

AMENDED IN SENATE APRIL 26, 2016

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, 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 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 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, transactions, 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~~ *agreements* between health care service plans or health insurers that contract with

providers for alternative rates of payment and ~~health care contracting~~ providers, and ~~contracts agreements~~ between *network vendors, as defined, or payors, as defined,* and general acute care ~~hospitals, hospitals that are contracting providers, as defined,~~ including a requirement that the health care service plan, health insurer, or *network vendor or payor* ~~includes include~~ in its network any one or more providers owned or controlled by, or affiliated with, the ~~health care contracting~~ 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. that is a contracting provider.~~ The bill would also prohibit a contracting provider from imposing these prohibited terms as a condition to its participation in a network or as a condition to more favorable contract rates. The bill, commencing January 1, 2017, would provide that any contract provision that violates these prohibitions in ~~a contract an agreement~~ 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: yes.  
State-mandated local program: 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~~*An agreement* between a general
- 4 acute care hospital *that is a contracting provider* and a *network*
- 5 *vendor or payor* shall not contain, directly or indirectly, any of the
- 6 following ~~terms: terms and a contracting provider shall not impose~~
- 7 *any of the following terms as a condition to its participation in a*
- 8 *network or as a condition to more favorable contract rates:*
- 9 (A) A requirement that the *network vendor or payor* ~~includes~~
- 10 *include* in its network any one or more providers owned or
- 11 controlled by, or affiliated with, the ~~general acute care hospital as~~

1 a condition of allowing the payor to include in its network the  
2 general acute care hospital: *contracting provider*.

3 (B) A requirement that a payor places all members of a provider  
4 group, whether medical group, independent practice association,  
5 organization, health care facility, or other person or institution  
6 licensed or authorized by the state to deliver or furnish health  
7 services, in the same a network vendor or payor refrain from  
8 offering a tiered network plan or place the contracting provider  
9 or any other provider owned, controlled, or affiliated with the  
10 contracting provider in a particular tier of a tiered network plan.

11 (C) A provision that sets rates for emergency services by any  
12 general acute care hospital a provider owned, controlled, or  
13 affiliated with a contracting provider not participating in a the  
14 network at a rate greater than that which is provided for pursuant  
15 to subdivision (d) of Section 1317.2a, and any regulations adopted  
16 pursuant to that section by the Department of Managed Health  
17 Care.

18 (D) A requirement that the network vendor or payor compensate  
19 the general acute care hospital contracting provider at the  
20 contracted rate for services by a provider acquired by the general  
21 acute care hospital contracting provider or its affiliate during the  
22 term of the contract and with which the network vendor or payor,  
23 at the time of acquisition, has a contract in effect.

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

28 (E) A requirement that the network vendor or payor submit  
29 disputes, other than claims for breach of contract, for resolution  
30 through arbitration. A separate and voluntary arbitration  
31 agreement that is negotiated and concluded after the execution of  
32 the contract between the contracting provider and the network  
33 vendor or payor and is not obtained under threat of  
34 nonparticipation in the network or threat of less favorable contract  
35 rates shall not be subject to this provision.

36 (F) A provision that prohibits offering incentives to subscribers,  
37 enrollees, insureds, or a payor's beneficiaries that encourages  
38 encourage a subscriber, enrollee, insured, or payor's beneficiary  
39 to access health care providers other than the general acute care

1 ~~hospital, contracting provider~~ or that ~~creates~~ *create* disincentives  
2 to access the ~~general acute care hospital~~. *contracting provider*.

3 (G) A provision that prohibits the disclosure of the contracted  
4 rate between the *network vendor* or payor and the ~~general acute~~  
5 ~~care hospital~~ *contracting provider* or its affiliates to subscribers,  
6 enrollees, insureds, payor’s beneficiaries, or the payor *at any time*  
7 before the services or products of the ~~general acute care hospital~~  
8 *contracting provider* or its affiliates are utilized and billed.

9 (2) Commencing January 1, 2017, any contract provision that  
10 violates subparagraphs (A) to (G), inclusive, of paragraph (1) in  
11 ~~a contract~~ *an agreement* between a ~~general acute care hospital~~  
12 *contracting provider* and a *network vendor* or payor entered into,  
13 issued, amended, or renewed before, on, or after January 1, 2017,  
14 shall become void and unenforceable.

15 (b) For purposes of this section, ~~“payor” shall have the same~~  
16 ~~meaning as set forth in subparagraph (A) of paragraph (3)~~  
17 ~~subdivision (d) of Section 1395.6.~~ *the following definitions shall*  
18 *apply:*

19 (1) *“Contracting provider” means a provider, as that term is*  
20 *defined in paragraph (4), that has a contract with a network vendor*  
21 *or payor.*

22 (2) *“Network vendor” means a person that enters into one or*  
23 *more contracts with a provider for discounted rates and other*  
24 *benefits and makes the discounted rates and other benefits under*  
25 *one or more of those contracts available to payors.*

26 (3) *“Payor” means a person that is financially responsible, in*  
27 *whole or in part, for paying or reimbursing the cost of health care*  
28 *services received by beneficiaries of a health care welfare benefit*  
29 *plan sponsored or arranged by that person.*

30 (4) *“Provider” means any medical group, independent practice*  
31 *association, organization, health care facility, or institution*  
32 *licensed or authorized by the state to deliver or furnish health*  
33 *services. Provider does not include a medical group with 10 or*  
34 *fewer professional persons that is not owned, controlled, or*  
35 *affiliated with a hospital or health care system.*

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~~ *An agreement* between a health  
39 care service plan and a ~~health care~~ *contracting provider* shall not  
40 contain, directly or indirectly, any of the following ~~terms~~: *terms*

1 *and a contracting provider shall not impose any of the following*  
2 *terms as a condition to its participation in a network or as a*  
3 *condition to more favorable contract rates:*

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

9 (B) A requirement that a health care service plan ~~places all~~  
10 ~~members of a provider group, whether medical group, independent~~  
11 ~~practice association, organization, health care facility, or other~~  
12 ~~person or institution licensed or authorized by the state to deliver~~  
13 ~~or furnish health services, in the same~~ *refrain from offering a tiered*  
14 *network plan or place the contracting provider or any other*  
15 *provider owned, controlled, or affiliated with the contracting*  
16 *provider in a particular tier of a tiered network plan.*

17 (C) A provision that sets rates for emergency services by ~~any~~  
18 ~~health care a provider owned, controlled, or affiliated with a~~  
19 ~~contracting provider~~ not participating in ~~a~~ *the* network at a rate  
20 greater than that which is provided for pursuant to subdivision (d)  
21 of Section 1317.2a, and any regulations adopted pursuant to that  
22 section by the department.

23 (D) A requirement that the health care service plan compensate  
24 the ~~health care~~ *contracting* provider at the contracted rate for  
25 services by a provider acquired by the ~~health care~~ *contracting*  
26 *provider or its affiliate* during the term of the contract and with  
27 which the health care service plan, at the time of acquisition, has  
28 a contract in effect.

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

33 *(E) A requirement that the health care service plan submit*  
34 *disputes, other than claims for breach of contract, for resolution*  
35 *through arbitration. A separate and voluntary arbitration*  
36 *agreement that is negotiated and concluded after the execution of*  
37 *the contract between the contracting provider and the health care*  
38 *service plan and is not obtained under threat of nonparticipation*  
39 *in the network or threat of less favorable contract rates shall not*  
40 *be subject to this provision.*

1 (F) A provision that prohibits offering incentives to subscribers  
2 or enrollees, or a payor's ~~beneficiaries~~, *beneficiaries* that  
3 ~~encourages~~ *encourage* an enrollee, subscriber, or payor's  
4 beneficiary to access health care providers other than the ~~health~~  
5 ~~care provider~~, *contracting provider* or that ~~creates~~ *create*  
6 disincentives to access the ~~health care~~ *contracting provider*.

7 (G) A provision that prohibits the disclosure of the contracted  
8 rate between the health care service plan and the ~~health care~~  
9 *contracting provider or its affiliates* to subscribers, enrollees,  
10 payor's beneficiaries, or the payor *at any time* before the services  
11 or products of the ~~health care~~ *contracting provider or its affiliates*  
12 are utilized and billed.

13 (2) Commencing January 1, 2017, any contract provision that  
14 violates subparagraphs (A) to (G), inclusive, of paragraph (1) in  
15 a ~~contract~~ *an agreement* between a health care service plan and a  
16 ~~health care~~ *contracting provider* entered into, issued, amended, or  
17 renewed before, on, or after January 1, 2017, shall become void  
18 and unenforceable.

19 (b) For purposes of this section, ~~“health care provider”~~ *the*  
20 *following definitions shall apply:*

21 (1) *“Contracting provider” means a provider, as that term is*  
22 *defined in paragraph (3), that has a contract with a health care*  
23 *service plan.*

24 (2) *“Payor” means a person that is financially responsible, in*  
25 *whole or in part, for paying or reimbursing the cost of health care*  
26 *services received by beneficiaries of a health care welfare benefit*  
27 *plan sponsored or arranged by that person.*

28 (3) *“Provider” means any* ~~professional person~~, *medical group,*  
29 *independent practice association, organization, health care facility,*  
30 *or other* ~~person or~~ *institution licensed or authorized by the state to*  
31 *deliver or furnish health services. Provider does not include a*  
32 *medical group with 10 or fewer professional persons that is not*  
33 *owned, controlled, or affiliated with a hospital or health care*  
34 *system.*

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

1 Article 10.5. Mergers and Acquisitions of Health Care Services  
2 *Service Plans and Risk-Based Organizations*

3  
4 1399.65. ~~(a) Any person that intends to merge with,~~  
5 ~~consolidate, acquire, purchase, or control, directly or indirectly,~~  
6 ~~any health care service plan or risk-bearing organization organized~~  
7 ~~and doing business in this state shall give notice to, and secure the~~  
8 ~~prior approval from, the director. Any person that intends to merge~~  
9 ~~with, consolidate, acquire, purchase, or control, directly or~~  
10 ~~indirectly, any health care service plan shall file an application for~~  
11 ~~licensure pursuant to Article 3 (commencing with Section 1349)~~  
12 ~~as a health care service plan under this chapter.~~

13 ~~(b) Any risk-bearing organization shall give notice to, and shall~~  
14 ~~secure the prior approval from, the director for any agreement,~~  
15 ~~collaboration, relationship, or joint venture entered into with~~  
16 ~~another risk-bearing organization or any other organization, such~~  
17 ~~as a hospital or health care service plan, for the purpose of~~  
18 ~~increasing the level of collaboration in the provision of health care~~  
19 ~~services, which may include, but are not limited to, each of the~~  
20 ~~following:~~

21 ~~(1) Sharing of physician resources in hospital or other~~  
22 ~~ambulatory settings.~~

23 ~~(2) Cobranding.~~

24 ~~(3) Expedited transfers to advanced care settings.~~

25 ~~(4) The provision of inpatient consultation coverage.~~

26 ~~(5) Enhanced electronic access and communications.~~

27 ~~(6) Colocated services.~~

28 ~~(7) Provision of capital for service site development.~~

29 ~~(8) Joint training programs.~~

30 ~~(9) Video technology to increase access to expert resources and~~  
31 ~~sharing of hospitalists or intensivists.~~

32 1399.66. (a) Prior to approving any transaction or agreement  
33 described in Section 1399.65, the department shall do both of the  
34 following:

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

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

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

1 (B) Does not adversely affect competition. In making this  
2 finding, the director shall request an advisory opinion from the  
3 Attorney General regarding whether competition would be  
4 adversely affected and what mitigation measures could be adopted  
5 to avoid this result.

6 (C) Does not jeopardize the financial stability of the parties or  
7 prejudice the interests of their purchasers, subscribers, enrollees,  
8 and patients.

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

11 (b) The director may give conditional approval for any  
12 transaction ~~or agreement~~ described in Section 1399.65 if the parties  
13 to the transaction ~~or agreement~~ commit to taking action to prevent  
14 adverse impacts on competition, or health care costs, access, and  
15 quality of care in this state.

16 ~~1399.67. (a) If the director determines that a material amount~~  
17 ~~of assets of a health care service plan or risk-bearing organization~~  
18 ~~is subject to merger, consolidation, acquisition, purchase, or~~  
19 ~~control, directly or indirectly, the Attorney General shall prepare~~  
20 ~~and submit to the department an independent health care impact~~  
21 ~~statement to assist the director in his or her approval of a~~  
22 ~~transaction described in subdivision (a) of Section 1399.65.~~

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

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

27 10133.651. (a) (1) ~~A contract~~*An agreement* between a health  
28 insurer and a ~~health care~~ *contracting* provider for the provision of  
29 covered benefits at alternative rates of payment to an insured shall  
30 not contain, directly or indirectly, any of the following ~~terms:~~ *terms*  
31 *and a contracting provider shall not impose any of the following*  
32 *terms as a condition to its participation in a network or as a*  
33 *condition to more favorable contract rates:*

34 (A) A requirement that the health insurer ~~includes~~ *include* in its  
35 network any one or more providers owned or controlled by, or  
36 affiliated with, the ~~health care~~ *contracting* provider as a condition  
37 of allowing the health insurer to include in its network the ~~health~~  
38 ~~care~~ *contracting* provider.

39 (B) A requirement that a health insurer ~~places all members of~~  
40 ~~a provider group, whether medical group, independent practice~~

1 association, organization, health care facility, or other person or  
 2 institution licensed or authorized by the state to deliver or furnish  
 3 health services, in the same *refrain from offering a tiered network*  
 4 *policy or place the contracting provider or any other provider*  
 5 *owned, controlled, or affiliated with the contracting provider in*  
 6 *a particular tier of a tiered network plan policy.*

7 (C) A provision that sets rates for emergency services by ~~any~~  
 8 ~~health care~~ a provider owned, controlled, or affiliated with a  
 9 contracting provider not participating in ~~a~~ the network at a rate  
 10 greater than that which is provided for pursuant to subdivision (d)  
 11 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~~ contracting provider at the contracted rate for services by a  
 15 provider acquired by the ~~health care~~ contracting provider or its  
 16 affiliate during the term of the contract and with which the health  
 17 insurer, at the time of acquisition, has 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 (E) A requirement that the health insurer submit disputes, other  
 23 than claims for breach of contract, for resolution through  
 24 arbitration. A separate and voluntary arbitration agreement that  
 25 is negotiated and concluded after the execution of the contract  
 26 between the contracting provider and the health insurer and is not  
 27 obtained under threat of nonparticipation in the network or threat  
 28 of less favorable contract rates shall not be subject to this  
 29 provision.

30 (F) A provision that prohibits offering incentives to insureds or  
 31 a payor's ~~beneficiaries~~, *beneficiaries that encourages encourage*  
 32 an insured or payor's beneficiary to access health care providers  
 33 other than the ~~health care provider~~, *contracting provider* or that  
 34 ~~creates create~~ disincentives to access the ~~health care~~ contracting  
 35 provider.

36 (G) A provision that prohibits the disclosure of the contracted  
 37 rate between the health insurer and the ~~health care~~ contracting  
 38 provider or its affiliates to insureds, payor's beneficiaries, or the  
 39 payor at any time before the services or products of the ~~health care~~  
 40 contracting provider or its affiliates are utilized and billed.

1 (2) Commencing January 1, 2017, any contract provision that  
2 violates subparagraphs (A) to (G), inclusive, of paragraph (1) in  
3 ~~a contract~~ *an agreement* between a health insurer and a ~~health care~~  
4 *contracting* provider entered into, issued, amended, or renewed  
5 before, on, or after January 1, 2017, shall become void and  
6 unenforceable.

7 (b) For purposes of this section, ~~“health care provider”~~ *the*  
8 *following definitions shall apply:*

9 (1) *“Contracting provider” means a provider, as that term is*  
10 *defined in paragraph (3), that has a contract with a health insurer.*

11 (2) *“Payor” means a person that is financially responsible, in*  
12 *whole or in part, for paying or reimbursing the cost of health care*  
13 *services received by beneficiaries of a health care welfare benefit*  
14 *plan sponsored or arranged by that person.*

15 (3) *“Provider” means any ~~professional person~~, medical group,*  
16 *independent practice association, organization, health care facility,*  
17 *or other person or institution licensed or authorized by the state to*  
18 *deliver or furnish health services. Provider does not include a*  
19 *medical group with 10 or fewer professional persons that is not*  
20 *owned, controlled, or affiliated with a hospital or health care*  
21 *system.*

22 SEC. 5. No reimbursement is required by this act pursuant to  
23 Section 6 of Article XIII B of the California Constitution because  
24 the only costs that may be incurred by a local agency or school  
25 district will be incurred because this act creates a new crime or  
26 infraction, eliminates a crime or infraction, or changes the penalty  
27 for a crime or infraction, within the meaning of Section 17556 of  
28 the Government Code, or changes the definition of a crime within  
29 the meaning of Section 6 of Article XIII B of the California  
30 Constitution.