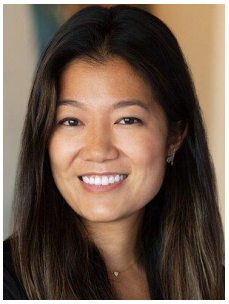
LAW360

Portfolio Media. Inc. | 230 Park Avenue, 7th Floor | New York, NY 10169 | www.law360.com
Phone: +1 646 783 7100 | Fax: +1 646 783 7161 | customerservice@law360.com

Expect More State Scrutiny Of PE In Healthcare M&A

By **Minna Lo Naranjo, Zachary Johns and Ryan Kantor** (December 3, 2024, 11:36 AM EST)


Minna Lo Naranjo


Zachary Johns


Ryan Kantor

Parties to certain merger, acquisition and joint venture transactions — and, in particular, private equity groups — in the U.S. are increasingly facing more penetrating reviews by federal and state antitrust enforcement authorities and regulators that will necessitate additional planning and preparation earlier in a transaction to reach closing successfully.

While a second Trump administration may be less enforcement-oriented than the Biden administration, some burdensome elements of the heightened antitrust enforcement environment are likely to persist.

In perhaps the most notable example of the forthcoming heightened enforcement burden parties face, the Federal Trade Commission on Nov. 12 published in the Federal Register changes to the Hart-Scott-Rodino Antitrust Improvements Act premerger notification rules by a unanimous vote and with the concurrence of the U.S. Department of Justice Antitrust Division.[1]

The long-awaited HSR rules, which will fundamentally reshape HSR and transactional antitrust practice in the U.S., go into effect on Feb. 10, 2025, and will substantially increase the burden on parties to an HSR reportable transaction. On inauguration day, the Trump administration may implement a blanket regulatory freeze, which could result in the new HSR rules' effective date being pushed back.

While the new HSR rules have received much of dealmakers' attention, state legislatures have been working in parallel to enact state-level transaction screening regimes that would add to parties' burdens under the forthcoming HSR rules, particularly for PE groups operating in the healthcare sector.

Indiana enacted legislation in March that requires additional pretransaction screening for PE group healthcare transactions, and at least five other states have proposed similar legislation.

In September, California Gov. Gavin Newsom vetoed proposed legislation that called for additional scrutiny of many transactions involving PE groups and various healthcare facilities and providers — excluding hospitals.

The proposed legislation would have required reportable transactions, which could capture acquisitions

of ownership interests below 15% of the target's market value or ownership shares, to notify the California attorney general at least 90 days before closing, with numerous mechanisms for extending the review period beyond 90 days.

Nevertheless, Newsom made clear in his veto message that a primary criticism of the bill was that the Office of Health Care Affordability should have jurisdiction, foretelling that a new bill proposal with similar requirements under OHCA's jurisdiction may be signed into law.

In the meantime, California, like many other states, continues to have a "mini-HSR" law that requires prior notification of certain healthcare industry transactions. Mini-HSR laws reflect efforts by states to identify, review and potentially challenge transactions that might consolidate healthcare markets.

At the same time, 11 state attorneys general submitted a public comment to the DOJ and FTC expressing concerns about how PE involvement in healthcare could increase costs, decrease quality and reduce access to care.[2]

Animated by the same skepticism toward further consolidation, some state legislatures have begun to propose laws explicitly targeting healthcare transactions involving PE firms. For PE healthcare transactions in those states, these proposed laws could prolong the closing process, increase burdens and create deal uncertainty, all of which may disincentivize PE investment in healthcare infrastructure.

Impact on PE From Existing State Mini-HSR Acts

So far, only one state — Indiana — has enacted a law explicitly mentioning PE transactions in healthcare as part of a broader state mini-HSR act.[3]

Under Indiana's mini-HSR act, which became effective on July 1, a merger or acquisition involving a "private equity partnership" and a "health care entity" — such as a healthcare provider, payor, health maintenance organization, pharmacy benefit manager or third-party administrator — is likely reportable.[4]

The relatively low size-of-person threshold of $10 million in total assets for each party counts the value of any assets or holdings of the PE firm and those of the healthcare entity, including those located outside Indiana.[5] As a result, Indiana's law may capture acquisitions by out-of-state PE sponsors of healthcare assets located in Indiana.[6]

Some state mini-HSR laws do not expressly target PE transactions, but contain language that may affect PE sponsors and portfolio companies — even those that are not parties to a reportable transaction.

For instance, Washington's mini-HSR act, in effect since Jan. 1, 2020, broadly defines a "hospital system" to include not only a parent company of a hospital that is a party to the transaction, but also any entities affiliated with that parent company through ownership or control.[7]

Therefore, a hospital system owned by a PE-managed investment fund may be required in its Washington mini-HSR filing to identify healthcare assets of other portfolio companies of the PE firm, even if those other portfolio companies are not parties to the transaction at issue.[8]

Moreover, following the new HSR rules' enactment, the Washington attorney general will gain far more visibility into PE group transactions reportable under the federal HSR Act because Washington's mini-

HSR act requires filing parties to provide the transaction's HSR filing to the Washington attorney general.[9] Other states also have broad definitions in their mini-HSR acts that could implicate PE firms and their other healthcare portfolio companies in certain parts of the premerger notices.[10]

Legislation Focused on PE Healthcare Transactions

Multiple states have proposed legislation targeting healthcare transactions involving PE firms. These states — California,[11] Connecticut,[12] Massachusetts,[13] Minnesota[14] and Oregon[15] — already have healthcare mini-HSR acts in effect; these mini-HSRs would be supplemented by the new PE disclosure requirements, should they pass.

California

As discussed, California's proposed law, A.B. 3129, was vetoed on Sept. 28 by Newsom, but it could be revived by the Legislature overriding the veto or updating the bill in future legislative sessions. Both scenarios remain possible, as Newsom's stated objection to the bill was jurisdictional rather than substantive.[16]

A.B. 3129 would have required a PE group to provide written notice to the California attorney general at least 90 days before closing on any transactions involving healthcare facilities (except hospitals), provider groups or providers.[17]

The initial 90-day waiting period could have been extended significantly based upon the California attorney general's election to hold public hearings,[18] seek additional information,[19] issue an adverse written determination that would force parties into time-consuming administrative and judicial proceedings,[20] or toll waiting periods under A.B. 3129 while other state or federal agencies reviewed the transaction.[21]

In addition, A.B. 3129 would have restricted the ability of PE firms from managing their healthcare portfolio companies, including with respect to decisions about patient care, payor contracts, billing procedures, or medical equipment or supplies.[22]

Given the veto of A.B. 3129, the existing California mini-HSR Act, which is called the Health Care Quality and Affordability Act, remains the sole healthcare premerger notification scheme in the state.

Key Takeaways

Laws requiring more extensive disclosure of PE involvement in healthcare transactions and in-depth reviews of these transactions will likely continue to be introduced in state legislatures, particularly if the Trump administration eases antitrust enforcement at the federal level through either policy or personnel choices.

PE groups that have participated in prior healthcare asset transactions should be aware that certain bills would require the identification of assets of other portfolio companies, even if those portfolio companies are not parties to the transaction at issue.

Often, these state laws will give state attorneys general additional visibility into PE group healthcare transactions when a deal is reportable under the federal HSR Act because many state statutes require parties to provide a copy of their transaction's HSR filing, which may include granular details on the

current and prior PE group healthcare transaction, particularly once the new HSR rules go into effect.

Further, any healthcare company considering a transaction should be aware that there may be relatively low thresholds for assets to be subject to these laws.

These laws place a greater emphasis on understanding the justifications for and anticipated benefits from any transaction, including the advancement of higher quality, greater access to care, lower costs to patients, increased innovation and greater benefits to healthcare workers.

Ensuring that these considerations are top of mind is important in an environment where healthcare transactions are likely to be subject to heightened scrutiny by both federal and some state antitrust enforcers.

Early on in the transaction, antitrust counsel for healthcare providers and PE funds should consider whether the transaction may be subject to any new legal requirements, and minimize the likelihood of unforeseen delays that may adversely affect transaction financing and deal certainty.

Minna Lo Naranjo is a partner at Morgan Lewis & Bockius LLP.

Zachary Johns is a partner at the firm.

Ryan Kantor is a partner, and deputy practice leader of the global antitrust and competition law practice, at the firm. He previously served as assistant chief of the healthcare and consumer products section in the DOJ's Antitrust Division,

Morgan Lewis partner David Brenneman, and associates Bernard Archbold, Damos Anderson and Frank Ren, contributed to this article.

[1] https://www.federalregister.gov/documents/2024/11/12/2024-25024/premerger-notification-reporting-and-waiting-period-requirements.

[2] Cal. Dep't of Justice et al., Comments of Eleven Attorneys General in Response to February 29, 2024 Request for Information on Consolidation in Healthcare Markets (June 5, 2024), https://downloads.regulations.gov/FTC-2024-0022-2098/attachment_1.pdf (reflecting public comment from attorneys general of California, Connecticut, Delaware, District of Columbia, Illinois, Minnesota, New Jersey, Oregon, Pennsylvania, Rhode Island, and Washington).

[3] Ind. Code § 25-1-8.5-1 et seq.

[4] Id. § 25-1-8.5-2(a).

[5] Id. § 25-1-8.5-4(a).

[6] Another state—Pennsylvania—has proposed a mini-HSR act in which a "private equity fund" is

explicitly included in the statutory definition of "[h]ealth care facility system." See H.B. 2012, Reg. Sess., § 1 (as amended July 1, 2024) (Pa. 2023).

[7] Wash. Rev. Code § 19.390.020(8) ("Hospital system" means … a parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership or control.").

[8] A proposed legislative update to Washington's mini-HSR act may extend the statute's reach to private equity sponsors and their portfolio companies. See S.B. 5241, 68th Leg., Reg. Sess., § 3 (as amended Feb. 8, 2024) (Wash. 2023) ("'Affiliate' means a person that directly, or indirectly through one or more intermediaries, controls or has ownership of, is controlled or owned by, or is under common control or ownership of a person.").

[9] Wash. Rev. Code § 19.390.060 ("Any provider or provider organization conducting business in this state that files a premerger notification with the federal trade commission or the United States department of justice, in compliance with the Hart-Scott-Rodino antitrust improvements act, Title 15 U.S.C. Sec. 18a, shall provide a copy of such filing to the attorney general.").

[10] See, e.g., Cal. Code Regs. tit. 22, §§ 97431(a), 97435(d) (size-of-person threshold includes revenues of "the submitter and all affiliates," where an "affiliate" is any entity that "controls, is controlled by, or is under common control with another legal entity" to provide health care services); 958 Mass. Code Regs. § 7.02 (defining "Corporate Affiliation" as "[a]ny relationship between two organizations that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete common control"); Or. Rev. Stat. § 415.500(4)(a) (defining "[h]ealth care entity" to include "[a]ny other entity … that is a parent organization of, or is an entity closely related to, an entity that has as a primary function the provision of health care items or services").

[11] A.B. 3129, Reg. Sess. (as amended August 15, 2024) (Cal. 2024).

[12] H.B. 5319, Feb. Sess. (Conn. 2024).

[13] H.B. 4653, 193rd Leg., Reg. Sess. (as amended July 15, 2024) (Mass. 2024).

[14] H.F. 4206, 93rd Leg., Reg. Sess. (Minn. 2024).

[15] H.B. 4130, Reg. Sess. (as amended Mar. 4, 2024) (Or. 2024).

[16] Governor Gavin Newsom's Veto Message, Cal. Assemb. Bill No. 3129, 2023-2024 Leg., (Sept. 28, 2024) (Governor Newsom indicated in his veto statement that the California Office of Health Care Affordability ("OHCA"), rather than the California Attorney General, "would be more appropriate … to oversee these consolidation issues as it is already doing much of this work.").

[17] See A.B. 3129, Reg. Sess., § 1190.10(a)-(b) (as amended June 27, 2024) (Cal. 2024).

[18] See id. § 1190.10(d).

[19] See id. § 1190.10(c).

[20] See id. § 1190.30.

[21] See id. § 1190.10(c)-(d), (g).

[22] See id. § 1190.40.