HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874] *(Chapter 2.2 added by Stats. 1975, Ch. 941.)*

ARTICLE 10.2. Mergers and Acquisitions of Health Care Service Plans [1399.65 - 1399.66] *(Article 10.2 added by Stats. 2018, Ch. 292, Sec. 1.)*

1399.65. (a) (1) A health care service plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, any entity, including another health care service plan or a health insurer licensed under the Insurance Code, shall give notice to, and secure prior approval from, the director.

(2) The transactions or agreements described in paragraph (1) may not be completed until the director approves the transaction or agreement.

(3) A health care service plan described in paragraph (1) shall meet all of the requirements of this chapter. The health care service plan shall file all the information necessary for the director to make the determination to approve, conditionally approve, or disapprove the transaction or agreement described in paragraph (1), including, but not limited to, a complete description of the proposed transaction or agreement, any modified exhibits for plan licensure pursuant to Section 1351, any approvals by federal or other state agencies required for the transaction or agreement, and any supporting documentation required by the director.

(4) The director may conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement in furtherance of this chapter. The director shall engage stakeholders in determining the measures for improvement. For a major transaction or agreement, the director shall obtain an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system, and other relevant provisions of this chapter. For any other transaction or agreement, the director may obtain an independent analysis consistent with this paragraph.

(5) If an entity involved in the transaction or agreement is a nonprofit corporation described in Section 5046 of the Corporations Code, the health care service plan shall file all the information required by Article 11 (commencing with Section 1399.70).

(b) In addition to any grounds for disapproval as a result of information provided by a health care service plan pursuant to paragraph (3) of subdivision (a), the director may disapprove the transaction or agreement if the director finds the transaction or agreement would substantially lessen competition in health care service plan products or create a monopoly in this state, including, but not limited to, health coverage products for a specific line of business. In making this finding, the director may obtain an opinion from a consultant or consultants with the expertise to assess the competitive impact of the transaction or agreement.

(c) Prior to approving, conditionally approving, or disapproving a major transaction or agreement, the department shall hold a public meeting on the proposed transaction or agreement. For any other transaction or agreement, the department may hold a public meeting on the proposed transaction or agreement. The public meeting shall be conducted pursuant to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code). The meeting shall permit the parties to the proposed transaction and members of the public to provide written and verbal comments regarding the proposed transaction. If a substantive change in the proposed transaction or agreement is submitted to the director after the initial public meeting, the director may conduct an additional public meeting to hear comments from interested parties with respect to that change. The director shall consider the testimony and comments received at the public meeting in making the determination to approve, conditionally approve, or disapprove the transaction or agreement.

(d) If the director determines a material amount of assets of a health care service plan is subject to purchase, acquisition, or control, the director shall prepare a statement describing the proposed transaction or agreement subject to subdivision (a) and make it available to the public. The statement shall be made available before the public meeting.

(e) This section does not limit the authority of the director to enforce any other provision of this chapter.

(f) For purposes of this section, “entity” means a health care service plan, an individual, a corporation, a limited liability company, a partnership, an association, a joint stock company, a business trust, an unincorporated organization, any similar entity, or any combination thereof acting in concert.

(g) (1) For purposes of this section, “major transaction or agreement” means a transaction or agreement that meets any of the following criteria:

(A) Affects a significant number of enrollees.

(B) Involves a material amount of assets.

(C) Adversely affects either the subscribers or enrollees or the stability of the health care delivery system because of the entity’s market position, including, but not limited to, the entity’s market exit from a market segment or the entity’s dominance of a market segment.

(2) The director shall, upon request, make available to the public his or her determination of whether a transaction or agreement meets the criteria set forth in this subdivision.

(Added by Stats. 2018, Ch. 292, Sec. 1. (AB 595) Effective January 1, 2019.)

1399.66. (a) Notwithstanding subdivision (d) of Section 1352, a health care service plan that files a material modification that is a transaction or agreement described in subdivision (a) of Section 1399.65 shall be subject to the same fees required by subdivision (a) of Section 1356.

(b) (1) In addition to paying the fees described in subdivision (a), the health care service plan shall reimburse the director for the reasonable costs of all of the following:

(A) The independent analysis described in paragraph (4) of subdivision (a) of Section 1399.65.

(B) The opinion described in subdivision (b) of Section 1399.65.

(C) The public meeting described in subdivision (c) of Section 1399.65.

(D) The statement described in subdivision (d) of Section 1399.65.

(2) The reimbursement required by this subdivision shall be irrespective of the director’s approval, conditional approval, or disapproval of the transaction or agreement described in subdivision (a) of Section 1399.65.

(3) If a transaction described in subdivision (a) of Section 1399.65 involves two health care service plans, the director shall determine whether the reimbursement requirements of this subdivision apply to one or both of the plans.

(Amended by Stats. 2019, Ch. 497, Sec. 152. (AB 991) Effective January 1, 2020.)