California Poised to Grant Attorney General Broad Approval Authority over Healthcare Transactions

June 16, 2022

On May 26, 2022, the Health Care Consolidation and Contracting Fairness Act of 2022 ("AB 2080" or "the bill") passed in the California Assembly. Following the defeat of two predecessor bills in 2020 and 2021,[1] AB 2080 emerged early this year as the third attempt by the California legislature to expand the existing oversight authority of the California Attorney General ("AG") over nonprofit healthcare facilities to encompass transactions involving for-profit healthcare providers.[2] The bill, currently before the state Senate, is poised to significantly alter California's regulatory landscape by granting the AG broad authority to review and approve (or reject) certain healthcare mergers, acquisitions and other transactions valued at $15 million or more.[3] Additionally, the bill prohibits the use of so-called "anti-competitive" payor contract clauses, a restriction that appears to be aimed squarely at providers whose market positions may allow them to obtain more favorable, above-market prices. Like its predecessors, AB 2080 is facing fierce opposition from providers and industry stakeholders, including the California Hospital Association and the California Medical Association.

Transaction Oversight. Effective January 1, 2023, transacting parties would be required to give the AG 90 days' advance notice of a proposed healthcare transaction. With limited exceptions, the bill would subject to the AG's approval (*i*) the transfer of a material amount of assets of a for-profit medical group, hospital system, insurer or pharmacy benefit manager and (*ii*) the transfer of "control, responsibility, or governance" of a material amount of a for-profit healthcare entity's assets. Because healthcare transactions require substantial investments of time, money and resources, the increased uncertainty generated by this bill is likely to chill transacting parties' enthusiasm in embarking upon them. The resources required to comply with the bill, the lengthy delay between application and approval by the AG, and the significant uncertainty of actually obtaining approval will likely hinder deal activity in California.

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1 Senate Bill 977 ("SB 977") and Assembly Bill 1132 ("AB 1132").

2 *See* CA Corp. Code § 5914 and § 5920.

3 As amended, AB 2080 does not capture transactions with values less than $15M. While an improvement over AB 1132's proposed $3M threshold, the currently proposed $15M threshold remains low and will impose a significant administrative and financial burden on California by requiring the AG to review relatively minor transactions. For context, the threshold under federal antitrust law is $94M+.

Further, AB 2080 applies to any corporation that operates or controls a healthcare entity if such entity provides covered healthcare or coverage to a California corporation. The bill thus raises the specter that California will try to exercise jurisdiction over deals involving multistate or national healthcare companies if the target has operations in California.

In making the determination to grant or withhold consent, the AG may consider "any factors that the Attorney General deems relevant," including, but in no way limited to, whether the transaction *may*:[4]

- have a significant impact on market competition, quality of or access to care, or costs for payors, purchasers or consumers;
- improve quality of care;
- have a significant impact on the access to or availability of healthcare for payors, purchasers or consumers;
- be in the public interest; and/or
- maintain access to care in a rural community.

As currently written, therefore, AB 2080 vests in the AG enormous discretion to reject a transaction not only based on amorphous factors and standards but also on the mere *possibility* that any one of those amorphous factors or standards is met.[5]

Reimbursement Requirement. In making the determination to grant or withhold consent, the AG is permitted to retain consultants, experts and others in assessing such transactions—and shall be entitled to reimbursement by the transacting parties of all reasonable costs. Further, the AG is entitled to reimbursement of all costs associated with "monitoring ongoing compliance" with the terms and conditions imposed by the AG on any approved transaction. Thus, apparently, the parties to an approved transaction could be subject to a regulatory monitorship that imposes continuing, or additional, compliance obligations for an undefined period of time, as determined on a case-by-case basis at the discretion of the AG. Such broad discretion may subject

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4 The analogous standard proposed under AB 1132 was "is likely to" rather than "may."

5 Compare, for example, Nevada's anti-consolidation law: Nevada AB 47 is tailored to the issue of market competition, requiring parties to a transaction involving physician group practices to provide 30 days' advance **notice** to the attorney general *only if* the group provides, or will provide, more than **50%** of the healthcare services within a given market. AB 47 does not expressly give the Nevada attorney general authority to approve or reject a healthcare transaction.

transacting parties to undefinable and unpredictable financial and administrative burdens.

Limited Right of Appeal. On May 2, 2022, the bill was amended to provide that, in the event the AG rejects a transaction, the affected parties may, within 30 days, request an adjudicative proceeding before an administrative law judge.[6] In practice, however, the amendment may not provide a meaningful right to appeal, because the AG has broad discretion to consider *any* factors he or she deems reasonable, not only the factors specifically enumerated in the bill. Because the bill does not provide clear-cut boundaries on the AG's discretion to reject a healthcare transaction, even where the transaction would pose no meaningful risk of impacting market competition, quality of care or access to care, the affected parties may not have meaningful grounds on which to appeal the AG's determination.

Payor Contracts. AB 2080 prohibits the enforcement of any payor contract terms that tend to reduce market competition, including the following types of payment clauses:

- **"All or nothing" clauses**—clauses requiring an insurer to contract with all facilities in a health system if it wants to include any of the facilities in its plan;
- **Most favored nation clauses**—clauses ensuring that a contracting insurer receives provider rates at least as favorable as the rates provided to any other insurer by such provider;
- **Anti-tiering clauses**—clauses requiring the insurer to accept terms for practitioners and other affiliates of a healthcare system; in particular, clauses requiring all such practitioners and affiliates to be placed in the most favorable tier of providers;
- **Anti-steering clauses**—clauses that restrict an insurer from steering patients to other networks, either directly or by offering incentives to encourage insureds to use or avoid certain healthcare practitioners; and
- **Gag clauses**—clauses prohibiting an insurer from sharing with patients and employers negotiated provider-specific prices and quality of care information.

These restrictions are likely to impede provider-payor contracting and cut against healthcare's macro-level shift towards value-based care models, because providers have little incentive to adopt downside-risk arrangements unless they are coupled with an

[6] Pursuant to the administrative adjudication provisions of Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

opportunity to capture greater market share.[7] By prohibiting contractual clauses intended to create preferred relationships, AB 2080 is likely to impede providers' adoption of more financially meaningful value-based arrangements.

Further, the bill indicates that so-called "anticompetitive" clauses existing *before* the January 1, 2023 effective date would not be grandfathered, and contracting parties would not be permitted to enforce them. In other words, the bill may—*immediately upon effectiveness*—invalidate countless managed care agreements between provider entities and payors, resulting in material uncertainty with respect to revenue cycle management, care coordination and patient access. By undermining the economics of managed care, which are predicated, in large part, on incentivizing in-network referral relationships and risk sharing, AB 2080 will force stakeholders to rethink their value-based care and vertical integration modeling. Investors in this space should take into account the strong possibility that these aspects of the bill may cause significant disruption and uncertainty for some time to come.

Looking Ahead. If the bill is enacted, California would join a handful of other states—including Connecticut, Massachusetts, Nevada, Oregon and Washington—seeking to broadly regulate providers in the for-profit sector.[8] Intending to combat the high costs of healthcare, these so-called "healthcare anti-consolidation" bills vary widely from state to state, including with respect to the scope of notice requirements, affected healthcare entities, waiting periods, review criteria and approval authority. Notably, state attorneys general in Connecticut, Massachusetts, Nevada and Washington have been granted a right to receive *notice* of a proposed healthcare transaction, but have not been granted express approval authority.[9] In Oregon, the legislature has vested the Oregon Health Authority, rather than the attorney general, with the authority to review and approve healthcare transactions. AB 2080 is unique in its intent to grant the AG broad approval authority over for-profit healthcare transactions.

Proponents feel confident that this third iteration of California's healthcare anti-consolidation bill will be the proverbial "charm." However, the bill has several hurdles to clear before it becomes law. AB 2080 has been referred to the Senate Committee on Health and the Senate Committee on Judiciary, but has not yet been scheduled for committee hearings. It must be heard in both committees prior to July 1, the last day for

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7 For example, in 2019, Congress introduced the "Lower Health Care Costs Act" (S.1895), which sought to ban anticompetitive contracting practices, including anti-tiering or anti-steering provisions, *except* within value-based arrangements.

8 Six states (Colorado, Connecticut, Hawaii, Massachusetts, Rhode Island and Washington) require pre-transaction notification to AGs from hospitals (including for-profit hospitals). Eight states (Delaware, Illinois, Kentucky, Maine, Michigan, Mississippi, New Jersey and West Virginia) require notice to another state agency under Certificate of Need programs.

9 *See* the "Equal Access to Care Act" (HB 2362), which went into effect January 1, 2022.

policy committees to meet and report bills before adjournment and summer recess. If the bill is timely heard, it will move to the Senate floor for a vote during the August 15–31 session. Should the bill pass in the Senate before the August 31 deadline, it moves to the Governor's office. The Governor would then have until September 30 to sign the bill into law, approve without signing, or veto the bill.

We will continue to monitor the bill's progress.

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Please do not hesitate to contact us with any questions.

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