

AMENDED IN SENATE APRIL 11, 2016

**SENATE BILL**

**No. 932**

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**Introduced by Senator Hernandez**

February 1, 2016

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*An act to add Sections 1260.5 and 1375.71 to, and to add Article 10.5 (commencing with Section 1399.65) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Section 10133.651 to the Insurance Code, relating to health care.*

LEGISLATIVE COUNSEL'S DIGEST

SB 932, as amended, Hernandez. Health care ~~mergers and acquisitions~~ *mergers, acquisitions, and collaborations*.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. *Existing law also provides for the regulation of health insurers by the Department of Insurance.* Existing law requires every nonprofit health care service plan applying to restructure, as defined, or convert its activities to secure the approval of the Director of the Department of Managed Health Care. Existing law requires the Director of the Department of Managed Health Care to provide the public notice of, reasonable access to, and an opportunity to comment on, public records relating to the ~~restructure~~ *restructuring* or conversion of a health care service plan. Existing law requires any nonprofit health care service plan that is formed under, or subject to, either the Nonprofit Public Benefit Corporation Law or the Nonprofit Mutual Benefit Corporation Law to secure the written consent of the Director of the Department of Managed Health Care prior to any merger. *If a health care service plan proposes a merger, consolidation, acquisition of a*

*controlling interest, or sale of the plan or all or substantially all of the assets of the plan, existing law requires the plan to file a notice of material modification with the Director of the Department of Managed Health Care, who shall, within 20 business days or additional time as the plan may specify, approve, disapprove, suspend, or postpone the effectiveness of the change, subject to specified procedural requirements.*

*Existing law requires risk-bearing organizations to provide certain organizational and financial capacity information to the Department of Managed Health Care.*

~~This bill would declare the intent of the Legislature to enact legislation that would require a review of health care mergers and acquisitions for impacts on health care costs, access, and quality of care. require any person that intends to merge with, consolidate, acquire, purchase, or control, directly or indirectly, any health care service plan or risk-bearing organization to give notice to, and to secure the prior approval from, the Director of the Department of Managed Health Care. The bill would require any risk-bearing organization to give notice to, and to secure the prior approval from, the Director of the Department of Managed Health Care for any agreement, collaboration, relationship, or joint venture entered into with another risk-bearing organization or any other organization, such as a hospital or health care service plan, for the purpose of increasing the level of collaboration in the provision of health care services. The bill would require the director to hold a public hearing and to make specified findings regarding the proposal prior to approving these transactions or agreements, including that the proposal does not adversely affect competition. In making this finding, the bill would require the director to request an advisory opinion from the Attorney General regarding whether competition would be adversely affected and what mitigation measures could be adopted to avoid this result. The bill would require the Attorney General to prepare and submit to the director an independent health care impact statement to assist the director in his or her approval of the transaction if the director determines that a material amount of assets, as defined by the director by regulation, of a health care service plan or risk-bearing organization is subject to merger, consolidation, acquisition, purchase, or control. The bill would authorize the director to give conditional approval for any transaction or agreement if the parties to the transaction or agreement commit to taking action to prevent adverse impacts on competition, or health care costs, access, and quality of care in this state.~~

*This bill would prohibit specified provisions in contracts between health care service plans or health insurers that contract with providers for alternative rates of payment and health care providers, and contracts between payors, as defined, and general acute care hospitals, including a requirement that the health care service plan, health insurer, or payor includes in its network any one or more providers owned or controlled by, or affiliated with, the health care provider or general acute care hospital as a condition of allowing the health care service plan, health insurer, or payor to include in its network the health care provider or general acute care hospital. The bill, commencing January 1, 2017, would provide that any contract provision that violates these prohibitions in a contract entered into, issued, amended, or renewed before, on, or after January 1, 2017, shall become void and unenforceable.*

*Because a willful violation of the act is a crime, the bill would impose a state-mandated local program.*

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that no reimbursement is required by this act for a specified reason.*

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~-yes.  
State-mandated local program: ~~no~~-yes.

*The people of the State of California do enact as follows:*

- 1     **SECTION 1.** *Section 1260.5 is added to the Health and Safety*
- 2 *Code, to read:*
- 3     1260.5. (a) (1) *A contract between a general acute care*
- 4 *hospital and a payor shall not contain, directly or indirectly, any*
- 5 *of the following terms:*
- 6     (A) *A requirement that the payor includes in its network any*
- 7 *one or more providers owned or controlled by, or affiliated with,*
- 8 *the general acute care hospital as a condition of allowing the*
- 9 *payor to include in its network the general acute care hospital.*
- 10    (B) *A requirement that a payor places all members of a provider*
- 11 *group, whether medical group, independent practice association,*
- 12 *organization, health care facility, or other person or institution*

1 licensed or authorized by the state to deliver or furnish health  
2 services, in the same tier of a tiered network plan.

3 (C) A provision that sets rates for emergency services by any  
4 general acute care hospital not participating in a network at a  
5 rate greater than that which is provided for pursuant to subdivision  
6 (d) of Section 1317.2a, and any regulations adopted pursuant to  
7 that section by the Department of Managed Health Care.

8 (D) A requirement that the payor compensate the general acute  
9 care hospital at the contracted rate for services by a provider  
10 acquired by the general acute care hospital during the term of the  
11 contract and with which the payor, at the time of acquisition, has  
12 a contract in effect.

13 (E) A requirement that the payor or general acute care hospital  
14 submit to binding arbitration, or any other alternative dispute  
15 resolution programs, any claims or causes of action that arise  
16 under state or federal antitrust laws.

17 (F) A provision that prohibits offering incentives to subscribers,  
18 enrollees, insureds, or a payor's beneficiaries that encourages a  
19 subscriber, enrollee, insured, or payor's beneficiary to access  
20 health care providers other than the general acute care hospital,  
21 or that creates disincentives to access the general acute care  
22 hospital.

23 (G) A provision that prohibits the disclosure of the contracted  
24 rate between the payor and the general acute care hospital to  
25 subscribers, enrollees, insureds, payor's beneficiaries, or the payor  
26 before the services or products of the general acute care hospital  
27 are utilized and billed.

28 (2) Commencing January 1, 2017, any contract provision that  
29 violates subparagraphs (A) to (G), inclusive, of paragraph (1) in  
30 a contract between a general acute care hospital and a payor  
31 entered into, issued, amended, or renewed before, on, or after  
32 January 1, 2017, shall become void and unenforceable.

33 (b) For purposes of this section, "payor" shall have the same  
34 meaning as set forth in subparagraph (A) of paragraph (3)  
35 subdivision (d) of Section 1395.6.

36 SEC. 2. Section 1375.71 is added to the Health and Safety  
37 Code, immediately following Section 1375.7, to read:

38 1375.71. (a) (1) A contract between a health care service  
39 plan and a health care provider shall not contain, directly or  
40 indirectly, any of the following terms:

1 (A) A requirement that the health care service plan includes in  
2 its network any one or more providers owned or controlled by, or  
3 affiliated with, the health care provider as a condition of allowing  
4 the health care service plan to include in its network the health  
5 care provider.

6 (B) A requirement that a health care service plan places all  
7 members of a provider group, whether medical group, independent  
8 practice association, organization, health care facility, or other  
9 person or institution licensed or authorized by the state to deliver  
10 or furnish health services, in the same tier of a tiered network plan.

11 (C) A provision that sets rates for emergency services by any  
12 health care provider not participating in a network at a rate  
13 greater than that which is provided for pursuant to subdivision  
14 (d) of Section 1317.2a, and any regulations adopted pursuant to  
15 that section by the department.

16 (D) A requirement that the health care service plan compensate  
17 the health care provider at the contracted rate for services by a  
18 provider acquired by the health care provider during the term of  
19 the contract and with which the health care service plan, at the  
20 time of acquisition, has a contract in effect.

21 (E) A requirement that the health care service plan, payor, or  
22 health care provider submit to binding arbitration, or any other  
23 alternative dispute resolution programs, any claims or causes of  
24 action that arise under state or federal antitrust laws.

25 (F) A provision that prohibits offering incentives to subscribers  
26 or enrollees, or a payor's beneficiaries, that encourages an  
27 enrollee, subscriber, or payor's beneficiary to access health care  
28 providers other than the health care provider, or that creates  
29 disincentives to access the health care provider.

30 (G) A provision that prohibits the disclosure of the contracted  
31 rate between the health care service plan and the health care  
32 provider to subscribers, enrollees, payor's beneficiaries, or the  
33 payor before the services or products of the health care provider  
34 are utilized and billed.

35 (2) Commencing January 1, 2017, any contract provision that  
36 violates subparagraphs (A) to (G), inclusive, of paragraph (1) in  
37 a contract between a health care service plan and a health care  
38 provider entered into, issued, amended, or renewed before, on, or  
39 after January 1, 2017, shall become void and unenforceable.

1 (b) For purposes of this section, “health care provider” means  
2 any professional person, medical group, independent practice  
3 association, organization, health care facility, or other person or  
4 institution licensed or authorized by the state to deliver or furnish  
5 health services.

6 SEC. 3. Article 10.5 (commencing with Section 1399.65) is  
7 added to Chapter 2.2 of Division 2 of the Health and Safety Code,  
8 to read:

9

10 Article 10.5. Mergers and Acquisitions of Health Care Services  
11 Plans and Risk-Based Organizations  
12

13 1399.65. (a) Any person that intends to merge with,  
14 consolidate, acquire, purchase, or control, directly or indirectly,  
15 any health care service plan or risk-bearing organization organized  
16 and doing business in this state shall give notice to, and secure  
17 the prior approval from, the director. Any person that intends to  
18 merge with, consolidate, acquire, purchase, or control, directly  
19 or indirectly, any health care service plan shall file an application  
20 for licensure pursuant to Article 3 (commencing with Section 1349)  
21 as a health care service plan under this chapter.

22 (b) Any risk-bearing organization shall give notice to, and shall  
23 secure the prior approval from, the director for any agreement,  
24 collaboration, relationship, or joint venture entered into with  
25 another risk-bearing organization or any other organization, such  
26 as a hospital or health care service plan, for the purpose of  
27 increasing the level of collaboration in the provision of health care  
28 services, which may include, but are not limited to, each of the  
29 following:

30 (1) Sharing of physician resources in hospital or other  
31 ambulatory settings.

32 (2) Cobranding.

33 (3) Expedited transfers to advanced care settings.

34 (4) The provision of inpatient consultation coverage.

35 (5) Enhanced electronic access and communications.

36 (6) Colocated services.

37 (7) Provision of capital for service site development.

38 (8) Joint training programs.

39 (9) Video technology to increase access to expert resources and  
40 sharing of hospitalists or intensivists.

1 1399.66. (a) Prior to approving any transaction or agreement  
2 described in Section 1399.65, the department shall do both of the  
3 following:

4 (1) Hold a public hearing on the proposal.

5 (2) Find that the proposal meets all of the following criteria:

6 (A) Provides short-term and long-term benefits to purchasers,  
7 subscribers, enrollees, and patients, in the form of lower prices,  
8 better quality, and improved access to care.

9 (B) Does not adversely affect competition. In making this  
10 finding, the director shall request an advisory opinion from the  
11 Attorney General regarding whether competition would be  
12 adversely affected and what mitigation measures could be adopted  
13 to avoid this result.

14 (C) Does not jeopardize the financial stability of the parties or  
15 prejudice the interests of their purchasers, subscribers, enrollees,  
16 and patients.

17 (D) Does not result in a significant effect on the availability or  
18 accessibility of existing health care services.

19 (b) The director may give conditional approval for any  
20 transaction or agreement described in Section 1399.65 if the  
21 parties to the transaction or agreement commit to taking action  
22 to prevent adverse impacts on competition, or health care costs,  
23 access, and quality of care in this state.

24 1399.67. (a) If the director determines that a material amount  
25 of assets of a health care service plan or risk-bearing organization  
26 is subject to merger, consolidation, acquisition, purchase, or  
27 control, directly or indirectly, the Attorney General shall prepare  
28 and submit to the department an independent health care impact  
29 statement to assist the director in his or her approval of a  
30 transaction described in subdivision (a) of Section 1399.65.

31 (b) The director shall develop by regulation a definition of a  
32 “material amount of assets” for purposes of this section.

33 SEC. 4. Section 10133.651 is added to the Insurance Code,  
34 immediately following Section 10133.65, to read:

35 10133.651. (a) (1) A contract between a health insurer and  
36 a health care provider for the provision of covered benefits at  
37 alternative rates of payment to an insured shall not contain,  
38 directly or indirectly, any of the following terms:

39 (A) A requirement that the health insurer includes in its network  
40 any one or more providers owned or controlled by, or affiliated

1 *with, the health care provider as a condition of allowing the health*  
2 *insurer to include in its network the health care provider.*

3 *(B) A requirement that a health insurer places all members of*  
4 *a provider group, whether medical group, independent practice*  
5 *association, organization, health care facility, or other person or*  
6 *institution licensed or authorized by the state to deliver or furnish*  
7 *health services, in the same tier of a tiered network plan.*

8 *(C) A provision that sets rates for emergency services by any*  
9 *health care provider not participating in a network at a rate*  
10 *greater than that which is provided for pursuant to subdivision*  
11 *(d) of Section 1317.2a of the Health and Safety Code, and any*  
12 *regulations adopted pursuant to that section by the department.*

13 *(D) A requirement that the health insurer compensate the health*  
14 *care provider at the contracted rate for services by a provider*  
15 *acquired by the health care provider during the term of the contract*  
16 *and with which the health insurer, at the time of acquisition, has*  
17 *a contract in effect.*

18 *(E) A requirement that the health insurer, payor, or health care*  
19 *provider submit to binding arbitration, or any other alternative*  
20 *dispute resolution programs, any claims or causes of action that*  
21 *arise under state or federal antitrust laws.*

22 *(F) A provision that prohibits offering incentives to insureds or*  
23 *a payor's beneficiaries, that encourages an insured or payor's*  
24 *beneficiary to access health care providers other than the health*  
25 *care provider, or that creates disincentives to access the health*  
26 *care provider.*

27 *(G) A provision that prohibits the disclosure of the contracted*  
28 *rate between the health insurer and the health care provider to*  
29 *insureds, payor's beneficiaries, or the payor before the services*  
30 *or products of the health care provider are utilized and billed.*

31 *(2) Commencing January 1, 2017, any contract provision that*  
32 *violates subparagraphs (A) to (G), inclusive, of paragraph (1) in*  
33 *a contract between a health insurer and a health care provider*  
34 *entered into, issued, amended, or renewed before, on, or after*  
35 *January 1, 2017, shall become void and unenforceable.*

36 *(b) For purposes of this section, "health care provider" means*  
37 *any professional person, medical group, independent practice*  
38 *association, organization, health care facility, or other person or*  
39 *institution licensed or authorized by the state to deliver or furnish*  
40 *health services.*

1     *SEC. 5. No reimbursement is required by this act pursuant to*  
2     *Section 6 of Article XIII B of the California Constitution because*  
3     *the only costs that may be incurred by a local agency or school*  
4     *district will be incurred because this act creates a new crime or*  
5     *infraction, eliminates a crime or infraction, or changes the penalty*  
6     *for a crime or infraction, within the meaning of Section 17556 of*  
7     *the Government Code, or changes the definition of a crime within*  
8     *the meaning of Section 6 of Article XIII B of the California*  
9     *Constitution.*

10    ~~SECTION 1. It is the intent of the Legislature to enact~~  
11    ~~legislation that would require a review of health care mergers and~~  
12    ~~acquisitions for impacts on health care costs, access, and quality~~  
13    ~~of care.~~