SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2023-2024 Regular Session

AB 1092 (Wood)
Version: June 28, 2023
Hearing Date: July 11, 2023
Fiscal: Yes
Urgency: No
AM

SUBJECT

Health care service plans: consolidation

DIGEST

This bill requires a health plan that intends to acquire or obtain control of an entity through a change of governance or control of a material amount of assets of that entity to give notice to, and secure prior approval from, the director of the Department of Managed Health Care (DMHC). The bill authorizes the DMHC director (director) to additionally conditionally approve the transaction or agreement if the health care service plan's agreement to control costs to subscribers and enrollees, contract with an independent entity to monitor conditions approved by the director associated with approval of a merger, consolidation, transaction or agreement, and makes failure to comply with a condition grounds for disciplinary action. The bill authorizes the director to disapprove a transaction or agreement because it would substantially lessen competition among a particular category of health care providers, and requires the director to provide the AG information related to competition.

EXECUTIVE SUMMARY

This bill seeks to expand on the provisions of AB 595 (Wood, Ch. 292, Stats. 2018) and additionally require a health plan that intends to acquire or obtain control of an entity through a change of governance or control of a material amount of assets of that entity to give notice to, and secure prior approval from, the director. It specifically includes controlling costs to subscribers and enrollees as a condition the director can place on approval of a merger, acquisition, or change of governance or control. Additionally, it authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in the health system or among a particular category of health care providers.

The bill is author sponsored. The bill is supported by various labor organization and health advocacy groups. It is opposed by the California Association of Health Plans and Vision Service Plan. The bill passed the Senate Health Committee on a vote of 9 to 2.

PROPOSED CHANGES TO THE LAW

Existing law:

1) The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health and other insurers. (Health & Saf. Code § 1340, et seq., and Ins. Code § 106, et seq.)

2) Requires a health plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, any entity, including another health plan or health insurer to give notice to, and secure prior approval from the DMHC director. (Health & Saf. Code § 1399.65.(a)(1).)

3) Requires a health plan described in 2) above to meet all of the Knox-Keene Act requirements and file all necessary information for the director to make a determination to approve, conditionally approve, or disapprove the transaction, as specified. (Health & Saf. Code § 1399.65(a)(3).)

4) Authorizes the director to conditionally approve the transaction, contingent upon an agreement to fulfill one or more conditions to benefit subscribers and enrollees, provide for a stable health care system, and impose other conditions specific to the transaction in furtherance of KKA. (Health & Saf. Code § 1399.65(a)(4).)

5) Requires DMHC to engage stakeholders in determining the measures for improvement. For a major transaction or agreement, requires the director to obtain an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system, and other relevant provisions law, and authorizes the director to obtain an independent analysis for other transactions. (Health & Saf. Code § 1399.65(a)(4).)

6) Authorizes the director to disapprove the transaction upon a finding that it would substantially lessen competition in the health care system or create a monopoly in this state, including, but not limited to, health coverage products for a specific line of business, in addition to any grounds for disapproval. (Health & Saf. Code § 1399.65(b).)

7) Establishes the Office of Health Care Affordability (OHCA) in the Department of Health Care Access and Information (HCAI), which is responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers and purchasers,

creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets. (Health & Saf. Code § 127501.)

8) Requires OHCA to review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving health plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities. (Health & Saf. Code § 127501.)

9) Requires OHCA to monitor cost trends and other market failures on competition, prices, access, quality, and equity.
    a) Requires OHCA to promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health plans, health insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities, in a manner supportive of the efforts of the Attorney General (AG), DMHC, and CDI.
    b) Requires OHCA to prospectively analyze those transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market. (Health & Saf. Code § 127507.)

10) Requires a health care entity to provide OHCA with written notice of agreements or transactions that will occur on or after April 1, 2024, at least 90 days prior to entering into an agreement to do either of the following:
    a) sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities; or,
    b) transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities. (Health & Saf. Code § 127507.)

11) Exempts the following from 11) above:
    a) agreements or transactions involving health plans that are subject to review by the DMHC director under the Knox-Keene Act;
    b) agreements or transactions involving health insurers that are subject to review by the Insurance Commissioner;
    c) agreements or transactions where a county is purchasing, acquiring, or taking control, responsibility, or governance of an entity to ensure continued access in that county; and
    d) agreements or transactions involving nonprofit corporations that are subject to review by the AG, as specified. (Health & Saf. Code § 127507.)

12) Authorizes agreements described in 13) above to be referred to OHCA for a cost and market impact review by the reviewing authority. (Health & Saf. Code § 127507.)

13) Authorizes the court, in any civil action brought by the AG or a district attorney, as specified, in addition to granting such prohibitory injunctions and other restraints as it may deem expedient to deter the defendant from, and insure against, his committing a future violation, as specified, to grant such mandatory injunctions as may be reasonably necessary to restore and preserve fair competition in the trade or commerce affected by the violation. (Bus. & Prof. Code § 16754.5.)

14) Establishes the Unfair Competition Law (UCL), which provides a statutory cause of action for any unlawful, unfair, or fraudulent business act or practice and unfair, deceptive, untrue, or misleading advertising, including over the internet. (Bus. & Prof. Code § 17200 et seq.)

15) Establishes the Cartwright Act as California's antitrust law that prohibits anticompetitive activity. (Bus. & Prof. Code § 16000 et. seq.)
    a) Provides that, except as expressly provided, every trust is unlawful, against public policy and void. (Bus. & Prof. Code § 16726.)
    b) In any civil action brought by the Attorney General or a district attorney under the Cartwright Act, the court may, in addition to granting such prohibitory injunctions and other restraints as it may deem expedient to deter the defendant from, and insure against, the defendant's committing a future violation of the Act, grant such mandatory injunctions as may be reasonably necessary to restore and preserve fair competition in the trade or commerce affected by the violation.

This bill:

1) Requires a health plan that intends to acquire or obtain control of an entity through a change of governance or control of a material amount of assets of that entity to give notice to, and secure prior approval from, the DMHC director.
    a) Acquiring an entity includes the sale, transfer, lease, exchange, option, conveyance, or other disposition of an entity's assets to a health care service plan if a material amount of the assets of the entity are involved in the agreement or transaction, and also includes the acquisition of an entity by a corporate affiliate of a health plan if the agreement or transaction will impact enrollees of the health plan in this state.
    b) Obtaining control of an entity occurs if the entity transfers control, responsibility, or governance of a material amount of its assets or operations to a health care service plan.
    c) Transfer includes the substitution of one or more new corporate members that would transfer the control of, responsibility for, or governance of the entity, and also includes the substitution of one or more members of the

entity's governing body, or an arrangement, written or oral, that would transfer voting control of the members of the governing body.

2) Authorizes the director to contract with an independent entity to monitor compliance with any or all conditions associated with approval of a transaction or agreement and report to DMHC. Requires the health plan to cooperate with the independent entity by, among other things, responding promptly to requests for information.
    a) Requires a plan to reimburse the director for the reasonable costs of the independent monitor authorized pursuant to this bill.
    b) Requires a contract entered into with a consultant or consultants under this bill to be on a noncompetitive bid basis and exempt from public contracting requirements, as specified.

3) Authorizes the director to conditionally approve the transaction, in addition to existing factors, contingent upon the health plan's agreement to control costs to subscribers and enrollees. Requires the director to review information from federal agencies and other state agencies, and agencies in other states that is relevant to any of the parties to the transaction and indicate compliance with those laws.

4) Authorizes the director to disapprove the transaction or agreement if the director finds the transaction or agreement would substantially lessen competition among a particular category of health care providers. Requires the director to provide to the AG information related to competition.

5) Provides that the bill does not narrow, abrogate, or otherwise alter the authority of the AG to maintain competitive markets, including, but not limited to, seeking injunctive relief, as specified, and prosecute state and federal antitrust and unfair competition violations.

6) Makes failure to comply with a condition associated with approval of a transaction or agreement grounds for disciplinary action by the director. Prohibits the director from waiving, or delaying implementation of, any requirement imposed on a health plan pursuant to these provisions.

COMMENTS

1. Stated need for the bill

The author writes:

> This bill expands regulatory oversight over health plan transactions, building on prior legislation (AB 595 (Wood), Chapter 292, Statutes of 2018), which requires an entity that intends to merge with a health plan to give notice to, and secure prior

approval from, the Department of Managed Health Care (DMHC) Director. This bill applies to health plans that merge or acquire other entities, like a physician group, for example. AB 1092 also authorizes the DMHC Director to disapprove a transaction with a finding that the transaction would substantially lessen competition and requires DMHC to forward competitive information to the Attorney General. A majority of studies show that mergers and acquisitions in health care are not lowering costs for anyone but the entities doing it and there are real concerns about how these mergers and acquisitions could reduce or limit access to certain health care services.

2. Health care consolidation in California

The Senate Health Committee analysis provides the following background on health care consolidation in California:

> According to a California Health Care Foundation issue brief (Gudiksen, Gu and King, 2021), between 2006 and 2014, the combined market share of the top four health insurers climbed from 74% to 83%, and the coronavirus pandemic fueled another round of consolidation including significant activity by private equity firms. Recent consolidations are occurring through transactions including joint ventures, strategic alliances, affiliations, and other agreements between companies. The brief indicates there is a large and growing body of evidence that mergers of health care companies have consistently resulted in increased prices for health care services with little to no improvement in quality. The brief also points out that DMHC regulates only the plans operating in California and not any parent corporations, and CDI does not have authority over mergers affecting an insurer that is not residing in the state. The brief suggests giving DMHC and CDI authority to include affordability standards when reviewing health plans sales in California.[1]

In November of 2020, the Assembly Health Committee held an Informational Hearing titled "Health Care Industry Consolidation and its Impact on California's Health Care Prices" and noted in the Background Paper for the Informational Hearing that:

> A critical factor in the fast growth of prices in California compared with the rest of the country is market concentration. This market concentration, including hospital and physician consolidation, has been proliferating in the state along with price acceleration according to a 2019 CHCF report entitled, "Sky's the Limit: Health Care Prices and Market Consolidation in California (Sky's the Limit report)." As market concentration rises, so do prices. The Sky's the Limit report points out that while there are potential benefits to hospital-physician consolidation (also known as vertical consolidation, further discussed below**),** including reduced transaction costs and technological interdependencies that improve coordination of care, such

[1] Sen. Health Committee Analysis AB 1092 (2023-24 Reg. Sess.) as amended Jun. 28, 2023 at p. 5.

integration can also result in higher prices, particularly when the hospital or physician organization has significant share in its market. The combined effect of higher hospital and physician prices results in higher health insurance premiums, making healthcare even more unaffordable.[2]

3. AB 595 (Wood, Ch. 292, Stats. 2018)

In 2018, the Legislature enacted AB 595 (Wood, Ch. 292, Stats. 2018) to require a health care service plan subject to the Knox-Keene Act that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, any entity, to give notice to, and secure prior approval from, the director. (Health & Saf. Code § 1399.65.) Under existing law, the director can conditionally approve the transaction or agreement contingent on certain factors, including the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement in furtherance of the Knox-Keene Act.

The Senate Health Committee analysis details a recent example of a merger review by the director in December 2021 where conditions were placed on the merger:

> DMHC reviewed Centene Corporation's acquisition of Magellan Health, Inc. DMHC's authority to review the sale or purchase of a health plan, in this case Magellan, as the parent company of two licensed plans triggered the review. DMHC conducted a comprehensive review of the merger including obtaining an independent impact analysis that evaluated the impact of the merger on subscribers and enrollees and the stability of the health care delivery system. As part of its review, DMHC considered the findings and recommendations in the independent impact analysis and conducted a public meeting to solicit input from the public. DMHC approved the acquisition and imposed several conditions on the plans, including:
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> - the plans will continue Magellan's market presence in California and continue its existing contracts to provide behavioral health services at the same rates for at least two years;
> - the plans will help to control health care costs and keep premium rate increases to a minimum, including no increases in premiums as a result of acquisition costs;
> - a third-party monitor will be put in place to oversee the plans' compliance with competition related conditions, including holding the Magellan and

[2] Asm. Comm. on Health, *Health Care Industry Consolidation and its Impact on California's Health Care Prices* (Nov. 12, 2020), available at https://ahea.assembly.ca.gov/sites/ahea.assembly.ca.gov/files/Final%20Consolidation%20background%20paper.pdf.

Centene plans separate to ensure the Magellan plans are run as a separate business; and

- the plans must invest $10 million to support the acceleration of behavioral health integration into primary care practices in California's health care delivery system.[3]

4. OHCA

OHCA was established last year through the California Health Care Quality and Affordability Act (Act) (SB 184 (Committee on Budget and Fiscal Review, Ch. 47, Stats. 2022)), which was enacted in recognition that health care affordability has reached a crisis point. OHCA's website notes that:

> Health care spending in California reached $10,299 per capita and $405 billion overall in 2020, up 30% from 2015. Californians with job-based coverage are facing higher out-of-pocket costs, with the share of workers with a large deductible ($1,000 or more) increasing from 6% in 2006 to 54% in 2020. For the third consecutive year, the 2022 CHCF California Health Policy Survey found that half of Californians (49%) – and fully two-thirds of those with lower incomes (under 200% of the federal policy level) – reported skipping or delaying at least one kind of health care due to cost in the past 12 months. Among those who reported skipping or delaying care due to cost, about half reported that their conditions worsened as a result.[4]

The Act emphasized that it is in the public interest that all Californians receive health care that is accessible, affordable, equitable, high-quality, and universal, and tasked OHCA with three primary responsibilities: managing spending targets, monitoring system performance, and assessing market consolidation. In order to perform these duties, OHCA "will collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a new Health Care Affordability Board. To ensure a balanced approach to slow spending growth, OHCA will monitor system performance by measuring quality, equity, adoption of alternative payment models, investment in primary care and behavioral health, and workforce stability. Through cost and market impact reviews, OHCA will analyze transactions that are likely to have significant impact on market competition, the state's ability to meet targets, or affordability for consumers and purchasers. Based on results of the review, OHCA will then coordinate with other state agencies to address consolidation as appropriate."[5] Enforcement by OHCA is not expected to begin until 2026, and in 2024 it will begin collecting notices related to transactions among health care entities, which will trigger cost and market impact reviews on transactions that are likely to

[3] Sen. Health Committee Analysis AB 1092 (2023-24 Reg. Sess.) as amended Jun. 28, 2023 at p. 5.
[4] Office of Health Care Affordability, *Overview*, available at https://hcai.ca.gov/ohca/.
[5] *Ibid*.

significantly impact market competition. OHCA will only review transactions existing law requires DMHC to consider if requested by DMHC.

5. This bill addresses the issue of consolidation in the health care industry by expanding the power of the DMHC Director to review transactions where a health care service plan intends to acquire or obtain control of an entity through a change of governance or control of a material amount of assets

This bill addresses the issue of consolidation in the health care industry by requiring a health care service plan that intends to acquire or obtain control of an entity through a change of governance or control of a material amount of assets of that entity to give notice to, and secure prior approval from, the director. The director is required to review information from federal agencies and other state agencies, including agencies in other states, that is relevant to any of the parties to the transaction, and that may indicate compliance with state or federal laws, including the laws of other states. The health care service seeking approval under these provisions is required to cooperate with the department in obtaining information from out-of-state agencies or federal agencies. It specifically includes controlling costs to subscribers and enrollees as a condition the director can place on approval of a merger, acquisition, or change of governance or control in regards to a merger, consolidation, or acquisition through a change of governance or control.

In recognition of the AG's existing authority to enforce antitrust violations, the bill specifically provides that it does not narrow, abrogate, or otherwise alter the authority of the AG to maintain competitive markets, including, but not limited to, seeking injunctive relief under Section 16754.5 of the Business and Professions Code, and prosecute state and federal antitrust and unfair competition violations.

6. Statements in support

The Western Center on Law and Poverty writes in support stating:

> Economic studies have shown that past health insurer mergers lead to premium increases and have no demonstrable effect on improving health care quality. To provide oversight, the Legislature passed AB 595 (Wood) in 2017-18, Chapter 292 of 2018, which required oversight by DMHC when health plans are acquired or merge, including when two health plans merge, that transaction be reviewed for impacts on competition, cost, quality and health disparities, and approved by the DMHC. The law required DMHC to hold a public meeting about the merger, and gave the department the authority to approve, deny or approve the merger with conditions to prevent negative impacts on consumers.

AB 1092 would close a gap in oversight, by requiring that when a health plan buys or takes control of another entity that is not another health plan, they go through the same review, public input and consent process.

Since AB 595's enactment, health plans have been purchasing and investing in other entities including physician groups and pharmacy benefit managers. In fact, United Healthcare, a health insurance company, may today be the largest employer of physicians in America, and it continues to grow. In recent years, Optum Health, a medical group owned by United Healthcare, purchased multiple physician entities in Southern California, Monarch, and DaVita Healthcare Partners – two of the largest in the state. Health plans acquiring other entities, like physician groups further concentrates the health care market, which can have negative impacts on costs and quality of care.

7. Statements in opposition

The California Association of Health Plans writes in opposition stating:

The impacts of AB 1092 extend beyond mergers and acquisitions by stating, "A health care service plan that intends to acquire or obtain control of an entity through a change of governance or control of a material amount of assets of that entity shall give notice to, and secure prior approval from, the director." The added language is very problematic as it would allow the DMHC director to reach deeper into health plan operations and control intracompany arrangements and changes in corporate governance. Even a relatively basic consolidation or transfer of assets within the same corporate family could trigger prior approval from state regulators and hold back innovative transactions.

AB 1092 adds burdensome new language to the existing provision of law that allows DMHC to conditionally approve health plan transactions. Specifically, the bill adds a contingency on health plans to "control costs to subscribers and enrollees." Health plans do their best to control costs for their enrollees, contingencies like this, while well meaning, are ill-defined and are very difficult to attain because they ignore the undercurrents of the health care market. The language fails to account for other cost drivers such as increases in utilization, provider rates, government mandates, and rising drug costs, all which impact consumer costs in the short and long term.

Other provisions of AB 1092 raise additional concerns. Current law already requires that proposed transactions by health plans be approved by the DMHC. It is unclear why subjecting health plan transactions to more stringent review by the Attorney General is necessary. At the very least, clarity is needed in terms of the scope of review by the Attorney General compared to review and approval by other state entities. While we understand the desire to ensure a competitive marketplace, we

have not been provided any reliable example of public harm to justify a deviation from prevailing standards.

Additionally, the newly enacted Office of Health Care Affordability aims to take a comprehensive approach to addressing rising healthcare costs. As part of its mission the Office is required to monitor the impact of consolidation and promote competitive markets in a manner supportive of the efforts of the Attorney General and the DMHC. This involves prospectively analyzing transactions and report on the anticipated impacts to the health care market. Considering this, it is not entirely clear why this bill is needed.

Vision Service Plan writes in opposition unless amended seeking an exemption from the bill for where an affiliate of a health care service plan makes an acquisition in the optometric space.

SUPPORT

American Federation of State, County and Municipal Employees California
California Agents and Health Insurance Professionals
California Pan - Ethnic Health Network
California Pharmacists Association
California Rural Legal Assistance Foundation
Service Employees International Union California
Health Access California
Leukemia & Lymphoma Society
NARAL Pro-choice California
National Health Law Program
Western Center on Law & Poverty, Inc.

OPPOSITION

California Association of Health Plans
Vision Service Plan

RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation:

SB 184 (Committee on Budget and Fiscal Review, Ch. 47, Stats. 2022), among many other provisions, created OHCA within HCAI to collect, analyze, and publicly report data on total health care expenditures, and enforce spending targets set by a Health Care Affordability Board.

AB 2080 (Wood, 2022) would have prohibited the use of six contract requirements, as specified, by a health care provider, health facility, and others that restrict the behavior of a health plan or insurer, and would have permitted the AG and any other state entity charged with reviewing health care market competition to review contracts containing these provisions and decide to consent or deny consent to the transaction, as specified. AB 2080 was not set for a hearing in the Senate Health Committee.

SB 977 (Monning, 2020) would have required the AG, beginning July 1, 2021, to establish the Health Policy Advisory Board for the purpose of evaluating and analyzing health care markets in California and providing recommendations to the AG's office, as specified. SB 977 was not taken up for a vote on the Assembly Floor.

SB 538 (Monning, 2018) would have prohibited contracts between hospitals and contracting agents, health care service plans, or health insurers from containing certain provisions, such as setting payment rates or other terms for nonparticipating affiliates of the hospital, and would have required the contracting agent, plan, or insurer to keep the contract's payment rates confidential from any payor, as defined, that is or may become financially responsible for the payment. SB 538 was never set for a hearing in the Assembly Health Committee.

AB 595 (Wood, Ch. 292, Stats. 2018) required a health care service plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, any entity, to give notice to, and secure prior approval from, the DMHC Director, as specified.

PRIOR VOTES

Senate Health Committee (Ayes 9, Noes 2)
Assembly Floor (Ayes 62, Noes 18)
Assembly Appropriations Committee (Ayes 11, Noes 4)
Assembly Health Committee (Ayes 10, Noes 4)

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