
SENATE COMMITTEE ON HEALTH

Senator Dr. Richard Pan, Chair

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AUTHOR: Monning
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Due to the COVID-19 Pandemic and the unprecedented nature of the 2020 Legislative Session, all Senate Policy Committees are working under a compressed timeline. This timeline does not allow this bill to be referred and heard by more than one committee as a typical timeline would allow. In order to fully vet the contents of this measure for the benefit of Senators and the public, this analysis includes information from the Senate Judiciary Committee.

SUBJECT: Health care system consolidation: Attorney General approval and enforcement.

SUMMARY: Requires a health care system, which is an entity or entities that includes or owns two or more hospitals within multiple counties or three or more hospitals in one county, to provide written notice to, and obtain the written consent of, the Attorney General prior to an affiliation or acquisition between the health care system and a health care facility or provider. Makes it unlawful conduct for a health system with substantial market power to engage in specified anticompetitive activities. Establishes the Health Policy Advisory Board to evaluate and analyze health care markets and produce an annual report.

Existing law:

- 1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurance, and the Attorney General (AG), who has charge of all legal matters in which California is interested, including enforcement against anticompetitive conduct through the Cartwright Act. [HSC §1340, et seq., INS §106, et seq., GOV §12500, et seq., BPC § 16700, et seq.]
- 2) Requires any non-profit corporation that operates or controls a health facility, as defined, to provide written notice to, and obtain the written consent of, the AG prior to entering into any agreement or transaction to do either of the following:
 - a) Sell, transfer, lease, exchange, option, convey, or otherwise dispose of, its assets to a for-profit corporation or entity, or another non-profit corporation; or,
 - b) Transfer control, responsibility, or governance of a material amount of the assets or operations of the non-profit corporation to any for-profit corporation or entity, or another non-profit corporation. [CORP §5914, §5920]
- 3) Requires the AG, within 90 days of the receipt of a written notice of a proposed transaction involving a non-profit health facility, to notify the non-profit corporation in writing of the decision to consent to, give conditional consent to, or not consent to the agreement or transaction. [CORP §5915§5920]
- 4) Permits the AG to extend the 90-day deadline described above for one additional 45-day period if any of the following conditions are satisfied: the extension is necessary to obtain specified information, the proposed transaction is substantially modified after the first public

meeting conducted by the AG, or the proposed transaction involves a multi-facility health system serving multiple communities. [CORP §5915,§5920]

- 5) Requires the AG to conduct one or more public meetings to hear comments from interested parties prior to issuing any written decision regarding a transaction involving a nonprofit health facility. [CORP §5916,§5922]
- 6) Provides the AG with the discretion to consent to, give conditional consent to, or not consent to any agreement or transaction involving a nonprofit health facility based on the consideration of any factors that the AG deems relevant, including but not limited to:
 - a) Whether the agreement or transaction is at fair market value;
 - b) Whether the proposed use of the proceeds from the transaction is consistent with the charitable trust on which the assets are held by the health facility or by the affiliated nonprofit health system;
 - c) Whether the transaction would create significant effects on the availability or accessibility of health care services to the affected community; or,
 - d) Whether the transaction is in the public interest. [CORP §5917, §5923]
- 7) Prohibits the AG from consenting to a health facility transaction in which the seller restricts the type or level of medical services that may be provided at the health facility that is the subject of the transaction. [CORP §5917.7]

This bill:

- 1) Requires the AG to establish the Health Policy Advisory Board, which is a 12 member board, responsible for evaluating and analyzing health care markets in California and providing recommendations to the AG; and producing a report annually on healthcare markets in California. Requires members of the board to be appointed by the AG, Senate Committee on Rules and the Speaker of the Assembly and include representatives from a health care system, health care provider, health plans, employer purchasers, union trusts, consumers and a university expert.
- 2) Requires a health care system to provide written notice to, and obtain the written consent of, the AG prior to an affiliation or acquisition between the health care system and a health care facility or provider. Requires the notice to contain information sufficient to evaluate the nature of the acquisition or affiliation or a waiver request.
- 3) Requires within 60 days, the AG to notify the health care system whether the AG has cleared the transaction, granted a waiver, or needs additional information. Requires within 45 days of certification that the parties have substantially complied with the request for additional information, the AG to grant or deny consent. Permits the AG to extend the timeframe by 14 days if a public hearing is held. Permits the parties and AG to consent to extend the timeframe by 45 days if the acquisition or affiliation is substantially changed or modified by the parties, or the acquisition involves health care facilities, or provider in multiple communities.
- 4) Permits the Health Policy Advisory Board, upon request of AG or otherwise in its discretion, to review a written notification from a health care system, and provide the AG with a written recommendation.

- 5) Permits the AG to adopt regulations including that extend the time periods in 3) above or regulations to provide a process for requesting a waiver.
- 6) Requires the AG to deny consent to an affiliation or acquisition of nonhospital health care facility, provider, or both, unless the health care system demonstrates that the affiliation or acquisition will result in a substantial likelihood of clinical integration, a substantial likelihood of increasing the availability and access of services to an underserved population, or both.
- 7) Permits the AG to deny consent to an affiliation or acquisition of a nonhospital health care facility, provider, or both, if there is a substantial likelihood of anticompetitive effects that outweigh the benefits of a substantial likelihood of clinical integration, a substantial likelihood of increase in services to an underserved population, or both.
- 8) Permits the AG to deny consent to an affiliation or acquisition if there is a substantial likelihood of anticompetitive effects in providing hospital or health care services which include, but are not limited to, a substantial likelihood of raising market prices, diminishing quality, reducing choice, or diminishing availability of, or diminishing access to, hospital or nonhospital health care services.
- 9) Requires the AG to apply the public interest standard in making a determination to grant or deny consent. The public interest standard is defined as being in the interests of the public in protecting competitive and accessible health care markets for prices, quality, choice, accessibility, and availability of health care services for local communities, regions, or the state as a whole. Prohibits acquisitions or affiliations from being presumed to be efficient for the purpose of assessing compliance with the public interest standard.
- 10) Permits a health care system located in a rural area to request, in writing, a waiver of the prohibition in 6) above. Requires the AG to grant a waiver if either of the following exists:
 - a) The affiliation or acquisition would directly benefit consumers of health care services in rural areas by improving the access or availability of those services; or,
 - b) The affiliation or acquisition is needed to improve the health, safety, and well-being of consumers of health care services in rural areas.
- 11) Requires the AG to put in writing the basis for the determinations in 6) – 10) above.
- 12) Permits the AG to hold a public meeting, which may be held in any of the counties in which the acquisition or affiliation will take place, to hear comments from interested parties. Requires the AG to provide public notice of the time and place of the hearing, as specified. Permits a second hearing if a substantive change or modification to the acquisition or affiliation is submitted to the AG after the first public meeting.
- 13) Permits any of the parties to the acquisition or affiliation to appeal the AGs final determination by a writ of mandate to the superior court pursuant to the Civil Code, as specified.
- 14) Requires any reviews required under existing law to be concurrent with the review under this bill, to the extent practicable.

- 15) Makes the following unlawful conduct of a health care system:
- a) A health care system with substantial market power in any market for hospitals or nonhospital health care services where the health care system's conduct has a substantial tendency to cause anticompetitive effects, including substantial likelihood of raising market prices, diminishing quality, reducing choice, increasing the total cost of care or diminishing availability of, or diminishing access to, hospital or nonhospital health care services.
 - b) A health care system is presumed to be acting unlawfully if it has substantial market power in any market for any service in trade or commerce and the health care system's conduct involves tying or exclusive dealing.
- 16) Exempts from 15) a health care system if its conduct directly and significantly benefits consumers of any services in that same market in which the conduct is taking place, or the health care system, and the conduct that it is committing, are located entirely within a rural area, it otherwise meets the criteria of this bill, the benefits are not achievable by less restrictive alternatives, the benefits substantially outweigh any actual or likely anticompetitive effects of the conduct, and no benefit is based on the need to meet a public federal, state, or local requirement or mandate of any kind.
- 17) Permits the AG to bring a civil action on behalf of the state or any of its political subdivisions or public agencies or in the name of the people of California. Requires any civil action to enforce any cause of action for a violation to be commenced within four years after the cause of action. Establishes civil fines and state monetary relief, interest on total damages, and the cost of suit.
- 18) Permits in any civil action brought by the AG, the court to, in addition to granting prohibitory injunctions and other restraints, grant those mandatory injunctions as may be reasonably necessary to restore and preserve fair competition in the trade or commerce affected by the violation.
- 19) Includes several definitions including:
- a) "Tying" is defined as the seller coercively conditioning the sale of one or more services on the sale of a second distinct service or services if the arrangement affects a more than trivial amount of sales of the second distinct service or services. The conditioning can be explicit, implicit, or as an economic imperative based on the pricing of those services;
 - b) "Exclusive dealing" is defined as an agreement in which a health plan or employer who buys health care services agrees implicitly or explicitly, whether coerced or voluntarily, to buy services exclusively from a health care system for a period of time. Exclusive dealing is presumed to be anticompetitive whether or not pricing practices are a component of that conduct;
 - c) "Substantial market power" can be shown in one of the following ways:
 - i) Conduct has an actual substantial anticompetitive effect, including, but not limited to, prices, quality, access, or availability of services, choice, or total cost of care. "Total cost of care" is defined as the measurement of direct and indirect costs, including, but not limited to, price and utilization, associated with an episode of care for a periods of health care coverage; and,

- ii) The health care system has a sufficiently substantial market share in one or more markets for any service in trade or commerce after accounting for barriers to entry to exercise substantial market power in those markets. The health care system is presumed to have substantial market power if, accounting for barriers to entry, it has greater than a 60% market share. Prohibits the presumption from being rebuttable if it has greater than a 75% market share.
- d) “Health care system” is any entity or system of entities that includes or owns two or more hospitals within multiple counties, or three or more hospitals within one county;
- e) “Acquisition” is the direct or indirect purchase in any manner, including, but not limited to, lease, transfer, exchange, option, receipt of a conveyance, creation of a joint venture, or any other manner of purchase, by a health care system, private equity group, or hedge fund of all, or any part of, the assets of a health care facility or provider. Includes any arrangement, written or oral, that alters voting control of, responsibility for, or control of the governing body of the health care provider;
- f) “Affiliation” is an agreement, association, partnership, joint venture, or other arrangement in which a health care system sets up a cooperative relationship involving a bundling of health care services, a sharing of control over health care services provided by that health care facility or provider, or in which a health care system otherwise acquires direct or indirect control over the operations of a health care facility or provider in whole or substantial part; and,
- g) “Clinical integration” is a showing by the health care system affiliating with or acquiring the healthcare facility that there will likely be a reduction in costs to the benefit of consumer care and outcomes or an increase in the quality of care. An increase or improvement in quality of care may include a showing or a reduction in morbidity or mortality, better population healthcare management, or any other commonly accepted metric or standard for improving consumer health and patient outcomes.
- h) “Provider” is an individual or group of individuals that provides health related services to consumers, including, but not limited to, licensees as defined under the Business and Professions Code.
- i) “Health care facility” is a facility, nonprofit or for-profit corporation, institution, clinic, place, or building where health-related services are provided, including but not limited to, a hospital, clinic, ambulatory surgery center, treatment center, or laboratory or physician office located outside of a hospital.

FISCAL EFFECT: This bill has not been analyzed yet by a fiscal committee.

COMMENTS:

- 1) *Author’s statement.* According to the author, access to affordable, quality healthcare for Californians is more important than ever. As some hospitals and provider groups struggle financially during the COVID-19 crisis, action by the Legislature is crucial to protect the healthcare system for today as well as for the future. Large healthcare systems that own multiple hospitals, and other providers such as physician practices or outpatient surgical centers, can use anti-competitive practices to raise prices and limit services without increasing the quality of care. In an effort to stop these types of market abuses, California Attorney General Xavier Becerra and union healthcare trust UEBT settled a landmark case against Sutter Health, Northern California’s largest healthcare system. The settlement prohibited Sutter Health from engaging in these types of practices and required it to make policy changes that would restore competition and choice in the market. While this settlement addressed Sutter Health’s specific market abuse, California must prevent new large healthcare systems from forming unless they increase care coordination to improve

quality or lower costs and/or increase access to care. This bill would ensure proper oversight of the growth of large healthcare systems and their impact on the healthcare market.

- 2) *Federal antitrust enforcement.* Antitrust authorities examine consolidated entities because antitrust offenses almost always raise the prices paid by consumers for goods or services. Even relatively small price increases can have tremendous overall effects statewide. When state or local governments pay too much for goods or services because of antitrust violations, either taxes must be increased or government services must be reduced. There are three bodies of federal antitrust laws: The Sherman Antitrust Act, the Clayton Act, and the Federal Trade Commission Act. All are used by state and federal governments to review the effects on competition from health care entity conduct and consolidations. Another federal law, the Hart-Scott-Rodina Act (HSR), requires advanced notification to the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) of large proposed mergers and acquisitions before they are finalized. Businesses may not merge with or acquire other businesses when the effect may be substantially to lessen competition. Under HSR, the FTC and the U.S. DOJ review most of the proposed transactions that affect commerce in the U.S. and are over a certain size, and either agency can take legal action to block deals that it believes would “substantially lessen competition.” Because the FTC and U.S. DOJ share jurisdiction over merger review, transactions requiring further review are assigned on a case-by-case basis depending on which agency has more expertise with the industry involved. The FTC and U.S. DOJ have issued Statements of Antitrust Enforcement Policy in Health Care that provide guidance on activities that are violations and activities that will not be challenged under antitrust laws.
- 3) *California’s Department of Justice (DOJ).* California’s DOJ, headed by the AG, houses an antitrust division where attorneys, investigators, and legal analysts are devoted to antitrust investigations and litigation. California and federal antitrust laws prohibit unwarranted restraints on free and open competition in commerce. These laws allow the AG to bring civil and criminal legal actions against individuals and businesses acting in restraint of trade. Anyone injured by an antitrust offense may recover from the wrongdoer an amount that is three times the damages suffered. In 2012, California DOJ issued civil investigative demands to a number of California plans and providers as part of the AG’s focus on the impact of consolidation of services on medical care costs to consumers. The *Wall Street Journal* reported that Dignity Health, Scripps, Sharp, Sutter and Cottage health systems were all sent subpoenas. The article states that the AG appears to be focusing on whether the systems’ “tie-ups with physicians, as well as ownership of hospitals, have given them the market power to boost prices in a way that violates antitrust law.”

The Cartwright Act is a California specific antitrust statute, but it does not give the AG the authority to approve or deny a merger. The following three activities are examples of activities that are illegal under the Cartwright Act:

Price-fixing. An informal understanding between competitors concerning prices is illegal. The agreement need not set specific prices; any agreement affecting price levels is illegal.

Tying arrangements. When a seller requires a buyer to purchase a product that the buyer does not want in order to be allowed to buy a product that the buyer does want. Tying is generally illegal if the seller has some degree of control over the market for the product that the buyer wants.

Monopoly. When a business unfairly keeps others from competing with it. Growth through superior ability and efficiency is not illegal. However, a business with significant market power may not, without legitimate business justification, take actions that exclude or handicap its competitors.

The AG also is required to review and make recommendations with regard to public utility mergers and acquisitions. The California Public Utilities Commission (PUC) approves mergers and acquisitions of public utilities. Public Utilities Code section 854(b)(3) requires the PUC to request an advisory opinion from the AG regarding whether competition will be adversely affected and what mitigation measures could be adopted to avoid this result when approving mergers, acquisitions or direct or indirect control of any public utility organized and doing business in California.

- 4) *Nonprofit Hospital Mergers.* California's charitable trust law, unlike the Cartwright Act, requires the AG's consent for any sale or transfer of a health care facility owned or operated by a nonprofit corporation whose assets are held in public trust. The charitable trusts section of the DOJ is tasked with protecting the public's interest in the property and assets committed to charitable purposes in California through registration, education and enforcement. The AG must consider whether the transaction may tend to create a monopoly or substantially lessen competition.
 - a) *Daughters of Charity.* In December of 2015, the AG granted conditional approval of a change of control and governance of the Daughters of Charity Health System to Integrity Inc., with conditions to ensure essential healthcare services for the communities serving the six health facilities included in the transaction. This has been described by the AG as the largest and most complex nonprofit hospital transactions in California history. DOJ conducted an in-depth review of the transaction, including five Health Care Impact Statements by an independent health care expert, six public meetings, and a public comment period. Under the system restructuring and support agreement, for at least the first three years of the 15-year agreement, the health system will continue to operate as a nonprofit public benefit corporation. After three years and before the expiration of the agreement, Integrity Inc. can exercise their option to purchase the health system. Conditions of the agreement include requirements for facilities to operate as hospitals offering emergency services and other facilities to operate as nursing homes for specified periods of time, investments in capital improvements, commitments to serve Medi-Cal and charity care patients, and all of the facilities will be required to submit an annual report to the AG describing in detail their compliance with the conditions.
 - b) *Sutter-Summit Merger.* A past merger between Sutter and Summit hospitals (two hospitals located 2.5 miles apart in the Oakland-Berkley region of the San Francisco Bay Area) which resulted in price increases and may be anticompetitive according to a 2008 working paper titled "The Price Effects of Hospital Mergers: A Case Study of the Sutter-Summit Transaction." This retrospective study by the Bureau of Economics of the FTC assessed whether antitrust enforcement matter was appropriate. Claims data from three large health insurers were used to compare the post-merger price change for Sutter and Summit to the price change for a set of control group hospitals. The results of the retrospective show that Summit's price increase was among the largest of any comparable hospital in California, indicating this transaction may have been anticompetitive. The study found that the contracted price increases for Summit following the merger ranged from approximately 29% to 72%, compared to

approximately 10% to 21% at Alta Bates. However, a full determination of whether antitrust enforcement was appropriate would require an analysis of impact on quality and if Summit was a “failing firm.” This additional analysis was beyond the scope of the retrospective.

- 4) *Consolidation.* A March 2018 UC Berkeley report on health care consolidation details the rapid consolidation of the hospital, physician, and insurance markets in California from 2010 to 2016. According to the U.S. Department of Justice (DOJ) and Federal Trade Commission’s (FTC’s) Horizontal Merger Guidelines, 44 counties had highly concentrated hospital markets. For physician markets, 12 counties had highly concentrated primary care markets, 20 counties had highly concentrated orthopedics markets, 22 counties had highly concentrated cardiology markets, 24 counties had highly concentrated hematology/oncology markets, and 26 counties had highly concentrated radiology markets. The commercial insurance market was also highly concentrated with 42 counties considered highly concentrated according to the Guidelines. There was also an increasing trend of hospitals purchasing physician practices. The percent of physicians working for foundations owned by hospitals increased from 24% to 39% between 2010 and 2016. The report found evidence that highly concentrated markets are associated with higher prices for a number of hospital and physician services and ACA premiums. In Northern California – which is considerably more concentrated than Southern California across all measures of health care market concentration that were analyzed – inpatient prices were 70% higher, outpatient prices were 17- 55% higher (depending on the specialty of physician performing the procedure), and ACA premiums were 35% higher than they were in Southern California. Even after adjusting for input cost differences (i.e. wages) between Northern California and Southern California, procedure prices are still often 20-30% higher in Northern California than Southern California. In sum, the pace of market consolidation in California has increased significantly. The vast majority of counties in California warrant concern and scrutiny according to the DOJ/FTC Guidelines. Consumers are paying more for health care as a result of market consolidation.
- 5) *Sutter litigation.* In April 2014, the United Food and Commercial Workers International Union and Employers Benefit Trust filed a lawsuit against Sutter on behalf of themselves and a class of other union trusts, local government entities, and employers. The plaintiffs sought compensation and injunctive relief for what they alleged were unlawful, anticompetitive business practices, which caused them to pay more than necessary for healthcare services and products. In March of 2018, AG Becerra, filed a similar lawsuit against Sutter on behalf of the people of California principally seeking injunctive relief to compel Sutter to correct its anticompetitive business practices moving forward, and to restore competition to healthcare markets in California, but also seeking disgorgement of funds unlawfully acquired. The two separate lawsuits were combined by the court into one case.
- 6) *Sutter settlement.* In October of 2019, on the eve of trial, the parties reached a preliminary settlement agreement to settle the lawsuits. The settlement agreement requires Sutter to pay \$575 million to compensate employers, union trusts, and state and local government entities and to reimburse fees and costs. It also requires Sutter to adhere to comprehensive injunctive relief to rebalance competition in healthcare markets in Northern California. The injunctive relief requires Sutter to limit charges for out-of-network services, stop all-or-nothing contracting, cease anticompetitive bundling, and institutes a court-appointed monitor to review Sutter's conduct for compliance with the settlement and report back to the Court. The settlement restrains Sutter from engaging in the practices that allowed it to charge higher

prices for hospital and physician services. The settlement requires Sutter to make their facilities generally available to participate in the networks of any commercial insurance plans, and generally prohibits Sutter from using some of its hospitals as leverage to get insurance providers to include other hospitals in their networks or in preferred tiers. The settlement sets caps on the rates that Sutter hospitals can charge for services provided at a Sutter hospital that is out-of-network, and it increases price transparency by allowing insurers and self-funded payers to share pricing terms in contracts with Sutter. Insurers and self-funded payers will be allowed to share pricing and quality information with individual members. A compliance monitor will ensure that Sutter is following the terms of the settlement. The settlement terms will last for ten years, with the possibility of one three-year extension. During this time, San Francisco Superior Court will retain jurisdiction to enforce the settlement agreement and to punish any violations. The settlement agreement is currently pending approval by the court.

- 7) *Prior legislation.* SB 538 (Monning of 2018) would have prohibited contracts between hospitals or any affiliate of a hospital and certain types of third-party administrators, health plans or health insurers from containing provisions that set payment rates or terms for nonparticipating providers, requiring contracts with one or more affiliated providers, requiring payors to attest to the contract terms, requiring arbitration for antitrust claims, requiring same cost-sharing for out-of-network hospitals, or keeping payment rates secret, as specified. Would have made any of these contract provisions void and unenforceable. *SB 538 was scheduled but not heard in the Assembly Health Committee on June 26, 2018.*

AB 595 (Wood, Chapter 292, Statutes of 2018) requires prior approval by the DMHC Director for a health plan that intends to merge or consolidate with, or enters into an agreement resulting in its purchase, acquisition or control by, any entity and allows the DMHC director to disapprove a transaction if the transaction would substantially lessen competition.

SB 932 (Hernandez of 2015) would have banned seven specified provisions from contracts between health care providers and payors and required prior approval from DMHC for mergers and other transactions between health plans, risk-based and other organizations. *SB 932 was held at the request of the author in the Senate Appropriations Committee.*

- 8) *Support.* The AG writes that the COVID-19 pandemic has created enormous financial strain on hospitals and physician practices statewide, making these providers more susceptible to affiliation and acquisition attempts by large healthcare systems, private equity groups, and hedge funds. This type of predatory practice, if left unchecked, will result in large healthcare systems continuing to grow and utilize abusive market practices to drive up prices and reduce access for patients. This bill would ensure proper oversight of large healthcare systems and strengthen patient access to affordable, quality healthcare. Even before the COVID-19 pandemic, anticompetitive behavior in the healthcare market was a growing concern, particularly as a result of large, dominant healthcare systems that own multiple hospitals and other providers such as physician practices or outpatient surgical centers. The bill would substantially strengthen the state's oversight over the formation and practices of large healthcare systems, helping to ensure access to affordable healthcare during a time when Californians need it the most. The California Labor Federation writes that while there is express antitrust law in California law, much of the statute dates back more than a century and much of the evolution of the law rests in case law. This bill is an effort to drag antitrust law into the 21st Century, using what the AG has learned in the process of recent litigation

and merger oversight activity and what a resurgence of academic literature has demonstrated. This bill takes a comprehensive, reasonable, and flexible approach to addressing health care industry consolidation. It expands oversight over new mergers and acquisitions, including “vertical” integration of physician groups and hospitals. The bill also addresses the problem of already highly consolidated markets in parts of the state by increasing the ability of the AG to prevent anti-competitive and anti-trust practices of providers with market power, without breaking up existing systems. Consolidation drives up prices for all Californians without improving our health outcomes or the quality of care. Providers argue that consolidation is necessary for efficiency and for improving quality. However, a 2020 study published in the *New England Journal of Medicine* found that hospital consolidation resulted in modestly worse patient experiences and no significant improvements in readmission or mortality rates. The COVID-19 pandemic has also exposed another consequence of unchecked consolidation – a shortage of hospital beds, especially in rural areas. The economic toll resulting from the pandemic will likely fuel consolidation trends as physician practices face massive losses or bankruptcy and become targets for acquisition by large systems. Health Access California writes that in the world of anti-trust, it is often said that is hard to un-ring the bell once a transaction has occurred. Considerable consolidation of hospitals, health systems and physician organizations has already occurred in California. This bill takes steps to curb anticompetitive practices that some health systems have allegedly engaged in as a result of their market power.

- 9) *Opposition.* The California Hospital Association (CHA) writes that this bill would strain access to the health care system by creating an extreme and burdensome process for transactions like mergers and affiliation. This, at a time when hospitals are already fighting to be there for their communities, would result in hospital closures and the loss of health care services throughout California. Although financial distress is a common reason for hospitals to merge or affiliate, these arrangements also occur for myriad other reasons such as financial efficiency, expanded access to services, clinical integration, better coordinated patient care, and bolstered support for nurses and physicians. Under existing law, the AG has broad authority to review all sales and significant asset transfers of not-for-profit hospitals. The AG may place conditions on these transactions or deny them all together. Additionally, the AG enforces The Cartwright Act, which describes and prohibits an array of anticompetitive activity. This bill would create a presumption that these transactions are anticompetitive, placing the burden of proof on the purchaser without due process and effectively creating a “guilty until proven innocent” system. Sales, affiliations, and mergers are complex and expensive investments that require thousands of hours of work from legal, financial, operational, and clinical experts. Because of this substantive investment of time and resources, purchasers need some degree of certainty surrounding the process before undertaking such a risk. The bill gives arbitrary and absolute discretion to the AG to determine whether criteria are met, without clear definitions or parameters. Sutter Health writes that this approach to the review of healthcare affiliations is inconsistent with generally accepted legal and economic principles of antitrust merger analysis and years of judicial precedent. The vast majority of mergers, acquisitions and comparable affiliations do not involve competitors and thus are unlikely to substantially lessen competition in the form of higher prices or inferior quality of or access to care. Sutter Health also writes that the proposed “substantial likelihood” standard is speculative and uncertain, given the difficulty of quantifying likely cost and quality effects before a transaction closes. This bill provides payers and large provider groups that do not own a hospital an unfair competitive advantage by excluding them from this process. This bill does not require a showing of significant market share in a properly defined relevant market, but instead permits a finding of “market

power” based simply on a finding of “substantial anticompetitive effect.” The California Medical Association (CMA) believes this bill is broadly written to seemingly trigger review and presumptive denial of any lease, loan, grant, service agreement, or contract change a physician or medical group has, attaching new and uncertain process to the list of financial and administrative hurdles doctors are already facing. CMA writes that the process created seems to favor larger systems that can afford the legal counsel to hopefully get them necessary approvals for such agreements.

10) *Policy comments.* This bill touches upon various issues within the jurisdiction of the Senate Judiciary Committee, including, but not limited—to consumer protection, due process, and civil actions. The Senate Judiciary Committee has historically tended to favor policies that fortify consumer protections and prohibit anticompetitive activities that result in harm to Californians. Last year, the Senate Judiciary Committee passed AB 824 (Wood, Chapter 531, Statutes of 2019) that codifies standards articulated by the California Supreme Court in which reverse payment settlements in pharmaceutical patent infringement cases are presumed to be anticompetitive unless procompetitive effects can be clearly and convincingly demonstrated, and subjects parties who engage in anticompetitive reverse payment settlements to a civil penalty. This bill contains some similar provisions from AB 824.

- a) As written, the range of transactions that could fall under the AG’s purview are not entirely clear, and could include transactions involving a single physician. The committee may wish to request amendments to refine these details and ensure that this review and approval process is transparent and focused on those transactions at risk of significant anticompetitive activities.
- b) Regular monitoring and review of California’s health care market can be a valuable mechanism for the state to identify gaps in services and unreasonable pricing. A Health Care Affordability office has been proposed in the Governor’s 2020-21 budget. It is unclear if and when this office may be established. The advisory board proposed in this bill would appear to duplicate some of the functions of the Governor’s proposed office. The board would also advise the AG on these reviews. As such, the committee may wish to ensure appropriate conflict of interest standards as members of the advisory board could potentially have an interest in the outcome of the reviews.

10) *Amendments.*

- a) The author requests amendments to require private equity group or hedge funds to obtain consent from the AG prior to affiliation or acquisition between the private equity group or hedge fund and a health care facility or provider; and,
- b) To permit, instead of require, the AG to grant a waiver under specified conditions, and permit the AG to adopt regulations regarding the process of requesting a waiver and the conditions the health care system, private equity group, or hedge fund are required to meet for obtaining a waiver.

SUPPORT AND OPPOSITION:

Support: Attorney General Becerra (sponsor)
California Labor Federation
Health Access California
Western Center on Law and Poverty

Oppose: California Chamber of Commerce
California Medical Association
California Hospital Association
Scripps Health
Sutter Health
United Hospital Association

-- END --