HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1219 Hospital, Hospital System, or Provider Organization Transactions
SPONSOR(S): Grall and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1064

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Facilities Subcommittee	15 Y, 0 N	Lloyd	Lloyd
2) Appropriations Committee	24 Y, 3 N	Jones	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Healthy competition in economic markets keeps prices low and quality high for consumers. When one entity becomes too strong, it can stifle competition, leading to higher prices and harm to consumers. The goal of antitrust law is to protect and foster competition in economic markets, based on the idea that an unregulated market can lead to coercive monopolies.

When large hospitals systematically acquire smaller physician practices—a process known as vertical integration—such transactions can lead to less competition, price increases, and sometimes, coercive monopolies. To prevent such a transaction from occurring, a plaintiff, often the Attorney General, may bring an antitrust suit against the hospital. If a merger or acquisition violates antitrust law, a court may order the transaction undone. It is difficult for the Office of the Attorney General (OAG) to address antitrust activity once a transaction has occurred. However, Florida law does not require parties to such potentially monopolistic transactions to notify the OAG prior to execution.

HB 1219 amends the Florida Antitrust Act relating to the transactions by hospitals, hospital systems, and provider organizations. The bill imposes certain reporting requirements when a transaction between two entities in the health care market results in an affiliation or a material change to the health care market which could create a monopoly. An entity that fails to comply with these reporting requirements is subject to a civil penalty up to $500,000.

The notice requirements will provide a mechanism for the OAG to review transactions before they occur to determine whether a proposed transaction has antitrust implications and, if warranted, pursue action to prevent coercive monopolies from forming in the health care market.

The bill has no impact on local governments. It may have a negative fiscal impact on the Department of Legal Affairs within the OAG; however, the overall fiscal impact of the bill on the OAG will be based on the number of filings the OAG receives and any civil penalties collected, which are indeterminate at this time. See *Fiscal Analysis & Economic Impact Statement*.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Federal Antitrust Law

Healthy competition in economic markets keeps prices low and quality high for consumers. When one entity becomes too strong, it can stifle competition, leading to higher prices and harm to consumers.

Antitrust law exists to protect competition, but not necessarily individual competitors, in economic markets. It is based on the idea that an unregulated market will lead to the creation of coercive monopolies.[1] Federal antitrust law includes the Sherman Antitrust Act, the Clayton Act, and the Federal Trade Commission Act. These laws are enforced in federal district court[2] by the U.S. Department of Justice, the Federal Trade Commission, state Attorneys General, and private plaintiffs. Antitrust case law is well-developed, and it is often difficult to distinguish aggressive, pro-competitive conduct—which is legal—from predatory, anti-competitive conduct.[3]

Clayton Act

The Clayton Act[4] prohibits specific business actions, including mergers and acquisitions, which may substantially lessen competition. To determine whether a merger violates the Clayton Act, a court must decide whether the merger is likely to create an appreciable danger of anticompetitive effects. The plaintiff must establish a prima facie case that a transaction is anticompetitive, such as by showing that an acquisition will significantly increase market concentration and lessen competition.[5] The burden then shifts to the defendant to rebut the prima facie case, such as by introducing evidence casting doubt on the plaintiff's prediction of anticompetitive effects.[6] If the defendant rebuts the prima facie case, the plaintiff has the final burden to demonstrate an antitrust violation.[7] If the plaintiff prevails, the customary remedy is for the court to order divestiture and unwind the merger.[8]

Sherman Antitrust Act

The Sherman Antitrust Act[9] prohibits any attempt to restrain trade or form a monopoly. A monopoly has two elements: (1) monopoly power and (2) willful acquisition or maintenance of that power, as opposed to power naturally resulting from a superior product, acumen, or historic accident. Stated differently, a plaintiff must prove the defendant acquired the monopoly power in a "predatory" manner. Penalties for violating the Sherman Act include imprisonment up to ten years and a fine up to $100 million for a corporation or $1 million for any other person.[10]

[1] John J. Miles, Antitrust Primer, 20140513 AHLA Seminar Papers 1 (2014) (stating the purpose of antitrust law is to "protect and promote competition as the primary method by which this country allocates scarce resources to maximize the welfare of consumers.").
[2] Steven Fox, Litigation Under Florida's Deceptive and Unfair Trade Practices Act, the Florida Antitrust Act, or Federal Antitrust Statutes, The Florida Bar, Business Litigation in Florida (2017) (federal district courts have exclusive jurisdiction over federal antitrust actions).
[3] Animesh Ballabh, Antitrust Law: An Overview, 88 J. Pat. & Trademark Off. Soc'y 877 (2006); John J. Miles, Antitrust Primer, 20140513 AHLA Seminar Papers 1 (2014).
[4] 15 U.S.C. § 18.
[5] *Olin Corp. v. FTC*, 986 F.2d 1295, 1305 (9th Cir. 1993) (discussing how plaintiff's establishment of a prima facie case on statistical evidence is first step in analysis); *Chicago Bridge & Iron Co. v. FTC*, 534 F.3d 410, 423 (5th Cir. 2008).
[6] Id.
[7] *Chicago Bridge & Iron*, 534 F.3d at 423.
[8] *St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, 778 F.3d 775, 792 (9th Cir. 2015).
[9] 15 U.S.C. §§ 1-38.
[10] 15 U.S.C. § 1.

Florida Antitrust Law

Florida Antitrust Act of 1980

The Florida Antitrust Act of 1980[11] (the FAA) is intended to complement federal antitrust law in order to foster effective competition. Implemented by the Office of the Attorney General (OAG), the FAA essentially tracks the federal Sherman Act, and prohibits:[12]

- Every contract, combination, or conspiracy in restraint of trade or commerce;[13] and
- Monopolization or attempted monopolization of any part of trade or commerce.[14]

A violation of Florida antitrust law may result in up to three years of prison and fines up to $1 million for a corporation and $100,000 for any other person.[15] There is also a private right of action for any person injured by certain violations.[16]

Florida Deceptive and Unfair Trade Practices Act (FDUTPA)

The FDUTPA broadly prohibits any unfair or deceptive act or practice committed in the conduct of any trade or commerce.[17] It provides a cause of action to make consumers whole for losses caused by fraudulent consumer practices. The FDUTPA applies to actions that do not yet constitute full-blown antitrust violations;[18] thus, an antitrust violation is also an unfair method of competition under the FDUTPA.[19] A willful violation of the FDUTPA is subject to a fine up to $10,000.[20]

Florida law does not provide a corollary to the federal Clayton Act, which specifically targets mergers and acquisitions that may lessen competition. However, the Attorney General considers the Florida Antitrust Act of 1980 and the FDUTPA broad enough to encompass those types of violations.[21]

Vertical Integration

When large hospitals or other medical facilities merge with one another or systematically acquire smaller physician practices, such transactions can lead to less competition, and sometimes, coercive monopolies.

Vertical integration broadly refers to transactions whereby a large medical entity, such as a hospital, acquires a smaller medical entity, such as a physician practice group, thereby expanding the hospital's market power. Vertical integration can occur in many ways, including by the following methods:

- **Complete buyout.** A hospital buys out a physician practice, including its physicians, staff, equipment, and patients. The physicians become hospital employees.
- **Asset purchase agreement.** A hospital acquires from a physician practice its channels of distribution, laboratories, equipment, or other assets.
- **Physician enterprise model.** A hospital and a physician practice enter into non-equity joint ventures together. The physicians preserve their autonomy and private practice model.[22]

[11] Ss. 542.15 – 542.36, F.S.
[12] S. 542.16, F.S.
[13] S. 542.18, F.S.
[14] S. 542.19, F.S.
[15] S. 542.21, F.S.
[16] Ss. 542.21 – 542.23, F.S.
[17] Ss. 501.201 – 501.213, F.S.
[18] Steven Fox, *Litigation Under Florida's Deceptive and Unfair Trade Practices Act, the Florida Antitrust Act, or Federal Antitrust Statutes*, THE FLORIDA BAR, Business Litigation in Florida (2017).
[19] *Id.*; *see Omni Healthcare, Inc. v. Health First, Inc.*, *not reported in* F.Supp.3d (2016).
[20] S. 501.2075, F.S.
[21] *Supra* note 18; FLORIDA ATTORNEY GENERAL, *Antitrust*, http://myfloridalegal.com/antitrust (last visited Mar. 3, 2021).
[22] John W. McDaniel, *The Physician Enterprise Model: A Nonemployment Alternative*, ACMPE Executive View, Vol. 8, No. 1 (Spring 2012).

- **Group practice subsidiary model.** A hospital purchases a physician practice group, but the physicians, who are not employed directly by the hospital, maintain control of the day-to-day operations of the practice group.[23]
- **Professional service agreement.** A hospital purchases a physician practice's technical component services and compensates the practice's physicians for professional services at the practice. The practice remains intact, while the hospital bills and collects professional fee-for-service revenue. The hospital compensates the practice for the services.[24]

Vertical integration has been on the rise in the last twenty years. Between 2002 and 2008 in the U.S., the share of physician practices owned by hospitals doubled,[25] and trends towards increased vertical integration continued from 2007 to 2013.[26] Whether the trend towards vertical integration benefits consumers is heavily debated.[27] Proponents of vertical integration argue that it can improve the quality and efficiency of care by strengthening ties between physicians and hospitals and improving communication.[28]

Critics of vertical integration argue that it increases a hospital's market share, potentially reducing or eliminating competition. Removing competition in the medical marketplace, in turn, may allow hospitals to raise their prices to a level that harms consumers.[29] Vertical integration may lead to:[30]

- Hospitals increasing their market power by amassing control over a larger bundle of services;
- Hospitals depriving their rivals of a source of destination for referrals; and
- Heightened incentives for physicians to supply unnecessary treatments to pay for kickbacks for inappropriate referrals.

One study analyzed the trends and effects of vertical integration in the U.S. and found that some loose forms of vertical integration might be socially beneficial. However, the study concluded that vertical integration increases healthcare costs:[31]

> Taken together, our results provide a mixed, although somewhat negative, picture of vertical integration from the perspective of the privately insured. Our most definitive finding is that hospital ownership of physician practices leads to higher prices and higher levels of hospital spending.

A recent study found that hospital acquisitions of physician practices were responsible for an average price increase of 14.1% in fees for physician services, with larger increases where the acquiring hospital was more dominant within its market. The price increases varied across specialties, ranging from a 15% price increase for primary care physicians up to a 33.5% price increase for cardiologists.[32]

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[23] PHYSICIANS PRACTICE, *Maintaining Independence as a Group Practice Subsidiary*, https://www.physicianspractice.com/maintaining-independence-group-practice-subsidiary (last visited Mar. 3, 2021).
[24] Marti Cox, *Physician-Hospital Alignment Models: An Evolving Lexicon*, MGMA, https://www.mgma.com/resources/resources/business-strategy/physician-hospital-alignment-models-an-evolving-l (last visited Mar. 3, 2021); CBIZ, *Professional Services Agreement: An Alternative Strategy to Hospital Employment*, https://www.cbiz.com/Portals/0/Documents/Accounting%20&%20Tax/Industries/Healthcare/Thought%20Leadership/A5Aug2015_Professional%20Services%20Agreement_An%20Alternative%20Strategy%20to%20Hospital%20Employment.pdf (last visited Mar. 3 2021).
[25] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending*, HEALTH AFFAIRS (May 2014), available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1279 (last visited Mar. 3, 2021).
[26] Cory Capps, David Dranove, and Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, JOURNAL OF HEALTH ECONOMICS (Apr. 22, 2018), https://www.sciencedirect.com/science/article/abs/pii/S016762961730485X (last visited Mar. 3, 2021).
[27] *Supra* note 25.
[28] *Id*.
[29] *Id*.
[30] *Id*.
[31] *Id*.
[32] *Supra* note 26.

The study estimated nearly half of the price increases were due to the exploitation of "facility fees," which hospitals are allowed to charge for procedures performed by hospital-owned physician groups.[33] When hospitals acquire physician practices, the simple change in ownership allows them to charge higher prices for the same procedure regardless of whether the procedure is performed in the hospital or in the physician's practice. The study found that the cardiologist specialty had the sharpest increase in vertical integration and prices, suggesting that more hospitals are acquiring cardiologists because of the higher reimbursement incentives for facility fees in that specialty. The study concluded:[34]

> Overall, we believe these results paint a relatively negative picture of hospital-physician VI [vertical integration]. However, given the evolving nature of healthcare reimbursement systems, future analyses will be important.

Experts in the field have also found that, in addition to commercial insurers paying more as a result of vertical mergers, so does Medicare. This is because Medicare pays both a physician fee and hospital facility fee when a physician's outpatient office is part of a hospital outpatient department. Medicare would pay only a physician fee prior to the hospital's acquisition of the outpatient physician office.[35] These increases in costs ultimately extend to consumers who face high co-pays and deductibles, resulting in many foregoing needed health care due to unaffordable prices.[36]

Antitrust Enforcement Mechanisms in Medical Markets

A plaintiff, such as the state Attorney General, may bring an antitrust suit to prevent a merger or acquisition in the medical market.[37] If a merger or acquisition violates antitrust law, a court may order divestiture, or that the transaction undone, or the court may order other remedies.[38]

For example, in *St. Alphonsus Medical Center v. St. Luke's Health System*, 778 F.3d 775 (9th Cir. 2015), an Idaho-based health care system[39] purchased the largest independent multi-specialty independent physician group in Idaho, resulting in the combined entity being the dominant provider in the area for primary care and giving it significant bargaining leverage over health insurance plans. Two local hospitals, the State of Idaho, and the FTC sued the acquiring health care system under state and federal antitrust law. The Court analyzed the transaction and found that, while the intent of the acquisition may have been to improve patient outcomes, the acquisition would likely have anticompetitive effects and ordered divestiture under the Clayton Act.[40]

Under current law, a hospital's acquisition of a physician practice or another hospital's assets may be challenged by:

- The FTC[41] under the federal Clayton Act;[42]
- A private plaintiff under the FDUTPA; or
- The Florida Attorney General under the FAA.[43]

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[33] *Id*.
[34] *Id*.
[35] Statement of Thomas L. Greaney, Visiting Professor of Law, UC Hastings College of Law, Chester A. Myers Professor Emeritus, Saint Louis University School of Law, before the U.S. Senate, Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights, p. 4 (June 12, 2019 https://www.judiciary.senate.gov/download/greaney-testimony (last visited Mar. 6, 2021).
[36] *Id*.
[37] *See, e.g., St. Alphonsus Med. Ctr. v. St. Luke's Health Sys.*, 778 F.3d 775 (9th Cir. 2015) (where two health care providers merged, FTC and private plaintiffs brought antitrust suit, and court ordered divestiture of merger).
[38] *Id.*
[39] The Compendium of U.S. Health Systems, 2016, defines a health system (sometimes referred to as health care system) as an organization that includes at least one hospital and at least one group of physicians that provides comprehensive care (including primary and specialty care) who are connected with each other and with the hospital through common ownership or joint management. *See* https://www.ahrq.gov/chsp/chsp-reports/resources-for-understanding-health-systems/defining-health-systems.html (last visited Mar. 3, 2021).
[40] *St. Alphonsus Med. Ctr*.at 792.
[41] *See id.* and *F.T.C. v. Hosp. Bd. of Directors of Lee Cnty.*, 38 F.3d 1184 (11th Cir. 1994).
[42] *See also F.T.C. v. Univ. Health, Inc.*, 938 F.2d 1206 (11th Cir. 1991) (ruling against proposed acquisition of one hospital by another under the Clayton Act).
[43] S. 542.27(2), F.S., the Attorney General may institute any action authorized by federal law pertaining to antitrust or restraints of trade.

However, there is no reporting mechanism in current law that would alert the Florida Attorney General to such acquisitions or transactions prior to their execution.

Effect of Proposed Changes

The bill amends the Florida Antitrust Act relating to the acquisition of hospitals or other provider entities in the health care market. It imposes certain reporting requirements when a transaction between two entities in the health care market results in an affiliation or a material change to the health care market which could create a monopoly. An entity that fails to comply with these reporting requirements is subject to a civil penalty up to $500,000.

It is difficult for the OAG to address antitrust activity once a transaction has occurred. These new notice requirements will provide a mechanism whereby the OAG will be able to review transactions before they are effective and will allow the OAG time to determine whether a proposed transaction has antitrust implications and if warranted, pursue action to prevent coercive monopolies from forming in the health care market.

Transactions Requiring Federal Reporting

Currently, when an entity operating in Florida reports a proposed merger or acquisition to the Federal Trade Commission or the U.S. Department of Justice under the federal Clayton Act, there is no requirement that Florida's Attorney General be notified. In these instances, the bill requires the entity to notify the OAG when it files any such report with the federal government.

Transactions Resulting in Material Change

In addition to the notices related to federal filings, the bill requires certain entities to notify the OAG of certain transactions not subject to the federal requirements.

A hospital, hospital system or provider organization must notify the OAG when it plans to enter into a transaction with another hospital, hospital system or provider organization, which is defined by the bill as a health care service entity which represents four or more health care providers in contracting with third-party payers for payments. Notice is only required for transactions that result in a material change, which is defined by the bill as a merger, acquisition or contract affiliation resulting in a combined revenue of $50 million or more.[44] The bill requires these entities to submit such notices at least 90 days prior to the effective date of the transaction.

Notice Content

Under the bill, notices of transactions involving material changes and notices of transactions requiring federal reporting must include the following content.

- The name and business addresses of the parties to the transaction.
- A description of the proposed relationship among the parties.
- A description of services that will be provided at each location.
- The primary service area to be served by each location, which the bill defines as the area measured by the fewest number of zip codes from which the party draws at least 75 percent of its patients.
- A description of all acquisitions made by the parties in the last 5 years, which the bill defines as any activity by which a party to the noticed transaction obtains control of another hospital, hospital system, or provider organization.

[44] The federal threshold for antitrust reporting purposes is currently $92 million. The threshold started at $50 million and is adjusted annually with changes in the Gross National Product pursuant to the Hart-Scott-Rodino Antitrust Improvements Act of 1976 and published by the Federal Trade Commission. 15 U.S.C. sec. 18a. https://www.federalregister.gov/documents/2021/02/02/2021-02110/revised-jurisdictional-thresholds-for-section-7a-of-the-clayton-act (last visited March 8, 2021), https://www.ftc.gov/news-events/blogs/competition-matters/2021/02/hsr-threshold-adjustments-reportability-2021 (last visited March 8, 2021).

When submitting this notice, the entity must identify any information that is a trade secret as defined in statute so that it can be protected from further disclosure. The bill expressly authorizes OAG to request additional information or issue a civil investigative demand for other documents or information relevant to antitrust investigations.[45] In addition, the bill expressly allows parties to a material change to voluntarily provide additional information to the OAG.

The bill requires the Attorney General to biennially report to the Legislature on its activities under this new section of law, beginning January 1, 2022.

The bill is effective July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Creates s. 542.275, F.S., relating to hospital, hospital system, or provider organization mergers, acquisitions, and other transactions; notice; reporting; penalty.
Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill establishes a civil penalty which must be deposited in the Legal Affairs Revolving Trust Fund. To the extent that the OAG imposes such penalties, it will experience an increase in revenue.

2. Expenditures:

According to the OAG, it will incur out-of-pocket expenses for staff and witnesses, expert fees and costs, court reporting costs, and the maintenance of a document review platform. The OAG projects transaction reviews costing a total of $320,000 annually. Additionally, to implement the requirements of the bill, the OAG estimates it will need seven attorneys with antitrust or health care experience, three financial analysts or health economists, and two legal assistants. The following table illustrates the OAG's asserted funding need:[46]

FTEs	Number	Rate	Total Salary & Benefits
Senior Legal Assistant	2	$36,478	$94,843
Economic Analyst	3	$43,498	$169,642
Assistant Attorney General	2	$51,636	$134,254
Senior Assistant Attorney General	5	$64,532	$419,458
Standard Expense Package (Professional)	10	$10,921	$109,210
Standard Expense Package (Support Staff)	2	$8,623	$17,246
Human Resources Package	12	$339	$4,068
Total FTE Costs	$948,721		
Special Category Antitrust Investigations	$320,000		
Total Nonrecurring	$47,472		
Total Recurring	$1,221,249		

[45] S. 542.28, F.S., currently authorizes the OAG to issue civil investigative demands, essentially a subpoena, for copies of any documents or information relevant to a civil antitrust investigation.
[46] Email from Daniel M. Olson, Director of Governmental Relations, Office of the Attorney General, Re: Bill analysis request – HB 1219 (Mar. 5, 2021) (on file with Finance & Facilities Subcommittee staff).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that the OAG discovers anticompetitive behavior under the new notice requirements of the bill, hospitals, hospital systems, and provider organizations engaging in such behavior will no longer be able to acquire and control monopolistic shares of the market. Entities that fail to comply with the notice requirements are subject to a civil penalty of up to $500,000. The bill also requires parties to the transaction to pay the reasonable expenses for the services of consultants, experts, accountants, economists, and other assistants used by the OAG to review transactions authorized by the act.

To the extent that the OAG is successful in reducing health care monopolies in the state, smaller or independent hospitals or group practices will be able to continue operating independently and may offer more competitive prices for health care services.

D. FISCAL COMMENTS:

To the extent that the OAG will be reviewing, reporting, and potentially pursuing civil penalties based on the number of notice filings received, additional resources may be needed. However, the number of notice filings that the OAG may receive each year is indeterminate at this time.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The OAG does not require rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.