Over Thirty Years of Protecting Patients

California AG Oversight of Nonprofit Hospital Mergers

For more than thirty years, California Attorneys General of both political parties have used their authority to oversee health care mergers to protect health care services to California communities. This authority is based on longstanding legal authority and legislation signed by Governors of both political parties, including Governor Pete Wilson, a Republican, in 1996, and Democratic Governors in the decades since.

Over these last thirty years of oversight of non-profit health transactions, Attorneys General have put in place conditions to ensure ongoing community access to:

- Hospital emergency rooms
- Labor and delivery services
- Other critical hospital services from cardiac care to kidney care
- Reproductive rights
- Services for the LGBTQ community, including gender-affirming care
- Charity care for the uninsured and underinsured
- Compliance with seismic standards
- And affordable care in general, with limits in the last decade on anti-competitive behavior and unjustified price hikes.

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The Attorney General is tasked with acting in the public interest, but the law also creates a process for public notice and community input, including public meetings and other opportunities for public comment. This public oversight of the health care business has time and again proven vital in protecting consumers from losing hospital services and facing higher prices as a result of mergers.

This brief details the history and extensive experience of California's Attorneys General in reviewing health care mergers, as policymakers discuss extending that authority to fill in gaps.

The Start: 1990s For-Profit Takeovers: Columbia/HCA and Sharp Health System

About thirty years ago, Columbia/HCA, a very profitable for-profit hospital system, was expanding across the country and attempted to buy non-profit Sharp Hospital System in San Diego County. Community concern, indeed alarm, led to numerous legislative oversight hearings and community forums. At the time, the state's Attorney General was Dan Lungren, a Republican whose father had been a community physician in Long Beach and helped establish a community hospital there so residents would not need to go up to Los Angeles to get hospital care. In the case of Sharp and Columbia/HCA, Attorney General Lungren intervened, based on the general authority of the Attorney General to protect the value of charitable assets held by nonprofits. The Attorney General questioned whether Columbia/HCA had correctly valued the assets of the Sharp health system or had significantly under-valued those assets. There were also allegations of "self-inurement", that the board and management of Sharp had undervalued the assets to encourage the sale in return for promises of future compensation by Columbia/HCA to board members and senior management. The transaction failed to proceed.

In the words of then Deputy Attorney General James Schwarz in 1997:

> Where a nonprofit hospital's representatives fail to bring the same competitive vigor (as the for-profit hospital acquiring the non-profit) to the negotiating process, either because they are conflicted because of a potential future financial relationship with the buyer or simply because they lack sufficient interest or diligence, it is the proper role of state attorneys general to provide those nonprofit directors with the incentive to meet their fiduciary obligations and, failing that, to intervene to protect the public interest[i].

Two pieces of legislation followed:

- AB 3101 (Isenberg), Chapter 1105 of 1996, sponsored by the Attorney General gave the Attorney General express authority to approve, deny or approve with

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conditions a sale of a non-profit health facility such as a hospital or nursing home to a for-profit entity. The approval by the Attorney General was contingent on:

- Impact on the availability and accessibility of health services for the community
- A determination that the transaction was in the public interest
- Preservation of the non-profit charitable trust, including assuring that the transaction was at fair market value
- A prohibition on self-inurement to any private person or entity

- SB 413 (Peace), Chapter 890 of 1997, barred self-inurement of the board or management of a non-profit health facility when such a transaction occurred.
  - Compensation of both board and senior management are subject to scrutiny.

Step Two: Non-Profit to Non-Profit Mergers of Hospitals & Nursing Homes

In 1999, AB 254 (Cedillo), Chapter 850, extended similar provisions to transactions in which a non-profit health facility such as a hospital or nursing home purchased or obtained control of another non-profit facility.[ii] These provisions are largely parallel to the provisions governing a situation in which a for-profit corporation purchases a non-profit hospital or non-profit nursing home. AB 254 also extended the prohibitions against self-inurement of the board and senior management to non-profit to non-profit transactions. Because most nursing homes in California are operated by for-profit chains, hospital transactions have been the most common types of transaction.

With the enactment of AB 254 in 1999 combined with AB 3101, the California Attorney General had oversight of mergers involving more than half of all California hospitals. This is because the law covered all transactions involving non-profit health facilities and non-profit hospitals have been half or somewhat more of all California hospitals.

The next phase of oversight by Attorneys General came through the implementation of these laws, including developing regulations, fighting litigation in which hospital purchasers attempted to narrow or evade conditions imposed by Attorneys General on hospital mergers, and subsequent legislation to refine the law. Subsequent legislation adjusted the time frames for review, clarified that the law applied to health facilities that had closed but where the non-profit tax status continued, added language access considerations, and various other changes.

While AB 254 with follow-up legislation and regulations extended oversight to most hospital mergers, there are some gaping holes in the AG oversight of mergers. For example, if a non-profit hospital leases or takes control of a for-profit hospital or a district hospital, the Attorney General does not have oversight. Similarly, if a county privatizes a county hospital by selling it to a non-profit hospital system, the Attorney General cannot step in to assure that services are maintained, even if those are services that low-income communities depend on. California once had forty county hospitals: it now has nineteen. The Attorney General's oversight also does not extend to health systems assuming control of physician groups: this is true whether the health system is non-profit, for-profit, academic medical center or a county health system. Of the ten largest physician groups in California which include almost half of all California physicians, every single one is affiliated with a non-profit hospital system, the University of California and Los Angeles County.[iii]

Thirty Years of Oversight, Thirty Years of Protecting Health Care

Time-Limited Review: Almost 90% Approval, But With Consumer Conditions

Since the enactment of AB 3101 in 1996, the Attorney General has had a time-limited period in which to review non-profit transactions. Originally, this was 60 days with one 45-day extension. The time period was later extended to 90 days, again with a possible 45-day extension.

A recent study of Attorney General oversight of health care mergers of California and four other much smaller states found that for the years 2010-2019, almost 90% of mergers were approved. Only a handful of mergers were denied while a small number of other transactions were withdrawn.[iv] In California, most of those approvals were accompanied by conditions to protect health care and competition.

Public Process, Public Interest

California law requires the Department of Justice to hold at least one public meeting, and more if it is a multi-facility transaction. In addition, the Department takes public comment from a wide variety of interested parties, including consumer and patient advocates, labor unions, local community groups, constituency representatives, and more, as well as the parties to the transaction.

The law requires that the Attorney General consider whether "The proposed agreement or transaction **is in the public interest.**"[v]

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Health Impact Analyses

Health impact analyses of the likely impact of a transaction emerged almost immediately after the Attorney General's authority was clarified in 1996 as important tools to preserve health care access for communities, while also recognizing that not all hospital capacity is essential to a community. Conditions to continue core services need to be considered: in some cases, hospitals even in what appear to be highly urban or dense suburban parts of California were the only hospitals within 15 miles[vi] in either direction. In contrast, particularly in the Los Angeles basin where small non-profit hospitals proliferated in the 1950s and 1960s as Los Angeles grew rapidly after World War II, some hospital capacity was duplicative of what other facilities provided. A review that took into account the impacts of consolidation on cost and quality might have reached a different conclusion but in the early years of the Attorney General's authority, the Department of Justice review focused more on capacity than on competition.

Health impact analyses include the geographic service area, other proximate health care facilities, populations served, services offered by both the hospital in question and the other proximate health care facilities, charity care provided, Medicaid patients, seismic compliance and other factors affecting availability and accessibility of health care services.

Time-Limited Conditions on Transactions to Continue Access: Five to Ten Years

Most mergers that have been approved have included conditions that are imposed for either five or ten years, a time-limited period.

These conditions have often included protecting existing services, including:

- Emergency rooms
- Labor and delivery
- Cardiac care, other specialty units
- Reproductive services
- Services for LGBTQ individuals, including gender affirming care
- Charity care
- Medi-Cal patients
- Language services for the community
- Seismic compliance (because a hospital at risk of collapse may not be available to serve a community after a major earthquake)
- Availability of hospital services provided by other hospitals that are geographically proximate (within 15 miles or 30 minutes)

Ensuring Competition & Preventing Price Hikes

Under then-Attorney General Xavier Becerra, the conclusion of the litigation involving Sutter hospitals with respect to anti-competitive behavior encouraged the California Department of Justice to look at the impact of consolidation on market competition and price hikes. A robust academic literature, much of it specific to California,[vii] found that consolidation was often accompanied by anti-competitive behavior which resulted in price hikes with little or no improvement in patient outcomes and indeed in some instances with increases in mortality. The result has been higher prices, more patient deaths, and other trends that are not good for consumers.

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Beginning in 2019 and 2020, Attorney General Becerra undertook to impose conditions on non-profit hospital transactions to assure that consolidation did not result in the kind of anti-competitive behavior and price hikes which led to the 2019 Sutter settlement. In denying a proposed joint venture between Adventist and St. Joseph's affecting the stretch of California north from Santa Rosa hundreds of miles north to near the Oregon border, the Attorney General found that the proposed transaction "was not in the public interest, has the potential to increase health care costs, and potentially limits access and availability of health care services."[viii] In 2020, the Attorney General imposed conditions limiting price hikes and anti-competitive behavior on a transaction involving Cedars-Sinai on the Westside of Los Angeles and Huntington Hartford serving Pasadena.[ix]

Anti-Trust Authority: Limited, Flawed, and Very Slow

This pro-active oversight over mergers allows the Attorney General to put in place common sense protections before bad behavior ensues, while relying on anti-trust arguments alone takes time, trust, and toil over many years.

In 1999, the Sutter system, which owned Alta Bates hospital in Berkeley, attempted to buy Summit hospital, a few miles away in Oakland. This transaction would create a monopoly for the non-Kaiser, non-Medi-Cal market in the East Bay of Berkeley and Oakland. Consumers who did not wish to join Kaiser or who were not on Medi-Cal would have one hospital system available. Then Attorney General Bill Lockyer sued to prevent the merger. The California Department of Justice lost at the trial court level when the federal magistrate failed to comprehend the rudiments of health care market

dynamics in California and because federal anti-trust law had lain nearly dormant for almost a century.[x]

As asserted by the California Department of Justice in its 1999 litigation, Sutter Health System used its monopoly position in the East Bay and its dominant market role in other markets to leverage anti-competitive provisions in commercial insurance contracts, driving up prices in Northern California far faster than in Southern California. A union trust fund associated with the United Food and Commercial Workers undertook litigation aimed at Sutter's anti-competitive practices. Later the California Department of Justice joined this litigation.[xi]

It took *fourteen years* of litigation before the Sutter case came to a settlement (and several more years before the settlement paid out). These were years in which Sutter allegedly used its market position to extract higher prices, as high as 300% or 400% of Medicare rates, year after year, while other health systems and other health plans such as Kaiser appeared to shadow price off Sutter's prices. Those costs were paid by employers, working families and individual consumers in the form of higher premiums and ever escalating copays and deductibles, worsening affordability for both consumers and purchasers.

Requiring the Attorney General to litigate on a case-by-case basis works well for those who continue to engage in anti-competitive practices to drive up prices while the case is pursued but it works far less well for consumers and other purchasers who pay those prices.

In contrast, during those same decades, nonprofit health facilities seeking to merge, acquire or be acquired were required to give advance notice to the Attorney General and seek Attorney General consent for the transaction. This allowed the Attorney General to assess the impact on the health of the community as well as the impact on competition and health care prices. It also created a venue for local public meetings to assess the impact on the community. This worked to protect communities and consumers.

Gaping Holes in the Public's Oversight of Health Care Mergers

Despite the best efforts of Attorneys General to provide important oversight of many mergers involving non-profit health facilities, including both hospitals and nursing homes, and fighting in federal court for decades against the anti-competitive practices of one major health system, gaping holes remain in the oversight of health care mergers and anti-competitive behavior.

Not All Hospital Mergers Get State Oversight

- If a for-profit hospital or private equity firm buys another for-profit hospital, no oversight exists.
- If a private equity firm takes control of a small, rural hospital run by a hospital district, no oversight exists.
- If the University of California acquires a health facility, no oversight exists—even though Stanford or Loma Linda health systems would face oversight by the Attorney General for doing the same thing.
- If non-profit Sutter or Adventist health systems take control of a district hospital, whether through a lease or other change in control, no oversight exists.
- If a county hospital is privatized and sold to a private health care entity, the only oversight is the local County Board of Supervisors.

Not Just Hospitals: Physician Organizations

Number of Physicians in the 10 Largest Health Systems in California, 2016 and 2018

	2016	2018
Kaiser Permanente	15,586	18,241
University of California Health	5,198	10,145
Dignity Health	1,730	7,821
Sutter Health	3,250	6,215
Stanford Health Care	2,452	3,081
Los Angeles County Health Services Department	1,652	1,983
Cedars-Sinai Health System	968	1,841
Sharp HealthCare	596	1,623
Adventist Health	724	1,420
Total, 10 largest systems	**33,112**	**56,805**
All largest systems percentage of statewide total	**30.7%**	**46.0%**

Note: Approximately 5% of physicians are counted as members of more than one system.
Source: An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California (PDF)

During the decades Attorneys General have overseen non-profit hospital mergers, physicians have consolidated into large physician organizations with no oversight and no protections for consumers.

By 2018, almost half of all physicians in California were in just ten large physician organizations, all of them affiliated with non-profit health systems or public agencies such as the University of California and Los Angeles County Health Services Department.[xii]

In the five years since 2018, consolidation of physician organizations has only continued so it is likely that now more than 50% of California physicians are consolidated into these ten groups. None of these groups are controlled by for-profit entities or private equity firms yet, but that is a trend in other states to watch.

Not all physician organizations are affiliated with health systems: some very large physician organizations such as Optum, Vituity, Team Health and more are independent of health systems. Some of these have for-profit ownership or control or private equity investments: many do not.

Not Just Sutter: Barring Anti-Competitive Behavior Across All Health Systems, Hospitals and Physician Organizations

The California Attorney General won an important battle against anti-competitive practices by winning a settlement in the long-running case involving Sutter Health system. The gaping hole here is that the settlement applies only to Sutter and not to rest of the health care system—and that it took years of litigation to win it. Giving the Attorney General the authority to enforce provisions similar to those included in the settlement without requiring litigation would extend the benefit of the Sutter settlement across the industry to all Californians.

Legislative Efforts: 2017-2022 and 2023

SB 538 (Monning), 2017-2018, failed in Assembly Health Committee. It would have codified across the entire health care industry a version of what came to be the provisions of the Sutter settlement. Because this legislation moved while the Sutter litigation was still pending, doubt was sown about the provisions of the eventual settlement.

SB 977 (Monning) of 2020 was an ambitious effort by the Attorney General's office to control anti-competitive behavior by health care industry players. Because it took an innovative approach to updating anti-trust law, hospitals, doctors and other health care industry players were able to argue about things as simple as definitions of terms. It failed on the Assembly floor.

AB 2080 (Wood) of 2022 had three components:

- First, AB 2080 would have extended the Attorney General's longstanding authority over nonprofit facility mergers to all hospitals, larger physician organizations, and other health care entities.
- Second, it would have imposed the now-final terms of the Sutter settlement across the health care industry by statute, giving the Attorney General authority to enforce those provisions without litigation.
- Third, it would have closed a loophole in AB 595 (Wood), Chapter 292 of 2018, which governs oversight of mergers by the Department of Managed Health Care. The gap in the current law deals with situations in which a health plan, like United, obtains control of other entities, like Optum Health which now has control of numerous physician practices in Southern California.

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AB 2080 was not heard in Senate Health in 2022 so the precise concerns of the then-chair Dr. Richard Pan, M.D., were never aired publicly.

All three pieces of legislation were opposed by the California Hospital Association and individual hospitals which rejected the need for oversight of transaction as well as timely enforcement of anti-competitive provisions. The California Medical Association opposed both SB 977 and AB 2080 for similar reasons since those measures were perceived as impacting physician organizations as well as hospitals. These measures were supported by Health Access, the California Labor Federation and individual unions as well as other purchasers such as Small Business Majority and Purchaser Business Group on Health.

The Role of Health Access

As the statewide health care consumer advocacy coalition, Health Access California, along with board members and partners, has participated in legislative efforts in the early 1990s concerning the conversion of non-profit health plans to for-profit, shareholder owned mega-health plans, particularly the conversion of Blue Cross of California. This resulted in the creation of both The California Endowment and the California Health Care Foundation in order to properly reimburse and recompensate the taxpayers of California for the non-profit tax status Blue Cross had enjoyed for decades leading up to the conversion in the early 1990s. These efforts were the immediate predecessor to legislative oversight that led to the enactment of AB 3101 (Isenberg) of 1996 and SB 413 (Peace) of 1997.

From 1997 to 1999, Health Access stepped forward to sponsor a series of legislation that culminated in the enactment of AB 254 (Cedillo) in 1999 that regulated non-profit to non-profit hospital transactions. Since then, Health Access has supported numerous efforts to improve the existing law, through working on implementing regulations that were substantially revised in 2000-2001, supporting subsequent legislation and intervening in numerous hospital mergers through offering comments from a consumer perspective.

Health Access has also actively participated in the public process to comment on many specific health industry mergers over the last two decades, often joining local community groups to talk about access to key services, community benefits, and costs.

These interventions have encouraged numerous Attorneys General to consider the impacts on consumers more broadly, including in recent years connecting the impacts of consolidation of health care markets on the conditions routinely imposed on hospital mergers.

Conclusion

California's Attorney General has had an important historic role reviewing health industry mergers and transactions. As the industry continues to consolidate and evolve, that extensive experience should apply to all transactions, not just those that involve a nonprofit hospital. California consumers need merger oversight to help ensure access to key services, from emergency rooms to charity care to reproductive and LGBTQ care, and to prevent anti-competitive prices and inflated health prices.

i The California Model | Health Affairs James Schwarz, 1997.
ii The original law governing non-profit to for-profit hospital mergers is in Corporations Code Sections 5914-5920 while the somewhat later law governing non-profit to non-profit hospital mergers is in Corporations Code 5921-5930.
iii California's Physician Practice Landscape: A Rapidly Changing Market with Limited Data (chcf.org). Yegian and Green, March 2022.
iv States' Merger Review Authority Is Associated With States Challenging Hospital Mergers, But Prices Continue To Increase | Health Affairs, Fulton et al, Health Affairs, December, 2021.
v Corporations Code Sections 5917 (i) and 5923 (i).
vi Fifteen miles or 30 minutes travel time to a hospital is the standard for geographic access for almost all commercial coverage in California. California Code of Regulations, Title 28, §1300.51 (d)(H)(i), governing managed care plans which make up 97% of the commercial market in California.
vii Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California (chcf.org). Gudiksen, Gu and King, 2021.
The Sky's the Limit - California Health Care Foundation (chcf.org). Scheffler, Arnold and Fulton, 2019.
viii California Department of Justice Denies Transaction between Adventist Health and St. Joseph Health Systems | State of California - Department of Justice - Office of the Attorney General
ix Attorney General Becerra Conditionally Approves Affiliation Agreement Between Cedars-Sinai and Huntington Memorial Hospital | State of California - Department of Justice - Office of the Attorney General
x Examining the Authority of California's Attorney General in Health Care Mergers (chcf.org). Chang, Greaney and King, 2020.
xi Examining the Authority of California's Attorney General in Health Care Mergers (chcf.org). Chang, Greaney and King, 2020.
xii Yegian and Green, California's Physician Practice Landscape: A Rapidly Changing Market with Limited Data (chcf.org), March 2022.