OFFICE OF HEALTH CARE AFFORDABILITY

HEALTH CARE SPENDING TARGETS;

DEFINITIONS

Title 22, California Code of Regulations (CCR), Section 97445

Section 100 CHANGES WITHOUT REGULATORY EFFECT

Pursuant to Title 1, Division 1, Chapter 1, Article 2, Section 100(a), of the CCR, the Department of Health Care Access and Information, the Office of Health Care Affordability (OHCA) submits this written statement explaining why the proposed amendments to section 97445 of Article 2, Chapter 11.5, Division 7, of Title 22, CCR, do not materially alter any requirement, right, responsibility, condition, prescription, or other regulatory element of any CCR provision.

Assembly Bill 1415, which takes effect January 1, 2026, re-lettered the subdivisions of Health and Safety Code section 127500.2, including the definition of "payer" in subdivision (o) to (q) and "physician organization" in subdivision (p) to (r). (Bonta, Chapter 641, Statutes of 2025, attached.)

The corresponding regulation cross-references in 22 CCR 97445, subsections (j) and (*l*) must therefore be correspondingly updated to match the newly enacted legislation, which does not materially alter any requirement, right, responsibility, condition, prescription, or other regulatory element. (Cal. Code Regs., tit. 1, § 100, subd. (a)(4), *revising a cross-reference*.)

Subject to the approval of the Office of Administrative Law, OHCA would revise text in the CCR as follows:

1. Section 97445(j)

   Replace the "o" in the cross-reference to the definition of "payer" with a "q" for Health and Safety Code section 127500.2.

2. Section 97445(*l*)

   Replace the "p" in the cross-reference to the definition of "physician organization" with an "r" for Health and Safety Code section 127500.2.

AB-1415 California Health Care Quality and Affordability Act. (2025-2026)

As Amends the Law Today | **As Amends the Law on Nov 18, 2025**

SECTION 1. Section 127500.2 of the Health and Safety Code is amended to read:

127500.2. As used in this chapter, the following definitions apply:

(a) (1) "Administrative costs and profits" means the total sum of all expenses not included in the numerator of the medical loss ratio calculation under state or federal law, including, but not limited to, all of the following:

(A) All categories of administrative expenditures.

(B) Net additions to reserves.

(C) Rate dividends or rebates.

(D) Profits or losses.

(E) Taxes and fees.

(2) For purposes of this chapter, "administrative costs and profits" for a fully integrated delivery system means those associated with its nonprofit health care services plan.

(b) "Affordability for consumers" means considering the totality of costs paid by consumers for covered benefits, including the enrollee share of premium and cost-sharing amounts paid towards the maximum out-of-pocket amount, including deductibles, copays, coinsurance, and other forms of cost sharing for public and private health coverage.

(c) "Affordability for purchasers" means considering the cost to purchasers, including, but not limited to, health plans and health insurers, employers purchasing group coverage, and the state, for health coverage and shall include premium costs, actuarial value of coverage for covered benefits, and the value delivered on health care spending in terms of improved quality and cost efficiency.

(d) "Alternative payment model" means a state or nationally recognized payment approach that financially incentivizes high-quality and cost-efficient care.

(e) "Board" means the Health Care Affordability Board established by Section 127501.10.

(f) "Director" means the Director of the Department of Health Care Access and Information.

(g) (1) "Exempted provider" means a provider that meets standards established by the board for exemption from either of the following:

(A) The statewide health care target.

(B) Specific targets set for health care sectors, including fully integrated delivery systems, geographic regions, and for individual health care entities.

(2) The factors used in setting standards for exemption may include, but are not limited to, annual gross and net revenues, patient volume, and high-cost outliers in a given service or geographic region.

(3) In determining whether a provider is an exempted provider, the board shall also consider any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the provider or that are subject to the control, governance, or financial control of the provider.

(4) A physician practice that does not meet the definition in subdivision ~~(p)~~ *(r)* is an exempted provider.

(h) "Fully integrated delivery system" means a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.

(i) "Geographic region" may either be the regions specified in Section 1385.01 or may be otherwise defined by the board.

(j) "Health care cost target" means the target percentage for the maximum annual increase in per capita total health care expenditures.

(k) "Health care entity" means a payer, provider, or a fully integrated delivery system.

(l) "Hedge fund" means a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of the strategies used to manage the funds. Hedge funds include, but are not limited to, a pool of funds managed or controlled by private limited partnerships or other types of private corporate or partnership formations. A hedge fund does not include either of the following:

(1) Natural persons or other entities that contribute, or promise to contribute, funds to the hedge fund, but otherwise do not participate in the management of the hedge fund or the fund's assets, or in any change in control of the hedge fund or the fund's assets.

(2) Entities that solely provide or manage debt financing secured in whole or in part by the assets of a health care facility, including, but not limited to, banks and credit unions, commercial real estate lenders, bond underwriters, and trustees.

~~(l)~~ *(m)* "Insurance market" means the public and private health insurance markets.

~~(m)~~ *(n)* "Line of business" means the different individual, small, and large group business lines, as defined in Section 1348.95 of this code and Section 10127.19 of the Insurance Code, as well as Medi-Cal, Medicare, Covered California, or self-insured public employee health plans.

(o) "Management services organization" means an entity that provides management and administrative support services for a provider in support of the delivery of health care services, excluding the direct provision of health services. Management and administrative support services shall include provider rate negotiation, revenue cycle management, or both. A management services organization does not include entities that own one or more health facilities, as defined in subdivision (a) or (b) of Section 1250.

~~(n)~~ *(p)* "Material change" means any change in ownership, operations, or governance for a health care entity, involving a material amount of assets of a health care entity.

~~(o)~~ *(q)* "Payer" means private and public health care payers, including all of the following:

(1) A health care service plan or a specialized mental health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) or a Medi-Cal managed care plan contracted with the State Department of Health Care Services to provide full scope benefits to a Medi-Cal enrollee pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(2) A health insurer licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.

(3) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare.

(4) A third-party administrator.

(5) Any other public or private entity, other than an individual, that pays for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees.

~~(p)~~ *(r)* "Physician organization" includes any of the following:

(1) An organization described in paragraph (2) of subdivision (g) of Section 1375.4.

(2) A risk-bearing organization, as defined in Section 1375.4.

(3) A restricted health care service plan and limited health care service plan under subdivision (a) of Section 1300.49 of Title 28 of the California Code of Regulations. The inclusion of restricted health care service plans and limited health care service plans in the definition of "physician organization" does not narrow, abrogate, or otherwise alter the regulatory authority of the Department of Managed Health Care over these entities.

(4) A medical foundation exempt from licensure pursuant to subdivision (l) of Section 1206.

(5) A medical group practice, a professional medical corporation, a medical partnership, or any lawfully organized group of physicians and surgeons that provides, delivers, furnishes, or otherwise arranges for health care services and is comprised of 25 or more physicians.

(6) Notwithstanding paragraph (5), an organization of less than 25 physicians, but that is a high-cost outlier whose costs for the same services provided are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI under the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671). The cost of delivering the same services in a geographic region shall be considered to the extent that cost substantially deviates from the statewide average and reflects higher costs in that region unrelated to the market dominance of providers in that region or unrelated to the ownership, management, or asset structure chosen by the organization.

(s) "Private equity group" means an investor or group of investors who primarily engage in the raising or returning of capital and who invest, develop, dispose of, or purchase any equity interest in assets, either as a parent company or through another entity the investor or investors completely or partially own or control. A private equity group does not include natural persons or other entities that contribute or promise to contribute funds to the private equity group, but otherwise do not participate in the management of the private equity group or the group's assets, or in any change in control of the private equity group or the group's assets.

~~(q)~~ *(t)* "Provider" means any of the following that delivers or furnishes health care services:

(1) A physician organization.

(2) A health facility, as defined in Section 1250, including a general acute care hospital.

(3) A clinic conducted, operated, or maintained as an outpatient department of a hospital, as described in subdivision (d) of Section 1206.

(4) A clinic described in subdivision (l) of Section 1206.

(5) A clinic described in subdivision (a) of Section 1204.

(6) A specialty clinic, as described in paragraphs (1) to (3), inclusive, of subdivision (b) of Section 1204.

(7) An ambulatory surgical center or accredited outpatient setting.

(8) A clinical laboratory licensed or registered with the State Department of Public Health under Chapter 3 (commencing with Section 1200) of the Business and Professions Code.

(9) An imaging facility that employs or contracts with persons that are subject to the Radiation Control Law (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104), or the Radiologic Technologists Act (Article 5 (commencing with Section 106955) of Chapter 4 of Part 1, or Article 6 (commencing with Section 107150) of Chapter 4 of Part 1 of Division 104).

~~(r)~~ *(u)* "Purchaser" means an individual, organization, or business entity that purchases health care services, including, but not limited to, trust funds, trade associations, and private and public employers who provide health care benefits to their employees, members, and dependents.

~~(s)~~ *(v)* "Total health care expenditures" means all health care spending in the state by public and private sources, including all of the following:

(1) All claims-based payments and encounters for covered health care benefits.

(2) All non-claims-based payments for covered health care benefits, such as capitation, salary, global budget, other alternative payment methods, or supplemental provider payments pursuant to the Medi-Cal program.

(3) All cost sharing for covered health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles.

(4) Administrative costs and profits.

(5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision.

SEC. 2. Section 127501 of the Health and Safety Code is amended to read:

127501. (a) There is hereby established, within the Department of Health Care Access and Information, the Office of Health Care Affordability. The Director of the Department of Health Care Access and Information shall be the director of the office and shall carry out all functions of that position, including enforcement.

(b) The office shall be responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets.

(c) The office shall do all of the following:

(1) Increase cost transparency through public reporting of per capita total health care spending and factors contributing to health care cost growth.

(2) Support the board, through data collection and analysis and recommendations, to establish a statewide health care cost target for per capita total health care spending.

(3) Support the board, through data collection and analysis and recommendations, to establish specific health care cost targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate.

(4) Collect and analyze data from existing and emerging public and private data sources that allow the office to track spending, set cost targets, approve performance improvement plans, monitor impacts on health care workforce stability, and carry out all other functions of the office.

(5) Analyze cost and quality trends for drugs covered by pharmaceutical and medical benefits. The office shall consider the data in the reports required pursuant to Section 1367.243 and Section 10123.205 of the Insurance Code and pharmaceutical data reported in the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

(6) Oversee the state's progress towards meeting the health care cost target by providing technical assistance, requiring public testimony, requiring submission of and monitoring compliance with performance improvement plans, and assessing administrative penalties through enforcement actions, including escalating administrative penalties for noncompliance.

(7) Promote, measure, and publicly report performance on quality and health equity through the adoption of a priority set of standard quality and equity measures for health care entities, with consideration for minimizing administrative burden and duplication.

(8) Advance standards for promoting the adoption of alternative payment models.

(9) Measure and promote sustained systemwide investment in primary care and behavioral health.

(10) Advance standards for health care workforce stability and training, as these relate to costs.

(11) Disseminate best practices from entities that comply with the cost target, including a summary of affordability efforts that enable the entity to meet the cost target.

(12) Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities.

(13) Analyze trends in the price of health care technologies.

(14) Analyze trends in the cost of labor for both management and administration, as well as nonsupervisorial health care workforce, as well as analyzing the profits of health care entities, if that data is available.

(15) Conduct ongoing research and evaluation on payers, fully integrated delivery systems, *management services organizations,* and providers, including physician organizations, to determine whether the definitions or other provisions of this chapter include those entities that significantly affect health care cost, quality, equity, and workforce stability.

(16) Adopt and promulgate regulations for the purpose of carrying out this chapter.

(17) Establish advisory or technical committees, as necessary.

(d) For purposes of implementing this chapter, including hiring staff and consultants, through the procurement authority and processes of the department, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the office may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Until January 1, 2026, contracts entered into or amended pursuant to this chapter are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

SEC. 3. *Section 127501.5 is added to the Health and Safety Code, to read:*

127501.5. *The office shall, in a manner prescribed by the office, establish requirements for management services organizations to submit data and other information as necessary to carry out the functions of the office.*

SEC. 4. Section 127507 of the Health and Safety Code is amended to read:

127507. (a) The office shall monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit margins, and other market failures on competition, prices, access, quality, and equity. In a manner supportive of the efforts of the Attorney General, the Department of Managed Health Care, and the Department of Insurance, as appropriate, the office shall promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities. The office shall prospectively analyze those transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market. The role of the office is to collect and report information that is informative to the public.

(b) This article does not apply to an exempted provider unless that provider is being acquired by, or affiliating with, an entity that is not an exempted provider. If an entity that is not an exempted provider is acquiring or affiliating with an exempted provider, the entity that is not an exempted provider shall meet the requirements of this article.

(c) (1) A health care entity shall provide the office with written notice of agreements or transactions that ~~will occur on or after April 1, 2024, that~~ do either of the following:

(A) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities.

(B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

(2) (A) A noticing entity shall provide the office with written notice of agreements or transactions between the noticing entity and a health care entity or management services organization, or an entity that owns or controls the health care entity or management services organization that do either of the following:

(i) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of the health care entity's or management services organization's assets to one or more entities.

(ii) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity or management services organization to one or more entities.

(B) In addition to reporting obligations under subparagraph (A), a management services organization shall provide the office with written notice of any agreement or transaction that is described in clauses (i) and (ii) of subparagraph (A) between the management services organization and any other entity.

(C) The office shall adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice to the office under more than one provision in subdivision (c).

~~(2)~~ *(3)* Written notice pursuant to paragraph (1) shall be provided to the office at least 90 days prior to entering into the agreement or transaction. If the conditions in paragraph (1) of subdivision (a) of Section 127507.2 apply, the office shall make the notice of material change publicly available, including all information and materials submitted to the office for review with regard to the material change.

~~(3)~~ *(4)* The office shall adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and consider appropriate thresholds, including, but not limited to, annual gross and net revenues and market share in a given service or region.

(d) The requirement to provide notice of a material change pursuant to subdivision (c) does not apply to any of the following:

(1) Agreements or transactions involving health care service plans that are subject to review by the Director of the Department of Managed Health Care for cost impact or market consolidation under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).

(2) Agreements or transactions involving health insurers that are subject to review by the Insurance Commissioner under Article 14 (commencing with Section 1091) of Chapter 1 of Part 2, of Division 1 of the Insurance Code.

(3) Agreements or transactions where a county is purchasing, acquiring, or taking control, responsibility, or governance of an entity to ensure continued access in that county.

(4) Agreements or transactions involving nonprofit corporations that are subject to review by the Attorney General under Article 2 (commencing with Section 5914) of Chapter 9 of Part 2, Division 2 of Title 1 of the Corporations Code.

(e) Agreements or transactions exempted under subdivision (d) from the requirement to provide a notice of material change may be referred to the office for a cost and market impact review by the reviewing authority.

(f) This article does not limit the Attorney General's review of the conversion or restructuring of charitable trusts held by a nonprofit health facility or by an affiliated nonprofit health system or the Attorney General's review of any health care agreement or transaction under any state or federal law.

(g) This article does not narrow, abrogate, or otherwise alter the corporate practice of medicine doctrine, which expressly prohibits the practice of medicine or control of medicine, medical corporations, medical partnerships, or physician practices by entities or individuals other than licensed physicians and surgeons.

(h) For purposes of this article, "noticing entity" includes all of the following:

(1) A private equity group or hedge fund.

(2) A newly created business entity created for the purpose of entering into agreements or transactions with a health care entity.

(3) A management services organization.

(4) An entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license.

Assembly Bill No. 1415

CHAPTER 641

An act to amend Sections 127500.2, 127501, and 127507 of, and to add Section 127501.5 to, the Health and Safety Code, relating to health care.

[Approved by Governor October 11, 2025. Filed with Secretary of State October 11, 2025.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1415, Bonta. California Health Care Quality and Affordability Act.

Existing law, the California Health Care Quality and Affordability Act, establishes within the Department of Health Care Access and Information the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. Existing law requires the office to conduct ongoing research and evaluation on payers, fully integrated delivery systems, and providers to determine whether the definitions or other provisions of the act include those entities that significantly affect health care cost, quality, equity, and workforce stability. Existing law defines multiple terms relating to these provisions, including a health care entity to mean a payer, provider, or a fully integrated delivery system and a provider to mean specified entities delivering or furnishing health care services.

This bill would update the definitions applying to these provisions, including defining a provider to mean specified entities delivering or furnishing health care services. The bill would include additional definitions, including, but not limited to, a hedge fund to mean a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of strategies used to manage the funds, subject to certain exceptions. The bill would require the office to conduct ongoing research and evaluation on management services organizations, as specified, and to establish requirements for management services organizations to submit data and other information as necessary to carry out the functions of the office.

Existing law requires a health care entity to provide the Office of Health Care Affordability with written notice of agreements or transactions that do specified actions, including sell or transfer, among other things, a material amount of its assets to one or more entities.

The bill would similarly require a noticing entity, as defined, to provide the office written notice of agreements or transactions between the noticing entity and a health care entity or management services organization, or an entity that owns, or controls the health care entity or management services

organization that perform the same specified actions described above. The bill would additionally require a management services organization to provide the office with written notice of any agreement or transaction between the organization and any other entity.

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

SECTION 1. Section 127500.2 of the Health and Safety Code is amended to read:

127500.2. As used in this chapter, the following definitions apply:

(a) (1) "Administrative costs and profits" means the total sum of all expenses not included in the numerator of the medical loss ratio calculation under state or federal law, including, but not limited to, all of the following:

(A) All categories of administrative expenditures.

(B) Net additions to reserves.

(C) Rate dividends or rebates.

(D) Profits or losses.

(E) Taxes and fees.

(2) For purposes of this chapter, "administrative costs and profits" for a fully integrated delivery system means those associated with its nonprofit health care services plan.

(b) "Affordability for consumers" means considering the totality of costs paid by consumers for covered benefits, including the enrollee share of premium and cost-sharing amounts paid towards the maximum out-of-pocket amount, including deductibles, copays, coinsurance, and other forms of cost sharing for public and private health coverage.

(c) "Affordability for purchasers" means considering the cost to purchasers, including, but not limited to, health plans and health insurers, employers purchasing group coverage, and the state, for health coverage and shall include premium costs, actuarial value of coverage for covered benefits, and the value delivered on health care spending in terms of improved quality and cost efficiency.

(d) "Alternative payment model" means a state or nationally recognized payment approach that financially incentivizes high-quality and cost-efficient care.

(e) "Board" means the Health Care Affordability Board established by Section 127501.10.

(f) "Director" means the Director of the Department of Health Care Access and Information.

(g) (1) "Exempted provider" means a provider that meets standards established by the board for exemption from either of the following:

(A) The statewide health care target.

(B) Specific targets set for health care sectors, including fully integrated delivery systems, geographic regions, and for individual health care entities.

(2) The factors used in setting standards for exemption may include, but are not limited to, annual gross and net revenues, patient volume, and high-cost outliers in a given service or geographic region.

(3) In determining whether a provider is an exempted provider, the board shall also consider any affiliates, subsidiaries, or other entities that control, govern, or are financially responsible for the provider or that are subject to the control, governance, or financial control of the provider.

(4) A physician practice that does not meet the definition in subdivision (r) is an exempted provider.

(h) "Fully integrated delivery system" means a system that includes a physician organization, health facility or health system, and a nonprofit health care service plan that provides health care services to enrollees in a specific geographic region of the state through an affiliate hospital system and an exclusive contract between the nonprofit health care service plan and a single physician organization in each geographic region to provide those medical services.

(i) "Geographic region" may either be the regions specified in Section 1385.01 or may be otherwise defined by the board.

(j) "Health care cost target" means the target percentage for the maximum annual increase in per capita total health care expenditures.

(k) "Health care entity" means a payer, provider, or a fully integrated delivery system.

(*l*) "Hedge fund" means a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of the strategies used to manage the funds. Hedge funds include, but are not limited to, a pool of funds managed or controlled by private limited partnerships or other types of private corporate or partnership formations. A hedge fund does not include either of the following:

(1) Natural persons or other entities that contribute, or promise to contribute, funds to the hedge fund, but otherwise do not participate in the management of the hedge fund or the fund's assets, or in any change in control of the hedge fund or the fund's assets.

(2) Entities that solely provide or manage debt financing secured in whole or in part by the assets of a health care facility, including, but not limited to, banks and credit unions, commercial real estate lenders, bond underwriters, and trustees.

(m) "Insurance market" means the public and private health insurance markets.

(n) "Line of business" means the different individual, small, and large group business lines, as defined in Section 1348.95 of this code and Section 10127.19 of the Insurance Code, as well as Medi-Cal, Medicare, Covered California, or self-insured public employee health plans.

(o) "Management services organization" means an entity that provides management and administrative support services for a provider in support of the delivery of health care services, excluding the direct provision of health services. Management and administrative support services shall include provider rate negotiation, revenue cycle management, or both. A

management services organization does not include entities that own one or more health facilities, as defined in subdivision (a) or (b) of Section 1250.

(p) "Material change" means any change in ownership, operations, or governance for a health care entity, involving a material amount of assets of a health care entity.

(q) "Payer" means private and public health care payers, including all of the following:

(1) A health care service plan or a specialized mental health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) or a Medi-Cal managed care plan contracted with the State Department of Health Care Services to provide full scope benefits to a Medi-Cal enrollee pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(2) A health insurer licensed to provide health insurance or specialized behavioral health-only policies, as defined in Section 106 of the Insurance Code.

(3) A publicly funded health care program, including, but not limited to, Medi-Cal and Medicare.

(4) A third-party administrator.

(5) Any other public or private entity, other than an individual, that pays for or arranges for the purchase of health care services on behalf of employees, dependents, or retirees.

(r) "Physician organization" includes any of the following:

(1) An organization described in paragraph (2) of subdivision (g) of Section 1375.4.

(2) A risk-bearing organization, as defined in Section 1375.4.

(3) A restricted health care service plan and limited health care service plan under subdivision (a) of Section 1300.49 of Title 28 of the California Code of Regulations. The inclusion of restricted health care service plans and limited health care service plans in the definition of "physician organization" does not narrow, abrogate, or otherwise alter the regulatory authority of the Department of Managed Health Care over these entities.

(4) A medical foundation exempt from licensure pursuant to subdivision (*l*) of Section 1206.

(5) A medical group practice, a professional medical corporation, a medical partnership, or any lawfully organized group of physicians and surgeons that provides, delivers, furnishes, or otherwise arranges for health care services and is comprised of 25 or more physicians.

(6) Notwithstanding paragraph (5), an organization of less than 25 physicians, but that is a high-cost outlier whose costs for the same services provided are substantially higher compared to the statewide average, as identified through data sources that include, but are not limited to, data from state and federal agencies, other relevant supplemental data, such as financial data on providers that is submitted to state agencies, or data reported to HCAI under the Health Care Payments Data Program, established pursuant

to Chapter 8.5 (commencing with Section 127671). The cost of delivering the same services in a geographic region shall be considered to the extent that cost substantially deviates from the statewide average and reflects higher costs in that region unrelated to the market dominance of providers in that region or unrelated to the ownership, management, or asset structure chosen by the organization.

(s) "Private equity group" means an investor or group of investors who primarily engage in the raising or returning of capital and who invest, develop, dispose of, or purchase any equity interest in assets, either as a parent company or through another entity the investor or investors completely or partially own or control. A private equity group does not include natural persons or other entities that contribute or promise to contribute funds to the private equity group, but otherwise do not participate in the management of the private equity group or the group's assets, or in any change in control of the private equity group or the group's assets.

(t) "Provider" means any of the following that delivers or furnishes health care services:

(1) A physician organization.

(2) A health facility, as defined in Section 1250, including a general acute care hospital.

(3) A clinic conducted, operated, or maintained as an outpatient department of a hospital, as described in subdivision (d) of Section 1206.

(4) A clinic described in subdivision (*l*) of Section 1206.

(5) A clinic described in subdivision (a) of Section 1204.

(6) A specialty clinic, as described in paragraphs (1) to (3), inclusive, of subdivision (b) of Section 1204.

(7) An ambulatory surgical center or accredited outpatient setting.

(8) A clinical laboratory licensed or registered with the State Department of Public Health under Chapter 3 (commencing with Section 1200) of the Business and Professions Code.

(9) An imaging facility that employs or contracts with persons that are subject to the Radiation Control Law (Chapter 8 (commencing with Section 114960) of Part 9 of Division 104), or the Radiologic Technologists Act (Article 5 (commencing with Section 106955) of Chapter 4 of Part 1, or Article 6 (commencing with Section 107150) of Chapter 4 of Part 1 of Division 104).

(u) "Purchaser" means an individual, organization, or business entity that purchases health care services, including, but not limited to, trust funds, trade associations, and private and public employers who provide health care benefits to their employees, members, and dependents.

(v) "Total health care expenditures" means all health care spending in the state by public and private sources, including all of the following:

(1) All claims-based payments and encounters for covered health care benefits.

(2) All non-claims-based payments for covered health care benefits, such as capitation, salary, global budget, other alternative payment methods, or supplemental provider payments pursuant to the Medi-Cal program.

(3) All cost sharing for covered health care benefits paid by residents of this state, including, but not limited to, copayments, coinsurance, and deductibles.

(4) Administrative costs and profits.

(5) Pharmacy rebates and any inpatient or outpatient prescription drug costs not otherwise included in this subdivision.

SEC. 2. Section 127501 of the Health and Safety Code is amended to read:

127501. (a) There is hereby established, within the Department of Health Care Access and Information, the Office of Health Care Affordability. The Director of the Department of Health Care Access and Information shall be the director of the office and shall carry out all functions of that position, including enforcement.

(b) The office shall be responsible for analyzing the health care market for cost trends and drivers of spending, developing data-informed policies for lowering health care costs for consumers and purchasers, creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforcing cost targets.

(c) The office shall do all of the following:

(1) Increase cost transparency through public reporting of per capita total health care spending and factors contributing to health care cost growth.

(2) Support the board, through data collection and analysis and recommendations, to establish a statewide health care cost target for per capita total health care spending.

(3) Support the board, through data collection and analysis and recommendations, to establish specific health care cost targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate.

(4) Collect and analyze data from existing and emerging public and private data sources that allow the office to track spending, set cost targets, approve performance improvement plans, monitor impacts on health care workforce stability, and carry out all other functions of the office.

(5) Analyze cost and quality trends for drugs covered by pharmaceutical and medical benefits. The office shall consider the data in the reports required pursuant to Section 1367.243 and Section 10123.205 of the Insurance Code and pharmaceutical data reported in the Health Care Payments Data Program, established pursuant to Chapter 8.5 (commencing with Section 127671).

(6) Oversee the state’s progress towards meeting the health care cost target by providing technical assistance, requiring public testimony, requiring submission of and monitoring compliance with performance improvement plans, and assessing administrative penalties through enforcement actions, including escalating administrative penalties for noncompliance.

(7) Promote, measure, and publicly report performance on quality and health equity through the adoption of a priority set of standard quality and equity measures for health care entities, with consideration for minimizing administrative burden and duplication.

(8) Advance standards for promoting the adoption of alternative payment models.

(9) Measure and promote sustained systemwide investment in primary care and behavioral health.

(10) Advance standards for health care workforce stability and training, as these relate to costs.

(11) Disseminate best practices from entities that comply with the cost target, including a summary of affordability efforts that enable the entity to meet the cost target.

(12) Review and evaluate consolidation, market power, and other market failures through cost and market impact reviews of mergers, acquisitions, or corporate affiliations involving health care service plans, health insurers, hospitals, physician organizations, pharmacy benefit managers, and other health care entities.

(13) Analyze trends in the price of health care technologies.

(14) Analyze trends in the cost of labor for both management and administration, as well as nonsupervisorial health care workforce, as well as analyzing the profits of health care entities, if that data is available.

(15) Conduct ongoing research and evaluation on payers, fully integrated delivery systems, management services organizations, and providers, including physician organizations, to determine whether the definitions or other provisions of this chapter include those entities that significantly affect health care cost, quality, equity, and workforce stability.

(16) Adopt and promulgate regulations for the purpose of carrying out this chapter.

(17) Establish advisory or technical committees, as necessary.

(d) For purposes of implementing this chapter, including hiring staff and consultants, through the procurement authority and processes of the department, facilitating and conducting meetings, conducting research and analysis, and developing the required reports, the office may enter into exclusive or nonexclusive contracts on a bid or negotiated basis. Until January 1, 2026, contracts entered into or amended pursuant to this chapter are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and are exempt from the review or approval of any division of the Department of General Services.

SEC. 3. Section 127501.5 is added to the Health and Safety Code, to read:

127501.5. The office shall, in a manner prescribed by the office, establish requirements for management services organizations to submit data and other information as necessary to carry out the functions of the office.

SEC. 4. Section 127507 of the Health and Safety Code is amended to read:

127507. (a) The office shall monitor cost trends, including conducting research and studies on the health care market, including, but not limited to, the impact of consolidation, market power, venture capital activity, profit

margins, and other market failures on competition, prices, access, quality, and equity. In a manner supportive of the efforts of the Attorney General, the Department of Managed Health Care, and the Department of Insurance, as appropriate, the office shall promote competitive health care markets by examining mergers, acquisitions, corporate affiliations, or other transactions that entail a material change to ownership, operations, or governance structure involving health care service plans, health insurers, hospitals or hospital systems, physician organizations, providers, pharmacy benefit managers, and other health care entities. The office shall prospectively analyze those transactions likely to have significant effects, seek input from the parties and the public, and report on the anticipated impacts to the health care market. The role of the office is to collect and report information that is informative to the public.

(b) This article does not apply to an exempted provider unless that provider is being acquired by, or affiliating with, an entity that is not an exempted provider. If an entity that is not an exempted provider is acquiring or affiliating with an exempted provider, the entity that is not an exempted provider shall meet the requirements of this article.

(c) (1) A health care entity shall provide the office with written notice of agreements or transactions that do either of the following:

(A) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of its assets to one or more entities.

(B) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity to one or more entities.

(2) (A) A noticing entity shall provide the office with written notice of agreements or transactions between the noticing entity and a health care entity or management services organization, or an entity that owns or controls the health care entity or management services organization that do either of the following:

(i) Sell, transfer, lease, exchange, option, encumber, convey, or otherwise dispose of a material amount of the health care entity's or management services organization's assets to one or more entities.

(ii) Transfer control, responsibility, or governance of a material amount of the assets or operations of the health care entity or management services organization to one or more entities.

(B) In addition to reporting obligations under subparagraph (A), a management services organization shall provide the office with written notice of any agreement or transaction that is described in clauses (i) and (ii) of subparagraph (A) between the management services organization and any other entity.

(C) The office shall adopt regulations to eliminate duplicative reporting if a noticing entity or health care entity is required to submit notice to the office under more than one provision in subdivision (c).

(3) Written notice pursuant to paragraph (1) shall be provided to the office at least 90 days prior to entering into the agreement or transaction. If the conditions in paragraph (1) of subdivision (a) of Section 127507.2 apply, the office shall make the notice of material change publicly available,

including all information and materials submitted to the office for review with regard to the material change.

(4) The office shall adopt regulations for proposed material changes that warrant a notification, establish appropriate fees, and consider appropriate thresholds, including, but not limited to, annual gross and net revenues and market share in a given service or region.

(d) The requirement to provide notice of a material change pursuant to subdivision (c) does not apply to any of the following:

(1) Agreements or transactions involving health care service plans that are subject to review by the Director of the Department of Managed Health Care for cost impact or market consolidation under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2).

(2) Agreements or transactions involving health insurers that are subject to review by the Insurance Commissioner under Article 14 (commencing with Section 1091) of Chapter 1 of Part 2, of Division 1 of the Insurance Code.

(3) Agreements or transactions where a county is purchasing, acquiring, or taking control, responsibility, or governance of an entity to ensure continued access in that county.

(4) Agreements or transactions involving nonprofit corporations that are subject to review by the Attorney General under Article 2 (commencing with Section 5914) of Chapter 9 of Part 2, Division 2 of Title 1 of the Corporations Code.

(e) Agreements or transactions exempted under subdivision (d) from the requirement to provide a notice of material change may be referred to the office for a cost and market impact review by the reviewing authority.

(f) This article does not limit the Attorney General's review of the conversion or restructuring of charitable trusts held by a nonprofit health facility or by an affiliated nonprofit health system or the Attorney General's review of any health care agreement or transaction under any state or federal law.

(g) This article does not narrow, abrogate, or otherwise alter the corporate practice of medicine doctrine, which expressly prohibits the practice of medicine or control of medicine, medical corporations, medical partnerships, or physician practices by entities or individuals other than licensed physicians and surgeons.

(h) For purposes of this article, "noticing entity" includes all of the following:

(1) A private equity group or hedge fund.

(2) A newly created business entity created for the purpose of entering into agreements or transactions with a health care entity.

(3) A management services organization.

(4) An entity that owns, operates, or controls a provider, regardless of whether the provider is currently operating, providing health care services, or has a pending or suspended license.

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