



# Collaborative Agreements in Health Care

## Complexities, Uncertainties, and Considerations for Oversight

In recent years, health care entities in California — including hospitals, medical groups, and health insurance companies — have consolidated in various ways, including through full mergers and acquisitions that change the ownership or control of the participating entities. At the same time, a variety of non-merger collaborative agreements have proliferated within the industry. Compared to traditional mergers and acquisitions, collaborative agreements preserve a degree of operational and financial independence for the contracting parties.

Both state and federal oversight of collaborative agreements in health care is complex and rapidly evolving. In California, the newly created Office of Health Care Affordability is tasked with implementing new pretransaction reporting requirements that could apply to collaborative agreements.<sup>1</sup> At the federal level, the Department of Justice (DOJ) issued and then recently withdrew guidance governing some of these transactions.<sup>2</sup>

This issue brief aims to examine the potential effects of collaborative health care agreements in California and to highlight some intricacies for their oversight in this dynamic area of policy and law.

### Proliferation of Collaborative Agreements in Health Care

Horizontal and vertical consolidation within the health care system can be accomplished through a variety of means.<sup>3</sup> A full *merger*<sup>4</sup> or *acquisition* is

traditionally the easiest to identify, as it involves the complete transfer or consolidation of the entities' governance, administration, operations, financial assets, or medical staffs to form a single integrated entity.<sup>5</sup> Organizations like the American Hospital Association track and report the number of health care mergers and acquisitions nationally.<sup>6</sup> Within the California market, recent mergers of note include the Providence-St. Joseph's merger of 2016 and the CVS-Aetna merger of 2018.<sup>7</sup>

Aside from these traditional forms of consolidation, certain types of nonmerger collaborative agreements have emerged as popular alternatives to mergers and acquisitions for many health systems across the country. According to a 2015 survey, 49% of hospitals reported their most recent activity was a "partnership," compared to 32% of hospitals most recently involved in a merger or acquisition.<sup>8</sup> Health systems are increasingly establishing these nonmerger agreements with independent urgent care centers, primary care practices, and long-term care facilities.<sup>9</sup>

Rather than entering into arrangements that transfer ownership interests, the participants in a nonmerger collaborative relationship keep a degree of operational and financial independence without fully integrating into one combined entity.<sup>10</sup> In this brief, the term *collaborative agreement* collectively refers to all affiliations, strategic alliances, joint ventures, partnerships, and other nontraditional transactions that do not involve full integration or a complete transfer of ownership or assets.

# Collaborative Agreements Exist on a Continuum of Integration

The key element in identifying and distinguishing the various types of nonmerger collaborative transactions is the degree of control retained by participants with respect to governance, legal status, branding, and financial and administrative operations.<sup>11</sup> Figure 1 illustrates and describes common types of collaborative health care agreements on a continuum based on these key structural variables.

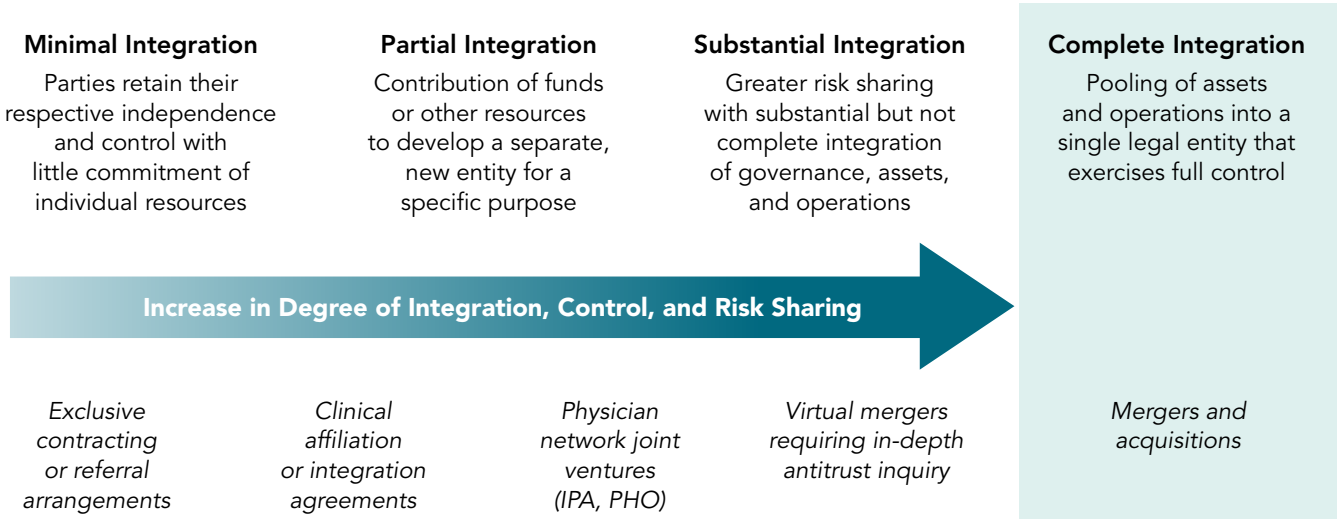
Affiliations, alliances, or collaborations that involve **minimal integration** of the participating entities are the furthest from a full merger on the continuum of transactions. These transactions can be more informal than formal and are arguably the simplest form of affiliation that involves the least integration. The parties keep their respective independence in governance and control, legal status, and financial operations,<sup>12</sup> without the creation of a new entity.<sup>13</sup> Unlike transactions toward the middle of the continuum, these contractual affiliations do not involve

integration of the entities’ balance sheets or shared governance, and often involve only a limited scope of shared responsibility or risk, thus making the transaction easier to execute.<sup>14</sup>

Next on the continuum are transactions that result in **partial integration** of the original parent entities through a large contribution of funds or other resources to create a separate business entity. Typically, this new entity is created to generate a new product or technology or to enter into a new market.<sup>15</sup> A common form of partial integration is a joint venture, in which the parties combine a part of their respective operations, but only those elements that serve the specific purpose of the joint venture.<sup>16</sup> Similarly, both parties exercise joint control of the new entity and share financial risk for the joint venture. As a result, unlike in an outright merger, the parent entities keep their respective organizational independence and remain competitors in all other aspects of their individual businesses.<sup>17</sup>

Structurally closest to the outright merger is an affiliation that results in **substantial integration** of governance and administration, financial assets, operations, and

Figure 1: Continuum of Collaborative Health Care Agreements



Source: Authors’ analysis of collaborative health care agreements.

staffs of the parties involved.<sup>18</sup> These types of integration are sometimes called “virtual mergers,” as they may be difficult to structurally distinguish from a full merger.<sup>19</sup> Like other partial integration transactions, these collaborative agreements create a new, third entity, but involve substantially greater integration and thus risk sharing. The transaction could form a small parent corporation, with its own board, in which the entities combine control and decisionmaking as to *all* aspects of each party’s operations to some degree, not just the aspects of each firm’s business that pertain to the limited joint venture purpose.<sup>20</sup> At the same time, a virtual merger falls short of complete integration or total control by either party, as the participants retain some assets and control over their own operations, with their own respective board of trustees.

## Uncertainties in the Effect of Collaborative Agreements

The effects of health care consolidation with traditional mergers and acquisitions are well studied.<sup>21</sup> The impact of collaborative agreements in health care such as strategic alliances, joint operating agreements, and other transactions that do not amount to transferring ownership interests or complete integration and control are less clear.

Proponents typically claim that health care affiliations and joint ventures are formed expressly to provide clinical benefits that further the public interest. At the same time, there is the risk that transacting entities could form exclusive relationships that may resemble and replicate the potential anticompetitive effects of a merger or acquisition. Due to the obscure and complex nature of these arrangements, there is often no clear line that distinguishes desirable arrangements that promote economic efficiency and innovation from those that may threaten competition and result in higher prices.

## Procompetitive Benefits

Parties to collaborative agreements generally argue that they are a cost-effective and efficient strategy to fill gaps in the participating providers’ care offerings and help increase access to care for patients.<sup>22</sup> Hospital systems seeking cost-effective delivery options for patients may enter into clinical affiliations with independent organizations that specialize in ambulatory surgery, urgent care, and imaging services to avoid high start-up costs and financial risks.<sup>23</sup>

For example, Community Hospital of the Monterey Peninsula entered into a cancer care affiliation with the Helen Diller Family Comprehensive Cancer Center of the University of California, San Francisco, in 2011.<sup>24</sup> The goal was to strengthen Community Hospital’s oncology services through clinical benefits such as local access to UC Health clinical trials, educational opportunities for medical staff and the public, and expedited referrals to specialists.<sup>25</sup>

These agreements are intended to, and may achieve, desirable procompetitive benefits from efficiencies gained in combining capabilities and resources or reaching economies of scale or scope, which could help lower prices or improve quality for consumers or both.<sup>26</sup> Still, questions remain as to whether the claimed benefits are achieved in ways that benefit patients or if those benefits could be achieved through arrangements that involve less integration of the two parties and therefore preserve more competition.

## Anticompetitive Risks

Even though entities in health care collaborative agreements remain separate entities by keeping some independence, they may be capable of conspiring and colluding in ways that could negatively impact consumers. Depending on the extent of the integration and risk sharing, certain collaborative relationships can

reduce the incentive of participants involved in the arrangement, who are otherwise competitors, to independently offer new or higher-quality services, adopt innovative technologies, or to compete in other ways such as pricing.

For example, health care entities in a collaborative agreement could share competitive information or aggregate market power to negotiate large price increases with no clear improvements in quality or access for patients.<sup>27</sup> Furthermore, since these agreements are typically kept confidential, it can be difficult for antitrust enforcers to know when these collaborative agreements become anticompetitive. When the entities use the guise of a collaborative agreement to fix prices on services or products, allocate service territories among themselves, or protect each other's markets to eliminate outside competition or to create barriers to entry — absent enough integration to achieve clinical benefits — it could be considered inherently anticompetitive and an outright or “per se” violation of antitrust law under the Sherman Act and Cartwright Act (see box).<sup>28</sup>

## Balancing of Factors to Assess the Aggregate Effect

While collaborative agreements that amount to market allocation or price fixing are inherently anticompetitive, some collaborative agreements may have procompetitive benefits that offset potential anticompetitive harm.<sup>29</sup> To assess the aggregate impact of an agreement on prices, quality, access, or innovation in the relevant market, antitrust enforcers and courts must evaluate a balance of these effects using a so-called “rule of reason” standard case by case.<sup>30</sup> The factors considered include the intent and nature of the agreement (economic integration and resulting efficiencies), the market power of the transacting entities before and after the transaction, the structure and competitive conditions of the relevant market, potential direct negative effects such as an increase in prices, and any objective justification for the restriction or restraint.<sup>31</sup>

Just as integration is the key distinction in characterizing various affiliation structures, the key inquiry from a competitive standpoint is whether the affiliation,

### Collaborative Conduct Potentially Subject to the “Per Se” Rule of Antitrust Law

- ▶ **Horizontal Price Fixing.** In health care affiliations or joint ventures, participating providers or physicians could act together as a single organization to affect prices. Horizontal price fixing occurs when separate entities act cooperatively to diminish competition and generate significant profits from supracompetitive pricing due to their joint market power, such as through sharing of competitive information, joint marketing, or using their collective bargaining power to jointly negotiate rates.
- ▶ **Horizontal Market Allocation.** Hospitals and physicians could negatively impact price and competition through an agreement to divide the market by allocating service types, patients, or service areas among themselves. A horizontal market-allocation agreement could include terms regarding the services each entity will and will not offer; restricting each entity's geographic scope regarding competition, solicitation, and advertisements between the entities; or restricting certain medical services to specified hospitals or redirecting patient admissions to maintain the providers' predetermined market share.

Note: These restraints may be subject to exemption when the entities share substantial financial risk for clinical integration.

however characterized, results in clinical integration and risk-sharing arrangements to promote efficiency and better care for the benefit of patients. For example, health maintenance organizations (HMOs), due to their capitated model and substantial risk sharing, are a type of collaborative structure in health care that is permitted because it is deemed necessary, procompetitive on balance, and in the public interest. Providers clinically integrated as part of the HMO could therefore coordinate on the prices offered to payers and negotiate together as a block for reimbursement rates.<sup>32</sup>

## Uncertainties Remain for Many Collaborative Agreements

The balance of factors may help evaluate the aggregate effect of some health care collaborative agreements. For most transactions, however, its application may be complicated by the nebulous and complex nature of structures in the continuum of collaborative transactions, making it difficult to determine their true nature and definitively determine their impact in the health care market.

An implication of the gradation in integration and control in the continuum of transactions is that a transacting party could exercise control without ownership. Somewhere in the continuum of transactions is integration and control sufficient to amass anticompetitive market power. In this continuum of transactions, the question then becomes: Where is the line at which the anticompetitive harms outweigh the procompetitive benefits? To further exacerbate this situation, details of these private agreements are typically not publicly disclosed, creating more ambiguities for antitrust enforcers to determine when these collaborative agreements become anticompetitive. As a result, in many cases, there remains a slippery slope between permissible joint operating agreements and problematic leveraging or bundling operations that amount to illegal cartels. This slippery slope is particularly difficult to assess for transactions involving substantial

integration and veering closest to a merger (i.e., a “virtual merger”) due to the vague distinction between a merger and a nonmerger collaboration.

More importantly, health care entities may use this gradation of control to streamline and gradually gain greater or central control in the long term, contributing to the ongoing impact of consolidation. As a result, even absent the full extent of mergers or acquisitions, collaborative agreements may make the health care market even more concentrated than it appears, with a potential negative impact on competition and patients.

For example, Cedars-Sinai Medical Center is a hospital system in California actively involved in agreements that span the continuum of transactions. In recent years, the Southern California system has expanded its geographic footprint and market power through various affiliations, partnerships, and joint ventures it had claimed to be procompetitive.<sup>33</sup> The continued expansion raised anticompetitive concerns from the California attorney general in 2020, culminating in a legal battle that resulted in competitive impact conditions imposed on the affiliation with Huntington Memorial Hospital.<sup>34</sup>

## Collaborative Agreements and Existing Merger Review and Antitrust Enforcement

The ambiguities and uncertainties in defining collaborative agreements described in this brief further contribute to complexities in their oversight and review by regulatory agencies and departments in California. On the one hand, certain collaborative transactions may be considered “not enough” of a merger to trigger pretransaction notice and review because the entities do not transfer a material amount of assets and remain separate. On the other hand, they may be considered “too much” of a merger to enable collusion because the transacting

parties are integrated and virtually acting as a single entity. As a result, certain collaborative agreements may be left unexamined.

## Pretransaction Merger Review

In California, health care entity transactions are subject to the oversight of the attorney general (AG),<sup>35</sup> who may block a transaction in court under antitrust laws when the effect may substantially lessen competition or create a monopoly.<sup>36</sup> However, while the AG may review and challenge any anticompetitive transaction, it is infeasible to identify and prevent such transactions before they occur without pretransaction notice.

In addition to the broad antitrust enforcement authority, the AG has administrative merger review authority for all transactions involving nonprofit health care entities.<sup>37</sup> The AG must receive pretransaction notice and approve any sale, transfer, or other forms of disposition of a “material amount of the assets” that involves a nonprofit health facility.<sup>38</sup> According to regulations, a transaction involves a “material amount of the assets or operations” if it either directly affects over 20% of the value of the health facility or involves the sale, transfer, or change in control of an entity with a fair market value over \$3 million.<sup>39</sup>

Notably, this pretransaction review authority does not capture transactions involving only for-profit entities,<sup>40</sup> or certain collaborative agreements that do not involve transfer of a material amount of the assets. Compared to an outright merger, a collaborative transaction may involve lesser amounts of assets or control, especially when the participating health care entities remain independent entities without complete integration (i.e., those transactions positioned lower on the continuum). Thus, these transactions may not meet the “material amount of the assets” threshold. As a result, those involving for-profit entities and collaborative transactions that do not meet the “material amount of the assets” standard do not currently generate pretransaction notice to the AG and are thus likely to be left unexamined.

## After-the-Fact Anticompetitive Conduct Review

Regulators may also review transactions for anticompetitive conduct after the fact, but the analysis under antitrust theories is highly complex due to the unique features of collaborative agreements. As illustrated previously, a collaborative agreement that unifies the participating entities’ economic interests could reduce their incentive to compete with one another and potentially lead to collusive conduct, including illegal price fixing and market allocation.<sup>41</sup> At the same time, antitrust enforcers may deem transacting entities — particularly those in a virtual merger, which is structurally just short of a full merger — to be so substantially integrated that they are functioning as “one single virtual firm” incapable of conspiring to anticompetitively restrain trade.<sup>42</sup>

In evaluating a collaborative agreement, the degree of integration of the transacting entities is inversely related to the potential for anticompetitive conduct violation. That is, the more the transaction resembles a full merger (sharing substantial financial risk and resulting in a single decisionmaker), the less likely that the transacting parties would be capable of conspiring with each other. But where integration is not so substantial and the original entities remain independent and capable of conspiring, the transaction would raise greater concerns for collusive anticompetitive conduct.

As such, antitrust review of a virtual merger is highly nuanced and specific to the facts of each transaction (see box for examples of collaborative agreements in California). Many health care joint operating agreements walk the fine line of being characterized as legitimate joint ventures while others without sufficient integration or other evidence of interdependence are determined to be cartels.<sup>43</sup> For example, in *New York v. St. Francis Hosp.*, the New York AG successfully challenged a virtual merger in which two hospitals agreed to jointly negotiate contracts with third-party payers and to divide the market for most services between



## Collaborative Agreements in California: Procompetitive or Anticompetitive?

Most collaborative agreements in health care are shrouded in ambiguities, complexities, and uncertainties, making it difficult to determine their true impact on consolidation and competition. Examples below illustrate some recent health care transactions seen in California.

- ▶ **Stanford Children’s Health and John Muir Health** renewed their “joint operating agreement” that began in 2012 for another 10 years to 2032. The long-standing partnership includes a full range of pediatric urology, surgical, out-patient, inpatient, neonatal, and emergency care. The two health organizations opened a pediatric intensive care unit in 2015 to offer critical care for children in Contra Costa County.<sup>\*</sup>
- ▶ **Dignity Health and San Joaquin General Hospital** entered a “management service agreement” in which Dignity would advise and assist in overseeing management of the day-to-day administration of San Joaquin. The parties claim the agreement would help San Joaquin more efficiently conduct its operations and ensure access to essential services for San Joaquin County residents.<sup>†</sup>
- ▶ **Prime Healthcare and Robotics Outpatient Center of Los Angeles** formed a “joint venture” in which Prime Healthcare made an undisclosed investment and would provide administrative services to the ambulatory surgery center. The transaction would give patients access to services at Robotics’ orthopedic, spine, and urology outpatient surgery facility.<sup>‡</sup>

<sup>\*</sup> Stanford Medicine Children’s Health, “[Stanford Medicine Children’s Health and John Muir Health Extend Their Long-Standing Operating Agreement for Another 10 Years](#),” press release, March 3, 2022.

<sup>†</sup> San Joaquin County, “[San Joaquin County Board of Supervisors and Dignity Health Announce Agreement on San Joaquin General Hospital](#),” press release, May 4, 2022.

<sup>‡</sup> Tim Svendsen, “[Prime Healthcare Forms Joint Venture with Robotics Ambulant Surgery Center in Downtown LA](#),” *Local News Today*, July 25, 2022.

them. The court held that the two hospitals conspired as separate entities through the arrangement because they did not fully integrate their operations or function as a single entity.<sup>44</sup>

## Rapidly Evolving Regulatory Landscape

In addition to the anti-trust and merger review authority described above, a rapidly evolving set of federal and state policies can apply to collaborative agreements in health care.

### Department of Justice Withdraws Decades-Old Federal Guidance Affecting Collaborative Agreements

In February 2023, the Department of Justice (DOJ) withdrew decades-old federal enforcement policy statements to remove some of the safe harbor

protections previously established for health care entity activities, including collaborative agreements.<sup>45</sup> The DOJ’s action directly acknowledges that drastic changes have occurred in the health care industry, in which consolidation has proliferated in various forms, including through joint ventures, joint operating arrangements, and other collaborative transactions. This action is also a recognition that the oversight and enforcement of these transactions are highly nuanced, and the outdated guidance applying a blanket antitrust standard may not serve more fact-specific enforcement goals.

Specific to the types of collaborative agreements described in this brief, the withdrawal removes the antitrust safety zone previously applicable to physician network joint ventures within a certain size and scope that share substantial financial risks.<sup>46</sup> Under previous guidance, physician networks such as independent practice associations could create organizations of independent physicians or physician practices that

contract with health plans, managed care organizations, and employers. Similarly, in multiprovider networks such as a physician hospital organization (PHO), a hospital and its member physicians could contract jointly to provide care to a specific population of patients without antitrust challenge if they could show substantial clinical integration and risk sharing.<sup>47</sup>

The withdrawal not only reflects the complexities in evaluating these transactions, but it also adds to the uncertainties surrounding the oversight of these transactions, which the DOJ has indicated is to be determined case by case. This new federal enforcement landscape potentially highlights the need to further monitor and enhance oversight of collaborative agreements in health care through state policies and regulations.

## California's Office of Health Care Affordability to Implement New Requirements

In California, the newly created Office of Health Care Affordability (OHCA) is implementing expanded reporting requirements for health care affiliations and transactions that could enhance the oversight of collaborative health care agreements. Effective January 2024, transacting health care entities, including hospitals or hospital systems and physician organizations,<sup>48</sup> must provide OHCA with written notice of agreements or transactions that either “sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one of more

entities” or “transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.”<sup>49</sup> If OHCA determines the transaction could significantly affect competition, the ability of the state to meet cost targets, or costs to consumers or purchasers, it may conduct a cost and market impact review, make recommendations for conditions, and refer the matter to the attorney general.<sup>50</sup>

This pretransaction reporting and review authority is notably broader — and includes more health care entities, like for-profit organizations — than what had been historically vested in the attorney general. As OHCA is currently promulgating regulations under this new authority, details of how they would apply to collaborative agreements as discussed in this brief are not yet determined.

## Conclusion

Health care entities across the country and within California are increasingly entering into affiliations and collaborative agreements short of full mergers and acquisitions. These agreements are often complex and may have ambiguous competitive impacts, requiring nuanced review and analysis that may not be adequately facilitated under existing merger review and anti-trust enforcement authority. Policymakers concerned with the potential benefits and known harms of consolidation in the health care industry may wish to extend the scrutiny given to these nontraditional partnership agreements in the immediate and longer term.



## About the Author

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The Source on Healthcare Price & Competition provides up-to-date and easily accessible research and analysis on health care price and competition in the US. For more information, visit [sourceonhealthcare.org](https://sourceonhealthcare.org).

## About the Foundation

The [California Health Care Foundation](https://www.chcf.org/) (CHCF) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with change-makers to create a more responsive, patient-centered health care system.

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## Endnotes

1. Cal. Health & Safety Code §§ 127501 through 127501.12.
2. US DOJ, "[Justice Department Withdraws Outdated Enforcement Policy Statements](#)," press release, February 3, 2023.
3. Katherine L. Gudiksen, Amy Y. Gu, and Jaime S. King, [Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California](#), California Health Care Foundation (CHCF), December 2021.
4. While a merger typically results in combination into a single entity, the term "merger" itself can be confusing and can refer to a statutory merger — one in which one of the parties retains its status as an entity — or statutory consolidation, a transaction in which both entities disappear. In this brief, the term "merger" encompasses both types of combinations.
5. Thomas H. Brock, *Minimizing Antitrust Exposure in a Virtual Merger*, *Healthcare Financial Management* 53, no. 9, (Sept. 1999): 41.
6. See American Hospital Association, "[New Report Shows 2022 Will Be the Most Financially Difficult for Hospitals and Health Systems Since the Start of Pandemic](#)," press release, September 15, 2022.
7. Samuel M. Chang et al., [Examining the Authority of California's Attorney General in Health Care Mergers](#), CHCF, April 2020. See "[Mergers & Other Transactions](#)," California Dept. of Managed Health Care, accessed February 27, 2023.
8. [The M&A and Partnership Mega-Trend: Deals for Growth and Survival](#), HealthLeaders Media, February 2015, 18.
9. Christopher Cheney, [Leveraging Resources Through Clinical Affiliations](#), *HealthLeaders* 18, no. 8 (Oct. 2015): 40–43.
10. Brock, *Minimizing Antitrust Exposure*, 38.
11. Brock, 41.
12. "Collaboration Among Health Care Organizations: A Review of Outcomes and Best Practices for Effective Performance," appendix D in [Evaluation of the Lovell Federal Health Care Center Merger: Findings, Conclusions, and Recommendations](#), (Washington, DC: National Academies Press, 2012), 229.
13. "Joint Ventures in the Health Care Sector," chap. 13 in John J. Miles, *Health Care and Antitrust Law*, Thomson Reuters (September 2022).
14. M&A and Partnership Mega-Trend, 11.
15. "Collaboration," 229.
16. Brock, *Minimizing Antitrust Exposure*, 38.
17. Miles, *Health Care and Antitrust Law*.
18. Brock, *Minimizing Antitrust Exposure*, 41.
19. Miles, *Health Care and Antitrust Law*, § 12.4.
20. Brock, *Minimizing Antitrust Exposure*, 38.
21. See Karyn Schwartz et al., "[What We Know About Provider Consolidation](#)," KFF, September 2, 2020; and *Antitrust Applied: Hospital Consolidation Concerns and Solutions: Hearing Before the Sen. Comm. on the Judiciary, Subcomm. on Competition Policy, Antitrust, and Consumer Rights*, 117th Cong., 1st Sess. (2021) (statement of Prof. Martin S. Gaynor, E.J. Barone Univ. Prof. of Economics and Public Policy, Carnegie Mellon Univ.).
22. Cheney, *Leveraging Resources*, 40.
23. Cheney, 43.
24. Elizabeth Fernandez, "[New UCSF Cancer Care Affiliation with Community Hospital in Monterey](#)," Univ. of California San Francisco, press release, August 1, 2011.
25. Cheney, *Leveraging Resources*, 42.
26. [Antitrust Guidelines for Collaborations Among Competitors](#) (PDF), Federal Trade Commission (FTC) and US Department of Justice (US DOJ), April 2000, 6.
27. Robert C. Jones and John J. Miles, [Health Law Practice Guide](#), § 32A:22, Amer. Health Lawyers Assn. (Sept. 2022).
28. *Antitrust Guidelines for Collaborations*, 5–6.
29. An informal, "quick look" analysis may be applied to determine whether the restraint is "per se" illegal. Under this approach, the court may make an initial assessment of whether the challenged conduct is obviously anticompetitive, without conducting a full-blown analysis of the relevant markets, competitive effects, or procompetitive justifications.
30. *Antitrust Guidelines for Collaborations*, 3.
31. See *Business Electronics Corp. v. Sharp Electronics Corp.*, 485 U.S. 717 (1988); *State Oil v. Kahn*, 522 U.S. 3, 10 (1997); and *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999).
32. [Improving Health Care: A Dose of Competition: A Report by the Federal Trade Commission and the Department of Justice](#) (PDF), FTC and US DOJ, July 2004, 13.
33. Jill Yegian and Katrina Connolly, [Los Angeles: Vast and Varied Health Care Market Inches Toward Consolidation](#), CHCF, January 2021.
34. *Pasadena Hospital d/b/a Huntington Hospital and Cedars-Sinai Health System v. California and Rob Bonta*, No. 21STC00978 (Cal. Super. Ct. L.A. Cnty), July 19, 2021.
35. The Department of Managed Health Care (DMHC) reviews mergers and consolidations involving health plans licensed by the DMHC. Such transactions typically involve a change of ownership or control. If a health plan enters into a collaborative agreement with a provider organization, the DMHC reviews the transaction to ensure it will not negatively impact health plan's enrollees' access to health care services, but the review does not focus on the competitive impacts of the transaction. If the collaborative agreement shifts the risk for any amount of professional (e.g., physician) services and hospital services

to the provider organization, the provider organization must either obtain a health plan license or apply to the DMHC for an exemption from licensure (Cal. Code Regs., tit. 28, § 1300.49).

36. Clayton Act, Section 7.
37. Cal. Corp. Code §§ 5913 through 5930.
38. Cal. Corp. Code § 5914(a)(1)(A)(B).
39. Cal. Code Regs., tit. 11, § 999.
40. California policymakers have introduced AB 1091 in the 2023 legislative session to propose prenotice reporting and administrative review for all health care entities, including for-profit entities.
41. *Antitrust Guidelines for Collaborations*.
42. Ryan P. Meyers, "[Partial Ownership of Subsidiaries, Unity of Purpose, and Antitrust Liability](#)," *Univ. of Chicago Law Review* 68, no. 4 (2001): 1401–27; and *HealthAmerica Pennsylvania, Inc. v. Susquehanna Health Sys.*, 278 F. Supp. 2d 423 (M.D. Pa. 2003).
43. Joseph F. Brodley, "Joint Ventures and Antitrust Policy," *Harvard Law Review* 95 (May 1982): 1521.
44. *New York ex rel. Spitzer v. Saint Francis Hosp.*, 94 F. Supp. 2d 399 (S.D. N.Y. 2000).
45. "Justice Department Withdraws," US DOJ.
46. *The Statements of Antitrust Enforcement Policy in Health Care* issued jointly by the DOJ and FTC in August 1996 (and withdrawn by the DOJ in February 2023) provided an "antitrust safety zone" for physician network joint ventures in which conduct such as collective bargaining would not be challenged if the physician participants share substantial financial risk and constitute 20% or less of the relevant market for the particular specialty in an exclusive physician network joint venture or 30% or less in a nonexclusive physician network joint venture.
47. Kristin Madison, "[Hospital-Physician Affiliations and Patient Treatment, Expenditures, and Outcomes](#)," *Health Services Research* 39, no. 2 (Apr. 2004): 257.
48. Other health care providers and entities including pharmacy benefit managers are also subject to the reporting requirement under Article 8, 127507 (a).
49. Cal. Health & Safety Code § 127507(c).
50. Cal. Health & Safety Code § 127507.2.