AMENDED IN SENATE MAY 26, 2017

AMENDED IN SENATE MAY 2, 2017

AMENDED IN SENATE APRIL 17, 2017

AMENDED IN SENATE MARCH 23, 2017

SENATE BILL No. 538

Introduced by Senator Monning

February 16, 2017

An act to add Section 513 to the Business and Professions Code, to add Sections 1268.9 and 1367.32 to the Health and Safety Code, and to add Section 10133.57 to the Insurance Code, relating to hospital contracts.

LEGISLATIVE COUNSEL'S DIGEST

SB 538, as amended, Monning. Hospital contracts.

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 provides for the licensure and regulation of health facilities, including general acute care hospitals, acute psychiatric hospitals, and special hospitals, administered by the State Department of Public Health. A violation of these provisions is a crime. Existing law, the Health Care Providers' Bill of Rights, prescribes restrictions on the types of contractual provisions that may be included in agreements between health care service plans and health care providers and agreements between health insurers and health care providers.

This bill, the Health Care Market Fairness Act of 2017, would prohibit contracts between hospitals and contracting agents, health care service plans, or health insurers from containing certain provisions, including, but not limited to, setting payment rates or other terms for nonparticipating affiliates of the hospital, requiring the contracting agent, plan, or insurer to keep the contract's payment rates confidential from any payor, as defined, that is or may become financially responsible for the payment, and requiring the contracting agent, plan, or insurer to submit to arbitration, or any other alternative dispute resolution program, any claims or causes of action that arise under state or federal antitrust laws after those claims or causes of action arise, except as provided. The bill would make any prohibited contract provision void and unenforceable. The bill would define "contracting agent" and "hospital" for those purposes. The bill would enact an identical provision under the health facility licensure and regulation provisions as that provision described above for contracts between hospitals and contracting agents. The bill would provide that its provisions are severable.

Existing law requires every health facility for which a license or special permit has been issued to be periodically inspected by the State Department of Public Health, or by another governmental entity under contract with the department. Existing law requires the department to inspect the facility for compliance with provisions of state law and regulations during a state periodic inspection, or at the same time that a federal periodic inspection is performed.

This bill would provide that the contracts made pursuant to the provisions described above are not subject to those inspection requirements.

Because a willful violation of the provisions relating to health care service plans is a crime, and a violation of those licensure and regulation provisions relating to hospitals 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:

SECTION 1. This act shall be known, and may be cited, as the Health Care Market Fairness Act of 2017.

SEC. 2. The Legislature finds and declares all of the following:

(a) There has been a surge in hospital consolidations in California, fueling the formation of ever larger multihospital systems. Almost one-half of all hospitals in California are in multihospital systems, with the two largest systems controlling almost 60 hospitals. According to recent studies, hospital prices in California grew between the years 2004 and 2013 across all hospitals, but prices at hospitals that are part of multihospital systems grew substantially more. The evidence indicates that higher prices are consistent with the use of contract provisions of the type addressed in this act.

(b) Concentration of hospitals also has had an impact on premium rates in California's 19 health insurance rating areas. Researchers found that reducing hospital concentration to levels that would exist in moderately competitive markets could reduce overall premiums by more than 2 percent and in three regions by more than 10 percent.

(c) Because they tend to lessen competition, increase prices, and reduce the affordability and availability of insurance coverage, and for the protection of other important state interests, the hospital contract provisions described in this act are deemed to be unfair, and against public policy, both of which are grounds for the revocation of any contract under the laws of this state.

(d) This act regulates the business of insurance, as that term is defined for purposes of the federal McCarran-Ferguson Act (15 U.S.C. Sec. 1012). Nothing in this act shall be construed to impose the regulatory requirements of the Insurance Code on health care service plans regulated by the Health and Safety Code, or on network vendors regulated by the Business and Professions Code.

SEC. 3. Section 513 is added to the Business and Professions Code, to read:

513. (a) A contract between a hospital or any affiliate of a hospital and a contracting agent shall not, directly or indirectly, do any of the following:

(1) Set payment rates or other terms for nonparticipating affiliates of the hospital.

(2) Require the contracting agent to contract with any one or more of the hospital's affiliates. This section does not prohibit a contract from requiring that the contracting agent contract with the medical group with which the hospital's medical staff is affiliated.

(3) Require payors to certify, attest, or otherwise confirm in writing that the payor is bound by the terms of the contract between the hospital and the contracting agent. A contracting agent shall be responsible for including and disclosing relevant terms of the provider contract in its contract with a payor.

(4) Require the contracting agent, as a condition to entering into the contract with the hospital or continuing the contract on its then current terms, to submit to arbitration, or any other alternative dispute resolution program, any claims or causes of action that arise under state or federal antitrust laws. This paragraph does not prohibit a hospital or any affiliate of a hospital and a contracting agent from entering into a consensual agreement to submit those claims or causes of action to arbitration or any other alternative dispute resolution program, other than as a condition to entering into the contract or continuing the contract on its then current terms.

(5) Require the contracting agent to impose the same cost-sharing obligations on beneficiaries when the hospital is in-network but at a different cost-sharing tier than any other in-network hospital. For purposes of this section, "cost sharing" includes copayment, coinsurance, deductible, or any other cost-sharing provision for covered benefits other than share of premium.

(6) Require the contracting agent to keep the contract's payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments. This paragraph does not prohibit a requirement that any communication of the contract's payment rates to an existing or potential payor be subject to a reasonable nondisclosure agreement.

(b) Any contract provision that violates subdivision (a) is void and unenforceable.

(c) For the purposes of this section, the following terms have the following meanings:

(1) "Affiliate" means, with respect to any person, any other person that, directly or indirectly, through one or more

intermediaries, controls, is controlled by, or is under common control with, that person. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, membership rights, by contract or otherwise, and the terms "controlled" and "controlling" have meanings correlative thereto.

(2) "Contracting agent" has the same meaning as set forth in Section 511.1.

(3) "Hospital" means any general acute care hospital, acute psychiatric hospital, or special hospital, as those terms are defined in Section 1250 of the Health and Safety Code.

(4) "Nonparticipating" means that with respect to the services rendered, the hospital or its affiliate is out of network according to the applicable health care service plan contract or health care welfare benefit plan.

(5) "Payor" means a person who is financially responsible, in whole or in part, for paying or reimbursing the cost of health care services received by beneficiaries of a health care welfare benefit plan sponsored or arranged by that person. This definition includes, but is not limited to, the health care welfare benefit plan itself.

SEC. 4. Section 1268.9 is added to the Health and Safety Code, to read:

1268.9. (a) A contract between a hospital or any affiliate of a hospital and a contracting agent shall not, directly or indirectly, do any of the following:

(1) Set payment rates or other terms for nonparticipating affiliates of the hospital.

(2) Require the contracting agent to contract with any one or more of the hospital's affiliates. This section does not prohibit a contract from requiring that the contracting agent contract with the medical group with which the hospital's medical staff is affiliated.

(3) Require payors to certify, attest, or otherwise confirm in writing that the payor is bound by the terms of the contract between the hospital and the contracting agent. A contracting agent shall be responsible for including and disclosing relevant terms of the provider contract in its contract with a payor.

(4) Require the contracting agent, as a condition to entering into the contract with the hospital or continuing the contract on its then

current terms, to submit to arbitration, or any other alternative dispute resolution program, any claims or causes of action that arise under state or federal antitrust laws. This paragraph does not prohibit a hospital or any affiliate of a hospital and a contracting agent from entering into a consensual agreement to submit those claims or causes of action to arbitration or any other alternative dispute resolution program, other than as a condition to entering into the contract or continuing the contract on its then current terms.

(5) Require the contracting agent to impose the same cost-sharing obligations on beneficiaries when the hospital is in-network but at a different cost-sharing tier than any other in-network hospital. For purposes of this section, "cost sharing" includes copayment, coinsurance, deductible, or any other cost-sharing provision for covered benefits other than share of premium.

(6) Require the contracting agent to keep the contract's payment rates ~~secret~~ confidential from any existing or potential payor that is or may become financially responsible for the payments. This paragraph does not prohibit a requirement that any communication of the contract's payment rates to an existing or potential payor be subject to a reasonable nondisclosure agreement.

(b) Any contract provision that violates subdivision (a) is void and unenforceable.

(c) For the purposes of this section, the following terms have the following meanings:

(1) "Affiliate" means, with respect to any person, any other person that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, that person. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, membership rights, by contract or otherwise, and the terms "controlled" and "controlling" have meanings correlative thereto.

(2) "Contracting agent" has the same meaning as set forth in Section 511.1 of the Business and Professions Code.

(3) "Hospital" means any general acute care hospital, acute psychiatric hospital, or special hospital, as those terms are defined in Section 1250.

(4) "Nonparticipating" means that, with respect to the services rendered, the hospital or its affiliate is out of network according to the applicable health care service plan contract or health care welfare benefit plan.

(5) "Payor" means a person who is financially responsible, in whole or in part, for paying or reimbursing the cost of health care services received by beneficiaries of a health care welfare benefit plan sponsored or arranged by that person. This definition includes, but is not limited to, the health care welfare benefit plan itself.

(d) The inspection requirements in Section 1279 do not apply to contracts made pursuant to this section.

SEC. 5. Section 1367.32 is added to the Health and Safety Code, to read:

1367.32. (a) A contract between a hospital or any affiliate of a hospital and a health care service plan shall not, directly or indirectly, do any of the following:

(1) Set payment rates or other terms for nonparticipating affiliates of the hospital.

(2) Require the health care service plan to contract with any one or more of the hospital's affiliates. This section does not prohibit a contract from requiring that the health care service plan contract with the medical group with which the hospital's medical staff is affiliated.

(3) Require payors to certify, attest, or otherwise confirm in writing that the payor is bound by the terms of the contract between the hospital and the health care service plan. A health care service plan shall be responsible for including and disclosing relevant terms of the provider contract in its contract with a payor.

(4) Require the health care service plan, as a condition to entering into the contract with the hospital or continuing the contract on its then current terms, to submit to arbitration, or any other alternative dispute resolution program, any claims or causes of action that arise under state or federal antitrust laws. This paragraph does not prohibit a hospital or any affiliate of a hospital and a health care service plan from entering into a consensual agreement to submit those claims or causes of action to arbitration or any other dispute resolution program, other than as a condition to entering into the contract or continuing the contract on its then current terms.

(5) Require the health care service plan to impose the same cost-sharing obligations on beneficiaries when the hospital is in-network but at a different cost-sharing tier than any other in-network hospital. For purposes of this section, "cost sharing" includes copayment, coinsurance, deductible, or any other cost-sharing provision for covered benefits other than share of premium.

(6) Require the health care service plan to keep the contract's payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments. This paragraph does not prohibit a requirement that any communication of the contract's payment rates to an existing or potential payor be subject to a reasonable nondisclosure agreement.

(b) Any contract provision that violates subdivision (a) is void and unenforceable.

(c) For the purposes of this section, the following terms have the following meanings:

(1) "Affiliate" means, with respect to any person, any other person that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, that person. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, membership rights, by contract or otherwise, and the terms "controlled" and "controlling" have meanings correlative thereto.

(2) "Hospital" means any general acute care hospital, acute psychiatric hospital, or special hospital, as those terms are defined in Section 1250.

(3) "Nonparticipating" means that with respect to the services rendered, the hospital or affiliate is out of network according to the applicable health care service plan contract or health care welfare benefit plan.

(4) "Payor" means a person that is financially responsible, in whole or in part, for paying or reimbursing the cost of health care services received by beneficiaries of a health care welfare benefit plan sponsored or arranged by that person. This definition includes, but is not limited to, the health care welfare benefit plan itself.

SEC. 6. Section 10133.57 is added to the Insurance Code, to read:

10133.57. (a) A contract between a hospital or any affiliate of a hospital and a health insurer shall not, directly or indirectly, do any of the following:

(1) Set payment rates or other terms for nonparticipating affiliates of the hospital.

(2) Require the health insurer to contract with any one or more of the hospital's affiliates. This section does not prohibit a contract from requiring that the ~~contracting agent~~ *health insurer* contract with the medical group with which the hospital's medical staff is affiliated.

(3) Require payors to certify, attest, or otherwise confirm in writing that the payor is bound by the terms of the contract between the hospital and the health insurer. A health insurer shall be responsible for including and disclosing relevant terms of the provider contract in its contract with a payor.

(4) Require the health insurer, as a condition to entering into the contract with the hospital or continuing the contract on its then current terms, to submit to arbitration, or any other alternative dispute resolution program, any claims or causes of action that arise under state or federal antitrust laws. This paragraph does not prohibit a hospital or any affiliate of a hospital and a health insurer from entering into a consensual agreement to submit those claims or causes of action to arbitration or any other alternative dispute resolution program, other than as a condition to entering into the contract or continuing the contract on its then current terms.

(5) Require the health insurer to impose the same cost-sharing obligations on beneficiaries when the hospital is in-network but at a different cost-sharing tier than any other in-network hospital. For purposes of this section, "cost sharing" includes copayment, coinsurance, deductible, or any other cost-sharing provision for covered benefits other than share of premium.

(6) Require the health insurer to keep the contract's payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments. This paragraph does not prohibit a requirement that any communication of the contract's payment rates to an existing or potential payor be subject to a reasonable nondisclosure agreement.

(b) Any contract provision that violates subdivision (a) is void and unenforceable.

(c) For the purposes of this section, the following terms have the following meanings:

(1) "Affiliate" means, with respect to any person, any other person that, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with, that person. The term "control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, membership rights, by contract or otherwise, and the terms "controlled" and "controlling" have meanings correlative thereto.

(2) "Hospital" means any general acute care hospital, acute psychiatric hospital, or special hospital, as those terms are defined in Section 1250 of the Health and Safety Code.

(3) "Nonparticipating" means that with respect to the services rendered, the hospital or affiliate is out of network according to the applicable health insurance policy or health care welfare benefit.

(4) "Payor" means a person that is financially responsible, in whole or in part, for paying or reimbursing the cost of health care services received by beneficiaries of a health care welfare benefit plan sponsored or arranged by that person. This definition includes, but is not limited to, the health care welfare benefit plan itself.

SEC. 7. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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

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