Post-Mortem Reflection on SB 977: The Significance of What Could’ve and Should’ve Been

In the 2020 legislative session, California attempted to markedly expand the attorney general’s (AG) powers to intervene in healthcare acquisitions and changes of control. Senate Bill (SB) 977 would have required AG approval before for-profit healthcare entities could consolidate in California. The passage of SB 977 would have been historic and a massive step in antitrust enforcement in the healthcare industry. Unfortunately, SB 977 failed this session without ever being discussed in the Assembly or the Senate. In this post, we review what SB 977 could have done, why it was significant, and what happened to prevent the passage of this consequential legislation.

What Did SB 977 Propose to Do?

SB 977 was a legislative attempt to curb the trend of unprecedented consolidation of healthcare entities in California. Had it passed, it would have been the most far-reaching healthcare antitrust law in the United States. The bill proposed to require certain healthcare parties to provide written notice and obtain the written consent of the AG prior to engaging in an acquisition or change of control. The AG would have 60 days to review the transaction and either approve or deny the transaction. The table below lays out the parties and transactions subject to SB 977:

<table>
<thead>
<tr>
<th>Who/What</th>
<th>Definition</th>
</tr>
</thead>
</table>

[1]
<table>
<thead>
<tr>
<th><strong>Buyers</strong></th>
<th><strong>Health care systems</strong></th>
<th>An entity or system of entities that includes or owns three or more hospitals in California, of which at least one is a general acute hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Private equity groups</strong></td>
<td>An investor or group of investors who engage in the raising or returning or capital and who invest, develop, or dispose of specified assets.</td>
</tr>
<tr>
<td></td>
<td><strong>Hedge funds</strong></td>
<td>A pool of funds by investors, including a pool of funds managed or controlled by private limited partnerships, if those investors or the management of that pool or private limited partnership employ investment strategies of any kind to earn a return on that pool of funds.</td>
</tr>
<tr>
<td><strong>Sellers</strong></td>
<td><strong>Health care facilities</strong></td>
<td>A facility, nonprofit or for-profit corporation, institution, clinic, place, or building where health-related physician, surgery, or laboratory services are provided</td>
</tr>
<tr>
<td></td>
<td><strong>Health care providers</strong></td>
<td>An individual or group of individuals that provides health-related physician, surgery, or laboratory services to consumers</td>
</tr>
<tr>
<td>Transactions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Change of control</td>
<td>An arrangement in which a health care system establishes a change in governance or 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 in substantial part</td>
<td></td>
</tr>
<tr>
<td>Acquisition between the entity and a health care facility or provider</td>
<td>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 a material amount of the assets or operations of a health care facility or provider</td>
<td></td>
</tr>
</tbody>
</table>

Notably, the final bill was amended from the original version which would have included a broader scope of parties and transactions. In the original bill, the definition of “provider” included any licensed health care professional, such as nurses, pharmacists, chiropractors, etc. The amended version limited “provider” to “health-related physician, surgery, or laboratory services” only.[2] The original version of the bill also required “affiliations” as a transaction that would require AG approval. “Affiliation” under the original bill meant an “agreement, association, partnership, joint venture, or other arrangement that results in a change of governance or control.”[3] The amended version, on the other hand, included only a “change of control”, which is a much narrower type of transaction.

Specifically, the bill authorizes the AG to deny consent to a change of control or an acquisition affecting relevant parties, unless the parties demonstrate that:

- The transaction will result in a substantial likelihood of clinical integration[4];
- The transaction will result in a substantial likelihood of increasing or
maintaining the availability and access of services to an underserved population; or

- The transaction will result in a substantial likelihood of both of the above.[5]

The bill also authorizes the AG to deny consent to a change of control or an acquisition between parties if there was a “substantial likelihood of anticompetitive effects that outweighed the benefits of a substantial likelihood of clinical integration, a substantial likelihood of an increase in, or maintenance of, services to an underserved population, or both.”[6] A substantial likelihood of anticompetitive effects in providing hospital or health care services includes a “substantial likelihood of raising market prices, diminishing quality, reducing choice, or diminishing availability of, or diminishing access to, hospital or health care services.”[7]

When making the determination whether to grant or deny consent, SB 977 requires the AG to use the “public interest standard.” The bill defines public interest as being in the interest of the public in “protecting competitive and accessible health care markets for prices, quality, choice, accessibility and availability.”[8]

Finally, the bill requires the AG to establish a Health Policy Advisory Board (the “Board”) to evaluate and analyze health care markets in California and provide recommendations to the AG’s office. The Board would be authorized to review the written notifications submitted by the parties to the transaction, in order to provide the AG with information on whether to consent to the change of control or acquisition.

**Why Was SB 977 So Important?**

Studies show that when hospitals and physician groups consolidate, consumers experience price increases of 20-44% in both inpatient and outpatient services[9] due to higher market concentration and increased market power.[10] Not only does consolidation increase costs, additional research indicates that horizontal mergers are associated with reductions of quality,[11] while vertical consolidation often failed to show the promised quality improvements or efficiencies.[12] Despite the evidence, healthcare consolidation has continued at an alarming rate. In 2018, a
study completed by the UC Berkeley’s Petris Center showed nearly 95% of hospital markets were highly concentrated.[13]

However, few state AG’s receive prior notice of mergers and many healthcare mergers fall under the Hart-Scott-Rodino Act, which leaves antitrust enforcement to the federal government.[14] Prior to the introduction of SB 977, California legislation allows the state AG to intervene in the consolidation of nonprofit health care organizations. Notably, transactions involving only for-profit organizations are omitted and do not require notice or AG approval. For such transactions, the AG has the power to challenge any merger through litigation. While this can be done through federal antitrust law, including the Sherman and Clayton Antitrust Acts, or California’s Cartwright Act, relying solely on antitrust litigation to prevent further consolidation and anticompetitive behavior is ineffective. While they have the potential to be highly successful, enforcement cases like the Sutter Health case require an immense amount of time and resources.[15] As such, legislation provides a quicker and more efficient remedy of blocking anticompetitive behavior before its effects harm consumers.

As existing California merger review authority is limited to transactions involving nonprofit organizations, SB 977 was an important piece of legislation because it attempted to give the state AG enhanced power to review and receive notice of acquisitions and changes of control of essentially all major healthcare entities, including for-profit health care systems, private equity groups, and hedge funds. SB 977 is consequential as it fills in an important gap in existing legislation by requiring AG notice and prior approval in acquisitions of physician practices and clinics by health systems, hedge funds and private equity, which is a big change from current practice.

Additionally, SB 977 also proposed to create new antitrust liability for health care systems with substantial market power when its conduct involved tying or exclusive dealing, or a substantial tendency to cause anticompetitive effects.[16] The legislation would give the AG additional powers to both police and fine systems for such anticompetitive conduct. Finally, the legislation also proposed to establish the Health Policy Advisory Board, a new agency that would review mergers when requested by the AG and provide assistance to the AG with information on whether
to grant or deny consent to the transaction.

Professor Tim Greaney, a Health Law professor at UC Hastings College of the Law, explained that SB 977 was a “major change and major transfer of power to the AG in California. It was a landmark legislation because it gave the AG the power of prior approval of both for profit and nonprofit mergers. It also enhanced the power of the attorney general by giving the office broad discretion by expanding the substantive review beyond antitrust principles to include broader public interest considerations. The justification for this bold move is that antitrust is more or less a paper tiger when it comes to concentrated health systems. Once they acquire market power, unless they engage in improper conduct to maintain that power, nothing in antitrust law stops them from charging high prices. In short, you can’t trust antitrust [litigation] alone to prevent this abuse of power, which is a sound reason for this legislation.”

**How Did it Fail and What’s Next?**

Unfortunately, SB 977 failed to pass at the end of the 2020 legislative session. The bill passed the Assembly Appropriations Committee, was read a second time in the Senate, and then ordered to a third reading, which is required to qualify the bill for the floor vote. While SB 977 was read for the third time, it never reached a floor vote and was left to die as the midnight deadline was reached.

There are likely a number of reasons that SB 977 failed to become law. The legislation unquestionably gives the Attorney General a substantial amount of power over healthcare transactions, which gave healthcare entities cause for concern. As such, the bill was strongly opposed by a large number of hospitals, physician groups, and organizations, including the California Hospital Association (CHA), the California Medical Association (CMA), and the American Investment Council, private equity’s largest trade and lobbying group. Carmela Coyle, CHA’s Chief Executive, said it was a dangerous measure that gave too much power to the Attorney General, and CMA stressed that it was overbroad and could force smaller practices out of business.[17] The opposition of such large and powerful organizations and lobbyists undoubtedly played a role in the bill’s failure.
Opponents of SB 977 also argued that the bill could make it harder for smaller healthcare facilities and provider groups to merge with larger healthcare systems as a last resort if they were going out of business. However, under the antitrust law “failing company doctrine”, mergers that may otherwise not be permissible are allowed to go forward where the firms face imminent bankruptcy and there are no less anticompetitive alternative buyers. While it’s relatively difficult for companies to successfully invoke this defense, it’s hard to see how the regulatory structure of SB 977 creates higher barriers for failing firms. If anything, the broad discretion given to the AG to take into account market conditions would seem to leave ample opportunity to consider the effects of allowing distressed hospitals to merge.

There is a possibility that it will be reintroduced when the California Legislature reconvenes on December 7, for the commencement of the 2021-2022 legislative term. Only time will tell if SB 977 re-emerges in the upcoming legislative term. The opposition to broadening consolidation review authority is strong, so legislators interested in enhancing the A.G.’s antitrust review will need to leverage the compelling economic evidence of the effect of healthcare consolidation against the loud and influential voices of lobbyists. If reintroduced, the bill will need to be sponsored by a legislator other than the original sponsor Senator Monning, who is leaving the Senate this year after reaching his term limit.

Nonetheless, SB 977 was an unparalleled and commendable attempt at strengthening merger review authority and could foreshadow the future of antitrust legislation governing healthcare entities. It took thirteen years of multiple bills for California to finally pass an all-payers claim database mandate, so while the road ahead may be long, stricter antitrust law in California shouldn’t be written off as a lost cause.

[2] Id.
Clinical integration, according to SB 977, means a “showing by the health care system, private equity group, or hedge fund making a change of control with or acquiring the health care 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 as a result of the acquisition or change of control.”

S.B. 977, supra note 1.


The Hart-Scott-Rodino Act requires parties to certain large mergers and acquisitions to provide the Federal Trade Commission and the Department of Justice
with premerger notice.

[15] Sutter Health was accused of violating California antitrust law by using its market power to increase costs. Sutter Health was sued by self-funded employers and the case was later joined by the state AG, Xavier Becerra. It ultimately settled moments before opening statements were set to begin. More about the Sutter Health case can be found [here](#).


---

**Spotlight on State: Wisconsin**

This is part of a [series of summaries](#) that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See [Wisconsin state page](#).

Wisconsin operates one of the largest private APCDs in the country, even though it is not mandated by statute. The Wisconsin Health Information Organization (WHIO), a private organization, gathers and makes healthcare claims data publicly accessible. With insurance claims data from sixteen commercial health plans and the state Medicaid program, the database provides consumers information about cost, population health, prescribing patterns, and more.

Wisconsin confers merger review authority of healthcare consolidation to the attorney general for all nonprofit hospitals. Not only does it mandate notice to the
AG, it requires approval from both the AG and relevant state agencies.

In healthcare market regulation, Wisconsin received a $2.4 million grant from CMS in 2014 to develop a state innovation plan to reduce Medicare and Medicaid costs. Wisconsin was one of the first five states to receive an approved 1332 waiver from the federal government. Recent state law mandates the Wisconsin Health Care Stability Plan (WIHSP), a publicly-funded reinsurance program, to expand access to care, reduce premium increases, keep more individuals insured, and entice insurers to offer insurance plans in the state. The program will pay insurers up to eighty percent of claims greater than $50,000 but less than $250,000. Wisconsin’s 1332 State Innovation Waiver to implement WIHSP was approved by HHS through 2023.

See below for an overview of existing Wisconsin state mandates. Click on citation tab for detailed information of specific statutes (click link to download statute text).

---

**Spotlight on State: Massachusetts**

*This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.*

See [Massachusetts state page](#).

Massachusetts remains a leader on the healthcare cost containment, price transparency, and market regulation fronts. Massachusetts’ Health Policy Commission (HPC), a unique and independent state agency, monitors healthcare spending growth in the state. Based upon the data it collects, the Commission recommends delivery and payment reform policies with the goal of improving healthcare and lowering costs.
The state is a staunch supporter of price transparency. The Massachusetts Center for Health Information and Analysis (CHIA) operates an active, comprehensive all-payer claims database with claims from public and private insurance payers in the state. Statute requires CHIA to maintain and annually update the online database that compares the quality and costs of several healthcare services, provides standardized quality measures, lists services available for persons with disabilities, and more. The state also requires health insurance carriers to notify consumers of any additional charges for out-of-network providers with a summary and description of the services provided. Finally, the state prohibits gag clauses that would limit the ability of health insurance carriers or providers from disclosing out-of-pocket costs to an insured.

Additionally, state law requires coverage parity for telemedicine when given by an in-network provider who would be covered for in-person services. The law further requires a form of cost-sharing parity by prohibiting the costs that patients pay for telemedicine services from exceeding those applicable to in-person consultations.

Massachusetts has robust antitrust laws that protect consumers from anticompetitive practices in health care. Statutes prohibit health insurance carriers from using most-favored nation, guaranteed participation, non-compete, all-or-nothing, and anti-tiering provisions in contracts with health care providers. In merger review, the state requires notice prior to any merger or acquisition of hospitals or physician groups. Major antitrust cases in recent years demonstrate that the state practices strong antitrust enforcement, including the merger of Beth Israel Deaconess Medical Center-Lahey Health and multiple consolidation efforts involving Partners Healthcare.

Massachusetts operates a state-based health insurance exchange under the Affordable Care Act named Health Connector. The state unsuccessfully applied for a federal 1332 innovation waiver in 2017, which the Centers for Medicare and Medicaid Services deemed incomplete. Various pieces of legislation introduced in recent years have also called for a public option health insurance plan or a single payer system, but neither of these proposals have passed yet.

See below for an overview of existing Massachusetts state mandates. Click on
Just Published: Research Report on Preventing Anticompetitive Contracting Practices in Healthcare Markets

As unrelenting consolidation in healthcare provider and insurer markets continues, policymakers need additional options to protect the public from escalating healthcare prices and low-quality care. High healthcare prices result from multiple factors, including third-party payers dampening consumers’ price sensitivity, patients and providers demanding expensive healthcare technologies, and healthcare markets consolidating. While these factors are visible, dominant insurers and healthcare providers can also use terms in their insurer-provider contracts in anticompetitive ways that thwart competition and lead to higher prices or lower quality but remain hidden from public view.

With support from Arnold Ventures and in collaboration with the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare in the School of Public Health, UC Berkeley, The Source conducted a 50-state survey that examines the potential for policymakers, antitrust enforcers, and state officials to increase scrutiny over five contracting practices – most-favored-nations clauses, all-or-nothing provisions, exclusive dealing arrangements, anti-tiering/anti-steering clauses, and gag clauses– that have the potential to create anticompetitive harms. In the newly released research report “Preventing Anticompetitive Contracting Practices in Healthcare Markets”, we identify and recommend a range of legislative
and regulatory options for states seeking to mitigate potential harms arising from the anticompetitive use of these terms.

This research report is the latest installment in a collaborative research series that leverages the latest and most comprehensive data on state laws, healthcare markets, and healthcare prices in provider and insurer markets in the United States in the last ten years and presents evidence-based information and analyses on the most effective strategies for states to address rapidly consolidating healthcare markets. In the first published report in the series, “Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States”, we identify best practices that state policymakers should consider to enhance oversight of anticompetitive healthcare mergers.

Additional research findings and analyses are published on the “Provider Contracts” and “Market Consolidation” key issue pages.

Download the new report here.

---

**Spotlight on State: Nevada**

*This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.*

**See Nevada state page.**

The Nevada legislature convenes in odd-numbered years. For several years, Nevada law has required all healthcare plans to cover telehealth services for an insured to the same extent they would cover services provided by other means. This includes plans from managed care organizations (MCOs), health maintenance organization (HMOs), benefit contracts, and group or blanket health insurance plans.
The state has proposed several legislation to promote price transparency in recent years, including proposals to create a state-funded all-payer claims database (APCD) and surprise billing protections to require all health carrier network plans to reimburse for unexpected charges from an out-of-network provider. However, none have passed in recent years.

The state’s proposal to study the cost and viability of a public option health insurance plan was also unsuccessful. Most notably, the Nevada Care Plan would have allowed anyone without health insurance to buy into the state’s Medicaid program. Since Medicaid has low reimbursement rates for doctors and other providers, the proposal may have provided an economical alternative to private insurance, but with fewer provider options. The legislature approved the Medicaid buy-in bill, but Republican Governor Brian Sandoval vetoed it.

Nevada was also the first state to target medicine prices for a specific ailment when it passed a law that requires more transparency from drug makers regarding their prices for diabetes medicines. The pharmaceutical industry filed and later dropped a lawsuit that claimed the insulin-pricing transparency law was unconstitutional because it interfered with the abilities of drug makers to protect trade secrets.

See below for an overview of existing Nevada state mandates. Click on citation tab for detailed information of specific statutes (click link to download statute text).

---

**Spotlight on State: Wyoming**

This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See Wyoming state page.
Wyoming was one of the first states to permit out-of-state regulated insurers to sell insurance products domestically to increase competition and decrease the cost to enter the market. Wyoming also requires studies of high hospital costs in the state, loss of medical services, and the use of out-of-state providers. While this statutory-mandated study is not yet complete, Wyoming Hospital Association attempts to compensate by offering an online price disclosure database for its hospitals. A coalition of Wyoming employers is also interested in obtaining charge data across all insured in order to better negotiate rates directly with providers. Additionally, the state adopted a resolution in support of promoting health care billing transparency, health savings accounts, and more.

In market consolidation oversight, Wyoming requires notification of nonprofit hospital mergers to the Attorney General. Additionally, the state requires approval of general nonprofit corporation mergers, as well as court approval of nonprofit hospitals mergers.

To address the rise in prescription drug prices, Wyoming recently enacted law that prevents pharmacy benefit managers (PBMs) from prohibiting or penalizing the disclosure of prescription cost information or affordable alternatives. The state also permits a pharmacist to substitute biosimilar products or generic pharmaceutical equivalents unless a prescriber clearly prohibits substitution.

See below for an overview of existing Wyoming state mandates. Click on citation tab for detailed information of specific statutes (click link to download statute text).

---

**Spotlight on State: New Series**

**Feature Summaries of Healthcare**
Price & Competition Policies by State

The Source is launching a new series of “Spotlight on State” summaries to highlight notable legislation and initiatives in health policy and reform of all 50 states. Utilizing the SLIHCQ Database launched in partnership with Catalyst for Payment Reform, our goal is to update the overview summaries of each of the individual state pages on The Source, along with an exciting new feature of an overview infographic chart that provides an at-a-glance summary of existing and proposed legislation in each of the key issue topics for each state.

The key topics covered include the following:

- Price transparency: all-payer claims database, surprise billing, gag clauses, right to shop/shared savings
- Provider merger review authority: AG notice, certificate of need, and approval requirements
- Anticompetitive contract prohibitions: most-favored nation, non-compete, all-or-nothing, anti-tiering/anti-steering
- Telehealth: coverage, reimbursement, cost-sharing
- Health system reform: single payer, public option, state-based exchange, Section 1332 reinsurance

As we update each state, it will be posted on the Source Blog, as well as the individual state page. Stay tuned as we roll out additional states each week!

The Source Roundup: September
This month in health policy research, surprise billing and changes in market structures fuel concerns about competition and consumer choice. In addition, some studies on pharmaceutical costs produced hopeful reports.

**Healthcare Market Competition and Consolidation**

*Consolidation Trends*

In a *Health Affairs* study, *Consolidation of Providers into Health Systems Increased Substantially, 2016-18*, Michael Furukawa et al. analyzed provider consolidation trends. The rate of physician affiliation with a health system increased by 11 to 51 percent in 2018. Based on the 556 health systems the authors identified, the median number of physicians per system grew by 29 percent. Mergers and acquisitions, creations of new systems, and expansions of previously existing facilities accounted for a net increase of eleven health systems. The study showed that, in only two years, there was substantial horizontal consolidation among health systems as well as vertical consolidation of physicians and hospitals into health systems. The researchers warn that this could complicate regulation efforts and they suggest further research on market concentration’s driving factors.

*Financial Integration and Impact on Quality*

Also published by *Health Affairs*, *Financial Integration’s Impact on Care Delivery and Payment Reforms: A Survey of Hospitals and Physician Practices* considered whether the potential benefits of healthcare integration outweigh their anticompetitive risks. In a nationally representative survey of 739 sample hospitals and 2,189 physician practices, Elliott S. Fisher et al. found integration between hospitals and physicians generally did not correspond to better quality. The researchers compared complex, simple, and independent hospital systems based on nine quality indicators and then compared physician practices across different integration systems using nine similar measurements. Though integrated systems supported positive scores for four of nine hospital measures and one of nine practice...
measures, complex integration systems did not indicate higher quality scores. Researchers observed few systems had installed recommended payment reforms and questioned whether systems lack adequate incentive to move to value-based payment from fee-for-service.

*Horizontal Consolidation and Impact on Wages*

Following research from *RAND Corporation*, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages* reached unique conclusions about hospital mergers’ effects on wages for American workers. The authors, Daniel Arnold and Christopher Whaley, determined in-market hospital mergers increased hospital prices by $521 and reduced wages by $638. This means that when provider concentration within a state increases healthcare costs, workers suffer the brunt of the effects through lower wages and benefits, because employers must pay more for the plans they provide to employees. Cross-market hospital mergers, however, did not raise prices or impact wages when the mergers crossed state lines.

*Vertical Consolidation Concerns Amid COVID-19*

Also this month, the *National Academy for State Health Policy* published *State Policies to Address Vertical Consolidation in Health Care* by Erin Fuse Brown about the COVID-19 pandemic's effect on vertical healthcare consolidation and its risks to consumers. Although the federal government contributed $175 billion under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the funds primarily benefited large hospital systems while independent providers and physician practices lost significant revenue. This could breed massive, exclusive networks that increase healthcare costs and decrease consumer choice without improving quality. Since COVID-19 compels vertical consolidation that is more likely to evade federal scrutiny, states should pursue policies that minimize associated risks. For example, states may gather comprehensive data, review and approve proposed transactions, oversee consolidated entities for anticompetitive conduct, and control outpatient costs.

**Surprise Billing**
Last month, the U.S. Department of Health and Human Services (HHS) published the Secretary of Health and Human Services’ Report on: Addressing Surprise Medical Billing and acknowledged the significant costs and injustices associated with surprise billing. In particular, the report found that ancillary providers, such as anesthesiologists and assistant surgeons, account for most surprise bills. In addition, when private staffing firms enter a market to staff emergency rooms or provide specialists, out-of-network billing increases by up to 66 percent, which contributes to increased surprise billing. The report recommends Congress enact permanent federal surprise billing legislation to protect patients’ abilities to make informed decisions, access transparent pricing, and avoid provider price-gouging.

Additionally, the University of Chicago Press published Surprise! Out-of-Network Billing for Emergency Care in the United States, in which Zach Cooper, et al. discuss out-of-network emergency care providers’ expensive surprise bills. Emergency care physicians use unchecked bargaining power with insurers to raise rates without issue because patients do not choose their emergency care provider. The article explains how New York implemented binding arbitration between insurers and providers and successfully lessened out-of-network billing by 12.8 percent.

**Pharmaceuticals**

In Medicare Part D Plans Rarely Cover Brand-Name Drugs When Generics Are Available, published by Health Affairs, a team of Vanderbilt and Kaiser Family Foundation researchers studied over 4.1 million Medicare plan-product combinations to assess pharmaceutical cost implications for Medicare and its beneficiaries. Stacie Dusetzina et al. found that Part D plans covered generic-only versions of drugs in 84 percent of cases, so brand-name drugs did not receive preference. In 15 percent of cases, Part D covered both generic and brand-name versions. In these cases, placing both versions of the drugs on the same coverage tier could create higher costs to beneficiaries. The researchers conclude that while states could prevent this by regulation, this may not be worthwhile because it would not likely generate huge savings. Instead, they recommend policymakers monitor coverage to ensure Part D consistently covers generics.
The New England Journal of Medicine published the study Patient and Plan Spending after State Specialty-Drug Out-of-Pocket Spending Caps to analyze the cost effects of three states that passed legislative caps at $150 per prescription on out-of-pocket spending for specialty drugs. Kai Yeung, et al. found that for users in the 95th percentile of specialty drug spending, the caps corresponded to an adjusted $351, or 32 percent, decrease in out-of-pocket costs per month per specialty-drug user. The study sampled 27,161 persons under age 65 in commercial health plans from three large nationwide insurers for three years before and three years after the legislation was passed. Notably, while the caps successfully generated savings for persons with serious conditions who spend the most on specialty drugs, the study did not detect increases in overall health plan spending.

If you find additional articles that you would like us to include in the monthly roundup, please send them our way! The Source team hopes you stay safe and healthy in the upcoming month.

Q&A: The What, When, Who and How of California’s New APCD: The Health Care Payments Data System

Last month, we discussed California healthcare proposals that were postponed or cut due to budget constraints brought on by the pandemic-induced recession. California’s proposed all-payers claims database (APCD) project, the Health Care Payments Data (HPD) Program, was one proposal that survived. The passage of the HPD Program demonstrates the Legislature’s understanding that health care price
transparency is important enough to withstand an extreme budget crunch. In this post, we take a look at the specifics of California’s new APCD and answer some important questions about its implementation and what it covers.

What are APCDs and why are they important?

An all-payer claims database is a large state-based database that collects medical claims, dental claims, pharmaceutical claims, and more from both public and private insurers. APCDs are important because they offer price and quality transparency within the extremely convoluted American health care system. 21 other states have implemented or are currently implementing APCD systems.[1] (see The Source APCD map and overview).

How did we get here and what is the current status of California’s APCD?

California’s path to implementation of an APCD has not been an easy one (see The Source Blog for the long history leading to its APCD). The first attempt to implement an APCD was in 2007, with the introduction of AB 1 by Assembly Member Fabian Nuñez. None of the numerous APCD bills that followed AB 1 survived, until the passage of AB 1810 in 2018, which mandates the Office of Statewide Health Planning and Development (OSHPD) to create and establish the Health Care Cost Transparency Database by July 2023.

AB 80, the health omnibus trailer bill for the 2020-2021 budget, enacted this June, takes the mandate forward to provide the specifications for its implementation. Specifically, AB 80 removed the provisions related to the Health Care Cost Transparency Database as termed in AB 1810 and ordered OSHPD to implement and administer the Health Care Payments Data (HPD) Program. The resulting system will be known as the Health Care Payments Data System (HPD System).[2]

What are the objectives of the HPD System?
California’s Health Care Payments Data Program is a public reporting initiative with a focus on informing policy decisions in support of quality, equity and affordability. The intent of the legislature in AB 1810 was to establish a system to collect information regarding the cost of health care and a process for aggregating such information from many disparate systems, improve data transparency to achieve a sustainable health care system with more equitable access to affordable and high-quality health care for all, and to encourage the use of such data to deliver health care that is cost effective and responsive to the needs of the enrollees.[3]

In short, the three main goals of the HPD System are to:

- Provide visibility on how California spends $300 billion on health care annually;
- Identify and act on opportunities to improve California’s health care system; and
- Support health care research that directly benefits Californians.4

What data will the HPD System collect and from where?

The HPD System will collect the following types of data:

- Claims and encounters for medical care, prescription drugs, and dental care, including information on the services provided, utilization data and the amount paid for the services;
- Enrollment data for all covered individuals, including the type of coverage and the member demographics, type of payer (e.g., Medicare, Medi-Cal, private payer), and type of plan (e.g., PPO, HMO);
- Provider data, including provider identifiers, specialty, and network affiliations; capitation, alternative payment models, and other non-claims payment data.5

The HPD System will likely primarily collect from three sources:

- Department of Health Care Services (DHCS) – including Medi-Cal managed care plans and fee-for-service claims (13 million covered lives);
Centers for Medicare & Medicaid Services (CMS) – Medicare claims (6 million covered lives);
Commercial plans and insurers – including both medical and dental claims (15 million covered lives).6

In all, the HPD System is expected to obtain data from about 34 million covered Californians out of approximately 39.5 million people living in California, which covers a large percentage of the total population. The 5.5 million people who aren’t covered include people without health insurance and those who are covered by a voluntary submitter.7

**Who is required to submit data and who is exempt?**

The HPD System will collect from both mandatory and voluntary submitters of data. Mandatory submitters include fully insured commercial health plans and insurers, DHCS for Medi-Cal managed care plans and fee for service data, self-insured entities as permitted under federal law, third party administrators of plans, and dental plans and insurers.8

Voluntary submitters include federal health benefit programs such as TRICARE, and private, self-insured employers. Private self-insured employers cannot be compelled to submit data due to Employee Retirement Income Security Act (ERISA) prohibitions and the U.S. Supreme Court decision in *Gobeille v. Liberty Mutual* but will be encouraged to participate in the program.9 CMS cannot be compelled to submit data, but Medicare fee-for-service data will be requested and data will be acquired from existing CMS systems.10

Finally, supplemental insurance plans, stop-loss plans, student health insurance, and chiropractic, discount and vision-only plans are excluded from mandatory submission. Plans that cover less than 50,000 individuals are also exempted from reporting data.

**How will the HPD System be implemented?**
The HPD System will use a tiered approach to providing data:

- Tier One will be implemented first and include “core” data that is readily available in health plans’ and insurers’ data warehouses, including data on claims and encounters, member enrollment, and provider information;
- Tier Two will be an “expansion” on core data and will include data on capitation arrangements, including alternative payments models, pharmacy rebates and pay for performance;
- Ultimately, the HPD System will reach Tier Three which is “maturity” and will include data on lab values and other clinical information through electronic medical records.11

How much will the HPD System cost?

The Legislature appropriated $60 million from the state’s General Fund as a one-time cost to plan, develop, and build the system through 2025. After 2025, the Legislature requires the development of a sustainability plan, so no additional General Fund financing will be provided. The HPD System will cost approximately $15 million a year to operate, which amounts to about 0.45 cents per covered individual. Funds are expected to come primarily from special funds created for the program, CMS Medicaid matching funds, and data user fees.

While the complete implementation of the HPD System by 2023 may seem far away, AB 80 and OSHPD have provided a comprehensive guideline and structure for California’s mandatory APCD to get the ball rolling. The HPD System will provide important insight on about 86% of Californian’s health care costs. With $300 billion spent annually on health care in California, undoubtedly an APCD is a necessary step in providing transparency of exorbitant health care costs.

Next month, we’ll focus on more measures included in AB 80, the omnibus budget trailer bill, including Medi-Cal best price and the supplemental payment pool for non-hospital 340B clinics.
This count only includes APCDs that are mandatory and currently active or in implementation. Some states currently have an existing voluntary APCD system, meaning no mandatory submission of data by any insurer is required. West Virginia and Tennessee have passed statutes to create a mandatory APCD, but there is a currently a hold on the implementation.

Trailer bills are legislation that accompany the annual state budget. These bills implement specific changes to state law that are required to fulfill the budget’s policies.


Off. of Statewide Health Plan. and Dev., Health Care Payments Data Program Report to the Legislature, at i, (2020).

Id. at 25.

Id. at 49.

While the ACA and Covered California have expanded health care coverage, about 7% of Californians, or 2.7 million, still remain uninsured.

Off. of Statewide Health Plan. and Dev., supra note 4, at 50.

ERISA was enacted in 1974 to regulate employee pension funds, but it also affects employee-sponsored health insurance plans. ERISA is a barrier to state regulation of these employee-sponsored health insurance plans because the act includes a preemption clause that preempts state law when the law interferes with nationally uniform plan administration.

CMS operates its own database where information can be pulled to include in individual state databases. The CMS database can be found here.

Off. of Statewide Health Plan. and Dev., supra note 4, at 21.
After much delay due to the pandemic induced hiatus, the preliminary approval hearing for the proposed settlement agreement in the Sutter Health antitrust case resumed on August 12 at the Superior Court of San Francisco. At the hearing, plaintiff attorneys on behalf of both class members UEBT and the Attorney General addressed in turn questions with respect to specific proposed terms raised in a tentative ruling by Judge Anne-Christine Massullo.[1] One key issue the court rested on was the selection of the independent compliance monitor, who will be responsible for evaluating and enforcing the compliance of the settlement terms for up to thirteen years.[2] At the last preliminary approval hearing in February, the parties requested to appoint Jesse Caplan of Affiliated Monitors in Boston, Massachusetts as the compliance monitor. However, while the court did not question the qualification of the choice, the court expressed significant reservations and lack of confidence in the selection process.

Judge Massullo appeared troubled by the fact that a nationwide search and outreach resulted in a choice who is neither a woman nor a person of color, but an individual from a firm with a lack of diversity in its management structure and not even based in California. The court repeatedly emphasized that the application and selection process for this role must be based on considerations of diversity, equity and inclusion. Yet, through the lens of the court and given the backdrop of the case (the parties’ previous choice of experts also showed lack of diversity), there was insufficient evidence presented to the court that this was adequately considered.
Judge Massullo noted that class members are sophisticated companies that value diversity and inclusion. For a role that is a multi-million dollar appointment to act as an officer of the court for the next decade or more, the selection process must be transparent and preserve public integrity and confidence.

Emilio Varanini from the AG’s office assured the court that the application and interview process, a long collaborative process involving both the AG’s office (headed by Deputy AG Cheryl Johnson) and Sutter’s counsel that began in October 2019, considered all necessary factors to promote diversity, equity, and inclusion. However, the qualified candidate must be an expert with appropriate experience in antitrust and healthcare and must be free of conflict of interest, which significantly narrowed down the broad pool of applicants to only five candidates. Additionally, the parties provided that Dionne Lomax, a managing director of Affiliated Monitors who is a woman of color, will work closely with Jesse Caplan on the case, and offers a great total package. In response to the court’s request to provide insight and transparency to the selection process, Varanini stated that the selection process of experts has always been confidential and for good reasons, citing adverse impact on the business of denied applicants, among others. At the same time, the fiduciary duty to the people and the integrity of both the AG’s office and Sutter as a large healthcare system ensures that the selection process is fair and reasonable.

Nonetheless, Judge Massullo indicated that because the appointment of the monitor is a material term of the contract, the court will not grant preliminary approval of the settlement agreement until it is satisfied that there is sufficient public record to show a fair and reasonable selection process. To that end, the supplemental filing should provide generic, non-confidential information that would provide additional insight to the outreach process, including the race and gender identity of all applicants and the total pool of applicants. Additionally, the court requested a supplemental declaration from deputy AG Cheryl Johnson regarding Dionne Lomax’s involvement with the monitor, as well as a report on the outreach process for hiring additional experts to assist the monitor.

The parties agreed to provide Sutter with a draft of the filing by August 17, and submit to court by August 24, jointly or otherwise. The court tentatively set a continued approval hearing for September 4 at 9:15AM. It may be taken off calendar
if the court has no additional questions based on the submissions, including other outstanding issues such as notice to class members and allocation of settlement funds, in which case the settlement approval could finally move forward to bring closure to this long dragged out case.
