

Assembly Bill No. 2289

Passed the Assembly August 25, 2004

Chief Clerk of the Assembly

Passed the Senate August 24, 2004

Secretary of the Senate

This bill was received by the Governor this _____ day of
_____, 2004, at _____ o'clock __M.

Private Secretary of the Governor



CHAPTER _____

An act to add Section 1375 to the Health and Safety Code, and to add Section 10123.671 to the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2289, Chan. Health care information.

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 violation of the act a crime. Existing law also provides for the licensure and regulation of health insurers by the Department of Insurance. Under existing law, a plan and a health insurer are required to provide specified information to their respective regulatory departments regarding their operations.

This bill would, except as specified, require a full-service health care service plan and a health insurer to report on or before July 1, 2005, to their respective regulatory departments certain information about the plan or insurer's policy regarding specified costs paid for benefits by, as applicable, enrollees, subscribers, and insureds.

Because the bill would specify an additional requirement for a health care service plan, the violation of which would be a crime, it 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.

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

SECTION 1. Section 1375 is added to the Health and Safety Code, to read:

1375. (a) On or before July 1, 2005, on a one-time basis, each full-service health care service plan shall file with the department a written statement describing all of the following for the five



largest, defined by the total number of enrollees currently enrolled, benefit plan designs in each of the small group market, the individual market, and the noncustomized large group market, currently being marketed or offered for enrollment:

(1) The plan's policy regarding share of premiums paid by enrollees or subscribers, if any.

(2) The annual out-of-pocket maximums, if any.

(3) The annual deductibles, if any.

(4) The copayments for the following:

(A) Office or physician visits.

(B) Hospitalization.

(C) Prescription drugs.

(D) Outpatient services other than physician visits.

(E) Emergency health coverage.

(F) Ambulance services.

(G) Durable medical equipment.

(H) Mental health services.

(I) Chemical dependency services.

(J) Home health services.

(K) Skilled nursing facilities.

(5) An estimate of the number of enrollees covered by the plan.

(b) Enrollment information provided to the department by a plan under this section shall be considered confidential and shall not be disclosed, except that the department may report aggregate data.

(c) A plan shall also provide information required pursuant to subdivision (a) about the five largest, defined by the total number of enrollees enrolled on January 1, 2001, benefit plan designs in the individual market, the small group market, and the noncustomized large group market, that have been approved by the department since January 1, 2000, but which the plan is not currently offering.

(d) If the plan requires different copayments for contracting providers and noncontracting providers, or other categories of providers, the plan shall provide the information by the category of provider.

(e) The information required pursuant to this section shall be reported in the format set forth for the uniform health plan benefits and coverage matrix described in paragraph (1) of subdivision (b) of Section 1363.



(f) The plan shall provide the department with copies of the benefit plans described in subdivision (a).

(g) This section shall not apply to any of the following:

(1) Health care service plan contracts authorized under Article 5.6 (commencing with Section 1374.60).

(2) Health care service plan contracts for enrollees in Medi-Cal, the Healthy Families Program, the Access for Infants and Mothers Program, the California Major Risk Medical Insurance Program, the California Public Employees' Retirement System, or Medicare.

(3) Health care service plan contracts provided to individuals eligible for continued coverage under the Health Insurance Portability and Accountability Act (HIPAA) or conversion plans.

(h) Nothing in this section requires a health care service plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract, nor to provide services through a provider who is not under contract with the plan.

SEC. 2. Section 10123.671 is added to the Insurance Code, to read:

10123.671. (a) On or before July 1, 2005, on a one-time basis every health insurer with a group health insurance policy that covers hospital, medical, or surgical expenses that contracts with providers for alternative rates pursuant to Section 10133 and that limits payments under those policies to services secured by insureds from providers charging alternative rates pursuant to the contracts, shall file with the department a written statement describing all of the following for the five largest, defined by the total number of insureds currently insured, benefit plan designs in each of the small group market, the individual market, and the noncustomized large group market, currently being marketed or offered:

(1) The insurer's policy regarding share of premiums paid by insureds, if any.

(2) The annual out-of-pocket maximums, if any.

(3) The annual deductibles or coinsurance, if any.

(4) The copayments for the following:

(A) Office or physician visits.

(B) Hospitalization.

(C) Prescription drugs.



- (D) Outpatient services other than physician visits.
- (E) Emergency health coverage.
- (F) Ambulance services.
- (G) Durable medical equipment.
- (H) Mental health services.
- (I) Chemical dependency services.
- (J) Home health services.
- (K) Skilled nursing facilities.
- (5) An estimate of the number of insureds covered by the plan.

(b) Enrollment information provided to the department by an insurer under this section shall be considered confidential and shall not be disclosed, except that the department may report aggregate data. The department shall maintain documents provided by insurers pursuant to this section and make them available upon request in the manner in which they were submitted. The department shall make the documents available upon request subject to any applicable confidentiality provisions.

(c) An insurer shall also provide information required pursuant to subdivision (a) about the five largest, defined by the total number of enrollees enrolled on January 1, 2001, benefit plan designs in the individual market, the small group market, and the noncustomized large group market, that have been approved by the department since January 1, 2000, but which the insurer is not currently offering.

(d) If the insurer requires different copayments for contracting providers and noncontracting providers, or other categories of providers, the insurer shall provide the information by the category of provider.

(e) The information required pursuant to this section shall be reported in the format set forth for the uniform health plan benefits and coverage matrix described in paragraph (1) of subdivision (b) of Section 1363 of the Health and Safety Code.

(f) The insurer shall provide the department with copies of the benefit plans described in subdivision (a).

(g) The written statement described in subdivision (a) shall be filed only for purposes of information and is not subject to approval or disapproval by the department.

(h) Nothing in this section shall require an insurer to cover services or provide benefits that are not otherwise covered under



the terms and conditions of the policy, nor to provide services through a provider who is not under contract with the insurer.

(i) This section shall not apply to health insurance policies provided to individuals eligible for continued coverage under the Health Insurance Portability and Accountability Act (HIPAA) or conversion plans.

SEC. 3. 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.



Approved _____, 2004

Governor

