. In both cases there is no noticeable pre-trend and none of the post-treatment coefficients are statistically different from

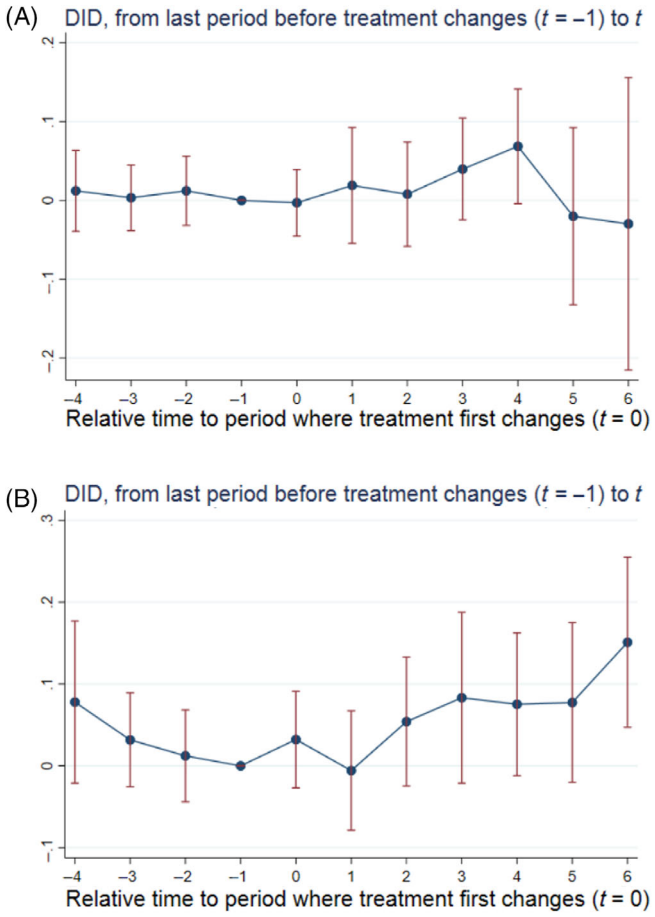

FIGURE 2 Effect of cross-market M&A on acquirers' prices by number of years as a cross-market acquirer. (A) Acquirers in 3 or fewer years. (B) Acquirers in 4 or more years. Standard errors were estimated using 100 bootstrap replications clustered at the hospital level. Panel A includes the 118 treated hospitals that were part of systems that acquired hospitals more than 50 miles away in three or fewer separate years between 2011 and 2017. Panel A includes the 96 treated hospitals that were part of systems that acquired hospitals more than 50 miles away in four or more separate years between 2011 and 2017. The regressions underlying these event study plots included hospital and year fixed effects as well as time-varying hospital- and county-level control variables. The hospital-level control variables included number of beds, indicator variables for the hospital's for-profit, government, or teaching hospital status, and the hospital's share of inpatient days from Medicare and Medicaid enrollees as well as its number of technologies. The county-level control variables included number of hospitals, uninsured rate, median household income, population, and unemployment rate. DID, difference-in-differences; M&A, mergers and acquisitions; *t*, time since treatment first changes.

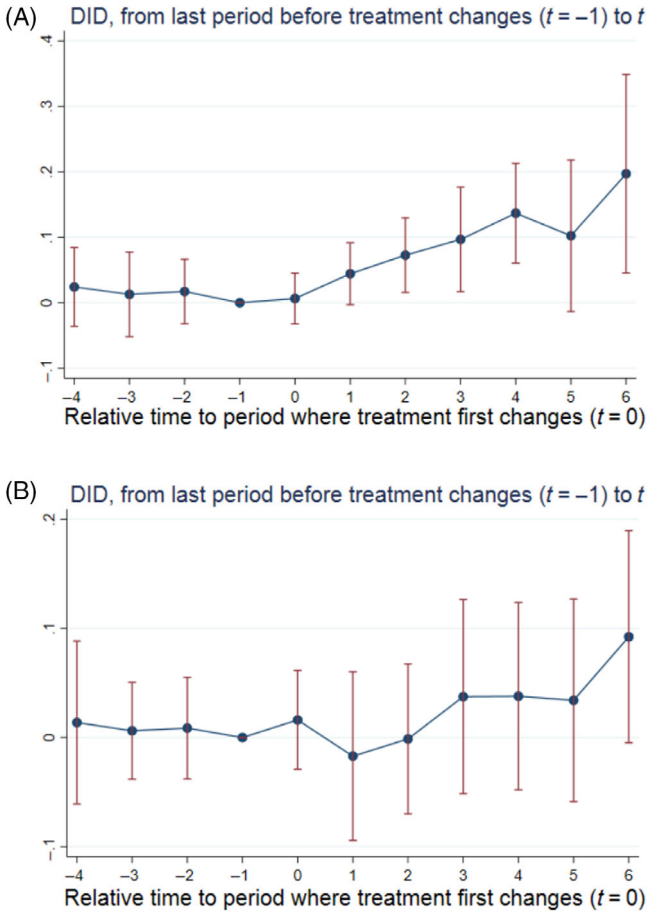

FIGURE 3 Effect of cross-market M&A on acquirers' prices by whether the target or acquiring hospital had greater market share. (A) Target Market Share > Acquirer Market Share. (B) Acquirer Market Share > Target Market Share. Standard errors were estimated using 100 bootstrap replications clustered at the hospital level. Panel A includes the 87 treated hospitals whose market shares were lower than those of the first cross-market targets they acquired during the study period. Panel B includes the 127 treated hospitals whose market shares were higher than those of the first cross-market targets they acquired during the study period. The regressions underlying these event study plots included hospital and year fixed effects as well as time-varying hospital- and county-level control variables. The hospital-level control variables included number of beds, indicator variables for the hospital's for-profit, government, or teaching hospital status, and the hospital's share of inpatient days from Medicare and Medicaid enrollees as well as its number of technologies. The county-level control variables included number of hospitals, uninsured rate, median household income, population, and unemployment rate. DID, difference-in-differences; M&A, mergers and acquisitions; *t*, time since treatment first changes.

zero. Panel B likewise shows minimal to no impact of cross-market mergers on acquirer quality when heart attack mortality and readmission rate are the dependent variables. None of the post-treatment coefficients are statistically different from zero for heart attack mortality. For the heart attack readmission rate event study, the $t = 6$ coefficient is positive and statistically significant ($0.494; p = 0.039$) which suggests cross-market mergers reduce acquirer quality by increasing the heart attack readmission rate, however, there was a pre-treatment trend in this case so this result is ambiguous. Panel C shows the event studies for pneumonia mortality and readmission rate. Just as in Panel A, both plots show the post-treatment coefficients all being close to zero and not statistically significant. Overall, our results point to cross-market mergers having no impact on acquirer quality.

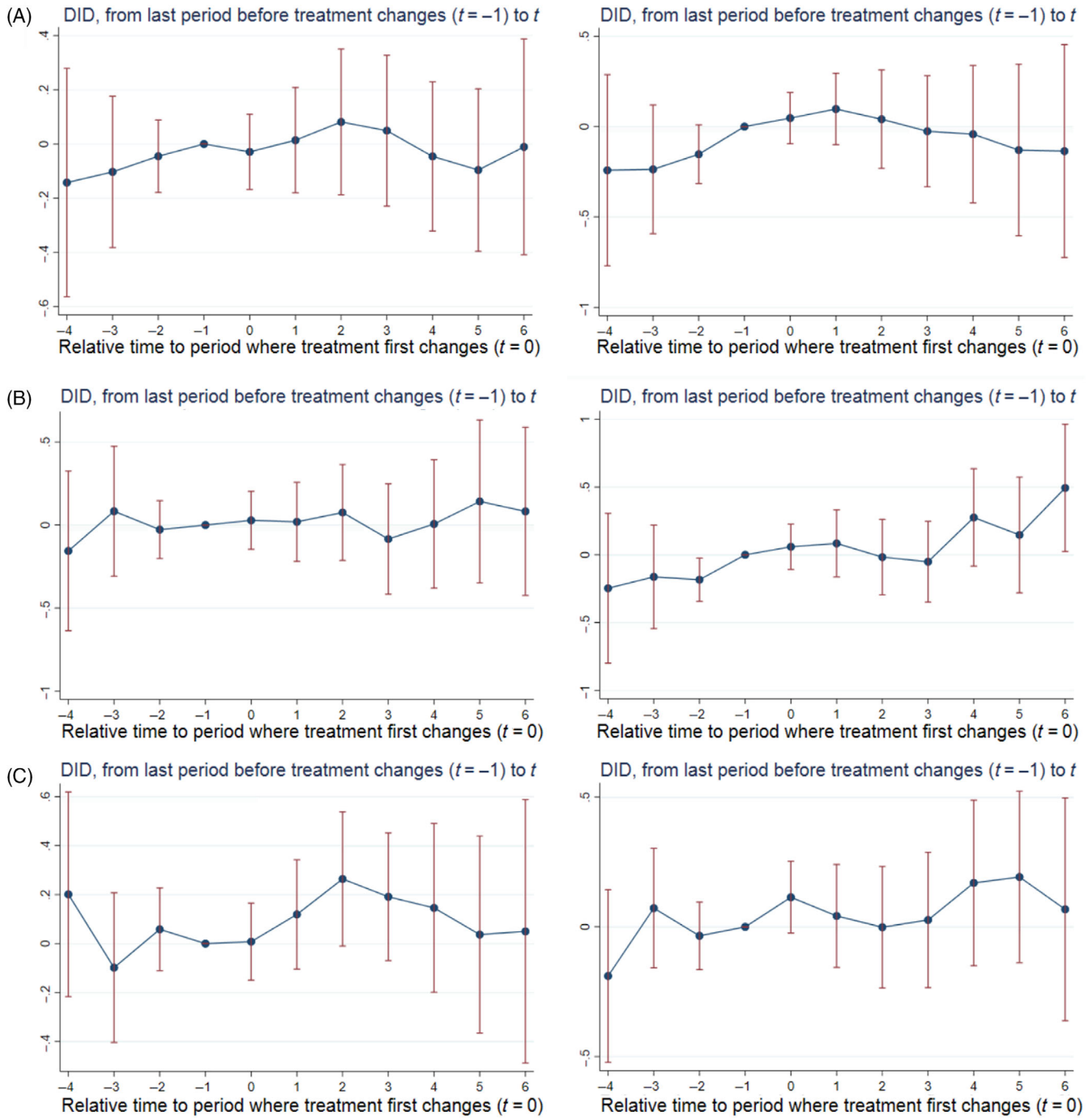

FIGURE 4 Effect of cross-market M&A on acquirers' quality. (A) Heart Failure. (B) Heart Attack. (C) Pneumonia. Standard errors were estimated using 100 bootstrap replications clustered at the hospital level. The regressions underlying these event study plots included hospital and year fixed effects as well as time-varying hospital- and county-level control variables. The hospital-level control variables included number of beds, indicator variables for the hospital's for-profit, government, or teaching hospital status, and the hospital's share of inpatient days from Medicare and Medicaid enrollees as well as its number of technologies. The county-level control variables included number of hospitals, uninsured rate, median household income, population, and unemployment rate. DID, difference-in-differences; M&A, mergers and acquisitions; *t*, time since treatment first changes.

5 | DISCUSSION

This article contributes to the small, but growing, literature that analyzes cross-market hospital mergers and acquisitions and examines whether they can lead to price increases and harm competition.[5,6] Similar to those studies, we find that cross-market hospital acquisitions are associated with acquirer price increases of 12.9% as compared with controls, 6 years following the merger or acquisition. Our

results suggest there is a time delay of a few years following successful completion of the merger before price effects emerge, which may be due to existing contracts with insurers or a desire to not immediately increase prices for other reasons.

In addition, we found larger price effects when the acquirer had lower market share than the target, although significant price increases were still found when the opposite was true. This finding makes intuitive sense, as acquirers with lower market share have more to gain from acquiring an entity with market power. We also found that the price effects following cross-market acquisitions existed for both within-state transactions and out-of-state transactions, but price effects of within-state transactions emerged earlier post-transaction. In contrast to Dafny et al.[6] our findings suggest that cross-market price effects extend across state lines, consistent with the theory that when common customers, such as the big 5 national insurers,[20] negotiate with multi-hospital systems that cross state lines, they can be subject to their market power.

In addition to being the first study to use healthcare claims data to find that cross-market acquisitions result in price increases, our novel contribution to the literature is that we have disentangled some of the price effects to provide guidance on the characteristics of acquiring hospital systems and cross-market mergers that are likely to have the greatest price effects over time. Our analysis of health systems that engaged in 4 or more cross-market acquisitions between 2011 and 2017 (approximately 45% of treated hospitals) revealed that those serial cross-market acquirers had 16.3% higher prices than controls 6 years after the acquisition. In contrast, health systems that acquired three or fewer cross-market entities during the study period showed some signs of price effects at year 4 but they proved transitory over time. We also analyzed the impact of cross-market hospital acquisitions on six quality measures and found no significant quality effects, suggesting that the price effects do not arise from post-transaction improvements in quality of care.

Our study has several limitations. First, the claims we used to calculate prices came from only three insurers – UnitedHealth, Aetna, and Humana. While these three insurers are large, national players, they account for only about a third of employer-sponsored health insurance enrollment in the United States. We expect the prices these three insurers receive to be correlated with those of other insurers, but to the extent that they are not, our price results could be biased (in either direction). It seems unlikely that quality would differ by insurer within the same hospital, but there could also be some bias in our quality estimates if the in-network hospitals for these three insurers differed from the in-network hospitals of other insurers. Second, we do not answer the distance gradient question of how the price effect changes as the distance between cross-market hospital targets and acquirers grows. We use a 50-mile threshold to define cross-market, but we are not able to comment on whether a 100-mile cross-market transaction has a larger price effect than a 300-mile cross-market transaction. Third, by reducing to a single hospital price we cannot provide detail on how changes in prices may vary heterogeneously for each specific DRG or service line. Fourth, we are unable to pinpoint a primary cross-market mechanism that is at work here. By focusing on acquirers' prices, we think it is unlikely that change-in-control or quality improvements explain the observed price increases, but whether tying, common customers, or multimarket contact is largely responsible remains unclear. These limitations are important for policymakers and antitrust regulators to consider in light of our findings. Future research that identifies the mechanism (or degree to which multiple mechanisms contribute) will be particularly useful in terms of guiding policymakers and antitrust regulators.

6 | CONCLUSION

Our findings provide additional empirical evidence of the potential price effects arising from healthcare system consolidation broadly and cross-market hospital acquisitions specifically. Our study also provides key guidance for antitrust enforcers and policymakers on the characteristics of health systems and acquisitions that are most likely to contribute to enduring price effects. More antitrust scrutiny of cross-market mergers – particularly those of serial acquirers – appears prudent given the current state of highly concentrated hospital markets in the United States.

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APPENDIX A

ECONOMETRIC MODEL TECHNICAL DETAILS AND IDENTIFYING ASSUMPTIONS

De Chaisemartin and D'Haultfoeuille (Forthcoming)* (hereafter, dCDH) take the perspective of a social planner seeking to conduct a cost–benefit analysis comparing groups' (hospitals') actual treatments to the counterfactual "status-quo" scenario where every group would have kept the same treatment (i.e., not acquired) as in period 1. In our context, the planner wants to know if the cross-market mergers that took place over the entire duration of the study period led to prices and quality to be higher or lower. As the planner wants to compare groups' actual treatments D to the status-quo treatments, the dCDH parameters of interest and all of their analysis are conditional on D.

Consider the case where treatment is not binary, but ordered and discrete: $D \in \{1,...,\underline{d}\}$ for $\underline{d} \geq 1$. For every g, let $T_g = F_{g'} - 1$ denote the last period where there is still a group with the same treatment as g's in period one and whose treatment has not changed since the start of the panel. For any g such that $F_g \leq T_g$, and for any $l \in \{0,...,T_g - F_g\}$, let $\delta_{g,l} = E\left(Y_{g,F_g+l} - Y_{g,F_g+l}(D_{g,1},...,D_{g,1})\right)$ be the expected difference between group g's actual outcome at $F_g + l$ and the counterfactual "status quo" outcome it would have obtained if its treatment had remained equal to its period one value from period one to $F_g + l$. dCDH consider designs where (1) groups' treatments are always either weakly higher or always weakly lower than their period one treatments and (2) there is at least one group g experiencing a treatment increase (decrease) at a time period where there is at least another group g' with the same period one treatment as g whose treatment has not changed since the start of the panel. (1) is satisfied in our context because each additional year that a treated hospital acquires a cross-market hospital adds 1 to its treatment dose (i.e., treatment never decreases) and (2) is satisfied because our control group of hospitals maintain a treatment dose of 0 throughout the study period. de dCDH show that if (1) and (2) are true then their parameters of interest are well-defined and can be unbiasedly estimated.

The identifying assumptions outlined in dCDH for ordered and discrete treatments are (1) treatment does not vary within (g,t) cells, (2) no anticipation, and (3) for every hospital the expectation of the never-treated outcome follows the same evolution. Assumption (3) is a generalization of the standard parallel trends assumption in difference-in-differences models and we test for parallel trends using the placebo estimator in dCDH. Assumption 1 holds by construction in our setting and we do not observe any evidence of assumption 2 being violated.

For all (g,t), let $N_t^g = \sum_{g':D_{g',1}=D_{g,1},F_{g'}>t} N_{g',t}$ denote the number of observations at period t in groups g' with the same period one treatment as g, and that kept the same treatment from period 1 to t. Under the three assumptions in the prior paragraph, de Chaisemartin and D'Haultfoeuille (2022) show $DID_{g,l}$ is an unbiased estimator of $\delta_{g,l}$ if

$$DID_{g,l} = Y_{g,F_g+l} - Y_{g,F_g-1} - \sum_{g':D_{g',1}=D_{g,1},F_{g'}>F_g+l} \frac{N_{g',F_g+l}}{N^g_{F_g+l}} \left(Y_{g',F_g+l} - Y_{g',F_g-1}\right).$$

$DID_{g,l}$ compares the $F_g - 1$-to-$F_g + l$ outcome evolution, in group g and in groups with g's period one treatment to period 1 to $F_g + 1$. Aggregating the $DID_{g,l}$ estimators into a DID_l estimator allows for the creation of an event study graph that has the distance to the first treatment change on the x-axis, the DID_l estimators on the y-axis to the right of zero, and placebo estimators on the y-axis. The resulting event study graph is useful to (1) test the parallel trends assumption and (2) provide reduced-form evidence of whether increasing the treatment for $l+1$ periods increases or decrease the outcome on average.

*De Chaisemartin C, D'Haultfoeuille X. Difference-in-Differences Estimators of Intertemporal Treatment Effects. *Rev Econ Stat*. Published online Forthcoming.

TABLE A1 Number of years that a treated hospital's system acquired a hospital more than 50 miles away between 2011 and 2017.

Number of years	Number of treated hospitals	Number of treated hospitals' systems
1	32	17
2	43	9
3	43	9
4	28	6
5	16	3
6	30	2
7	22	1
Total	214	47

Note: Treatment hospitals included hospitals (or hospitals within systems) that met the following criteria: (1) hospitals that made an acquisition from 2009 to 2017 of a hospital (or system) that was further than 50 miles away, with the first acquisition occurring from 2011 to 2015; and (2) hospitals that were never a target of an acquisition from 2009 to 2017. For example, a treated hospital whose system acquired one or more hospitals that were more than 50 miles away from it in 2011, 2013, and 2016 (3 years between 2011 and 2017) was included in the row in which the "Number of Years" column equaled 3. Control hospitals were never part of merger activity (either as a target or acquirer) from 2009 to 2017.

TABLE A2 Price event study regression coefficient estimates underlying Figure 1.

	(1)
	ln (price)
$t = -4$	0.020
	(0.025)
$t = -3$	0.010
	(0.010)
$t = -2$	0.012
	(0.014)
$t = 0$	0.013
	(0.017)
$t = 1$	0.008
	(0.034)
$t = 2$	0.029
	(0.023)
$t = 3$	0.061***
	(0.020)
$t = 4$	0.072**
	(0.032)
$t = 5$	0.054**
	(0.026)
$t = 6$	0.121**
	(0.059)
Observations	10,521
Time-varying control variables	Yes
Fixed effects	Hospital, Year

Note: Standard errors are in parentheses and were estimated using 100 bootstrap replications clustered at the hospital level. The coefficients estimates are depicted in Figure 1 in the main text; $t = -1$ is the omitted reference period. The time-varying control variables are described in the data section of the main text. ***$p < 0.01$; **$p < 0.05$; *$p < 0.1$.

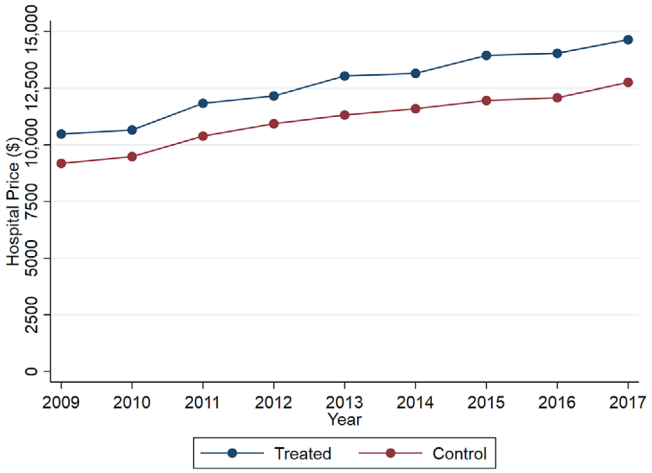


FIGURE A1 Unadjusted price trends for treated and control hospitals. Average hospital prices across the 214 treated hospitals and 955 control hospitals in our analytic sample. By construction the treated group includes only hospitals that were first treated during the 2011–2015 window of our study period (2009–2017). The breakdown by treatment year for the 214 treated hospitals is 80 in 2011, 31 in 2012, 49 in 2013, 37 in 2014, and 17 in 2015.

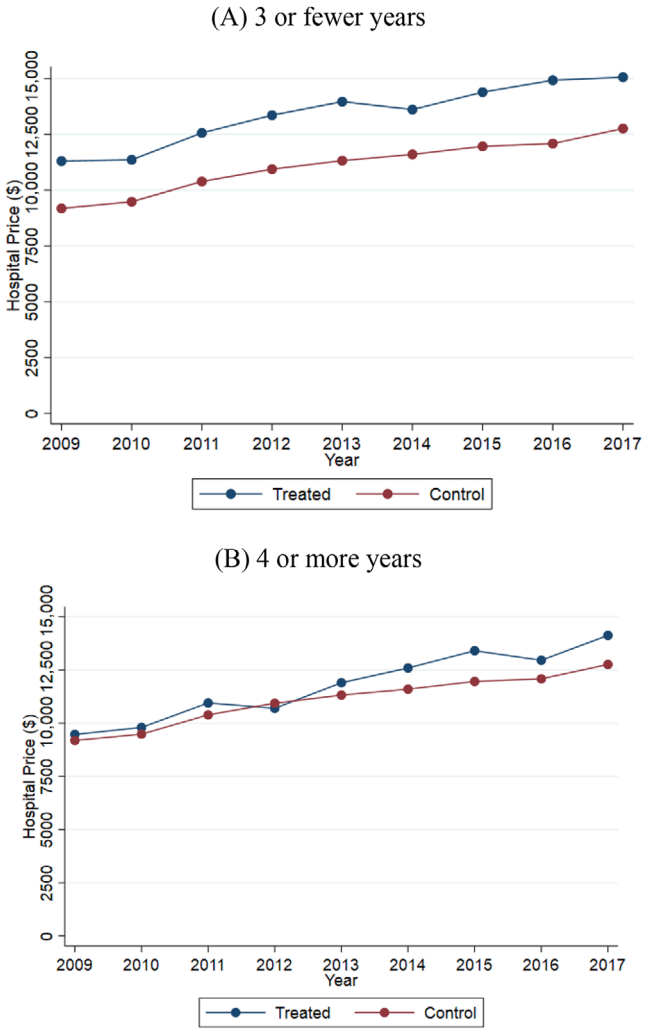
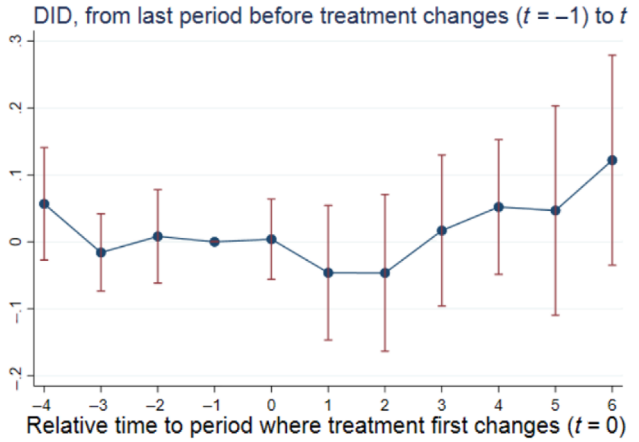


FIGURE A2 Unadjusted price trends for treated and control hospitals by number of years from 2011 to 2017 that treated hospitals' systems acquired hospitals across markets. (A) 3 or fewer years. (B) 4 or more years. Average hospital prices across the 214 treated hospitals and 955 control hospitals in our baseline sample. Panel A shows the average price across the 118 treated hospitals that were part of systems that acquired cross-market hospitals in 3 or fewer years from 2011 to 2017. Panel B shows the average price across the 96 treated hospitals that were part of systems that acquired cross-market hospitals in 4 or more years from 2011 to 2017. The control group line is the same in Panels A and B and is the same control group line plotted in Figure A1.

(A) Out-of-state



(B) In-state

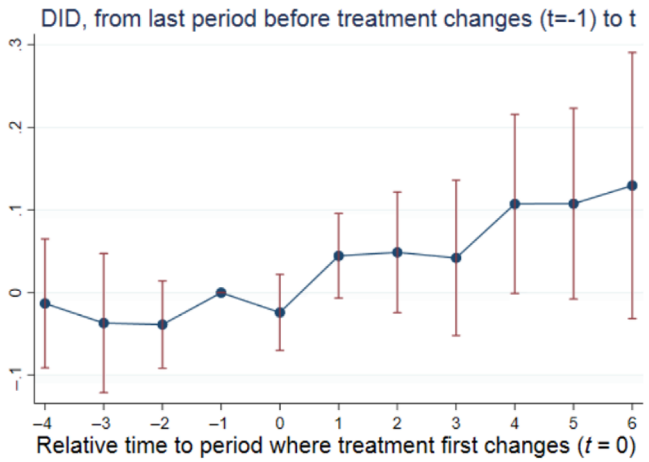


FIGURE A3 Price event study results – out-of-state vs. in-state cross-market mergers. (A) Out-of-state. (B) In-state. Standard errors were estimated using 100 bootstrap replications clustered at the hospital level. Panel A includes the 68 treated hospitals that were only out-of-state cross-market acquirers between 2011 and 2017. Panel A includes the 60 treated hospitals that were only in-state cross-market acquirers between 2011 and 2017. The remaining 86 (=214–68-60) treated hospitals were excluded from this analysis because they were part of systems that made both in-state and out-of-state cross-market acquisitions during the study period. The regressions underlying these event study plots included hospital and year fixed effects as well as the time-varying hospital- and county-level control variables described in the data section of the main text.

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Considerations for state-imposed conditions on healthcare provider transactions

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The widespread consolidation of health systems, hospitals, and physicians has contributed to the high price of healthcare across the United States. While federal antitrust enforcers continue to play an important role in overseeing large mergers, acquisitions, and other consolidating transactions of major healthcare providers, state oversight over healthcare markets is essential to slow consolidation more broadly and address market failures across the country. State laws govern the scope of authority held by state attorneys general and other state agencies to receive notice of, review, and approve, conditionally approve, or block healthcare provider transactions, which can significantly impact the breadth and content of oversight. While blocking potentially anticompetitive transactions can help states maintain any competitive forces that remain in the market, in some situations, approving a transaction with conditions may be the best path forward. Applying conditions to transactions may allow state officials to oversee and govern the behavior of providers post-transaction while states pursue other legislative fixes. Although the use of conditions is a relatively common practice at the state level, little research has been done to explore their use among states. Following a search in all 50 states, this paper examines decisions from state officials imposing conditions intended to address the impacts of transactions on healthcare price, access, and quality and provides recommendations for the effective use of conditions moving forward.

KEYWORDS

consolidation, conditions, merger, acquisition, consent decree, conditional approval, market failure, healthcare

1. Introduction

Unfettered consolidation among healthcare providers, including health systems, hospitals, and physicians, has deeply impacted how Americans receive health care and how much they pay for it. Most healthcare provider markets across the United States are now considered highly concentrated (1), and a majority of hospitals are associated with increasingly powerful health systems (2). Healthcare experts consistently find that highly concentrated healthcare provider markets are associated with higher prices, mixed quality outcomes, and reduced access to healthcare services (3), while other studies have shown that health systems with substantial market power can wield it across markets to engage in anticompetitive practices (4).

Addressing the existing market failures that plague most hospital markets in the U.S. will necessarily involve broad policy interventions to restrain high and rising healthcare prices and

to protect access to affordable healthcare services (5). At the state level, these types of policies include initiatives that aim to more directly control healthcare costs such as creating cost-growth benchmarks, public options, affordability standards authorizing state insurance commissioners to reject contracts with excessive rate increases, direct price caps on out-of-network, in-network prices, or both, among others (6). Although a few states have attempted some of these policies and more are showing interest, mustering the political willpower to create and implement them takes time (6).

In the meantime, consolidation continues apace, and state regulators and enforcers tasked with overseeing mergers, acquisitions, and other consolidating healthcare provider transactions must decide whether and how to challenge these transactions. Generally, their options include letting the transaction proceed unimpeded, imposing conditions to dictate behavior post-transaction, or attempting to prevent the transaction from going through. Due to the highly concentrated nature of healthcare markets throughout the U.S., we argue that states should utilize the legal authority they have to block potentially anticompetitive healthcare transactions when possible. However, when blocking a potentially anticompetitive transaction is not an option because of resource constraints, legal limitations, political pressures, or because the transaction is truly in the public interest, imposing conditions on the transaction that dictate the healthcare providers' behavior post-transaction, can serve as an important tool, allowing states time to pursue legislative fixes for any existing market failures.

Healthcare markets have consolidated substantially throughout the last 30 years due to permissive enforcement strategies at both the federal and state levels and a lack of alignment between antitrust guidelines and healthcare market practices (7). The federal antitrust agencies—the Federal Trade Commission (FTC) and the Department of Justice (DOJ)—are restricted by only receiving notice of large transactions due to the high reporting threshold of the Hart-Scott-Rodino Antitrust Improvements Act (8), limited resources to analyze and challenge a significant number of cases (9), and a significant burden to show that a transaction will substantially lessen competition under federal antitrust law (10). Furthermore, federal antitrust enforcement tends to focus on horizontal merger challenges rather than vertical, cross-market, or other types of consolidation, which commonly occur in healthcare (4). State entities tasked with overseeing healthcare transactions, including state attorneys general, state health agencies, and certificate of need (CON) programs, face similar resource limitations and are also constrained by the boundaries of their varying legal authorities to receive notice of, thoroughly review, and potentially block transactions (11).

When it comes to challenging problematic transactions, federal antitrust enforcers have expressed a preference for blocking anticompetitive transactions or imposing structural remedies, such as divestiture of any entities that create competition concerns, instead of relying on what are called conduct remedies, which permit the transaction to go through but include conditions that seek to prevent anticompetitive behavior (12). While various state entities have also successfully blocked healthcare provider transactions, we have found that state enforcers and regulators more often utilize conditions to manage, rather than trying to block, transactions that raise concerns (11). While the use of conditions can provide guardrails to ensure that healthcare providers behave in the public interest, the fact that these conditions are most often time-limited and only apply to the providers involved in the transaction suggests that their use cannot be relied upon as a long-term regulatory solution in most situations.

State officials may rely on conditions instead of blocking potentially anticompetitive transactions for a few reasons. First, states review and make decisions regarding a broader range of transactions than federal antitrust enforcers, including transactions that are either too small for federal antitrust scrutiny or are unlikely to harm competition in ways that form the basis of a convincing antitrust case (13). Furthermore, when state attorneys general consider proposed transactions under state or federal antitrust law, they may not have or wish to expend limited resources to litigate a case that does not fit the mold for a strong, traditional antitrust suit (14). Second, unlike federal antitrust enforcers, state attorneys general and various state agencies must often balance various, sometimes competing, priorities that extend beyond preserving competition when reviewing transactions, such as maintaining access to healthcare services (e.g., saving a financially failing hospital that provides essential services to a community), improving equitable access to care, protecting jobs, overseeing a hospital's nonprofit obligations, and then weigh any claimed benefits and efficiencies from the transaction against the risks of adverse outcomes. Third, state officials can be statutorily limited by the factors they can consider in making their decision or by constraints on the type or size of the transactions they review. This means they may not have the power to block a transaction on competition grounds or do not have authority over certain transactions. Despite these dynamics, the widely held goals of protecting any remaining competition, controlling costs, preserving access, and improving equity cannot be achieved in the long run if consolidation continues unencumbered and without farther-reaching intervention to address pervasive market failures.

Whatever the reasons for placing conditions on a transaction, state enforcers and regulators must acknowledge and consider the serious potential drawbacks of allowing transactions to proceed in this way. Short-term conditions only dictate conduct momentarily, enabling healthcare providers to reap significant benefits from the accumulated market power after the conditions expire. As a result, harms from transactions are merely delayed, left to be dealt with by another administration, another agency, or often not at all. As one judge noted in rejecting a settlement proposed by the Massachusetts attorney general, imposing conditions on a problematic transaction is "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 (15)." Further, even during the period in which conditions are imposed, the necessary regulatory oversight and monitoring of conditions to ensure compliance requires significant resources and expertise, which many states do not have the resources to consistently provide.

Although the use of conditions has been and continues to be a relatively common practice among states, little research has been done to explore their use at the state level. To examine the scope and usefulness of conditions, we searched for all available decisions by states that apply conditions on healthcare provider transactions. We reviewed over 80 decisions placing conditions on healthcare provider transactions from 12 states under varying legal authorities. This paper examines the array of conditions that state attorneys general and various state agencies have imposed on healthcare provider transactions over the past decade and offers considerations

and recommendations for deciding whether—and how—to impose conditions.

Part I of this paper provides a brief overview of the various sources of legal authority available to state officials to review and condition approval of transactions. Part II provides a taxonomy of the types of conditions imposed through these different processes and their enforcement mechanisms. Lastly, Part III provides important considerations for state officials looking to impose conditions as a means to allow transactions to proceed. Often, there is no perfect solution when attempting to balance multiple facets of a healthcare market. While imposing conditions on transactions in some cases may be the best option, it should be done with specific goals in mind and an understanding of the consequences of permitting transactions to proceed with time-limited requirements.

2. Overview of state healthcare transaction conditional approval authority

The statutory authority to review and subsequently approve, conditionally approve, or deny healthcare transactions varies notably among the states (11). The actions state officials take and the types of conditions they impose will often depend largely on the kind of legal authority they have to review various types of transactions. This authority also dictates whether state officials must go to court or can approve transactions outside of court through an administrative process (16). For instance, a state attorney general that has challenged a transaction under antitrust law may enter into a court-approved negotiated settlement, known as a consent decree, with the transacting entities to impose conditions on the transaction. Whereas, when a state agency (or the attorney general in some states) has a form of administrative review authority, they can impose conditions on a proposed merger, which we refer to as a conditional approval. By analyzing the laws undergirding these different processes, we found that the legal boundaries of the approval authority often dictate whether state officials can impose conditions and the types of conditions imposed. For example, if an attorney general's authority to review nonprofit hospital transactions is limited to statutorily delineated factors that focus on the protection of charitable assets, it is unlikely that they can impose conditions aimed at protecting broader competition concerns, like imposing price restraints. As agencies are bound by their legal authority, not all conditions are available for every type of approval process.

In every state, attorneys general have the authority to bring suits as *parens patriae* on behalf of the citizens of their state under state antitrust laws, federal antitrust laws, or both, as well as under consumer protection laws (16). Different states have invoked this authority to varying degrees in the healthcare context. For example, the Pennsylvania attorney general has challenged hospital transactions in court under antitrust laws that ended with consent decrees between the attorney general and the transacting healthcare providers that impose conditions mainly addressing competitive harms arising from the deal (17, 18).

In addition to enforcing antitrust laws, state attorneys general are also charged through statute and common law with the duty to oversee nonprofit and charitable organizations, to ensure the organizations fulfill their fiduciary duties, that charitable assets are appropriately managed and spent, and that the organizations are fulfilling their charitable mission (19). When it comes to transactions involving nonprofit hospitals specifically, several states have statutorily outlined administrative review and approval processes that permit the attorney general to oversee and place conditions on these transactions when necessary. For example, Connecticut's attorney general reviews and has conditional approval authority over nonprofit hospital conversions, meaning instances where a nonprofit hospital enters into an agreement to transfer a material amount of its assets or operations to a for-profit entity (20). The New Hampshire Director of Charitable Trusts, housed within the attorney general's office, reviews and has approval authority over transactions involving healthcare charitable trusts, including nonprofit hospitals (21). In the healthcare context, charitable trusts are often established by donors to fund healthcare services, charity care, or similar purposes (22). Attorneys general are responsible for ensuring these trusts are used in accordance with the donors' original intent, even after changes in the organization or structure of the hospital to which the charitable trust was given (22). California also has a process in place for reviewing and approving transactions involving a nonprofit hospital (23). The statutes governing this process provide the attorney general with a notable amount of discretion to review these transactions under a wide range of factors (23). Considering that over half of the hospitals in the U.S. are nonprofit and nonprofit hospitals owe special obligations to the communities they serve, this type of review provides crucial oversight over a significant number of transactions (24). Further, in some instances, nonprofit oversight authority will allow state attorneys general to impose conditions related to competition and market function (25).

A few states grant authority to their department of health or similar state health agency to conduct reviews and approve, conditionally approve, or deny transactions, with some states outlining processes where the department of health conducts concurrent reviews of transactions with the state attorney general (13). For example, under the Rhode Island Hospital Conversions Act, the Rhode Island Department of Health and the Rhode Island attorney general conduct concurrent reviews of healthcare provider transactions (26). The Act assigns differing review criteria to the attorney general and department of health, as well as different sets of criteria depending on whether the transaction is solely among nonprofit hospitals or whether for-profit entities are involved. While Rhode Island attorney general's review and approval focuses on whether the transaction is fair, whether the hospital board acted appropriately, and whether the transaction is proper under Rhode Island's Nonprofit Corporation Act, Charitable Trust Act, and Antitrust Act, the Department of Health's review and decision focuses on how the transaction will impact the community and access to affordable care (27).

Certificate of Need (CON) programs can also provide the statutory authority to review and approve healthcare provider transactions. CON programs are regulatory mechanisms that require hospitals and health systems to apply for permission from the state agency in charge of the CON program before making significant capital expenditures or changes to their facilities, services, or equipment (28). Although 35 states currently have CON programs, these programs vary from state to state, both in the activities that trigger review and the types of entities they regulate (29). Notably, not all CON programs grant the oversight agency authority over provider transactions, such as mergers and acquisitions, or permit the agency

to impose conditions (29). Some states though, such as Connecticut and Massachusetts, do have broader CON programs that can serve as a means to review transactions and examine the impact of the transaction on the healthcare landscape and approve, condition, or deny the transaction (30, 31). Although there is a widely held belief that CON programs should be repealed because they create anticompetitive barriers to entry into hospital markets, they can potentially be useful as a means to receive notice of, review, and make decisions about potential transactions or expansions by a dominant health system that may have a broad impact on health care delivery throughout the state (32).

Beyond CON programs, three states have created independent state agencies tasked with overseeing healthcare markets, including providing in-depth reviews of a wide range of proposed healthcare transactions as well as monitoring other state price and transparency policies (33). In 2012, Massachusetts' created the Health Policy Commission (HPC), which reviews a wide range of transactions and submits reports advising the Massachusetts' attorney general and the Massachusetts Department of Public Health on the potential impacts of the transaction on a wide variety of measures and provides a recommendation as to whether the transaction should proceed unimpeded (34). Recent legislation in California has bestowed similar authority and responsibilities to the California Office of Health Care Affordability (OHCA), requiring the agency to conduct intensive reviews of certain transactions and refer concerning transactions to the California attorney general for enforcement (35). Oregon has gone a step further in granting the Oregon Health Authority (OHA) the ability to not only review transactions but also to approve, condition, or deny healthcare transactions after the two-stage review examining a transaction's potential impact on cost, access, equity, and quality (36).

The last mechanism some states have relied upon to oversee hospital and health system transactions is a more transaction-specific legal mechanism known as a Certificate of Public Advantage (COPA). When a state grants a hospital or health system a COPA it shields the transaction from federal antitrust enforcement under the state action doctrine, which provides immunity to the merging healthcare providers as long as the state clearly articulates its intent to displace competition in favor of regulation and provides active oversight through the attorney general or other state health agency (37). Conditions imposed through a COPA differ from conditions applied by the other authorities discussed above because they require state legislation to authorize, attempt to replace competition with regulation, and mandate intensive oversight by the state throughout the healthcare entity's existence. While this review did not focus on conditions imposed through COPAs, the evidence of the consequences when COPAs are repealed is useful in illustrating the issue with time-limited conditions when coupled with a lack of broader policies to manage the failures of competition. There has also been concern about the potential for regulatory capture, in which regulators are influenced by the entities they regulate, compromising their impartiality and effectiveness in protecting the public interest (38). Because of these parallels, COPAs can provide insights into the potential shortfalls of conditions imposed by state authorities.

States across the country have used these various legal avenues to impose conditions on healthcare provider transactions. The comprehensive administrative processes laid out in some states, like California and Oregon, can provide for a more consistent and transparent approach to reviewing transactions. This oversight is important not only for state officials to gather information and data on the changes to the state's healthcare markets that can help inform decisions on future transactions, but also to help ensure that conditions are thoughtfully tailored to substantive concerns and goals and that oversight of those conditions does not waiver with changes in administrations or priorities. Further, assigning responsibility and providing enough resources to a state entity for thorough oversight over imposed conditions is crucial not only to ensure compliance, but also to monitor whether they are achieving their intended effects. The next section will discuss the major categories of conditions and how they have been used to address concerns arising from transactions related to competition, access, quality, and other issues plaguing our healthcare markets.

3. Taxonomy of state-imposed conditions

In recent years, states have relied on the legal authorities discussed above to varying degrees to review and subsequently impose conditions on healthcare provider transactions. To identify and examine these conditions, we conducted searches for all 50 states based on the type of legal authorities available in each state and collected publicly available decisions imposing conditions on transactions that were subsequently consummated. To collect conditional approvals from administrative processes, we searched the websites of state attorneys general, CON programs, departments of health, and other healthcare market oversight entities for public postings or other notifications issued between 2012 and 2022 regarding the review and approval of healthcare provider transactions in all 50 states. As we only found nine states with strong public information practices for publishing pre-transactions reviews and decisions, we also conducted online searches for news articles and scholarly works examining healthcare provider transactions to look for any discussion and documentation of conditionally approved transactions. For consent decrees, we also searched the websites of state attorneys general, news sources, and legal databases in all 50 states for consent decrees issued between 2012 and 2022. Our search for consent decrees was limited in many states due to restricted access to state court documents. Because we limited our search for conditional approvals and consent decrees to publicly available information, our data is biased toward states with a commitment to transparency and transactions that garnered media coverage. The lag time between decisions and public availability of the decision may also be a limiting factor, as there may have been conditional approvals that had not yet been published. Nonetheless, we found over 80 decisions imposing conditions from 12 states that formed the basis for our review. As we do not explicitly discuss all the decisions and specific conditions we reviewed, a complete list of the decisions is available as Supplementary material.

After analyzing all available decisions from state attorneys general and state agencies imposing conditions on impending mergers, we found the conditions imposed by state officials generally fall into several major categories, including (1) conditions aimed at managing competition and price, (2) conditions to protect the workforce of hospitals, (3) conditions safeguarding continued and equitable access to services, (4) conditions on financial commitments and investments, (5) conditions to ensure high-quality care, (6) conditions regarding

charity care and community benefit requirements, (7) conditions to manage oversight and reporting for compliance, and (8) provisions governing enforcement of the conditions. Table 1 illustrates the frequency in each state of the different conditions and Table 2 provides examples of the types of conditions commonly seen in the different categories across states. Conditions in all categories either require or prohibit certain conduct and are generally in place anywhere from 2 to 15 years.

3.1. Competition

In transactions that have raised competitive concerns, state attorneys general and state agencies have imposed various conditions that either directly or indirectly seek to stem potential anticompetitive conduct enabled by any accumulated market power from the transaction. In response to concerns about post-transaction price increases that ultimately affect patients' access to affordable care, some states have imposed conditions that directly target prices through provisions such as price or rate restraints, while others address behavior that can indirectly lead to price increases, such as conditions that help maintain fair provider-payer negotiations or prohibit certain contracting practices with payers. This section will review the various types of conditions intended to prevent this behavior and the potential impacts of these requirements.

3.1.1. Price and rate restraints

In response to extensive research that has predominantly found that prices often increase post-transaction, at least four states have attempted to prevent price increases following a transaction by imposing various types of limits on price increases (1, 39). While these price restraints may be effective in preventing the immediate price increases seen post-transaction if accompanied by thorough oversight and accurate data, effectively regulating prices has proven challenging, and experiences from price regulation in COPAs illustrate that using conditions should not be the preferred, long-term solution to managing the price increases frequently seen in consolidating markets (37).

Massachusetts passed legislation in 2012 that established a Cost Growth Benchmark (CGB), a cost containment strategy that sets a limit on the annual increase in the state's healthcare spending and granted the HPC the authority to monitor and enforce compliance with the benchmark (40, 41). Since then, the state has used the CGB as a ceiling in several instances to limit price increases following healthcare mergers. For example, in 2018, the negotiated consent decree between the Massachusetts attorney general and Beth Israel Lahey Health set an "unprecedented" price cap by prohibiting post-merger price increases from exceeding 0.1% below the state's CBG for 7 years (42, 43). Massachusetts' CON program, called the Determination of Need (DoN) program, has also used the state's CBG as a limit for post-merger price increases, prohibiting the merged entity from increasing prices above the CGB (44). For states that have a CBG, using it as a threshold when instituting price caps can be a relatively straightforward way to set the caps, and having specific mergers conditioned to follow the CBG can add an extra means of enforcement for entities that exceed the benchmark. Furthermore, once conditions expire, the CGB could provide a backstop for excessive price increases moving forward.

Since California has not yet implemented a CGB, the state has used different measures to control post-merger price increases. The California attorney general's office has imposed conditions in recent transactions that require providers to maintain their existing payer contracts for 5 years and impose percentage caps for annual price increases for any contract renewals during that time. These percentage caps have ranged from 4.8 to 6% for contract renewals (45, 46), although one of these approvals set the cap at 6% for commercial prices and 2.8% for Medi-Cal prices (47). Another conditional approval involving Kaiser Permanente set absolute price caps for Managed MediCal and Medicare contracts for 10 years, in addition to renewal annual increase percentage caps for commercial contracts (48). In all of these decisions, the attorney general's office is permitted to extend conditions another 3 years and in making that decision shall consider whether the providers have materially violated any of the competition-related conditions. Although these caps protect against price hikes for their lifespan, without broader price regulation policies in place, very little prevents potential increases once the conditions expire.

So far, compliance reporting with these conditional approvals has shown that the restraints have been followed, and little to no empirical evidence exists as to the impact on price after the expiration of these price restraints. There have been multiple investigations, however, into the impacts on price after states repeal COPAs. While COPA price restraints apply to large transactions that significantly impact competition, evidence on the impact of repealing COPA regulations may shed light on the implications of time-limited conditions in other settings. In a policy paper summarizing the results of their five-year COPA Assessment Project, the FTC pointed to several COPA case studies that found that when states repeal COPAs, significant price increases follow (37). For example, one recent study found that for all three COPAs that were repealed prior to 2015, the prices of the previously regulated hospitals substantially increased when compared to controls (49). In light of this research and the frequency with which COPAs are repealed, the FTC has advised states against using COPAs, concluding that hospital mergers with COPA protections often result in unconstrained market power leading to higher prices and lower quality of care in some circumstances (37).

The experiences with COPAs can potentially serve as a cautionary tale about the time-limited nature of most price restraints imposed through conditions. While in place, the state authority responsible for oversight will need recent, accurate pricing data, access to payer contracts, and the expertise to decipher the materials provided to effectively enforce these types of conditions. Ideally, state officials should also be able to modify conditions to respond to changes in healthcare market dynamics, address the effectiveness of the conditions, or extend conditions if necessary. In situations where a time-limited price restraint is imposed, that duration should reflect the time it may take to institute other means of price regulation or pass price regulation legislation (6).

3.1.2. Conditions on healthcare provider-payer negotiations

States have also approached managing potential price increases by imposing conditions on the negotiations between healthcare providers and payers. Recognizing that some transactions lead to an accumulation of market power that may unfairly provide hospitals and health systems with additional leverage, a few states have imposed

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TABLE 1 Frequency of condition type by state.

State	# of decisions	Competition and price	Workforce	Access and equity	Financial	Quality	Charity care and community benefits	Notice of future changes	Compliance reporting	Independent monitor
CA	14	25%	71%	100%	43%	14%	100%	100%	100%	36%
CT	15	33%	33%	80%	–	27%	67%	60%	93%	53%
ME	6	17%	–	–	–	67%	–	33%	100%	–
MA	5	20%	–	100%	20%	20%	–	40%	100%	20%
MI	4	–	100%	100%	100%	–	100%	100%	100%	100%
NH	8	13%	13%	75%	–	13%	75%	50%	63%	–
NJ	7	–	86%	100%	–	43%	100%	71%	100%	–
NY	1	100%	–	100%	–	–	–	–	100%	100%
NV	1	100%	–	–	–	–	–	100%	–	100%
PA	2	100%	100%	100%	–	–	–	–	–	–
RI	12	–	50%	58%	1%	58%	42%	50%	92%	1%
WA	6	–	–	83%	–	–	83%	17%	100%	–
Total	81	20%	42%	78%	15%	27%	63%	59%	90%	26%

conditions that dictate the process of these negotiations. For example, the five-year consent decree between Concord Hospital, Inc., LRGHealthcare, and the New Hampshire Consumer Protection and Antitrust Bureau, created a binding arbitration process that is available to payers in the event the hospitals demand unfair rates creating an impasse in negotiations (50). In a different approach, the agreement between the New York attorney general, Faxton-St. Luke's Healthcare, and St. Elizabeth Medical Center requires the hospitals to negotiate in good faith with payers. If payers believe that the hospitals are acting unfairly, the agreement grants them the right to continue their currently-existing contracts with the hospital for 5 years at current prices (51). Lastly, in two recent decisions from the California attorney general's office, the conditions state that in the event that the hospitals violate the price restraints or other competition-related conditions, the payer may request separate negotiating teams and firewalls between the transacting hospitals as a remedy (45, 46). Like the price restraints discussed above, provisions such as these can be useful to manage potential price increases for a few years post-transaction, but in the conditions we reviewed, they do not provide avenues for fair negotiations in perpetuity.

3.1.3. Prohibitions on anticompetitive contracting practices

In addition to conditions that can help manage the negotiation process, states have also imposed conditions prohibiting specific anticompetitive contracting terms and practices. While prohibitions on anticompetitive contracting terms and practices have been utilized in consent decrees under antitrust law (52), California's attorney general office has been at the forefront of prohibiting these anticompetitive contracting practices using their administrative nonprofit review authority. Specifically, decisions have included conditions that prohibit practices that resemble anticompetitive tying, including bans on the use of all-or-nothing clauses, which require a health plan that wants to contract with at least one provider in a health system to contract with all providers in that system—effectively tying all the providers or facilities in the system together at a supracompetitive price (45–48). These conditions also prohibit less extreme forms of tying, such as conditioning the participation of one facility in a payer's network on the inclusion of one or more less desirable facilities. Additionally, when approving a merger between Methodist Hospital of Southern California and USC Health System, the attorney general imposed conditions that prohibit a practice known as "*de facto* all-or-nothing contracting," in which a health system sets significantly higher prices or out-of-network fees for its hospitals if the payer chooses not to contract with all of the system's hospitals (45). Lastly, the attorney general prohibited the inclusion of anti-tiering/anti-steering provisions, which require insurers to place all physicians, hospitals, and other facilities associated with a hospital system in the most favorable tier of providers or at the lowest cost-sharing rate to avoid steering patients away from that network (48). All the decisions prohibiting these practices put these restrictions in place for 10 years, with the option for the attorney general's office to extend them for another 3 years. These conditions, in theory, have the potential to prevent newly merged entities from overtly leveraging their power to reduce competition and can provide a means of deterrent beyond the threat of an antitrust suit for anticompetitive behavior. That being said, overseeing these types of conditions could be challenging if the state entity charged with oversight does not have

TABLE 2 Examples of conditions imposed.

Competition and Price	Workforce	Access and equity	Financial commitments and investments	Quality	Charity care and community benefits	Notice of future transactions or other changes	Compliance reporting/ independent monitor
Prohibit price increases exceeding certain benchmarks Prohibit certain anticompetitive contracting practices, such as tying, all-or-nothing contracting, anti-tiering/steering clauses, most-favored-nation clauses, and exclusive contracting Payers may request separate negotiations or firewalls Prohibit the imposition of system-wide rates unless payer proposes it	Require hospital to retain all or most employees post-transaction Provide notice to state officials of any planned reductions in workforce Prohibit noncompete clauses Prohibit changes to employee benefits Require initiatives for physician employment Maintain privileges for medical staff in good standing	Require that hospital remain open and maintain current licensure Hospital must maintain all or specific set of services at current level Hospital must maintain reproductive care services Require participation in state Medicaid program and/or initiatives to increase number of Medicaid patients May not discriminate based on patient's ability to pay or payment source Prohibits any form of discrimination Provide culturally and linguistically appropriate services	Require putting aside a certain amount of money to cover operating costs Require a certain amount in capital improvement expenditures at acquired hospital Reinforce existing capital improvement agreements	Must submit annual reports on quality and outcome measures Must implement certain quality of care initiatives Must appoint evaluation team to monitor quality of care Participate in health information exchanges Notify state officials of changes to quality programs Submit a plan detailing how reported savings will be used to improve quality and access Report on improvement in quality outcomes attributable to transaction	Require a minimum spending amount for charity care and/or community benefits Maintain current charity care policy Maintain current community benefit programs Inform patients of charity care and/or financial assistance policies Provide written notice to state officials of changes to charity care policy Provide free or discounted care to low-income patients (e.g., 175% of federal poverty guidelines)	Notify state officials of future transactions Notify state officials of any reductions in services Annual reporting of changes in payer mix and whether it has had an impact on access	Annual reporting on compliance with conditions Appoint independent monitor to monitor compliance Report on implementation of proposed efficiencies from transaction Report on access, quality, and cost of health services Provide annual audited financial statements Report on implementation of certain required initiatives Report on capital investments

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access to the contracts or if these terms are not explicitly in the contracts, but are instead negotiated in closed-door negotiations, and the enforcers must rely on payers or other parties to report noncompliance.

When competition-related conditions are time-limited, they may prevent anticompetitive behavior if overseen and enforced effectively but ultimately do not provide a long-term check on any future anticompetitive behavior. When conditions expire, states have the option to threaten or bring an antitrust suit, but that endeavor is lengthy and the outcome uncertain (53). Alternatively, during the time conditions are in place, state legislatures could move to pass legislation that would indefinitely and uniformly prohibit anticompetitive contracting practices or install other price-regulating policies. When a transaction raises competitive concerns, state officials and antitrust enforcers should consider blocking such transactions outright unless there are extremely compelling reasons not to do so.

3.2. Workforce

Interest has been growing in the impact of hospital and health system transactions on local labor markets, both in terms of competition as well as ensuring there are enough providers and staff to preserve access to services (54). Hospitals are often the largest employer in a region, and there have been concerns that diminished competition from the acquisition of hospitals and physicians can lead to limited physician employment opportunities as well as significant layoffs of staff post-transaction (55, 56).

When health systems acquire physician groups and then limit the physicians' ability to work with other hospitals through noncompete clauses or exclusivity agreements, the impact is two-fold. First, physicians are unable to work with other hospitals or health systems or leave that health system unless they are willing to move to another area or even another state (57). Second, competing hospitals that may have previously relied on those physicians to provide services no longer have access to them, which can impact their ability to provide care (58). At least four states have imposed conditions prohibiting non-compete agreements, exclusivity arrangements, and other restrictions on physician employment (17, 18, 50, 59, 60). For example, in 2012, the Maine attorney general entered into a consent decree with MaineHealth after it sought to acquire the only two large cardiology groups in the Portland, Maine area. Conditions included that the cardiologists could not be hindered in their ability to compete or participate in physician networks (59). Around the same time, Renown Health in Nevada sought to acquire two medical practices that provided essentially all the cardiology services in the area. The Nevada attorney general along with the FTC, reached a consent decree with Renown Health to temporarily free the acquired cardiologists from their non-compete agreements to permit them to leave the system without legal repercussions to restore competition for cardiology services (60). In addition to prohibiting non-compete agreements, in the consent decree with LRGHealthcare, the New Hampshire Consumer Protection and Antitrust Bureau also prohibited the use of exclusivity clauses that prevent providers from contracting with other hospitals or health systems (50). The use of noncompete clauses in healthcare in particular has long been an area of contention, with physicians arguing that it hampers career growth and hospitals claiming that noncompete clauses help protect their investment in training physicians and keep services appropriately staffed (61). Although the FTC is currently considering a rule banning noncompete clauses, which would extend to physicians employed by health systems and hospitals (62), restricting these practices through conditions in states that do not already ban them and in situations where they will actively harm competition in a specific market can be a useful tool for states in the meantime.

At least two other states have also imposed conditions to try to monitor and protect the workforce at hospitals post-transaction, specifically against immediate layoffs that impact services and the economic health of an area. In the recent acquisition of two community hospitals in Rhode Island, both the Rhode Island Department of Health and the Rhode Island attorney general imposed conditions to protect the employees of both hospitals. The Department of Health prohibited any layoffs for a year post-transaction (63), whereas the attorney general prohibited any changes to employee benefits for 6 months post-transaction and required that the attorney general's office must be notified 10 days before there are any reductions to the workforce (64). New Jersey's CON program also considers the impact of transactions on hospital employees and many of its conditional approvals have reinforced the healthcare entities' commitment to retaining nearly all employees after the transaction and have required explanations for any workforce reductions (65). Especially in transactions involving financially struggling hospitals and hospitals in rural areas, layoffs may be a strategic step in cutting costs, but state officials should have the ability to closely monitor changes in the workforce to determine whether the layoffs go beyond achieving efficiencies and impact access to quality care for patients.

3.3. Access and equity

While consolidation can have troubling consequences for healthcare prices as well as labor markets that indirectly impact access to care, healthcare provider consolidation can also lead to a direct loss of access to services. Conditions geared toward preserving access to care try to address the fact that while mergers and other transactions may provide valuable and necessary resources to hospitals, they can also lead to the termination of less profitable services or even the eventual closure of acquired hospitals (66, 67). Across the states we reviewed, most decisions had provisions intended to protect or promote access. Examples of these provisions include requiring the transacting hospitals to maintain all current services or maintain specific critical services, such as 24/7 emergency departments, maternal care services, or mental and behavioral health services. Additionally, conditions have been utilized to enforce notice requirements for reductions or terminations of services, with some conditional approvals requiring hospitals to provide advance notice to or obtain prior approval from state officials before making any changes to their services (68–70). Identifying essential services and the services most vulnerable to elimination as well as finding opportunities to improve equitable access to care should be a crucial part of any pre-transaction review and approval process. Below, we discuss how states have sought to address specific concerns related to reproductive services, rural health services, Medicaid and Medicare services, access for underserved communities, and cultural and language barriers to access.

Several states have sought to address the loss of access to reproductive health care resulting from transactions involving Catholic hospitals, which must adhere to the Ethical and Religious Directives for Catholic Health Care Services (ERDs) (71). The ERDs establish the ethical and moral boundaries within which care providers must operate, specifically forbidding providers in their health systems from providing various reproductive health services, including abortion, contraception, and tubal ligation. In 2019, as a condition for approving the vast merger between Dignity Health and Catholic Health Initiatives creating CommonSpirit, the California attorney general required that the hospitals in California continue reproductive health services for 5 years, and for an additional 5 years, notify the attorney general prior to eliminating those services (70). The New York attorney general has also included provisions protecting access to reproductive care services in the negotiated consent decree governing the affiliation between Faxton-St. Luke's Healthcare System and St. Elizabeth Medical Center (51). The growing footprint of Catholic hospitals across the country has raised further access concerns regarding gender-affirming and end-of-life care services in the secular hospitals and health systems they acquire (72, 73). As access to services that contravene the Catholic ERDs becomes more constrained across the country, state enforcers and regulators can protect these services by imposing access-oriented conditions more frequently and for longer periods of time.

Hospital transactions in underserved and rural areas, in particular, often disproportionately impact access to care (66). Rural hospitals face a double-edged sword when it comes to consolidation: while transactions like mergers and acquisitions may bring in an influx of capital and improved infrastructure, often the acquirer opts to eliminate services as a cost-savings strategy, frequently targeting those that are duplicated, less profitable, or have lower reimbursement rates (66). For those in rural areas with an already limited pool of healthcare options, the elimination of these services can delay access to emergency treatment, increase treatment costs, and cause patients to forego care altogether (74). The discontinuation of services, such as emergency departments and labor and delivery units, also contributes to worse health outcomes, more expensive care, and exacerbation of already problematic inequities in care (75, 76). Utilizing conditions like those mentioned above is crucial to preserving access to services until another long-term solution can be found to protect access in these areas.

In addition to requiring the continuation of services, some states have also taken steps to encourage more equitable access to services. For example, requiring hospitals to continue or increase their participation in Medicaid and Medicare can be particularly impactful in rural and underserved areas, where access to care is an issue both in the number of available providers and the distance patients must travel to seek care (77). Both the Massachusetts attorney general and the DoN program have imposed conditions requiring provider participation in MassHealth (Massachusetts's Medicaid program) and the State Children's Health Insurance Program on the merger creating Beth Israel Lahey Health after the HPC found that the inpatient Medicaid mix would be among the lowest of the major health systems in eastern Massachusetts (43, 78, 79). Specifically, the consent decree negotiated by the attorney general guarantees that there will be no caps on MassHealth patients and requires the health system to create a new program to increase the number of MassHealth patients (43). Examining the patient mix at transacting hospitals and the demographics of the communities they serve can be an important step in identifying opportunities to improve access for these populations.

State officials have also identified opportunities to ensure healthcare providers meet the needs of the various communities they serve. At least two states, California and Massachusetts, have required the transacting systems to make financial commitments to bolster access and support community entities providing services for low-income and underserved communities (43, 70, 80). For example, in the agreement with Beth Israel Lahey Health, the Massachusetts attorney general received a $71.6 million commitment from the health system that provides financial support for community health centers, safety net hospitals, and behavioral health access (43). State officials have also included provisions that aim to make sure hospitals and health systems hear the voices of community members moving forward. For example, California has required transacting hospitals to maintain a community board that must be consulted prior to changes to services or community benefit programs (44, 46, 47), while Connecticut often requires community members to be placed on the hospital boards (81–83). Conditions like these, which are designed to maintain and grow access to healthcare services for underserved communities, can grant states time to develop alternative options for those populations after the conditions expire or after the initial financial commitments have been made.

In addition to the challenges with access to healthcare services, many patients experience significant language and cultural barriers that compromise their care (84). These barriers create extremely challenging circumstances for some people seeking to avail themselves of the healthcare system, making it difficult for patients to communicate their symptoms, ask questions of clinicians, or understand provider instructions, which in turn impedes the abilities of providers to administer appropriate patient care (85). In recognition of how language and cultural barriers impact health equity, California, Connecticut, New Jersey, Rhode Island, and Washington have imposed requirements for hospitals to address access to language services that often reiterate existing laws. While there are laws and regulations at the federal level requiring similar policies (85), these conditions can help reinforce those requirements.

Many of the conditions described in this section respond to concerning trends across the country involving increasingly shrinking access to services. While conditions can serve as a stopgap solution to preserve access, in most cases, they do not offer viable, long-term solutions, especially for hospitals facing increasing financial troubles that would benefit from broader and more permanent policies designed to protect the access to health care communities rely on.

3.4. Financial commitments and investments

While conditions that protect and enhance access to services are critical, going a step further and imposing conditions aimed at protecting the continued operation of financially struggling hospitals can be a more challenging task. One way is for conditions to reiterate the transacting parties' agreement to provide capital commitments post-transaction. For example, the California attorney general's office has reiterated transacting health systems' investment commitments going toward improving facilities (86, 87). Including promises set out in the agreement between the parties in the formal conditions may

enable the attorney general to enforce provisions in the agreement that may have otherwise been difficult to oversee or enforce.

In our sample, two state attorneys general went a little further and imposed conditions on transacting providers that required either investing or setting aside finances to ensure that the community received the promised benefits of the transaction. In 2015, the California attorney general's office took a more involved approach in the decision conditionally approving BlueMountain Capital Management's, a private equity firm, acquisition of Daughters of Charity Health System, saving the failing health system from bankruptcy (88). To ensure that the health system would actually be financially supported moving forward, the California attorney general's office required that $180 million be invested in capital improvement expenditures at the health systems facilities as part of the conditional approval of the deal (88). More recently, the Rhode Island attorney general took unique steps to safeguard the continued operation of Roger Williams Medical Center and Our Lady of Fatima Hospital, two local safety net hospitals, owned by Los Angeles-based for-profit Prospect Medical Holdings (PMH) (89). In the proposed transaction, a private equity group effectively wanted PMH to buy out their existing ownership stake. The Rhode Island attorney general was concerned that this transaction would contribute to PMH's increasingly vulnerable financial state and would threaten the viability of the two hospitals that are financially dependent on it (90). To protect the two hospitals from PMH's troubling business practices, the attorney general required several financial commitments from the transacting entities, including requiring the transacting entities to put $80 million in an escrow account that can be drawn upon to cover the two hospitals' operating and capital expenses if Prospect fails to fulfill its financial obligations (64). The attorney general also required that any transfers of assets or encumbrances must undergo prior approval by the attorney general for 5 years. Although these types of protections are only in place for a few years, keeping hospitals operational for a while is a better outcome than them closing in that time.

3.5. Quality of care

While maintaining access to affordable care is crucial, states have also imposed conditions intended to monitor that hospitals deliver on promises to maintain or improve the quality of that care post-transaction. While hospitals and health systems frequently claim transactions will serve patients' interests by improving the quality of care, studies have found that the assertion that transactions improve quality is often unsubstantiated (91–93). For instance, Nancy Beaulieu and colleagues at Harvard University analyzed the quality impacts following 246 hospital acquisitions by health systems and found modestly worse patient experiences and no significant changes in readmission or mortality rates (91).

To monitor the quality of care after mergers and to ensure patient care is not compromised in the interest of other priorities, some states have imposed conditions to hold hospitals accountable for post-transaction quality of care. Maine has required annual reports on quality improvements and outcome measures for 3 years in nearly all its CON conditional approvals (94). Rhode Island has addressed post-transaction quality by requiring hospitals to increase patient enrollment in CurrentCare, a platform that provides real-time patient information as well as data on various quality, efficiency, and safety measures, and to implement quality improvement initiatives, including launching programs to prevent unnecessary hospital admission and readmissions and to improve screenings for alcohol abuse (95–97). Monitoring quality over time is critical to understanding how transactions impact patient outcomes and conditions that require transacting hospitals to provide data on patient experience, quality of care, and patient outcomes can be a useful tool to allow that state to identify trends and changes.

3.6. Charity care and community benefits

In addition to many of the conditions mentioned above, transactions involving nonprofit hospitals require additional considerations and conditions unique to nonprofits. Unlike their for-profit counterparts, nonprofit hospitals are expected to provide community benefits, including charity care (free or discounted care) in exchange for exemptions from local, state, and federal taxes (98). Recently there has been a growing spotlight on the behavior of nonprofit hospitals and significant questions as to whether they are fulfilling the responsibilities tied to their tax-exempt status (99, 100). In fact, recent research has shown that nonprofit hospitals devote a smaller or similar share of their operating expenses to charity care than for-profit hospitals (101). Factors contributing to this trend likely include the lack of clear requirements and consistent oversight from federal and state officials (102, 103). At the federal level, the IRS does not specify quantitative measures for charity care or community benefits, while state requirements and oversight vary widely across the country (102, 104).

Recognizing these shortcomings and the importance of nonprofits' obligations to the communities they serve, many of the states we reviewed, including California, Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, Rhode Island, and Washington have used their approval authority to impose conditions intended to protect against any reductions or eliminations in charity care or other community benefits post-transaction. Conditions addressing community benefits generally included conditions such as requiring hospitals to maintain their current charity care policies, notifying the appropriate state officials of any intended changes to the policies, requiring hospitals to notify patients of the availability of financial assistance or post those policies publicly, and requiring hospitals to maintain or implement community benefit programs that address population health and social needs.

Going a step further, the California attorney general's office through its nonprofit review has set required minimum amounts hospitals must spend on charity care and community benefits for several years post-transaction in virtually all conditional approvals (105). In 2018, multiple hospitals petitioned the California attorney general to significantly reduce these obligations in light of the Affordable Care Act making health insurance more widely available (106). The attorney general denied these requests and mandated that the hospitals immediately pay the outstanding amounts of their obligations under the conditions to tax-exempt entities providing direct medical services to the community in the hospitals' service areas for failure to meet their charity care requirements in the previous years (106). Conditions that impose minimum charity care or community benefits requirements can set meaningful and enforceable standards for nonprofits to follow and create a means of enforcement

in the absence of state or federal law should the hospitals fall short of these obligations to the communities they serve.

3.7. Post-transaction oversight

For any of the conditions discussed above to be meaningful, there must continuous and in-depth oversight to hold hospitals and health systems accountable to their obligations. Effective oversight requires two components: (1) hospitals or health systems need to provide recent and accurate data illustrating compliance, and (2) states need the resources and expertise to analyze that information.

First, the state conditional approvals and consent decrees we reviewed impose various reporting requirements to demonstrate compliance for the duration of the conditions. For example, in all conditional approvals in California and Connecticut, hospitals must submit annual reports detailing their compliance with the conditions imposed. Similar requirements have also been set in statutes and regulations, rather than in the conditions themselves, as seen for several states' CON programs, including Massachusetts (107), Maine (108), and Washington (109). As part of compliance reporting, states have also required healthcare entities to submit information to help the oversight entity monitor other potential changes that arise from the transaction. This information can include detailed financial reports, healthcare quality reports, and reports on the efficiencies achieved as part of the merger. Reporting requirements provide the state with valuable information with which to verify compliance and assess the impacts of the merger. Relying only on self-reported data provided by the monitored healthcare entities, however, leaves open the possibility that only the most favorable data will be disclosed, data may be incomplete, or it may not fully reflect the realities of operations. Therefore, state officials should consider taking steps to confirm the validity and accuracy of the submitted information.

Second, states need to devote significant time, funding, and expertise to effectively analyze and assess compliance. While state agencies and attorney general offices are responsible for this task, some have found ways to minimize that burden. States including California, Connecticut, Massachusetts, and Michigan have utilized third-party independent monitors at the expense of the healthcare entities to continuously assess compliance and outcomes post-merger. The use of an independent monitor may also have the added benefit of minimizing actual or perceived bias in the oversight process, thereby increasing confidence in the findings. The efficacy of an independent monitor greatly depends on who picks the monitor and who the monitor is. Because their role is to assist state officials in overseeing conditioned transactions, the state should select the monitor. Leaving the decision to the transacting entities allows them to pick a monitor who may not be objective or will not provide thorough oversight. Furthermore, because of the specific expertise and experience required to fully understand and evaluate the intricacies of healthcare finances, operations, facilities, investments, and staffing, some of those most qualified to conduct compliance reviews may also have ties to the industry, potentially compromising their objectivity. Therefore, independent monitors less closely tied to the industry, such as academics or retired professionals, may be better suited for this role.

Oversight can serve as not only a check on adherence to conditions but a mechanism for deterrence, discouraging entities from ignoring their obligations. By failing to hold entities accountable to the goals of reducing costs, maintaining competition, and promoting access, equity, and quality, the power of conditions in future approvals becomes significantly weaker. States should only approve transactions with conditions if they are equipped and committed to monitoring and oversight.

3.8. Enforcement

Reporting and oversight can only hold parties accountable if there are consequences for noncompliance. Enforcement provisions without appropriate remedies or penalties are neither a deterrent nor a punishment. The remedy chosen should depend upon the entities, the infraction, and the state's goals. Many state officials first address noncompliance by offering to facilitate compliance or remediate improper conduct, such as requiring entities to submit performance plans, refund excess revenue generated through noncompliance, or require funding for health priorities or community benefit programs. For example, the Pennsylvania attorney general will first provide a reasonable opportunity for the entity to cure its noncompliance with consent decrees within 60 days and may take remedial action thereafter (17, 18). In its consent decree with MaineHealth, the Maine attorney general required that if the entities violate the conditions relating to rate restrictions, they shall refund 110% of excess revenue generated from non-compliance to affected commercial payers (59). Per Massachusetts DoN regulations, the DoN program may require the noncomplying healthcare entity to fund projects which address one or more of the established health priorities for instances of non-compliance (110).

Several states also require the entity to reimburse enforcement actions that seek to hold them accountable. The Michigan attorney general's office has required providers to allocate a certain amount of money to cover the attorney general's expenses for non-compliance enforcement actions if the entities do not remedy the violation within a given amount of time (111). By law, the California attorney general is entitled to recover attorney fees and costs incurred in remedying each violation of a condition of approval (112). Holding the transacting providers responsible for the costs of enforcement in light of continued noncompliance, not only eases some of the burden on state resources but also can serve as a deterrent for noncompliance.

Enforcement, however, is not necessarily a straightforward endeavor. In 2019, as part of the conditions granting a CON for the merger of two health systems creating Nuvance Health, the Connecticut Office of Health Strategy (OHS), required the merged entity to annually attest that they have maintained certain services as well as to maintain sufficient staffing for OB/GYN services at Danbury, Norwalk, and Sharon Hospitals (82). Within 2 years, however, OHS received complaints alleging that Sharon Hospital was not in compliance with these conditions, leading the agency to launch an investigation into the alleged noncompliance after receiving conflicting information from the hospital (113). In the midst of the allegations of noncompliance, the provider applied for a subsequent CON to formally allow Sharon Hospital to terminate its labor and delivery services despite the conditions previously imposed, citing declining birthrates and challenges attracting and retaining staff to support maternity services (114–116). In response, there has been significant pushback from the community as well as other state officials against the termination request (116, 117). In particular, the

Connecticut attorney general's comment to OHS regarding the termination request aptly outlines how the closure will impact patients, particularly Medicaid and other low-income patients, which comprised 48% of the hospital's post-birth discharges in 2021, and how terminating these services will erect barriers to access for those patients (117). OHS's noncompliance investigation and its consideration of the new request to terminate services both appear to be ongoing, however, they illustrate the difficult position state officials might find themselves in when providers attempt to circumvent conditions that are responsive to community needs, claiming that they threaten financial sustainability. Despite these claims, providers must still be held responsible for noncompliance and should not be able to inappropriately deprive patients of accessible care. Circumstances like the one in Connecticut also shed light on the need for better policies beyond conditions that can help hospitals that are truly struggling without compromising access.

Because effective oversight and enforcement of conditions are complicated, time-consuming, resource-intensive, and sometimes may ultimately prove ineffective, it is important to distinguish between deals that can serve the interests of the community but need oversight, from transactions that pose significant risks such that, even with conditions, monitoring, and enforcement, they may do more harm than good. Making this determination is dependent on a variety of factors, such as size, hospital type, financial status, geography, market landscape, pricing practices, and community needs. For example, a conditional approval of an acquisition that will prevent a small struggling rural hospital from shuttering, can not only help keep the hospital open but can, in theory, also protect against the loss of critical services for the community. In contrast, for a merger that, due to its size or accumulated market power, is likely to further diminish competition and lead to anticompetitive price increases, conditions are hardly going to replace the resulting loss of competitive forces and will just leave the market more consolidated. As the consensus is that it is difficult to "unscramble the egg" after a transaction has occurred (118), even in situations where conditions are likely useful, state officials should consider the potential consequences of a healthcare provider's failure to adhere to the conditions, what may result after the expiration of the conditions, and how the state can use the time the conditions are in place to prepare other policies or solutions to prevent any negative outcomes in the long-term. The next section delves into the shifting perspectives on the use of conditions, the specific situations when states should consider imposing conditions, and the steps to achieve useful and effective conditions.

4. Considerations for states

Although it is relatively common for states to impose conditions on hospital and health system transactions, there is notable skepticism about the use of conditions as a remedy when a transaction raises competitive concerns among federal antitrust enforcers, courts, and scholars. Critiques include evidence from other industries that conditions generally have not achieved their intended purposes, that they "risk excessive government entanglement in the market," and ultimately still allow markets to consolidate and entities to accumulate market power (119–124). Alongside these concerns about the use of conditions, there has also been a shedding of a long-held presumption that many hospital transactions create sufficient efficiencies to warrant them to proceed unimpeded except in particularly egregious cases of consolidation (125). State officials should consider these shifts as well as the challenges of oversight and enforcement when considering conditionally approving hospital deals.

In light of these changing attitudes and the well-documented detrimental effects of hospital consolidation, state review should carefully consider the long-term consequences of permitting a transaction to proceed with conditions and how necessary it is to permit the transaction to move forward. While there are situations in which conditions are the best outcome, there are many situations in which they are not, especially when the transaction raises competitive red flags. The clearest situation in which imposing conditions can provide a positive outcome is in a transaction that prevents a hospital from closing and preserves the community's access to care. Rural hospitals are often vulnerable and have been closing at an alarming rate. Since 2010, over 100 rural hospitals have closed and another 89 have significantly reduced services, leaving healthcare deserts across the country (126, 127). In these cases, the repercussions of a hospital closing are considerably worse than imperfect conditions, which can be used to at least keep the hospital operational for a certain period, giving the state time to develop alternative means of accessing care for the impacted population.

Conditions may also be an appropriate route to take for transactions that would have otherwise escaped any sort of scrutiny and would be challenging to block under existing federal or state law, yet raise competition concerns. These transactions include those that do not trigger federal antitrust review, such as smaller transactions, and those that would be difficult for state officials to challenge under state or federal antitrust law, such as those that do not fit neatly into the traditional horizontal merger antitrust analysis (e.g., cross-market or vertical mergers). The relatively high threshold for federal antitrust review creates a chasm through which potentially problematic transactions can fall without state-based review processes to catch them. For instance, research has shown how "stealth consolidation," or the accumulation of seemingly innocuous individual transactions, can lead to damaging effects on markets (128). These risks are why state pre-transaction review and approval processes are so important and why it is essential that legislatures grant state officials broad authority to review and subsequently block or condition transactions on grounds that impact access to affordable care. When blocking a transaction is not an option, imposing conditions is the next best option as long as there are clear goals as to what the state or the providers should accomplish in the time frame of the conditions. Conditions should aim not only to prevent harm but also to ensure that the proposed benefits are realized as well.

In most other circumstances when the impact on competition is a concern, state officials should err on the side of taking steps to block the transaction. The status quo of permitting most transactions to proceed has left most healthcare markets across the U.S. consolidated, leaving too many without access to quality and affordable health care. Competitive forces are simply insufficient to restrain prices in most markets, so even small transactions that typically go unnoticed by federal antitrust regulators can be harmful. If a potential deal would require multiple conditions to safeguard state priorities, the more effective strategy is likely to block the deal outright, rather than attempt to address the negative effects through conditions that require a heavy commitment of time, resources, and staff and that may ultimately not mitigate the harm caused by the transaction or, at best,

provide just a temporary delay. A stronger stance against consolidation is desperately needed to preserve the competitive markets we have left.

4.1. Recommendations for imposing conditions

In situations where permitting a transaction to proceed with conditions remains the best option, several broad considerations should be taken into account. First, the conditions should be transaction-specific and thoughtfully tailored to address the precise areas of concern raised during the review process and address likely responses to the conditions by the hospital. For example, if as a condition of approval, the hospital must keep certain services available, a price restraint might also be prudent to prevent any price hikes on those services. This tailored application of conditions requires an in-depth review of the transaction that examines how the transaction will impact prices, access, equity, and quality, and should include gathering and considering input from the community, physicians, nurses, and other hospital staff, through public comments and holding public hearings. This process takes time and resources and states like Massachusetts, California, and Oregon can rely on outside sources to provide in-depth reports and pinpoint areas of concern. In Massachusetts, the HPC conducts Cost and Market Impact Reports (34), whereas the California attorney general has utilized academics or other consultants to produce reports on the potential impacts of proposed transactions (25, 105). These publicly available reports from both states have identified potential negative impacts from transactions that have subsequently informed the conditions imposed. In a different approach, Oregon law permits the OHA to convene a Community Review Board to help review transactions, which must include members from the communities affected by the transaction (36, 129). The Board then provides non-binding recommendations to the OHA as to whether to approve, condition, or block the transaction (36).

Second, if they have discretion, state officials should carefully consider the length of time conditions are imposed, what goals the state can accomplish in that time, and the lasting impacts of imposing conditions for that length of time. States should consider enabling the reviewing entity to modify or lengthen conditions if market conditions have changed or if conditions have not been followed. While conditions imposed through administrative processes are often time-limited by law, conditions in consent decrees can theoretically last in perpetuity, but practically that may be challenging to achieve and oversee. Although longer-term conditions can be useful to achieve and sustain state priorities, years of monitoring can be burdensome, requiring a significant expenditure of time, resources, and personnel. When possible, targeting longer-term conditions on the areas with the most significant risk may prove to be more efficient and effective, directing resources where they can have the most impact. In other cases, states should consider whether imposing conditions for a limited period would enable the state to pass legislation, attract another entity to provide services in the area, or otherwise promote competition in the area. That being said, if it seems likely that the imposition of conditions would only serve to delay the adverse outcomes, not prevent them by providing time and resources for more permanent changes, states should reconsider approval or face the reality of overseeing long-term conditions.

Third, while certain conditions can temporarily fill existing healthcare policy gaps, they should not be relied upon in lieu of broader policies and passing comprehensive healthcare legislation. But as these policies make their way through the legislative process, conditions may be an acceptable way to impose those policies on particular entities, before they are enacted state-wide, and use the experience of overseeing and enforcing those conditions to inform future legislation. There may also be less political opposition to imposing conditions compared to passing certain kinds of legislation, such as strong policies for price regulation. Using conditions in this way can also raise public awareness of the need for legislation, potentially provide proof of efficacy, or provide a means of enforcement before a law is passed. For example, if a state is considering passing legislation banning anticompetitive contracting practices like all-or-nothing or tying, punishing a health system for noncompliance with conditions prohibiting those practices may be more efficient and effective than the attorney general having to pursue an antitrust suit, such as the long and resource-intensive state case against Sutter Health (130).

Fourth, state officials need a deep understanding of both the state and local healthcare markets as well as the likely impacts of the transaction to target conditions to the current market conditions. Information such as how consolidated a market is already, current market dynamics, preexisting quality concerns, the patient mix at neighboring hospitals, and recent changes to available services should inform the conditions imposed. Having a state agency, like Massachusetts's HPC, that tracks and can provide credible data analysis on healthcare cost and quality measurements can immensely help with this endeavor. However, access to robust data is still something states are grappling with, even those with an all-payer claims databases (131). Although not comprehensive, conditions that require extensive reporting could begin to supply information that could be used to inform future conditions or larger policy initiatives.

Fifth, compliance requirements should mandate that the transacting hospitals demonstrate not only that they are complying with any conduct restrictions, but also provide substantial and explicit evidence and data that they are achieving any purported efficiencies, cost-savings, or other alleged benefits and how those benefits are improving access and quality of care. Further, any instances of noncompliance with any of the requirements should be met with sufficient penalties to serve as effective deterrents. Beyond hefty fines, provisions requiring other remedies could also be included within the approval decision or mandated in statutes or regulations. Examples include the California attorney general specifically requiring hospitals that do not comply with charity care requirements to pay those deficiencies directly to local nonprofits providing direct medical services and the Massachusetts DoN program regulations requiring noncomplying entities to spend an amount equal to a certain percentage of the transaction cost on DoN program-approved projects (106, 110). Conditions are relatively meaningless if they are not enforced and do not ensure that the approval benefits the community.

To achieve all these recommendations, state officials must have sufficient oversight authority through the attorney general's office, CON program, or another state agency to conduct in-depth reviews of a wide range of transactions and the flexibility to approve, reject, or condition the transaction to address concerns on various fronts. State legislatures need to make sure that new laws granting authority or amendments to existing authority allow state officials to impose

meaningful conditions without being accused of overstepping their authority. State officials should be given broad enough authority to adapt to changing trends in how healthcare deals are structured and address concerns unique to certain transactions, such as the involvement of private equity in the healthcare space (132).

4.2. Potential provider responses to conditions

In cases where strong conditions are the best path forward, it is also important to recognize that state officials may face significant resistance from health systems and hospitals. The imposition of strict conditions has led to entities abandoning transactions (133), and while this can be a positive outcome if the transaction would have led to more consolidation without many distinct benefits, state officials should be aware that some entities may be prepared to let the deal fall through to avoid conditions, even if that means letting a hospital close. For example, the California attorney general imposed relatively modest conditions intended to protect basic services for the largely uninsured and Latino-majority community on the acquisition of Madera Community Hospital. In response, the acquirer Trinity Health, a nonprofit Catholic health system, pulled out of the deal, ultimately leaving Madera without much-needed financial help and forcing it to close (134, 135). The closure has meant the loss of the only facility providing adult emergency services in the county (135). Situations like this one illustrate the need for states to have more policies at their disposal to prevent the closures of hospitals providing much-needed services, such as global budgets and other policy options geared at helping struggling hospitals (136, 137). While an acquisition may be the most appropriate solution in some cases, that should not dissuade state officials from imposing strong conditions on already powerful health systems.

Transacting providers may also challenge the conditions imposed through administrative approval processes. In 2020, in the first transaction the California attorney general utilized conditions to address competitive issues, the hospitals sued the attorney general claiming that imposing those types of conditions was outside the attorney general's nonprofit hospital approval statutory authority (138). The case was ultimately settled with slight changes to the competitive impact conditions, but the challenge illustrates a potential hurdle facing state officials wanting to impose types of conditions that they have not previously used (46). While agency decisions reached through administrative processes are generally given deference in court, having to defend those decisions in court takes up valuable time and resources (11). The California attorney general has since imposed similar conditions on other transactions without issue, illustrating that while there might be initial pushback, setting that precedent for using transaction oversight authority to its fullest extent is a worthwhile endeavor (105). Despite being limited to transactions involving nonprofits, California's attorney general has a relatively broad authority to review transactions for a variety of factors, including competition, access, quality, as well as factors specific to nonprofits, and impose conditions relating to each of those categories, but not all state officials have been granted that same breadth of review (13). For conditions to target all potential impacts on the market, state officials need broad statutory authority to address a wide range of concerns and the means to track and enforce conditions throughout their existence.

5. Conclusion

Being able to utilize conditions is an important tool for many states to ensure hospitals and health systems deliver on the promises of the benefits of transactions and that they continue to serve their communities. The use of conditions, however, should be carefully considered when a deal raises competitive concerns and threatens the last vestiges of competitive forces we have left. Any time state officials impose conditions, they should do so with an eye toward future policies and with the intention of fulfilling concrete goals that will defend or improve access to affordable care for years to come.

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AM, KG, and JK contributed to the conception of the work. AM and RD collected research and drafted the manuscript. All authors participated in substantially editing and revising the manuscript critically for important intellectual content and have read and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

Supplementary material

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

BY ERIN C. FUSE BROWN AND KATHERINE L. GUDIKSEN

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CONTENTS

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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
1. Require prior notice to state officials of proposed health care transactions.	• 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?
2. Require concurrent notification and review by both the attorney general and the health department or other health care market oversight body.	• 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?
3. Authorize the attorney general or state agency to block or impose conditions upon harmful transactions without a court order.	• Which agency or agencies should have the authority to block a transaction?
4. Establish health care transaction review criteria to assess whether the transaction is in the public interest.	• How should a state define what it means for a transaction to be "in the public interest"?
5. Have robust mechanisms for monitoring compliance with conditions, including significant penalties for noncompliance.	• 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?
6. Allocate sufficient time and resources for implementation of health care market oversight programs.	• How long should states have to review a transaction?
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.	

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.

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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

[a] The 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*

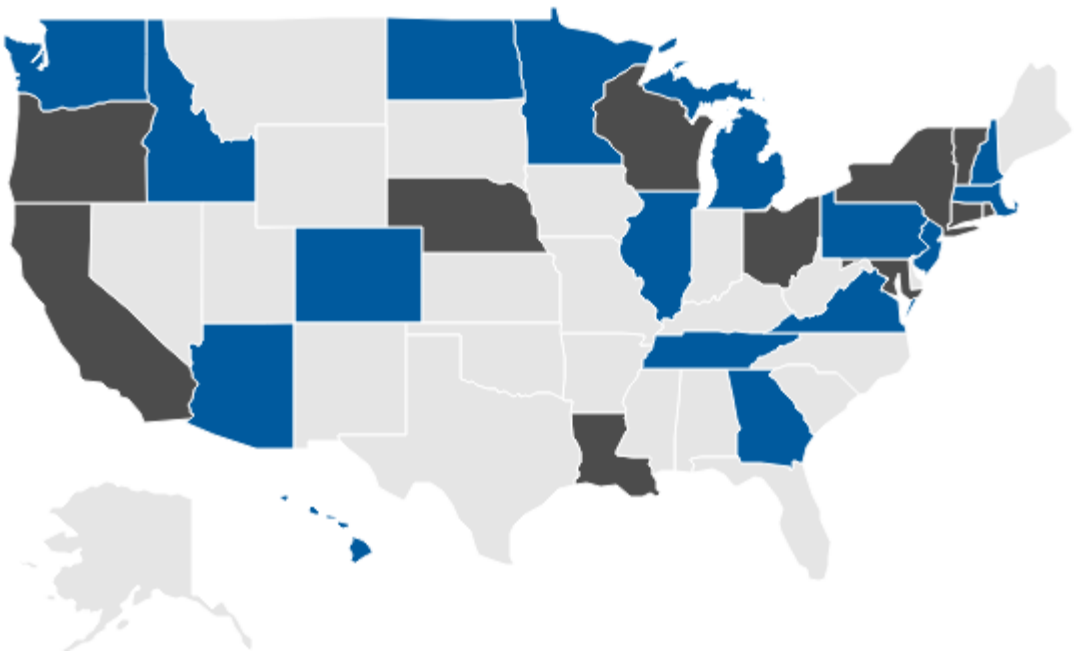
*Authority includes some nonhospital transactions, including provider groups and/or private equity transactions. The authority in states without the asterisk is specific to hospitals or health facilities.

[c]In 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.

States Requiring Pre-transaction Notification to the Attorney General

Many states require merging health care entities to file a pre-transaction notice with the state AG and wait a specified amount of time before closing, allowing the AG sufficient time to review the likely impacts of the merger and to gather public input (see Figure 1). In some states, the notification requirement is limited to transactions that result in a change in control of a nonprofit health care entity, and the statutorily required review is typically limited to traditional charitable trust concerns, such as whether the transaction price is fair market value or whether the charitable assets were properly transferred. Nonetheless, if the charitable trust division has concerns about whether a transaction raises competitive concerns, it can notify the antitrust division of the AG's office for independent antitrust review. In these states, the transacting parties are not legally required to pause the transaction while the AG completes the review, but the transacting parties may choose to delay closing the transaction until review is completed to avoid having to unwind a merger if the AG challenges it in court.

Figure 1. Attorney General Authority to Oversee Health Care Transactions



Limiting the pre-transaction notification to nonprofit entities fits within the traditional charitable trust authority of the AG, but it risks missing transactions involving for-profit hospitals, facilities, or physician practices, which are typically organized as for-profit entities. Six states require all hospitals to provide notice of transactions, and three of these states also require provider groups to submit notice (see Table 1).

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 Minnesota[32]— 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

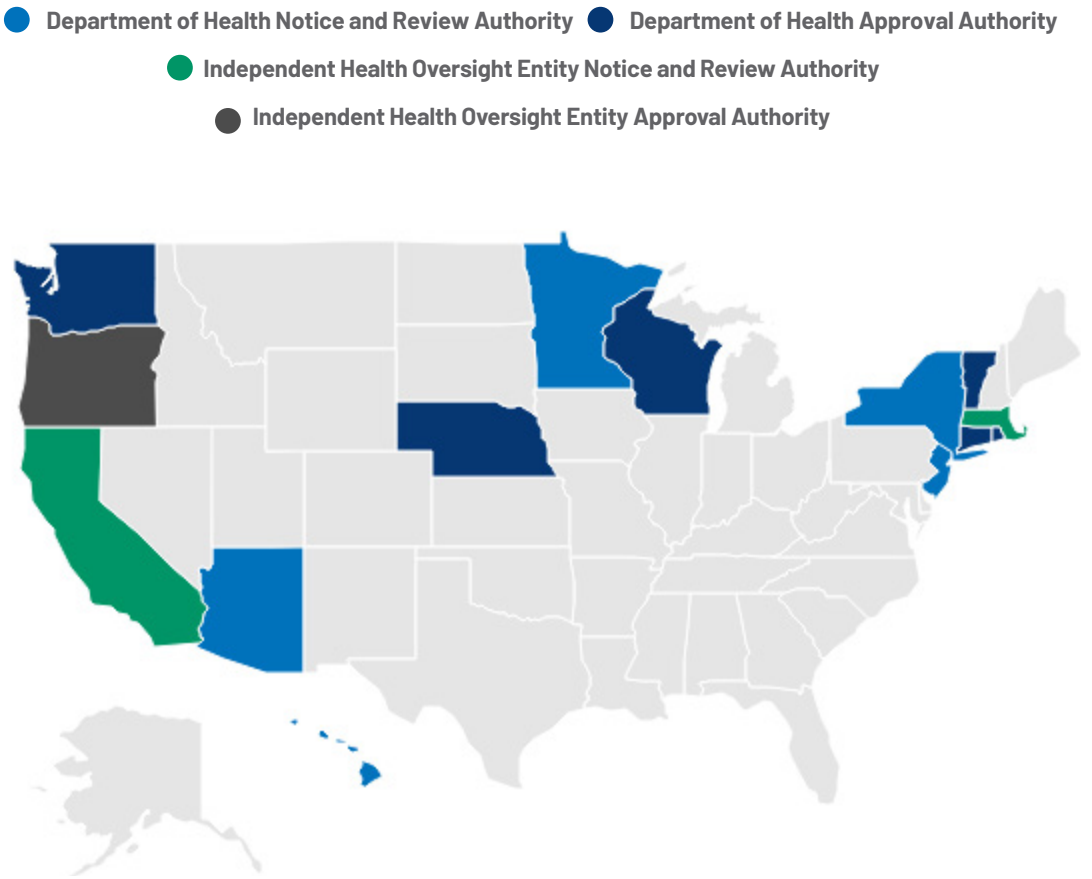
Recognizing the difficulty and expense of obtaining a court order to block a transaction, states may authorize the AG to block or impose conditions on health care transactions administratively. Ten states require the AG to approve transactions for a change in control of a nonprofit hospital (see Figure 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). Massachusetts[40] created an independent health care market oversight body that must be notified before a material change transaction. Additionally, California[41] and Oregon[42] 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.

[d]In 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



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.

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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]

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]

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 workforce[53] 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.

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.

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.

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.

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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