# California Lawmakers Seek to Increase Oversight of Healthcare Transactions Involving Private Equity and Hedge Funds with AB-3129

The California Legislature wrapped up its annual introduction period for new bills on February 16. Among the wide swath of proposed health care bills, one, in particular, has caught the attention of many legal experts and players in the health care field. AB-3129 was introduced by Assemblymember Jim Wood and Attorney General (AG) Rob Bonta on the last day of the introduction period.  It proposes sweeping regulations around how private equity firms and hedge funds can participate in owning and managing healthcare facilities. The introduction of the bill comes amidst nationwide concern regarding the effects of private equity acquisitions in the health care market.

In this month's California Legislative Beat, we take a deeper dive into better understanding what this bill says, the impacts this bill could have on the health care market and competition, and the general reactions to the bill so far.

## Background on the Issue

The influence and impact of private equity and hedge fund ownership of the healthcare market has increasingly become a topic of interest for both state and federal law makers, as the practice has grown expansively in the past decade. According to Pitchbook, in 2023 alone, 780 private equity deals were announced or closed in the health care space. While this volume was a decline from the 2022 deal year, it was still the third-highest year on record.

While some see the growing influence of private equity and hedge fund ownership as a positive way to inject funds into struggling health care practices, others have scrutinized these transactions for a variety of reasons including the creation of market monopolies.

Nationwide, we have been seeing a trend towards increasing regulation and oversight over healthcare transactions, with 24 states enacting laws related to health system consolidation and competition in 2023. Both states and federal agencies have been delving into the impacts of private equity and hedge fund ownership of the healthcare system. In the past quarter alone, Oregon introduced legislation to tighten restrictions on the corporate practice of medicine, the U.S. Senate Budget Committee launched a bipartisan investigation into the impacts of private equity ownership of hospitals, and the Federal Trade Commission (FTC) held a virtual workshop to examine the role of private equity in healthcare. New merger guidelines issued in 2023 by the Federal Trade Commission and Department of Justice are another indication that the Federal government is more closely examining proposed health system mergers. The finalized guidelines provide an overview of the factors and frameworks agencies use when reviewing mergers and acquisitions across varying sectors.

The FTC has also taken more targeted action against private equity firms in recent months. In September 2023, the agency launched a lawsuit against U.S. Anesthesia Partners Inc. (USAP) and private equity firm, Welsh, Carson, Anderson & Stowe in Texas for allegedly executing a multi-year anticompetitive scheme to consolidate anesthesiology practices in the state. The roll-up of these practices allegedly created a monopoly over anesthesia services in Texas and drove up prices for patients.

California has also faced problems originated by private equity-owned health care companies. Prospect Medical Holding, a private equity-backed hospital chain, recently faced

Congressional scrutiny and national media attention for allegedly profiteering. Meanwhile, Pipeline Health, another private equity-backed hospital chain, went bankrupt and closed a hospital in Chicago but still owns and runs hospitals in Southern California.

## What the Bill Says

If passed, AB-3129 will require the AG's approval for health care acquisitions or changes of control that involve a private equity group or hedge fund and a healthcare facility or provider group. The bill is similar to existing laws that require healthcare non-profits to provide and obtain written consent from the AG before a transfer or sale, but would expand that oversight to include acquisitions of for-profit health care entities, including health care facilities and provider groups, by private equity firms.

Under this new bill, private equity groups and hedge funds will be required to provide written notice and obtain written consent from the AG prior to a change or control or acquisition. The notice must be provided at the same time as other state or federal agency notifications, and at least 90 days before the change in control or acquisition is to take place.

After the notice is provided, the AG has 60-days to grant approval for these transactions after making an assessment regarding relevant factors such as whether the acquiring party has sufficient funds to operate in the market for three or more years, and ensuring the transaction will continue to maintain health care access to the local community. The AG may deny these requests if there is a substantial likelihood for the transaction to have anticompetitive effects or if it would affect the access and availability of health care services.

The bill also has a special carveout for proposals involving non-physician providers who generate an annual revenue below

$4M or involve fewer than ten providers and provider groups who generate less than $10M in annual revenue. Transactions involving groups who meet these criteria are not subject to AG approval, but still require notice to be given.

Keeping in line with California's existing bans on the corporate practice of medicine, the bill prohibits private equity groups and hedge funds from being involved in any manner that would control or direct a physician or psychiatric practice. Likewise, physicians and psychiatric practices will not be allowed to enter into agreements where private equity firms or hedge funds control their practice in any form.

If implemented, AB-3129 will be a further extension of California's growing regulations over health care transaction oversight. In some ways, this bill can be seen as an extension of the authority given to California's Office of Health Care Affordability (OHCA) to collect and review notices of material transactions.  OHCA, however, does not have the authority to block a transaction; they must go to court or use the authority of another state agency to block a transaction. AB-3129 would give further the AG the authority to approve, deny, or impose conditions on a transaction without court approval. Parties can request that the AG reconsider a decision that denies consent or imposes conditions. AB-3129 would also allow the parties to seek subsequent judicial review of the Attorney General's final determination

## Criticisms of AB-3129

Opponents of AB-3129 have asserted that the new bill could bring about the very outcomes that it seeks to protect against. Specifically, some lawmakers believe that the added restrictions will make it more difficult for struggling healthcare systems to find buyers and stifle the deals that are currently keeping some facilities open. The push to restrict private equity acquisitions alongside the existing non-profit limitations lead some to fear that some practices

may be headed towards bankruptcy if this law is enacted. They argue that the negative effects of private equity investments are blown out of proportion, and that for every publicized private equity failure, there are hundreds of transactions that have actually provided support and resources to the broader health care landscape.

Moreover, others believe that the process is duplicative of the existing OHCA review regulations, and will serve to add increased costs, complexity, and timelines for affected parties which could ultimately lead to a "chilling" effect on the California healthcare investment market. These new restrictions alongside existing prohibitions are believed to potentially have wider reaching effects by upending management service organization (MSO), operating, shareholder, and other business agreements.

Lastly, those who oppose AB-3129 feel that the legislation provides an inappropriate amount of power to the AG and are in favor of rolling back the AG's power. Those who challenge the bill state that the standards and definitions in the law are currently unclear as they stand, and ask for more clarified definitions when it comes to terms and phrases such as "anticompetitive effects," "public interest," and "significant effect on access or availability of healthcare services to the affected community."

## Arguments in Support of AB-3129

Assemblyman Wood, who is also a dentist by training and in his last term, expressed interest in this issue because his district has been impacted by these types of acquisitions. Specifically, the Assemblyman has noted that a single investor has bought up several nursing homes in his rural district and has argued that while each deal is small individually, when taken together, they have a significant impact. The AG has also backed the legislation because he believes that it will help to crack down on the alleged profiteering within this

space.

While some argue that private equity-backed transactions have the potential to improve efficiency in the health care system, research indicates that the resulting market consolidation can result in reduced competition, and increased costs for patients, without a commensurate improvement in patient care. By giving the AG greater oversight power, supporters seek to ensure greater scrutiny over deals that could potentially have anticompetitive effects or negatively affect healthcare access and costs in the communities where these facilities operate.

Given the current climate surrounding private equity and hedge fund investments into the healthcare market, there has been a growing push to strengthen existing California bans on the corporate practice of medicine. Increasingly, advocates have been trying to assert the delineation between corporate decision-making and the ability of providers to exercise their professional medical judgments, in the hopes that it will solve systemic issues including increased physician burnout. In a press release, Assemblyman Wood asserted that his bill was "essential and critical" because it could also protect physicians from outside influences interfering with their practice of medicine.

## What Comes Next

If AB-3129 is passed by the end of September 2024, it would go into effect on January 1, 2025, potentially giving investors limited time to exit the market, if they choose to.

AB-3129 was introduced on February 16 and was referred to both the Health and Judiciary Committees March 11. *The Source* anticipates that this bill will be discussed in committee hearings soon.

Stay tuned as we will continue to track this bill and provide

updates as it moves through the legislative process.

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# AB 2303

Health and care facilities: prospective payment system rate increase. Existing law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis and at a per-visit prospective payment system rate, as defined. Existing law establishes 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer and includes increases beginning on June 1, 2024. Existing law generally requires the State Department of Public Health to license, regulate, and inspect health and care facilities. This bill would require the State Department of Health Care Services, on or before April 1, 2025, to submit a request for approval to the federal Centers for Medicare and Medicaid Services to authorize a waiver for specified health care facilities to request a change in its prospective payment system rate.

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# AB 2342

Medi-Cal: critical access hospitals: islands. Under existing law, a hospital designated by the department as a critical access hospital, and certified as such by the Secretary of the

United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Existing law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits. This bill, subject to appropriation and the availability of federal funding, would require the department to provide an annual supplemental payment, for services covered under Medi-Cal, to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coast of the state but is still within the jurisdiction of the state. The bill would specify the formula of the payment amount, which would be in addition to any supplemental payment described above. This bill would make legislative findings and declarations as to the necessity of a special statute for critical access hospitals operating on those islands.

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# SB 999

Health coverage: mental health and substance use disorders. This bill would require a health care service plan and a disability insurer, and an entity acting on a plan’s or insurer’s behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to

treatment. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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# SB 1061

Consumer debt: medical debt. Existing law, the Consumer Credit Reporting Agencies Act, defines and regulates consumer credit reports and consumer credit reporting agencies. The act prohibits a consumer credit reporting agency from making any consumer credit report containing specified items of information, including accounts placed for collection or charged to profit and loss that antedate the report by more than 7 years. This bill would prohibit a consumer credit reporting agency from making a consumer credit report containing information about medical debt.

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# AB 2319

California Dignity in Pregnancy and Childbirth Act. This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to also include hospitals that provide perinatal or prenatal care, as defined. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed

by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted. The bill would require, by February 1 of each year, that a facility provide the department with proof of compliance, with specified requirements. The bill would authorize the department to issue an administrative penalty if it determines that a facility has violated these provisions, and would require the department to annually post on its internet website a list of facilities that did not submit timely proof of compliance and have been issued administrative penalties. The bill would specify that, for these purposes, each health care provider that does not complete the required training constitutes a separate violation. The bill would vest the State Department of Public Health with full administrative power, authority, and jurisdiction to implement and enforce the California Dignity in Pregnancy and Childbirth Act. The bill would require the department to solicit participation and adopt regulations to further the purposes of the act, as specified.

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# AB 2348

Emergency medical services. This bill would require the authority to develop planning and implementation guidelines for response times. This bill would require the authority to develop a statewide standard methodology for calculation and reporting by a LEMSA of response time. The bill would require the authority to ensure the guidelines include a list of specified standardized terminology for a LEMSA to use when granting exemptions or when modifying original response time data for public and contractual reporting of 911 response time. The bill would require a LEMSA to report contracted provider response times to the authority in a data dispatch

form, as specified. The bill would require a noncontracted ambulance provider to report response times to the LEMSA that has jurisdiction over the provider. The bill would require the LEMSA to post contracted and noncontracted provider response times monthly on the LEMSA's internet website in specified formats. This bill would require a LEMSA to include in an EMS plan the LEMSA's annual budget, a list of administrative exemptions and a list of administrative modifications relating to response time that were approved by the LEMSA, and any exemptions granted by the LEMSA in the previous calendar year. The bill would require a LEMSA to make its plan accessible on its internet website, and would require the authority to make each EMS plan submitted to the authority accessible on the authority's internet website, as specified. The bill would require a LEMSA to use the above-described standardized terminology developed by the authority to the extent possible.

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# AB 2376

Medi-Cal. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program. This bill would state the intent of the Legislature to enact legislation to allow for acute care hospitals that accept Medi-Cal coverage to directly bill for inpatient detox services and Medically Assisted Treatment for substance abuse issues, as specified.

# AB 2428

Medi-Cal: Community-Based Adult Services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to standardize applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care, in accordance with the Terms and Conditions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative. This bill, for purposes of the mutual agreement between a Medi-Cal managed care plan and a network provider, would require that the reimbursement be in an amount equal to or greater than the amount paid for the service in the Medi-Cal fee-for-service delivery system. Under the bill, no later than January 1, 2025, for payments commencing on July 1, 2019, a Medi-Cal managed care plan that has not reimbursed a network provider furnishing CBAS according to those provisions would be required to reimburse the network provider the difference between the amount required and the amount that has been paid. This bill would prohibit the changes made by the bill to the above-described reimbursement from being construed as requiring the department to retroactively recalculate the capitation rates for purposes of any reimbursement of the difference between the amount required and the amount that has been paid.

# AB 2435

California Health Benefit Exchange. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, governed by an executive board, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers of the executive board. Existing law authorizes the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2025, with the exception of regulations implementing prescribed provisions relating to criminal background history checks for persons with access to confidential, personal, or financial information. Existing law authorizes the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2030. Existing law provides that these extensions apply to a regulation adopted before January 1, 2022. This bill would extend the authority of the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2030, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2035. The bill would provide that these prescribed time extensions apply to a regulation adopted before January 1, 2025.