

ASSEMBLY BILL

No. 562

Introduced by Assembly Member Cook

February 25, 2009

An act to add Article 12 (commencing with Section 1399.850) to Chapter 2.2 of Division 2 of the Health and Safety Code, and to add Chapter 7.5 (commencing with Section 10650) to Part 2 of Division 2 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 562, as introduced, Cook. Health care coverage: report of claim 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. Existing law provides for the regulation of health insurers by the Department of Insurance.

Existing law, the federal Health Insurance Portability and Accountability Act of 1996, establishes certain requirements relating to the provision of health insurance and the protection of privacy of individually identifiable health information. The act authorizes group health plans to permit health insurance issuers, as defined, to disclose protected health information to plan sponsors if specified requirements are met.

This bill would, on and after July 1, 2010, require a health insurance issuer that receives a written request for a written report of claim information from a plan, plan sponsor, or plan administrator with respect to a group health plan issued by the issuer, to provide that report to the requesting party no later than 30 days after receipt of the request. The bill would require the report to be provided in a specified manner and

to include specified information. The bill would prohibit the health insurance issuer from disclosing any information protected under federal or state law, and would also prohibit the issuer from disclosing protected health information to the plan sponsor unless an authorized representative of the plan sponsor makes a specified certification. The bill would make a health insurance issuer that fails to comply with these requirements subject to administrative penalties. The bill would define various terms and enact related provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes.
 State-mandated local program: no.

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

1 SECTION 1. Article 12 (commencing with Section 1399.850)
 2 is added to Chapter 2.2 of Division 2 of the Health and Safety
 3 Code, to read:

4
 5 Article 12. Reporting of Claims Information
 6

7 1399.850. (a) For purposes of this article, except as provided
 8 in subdivision (b), the following terms have the following
 9 meanings:

- 10 (1) "Employer" has the same meaning as that term is defined
 11 in Section 1002(5) of Title 29 of the United States Code.
- 12 (2) "Governmental entity" means a state agency or political
 13 subdivision of the state.
- 14 (3) "Group health plan" has the same meaning as that term is
 15 defined in Section 160.103 of Title 45 of the Code of Federal
 16 Regulations, except that the term does not include disability income
 17 insurance or long-term care insurance.
- 18 (4) "Health insurance issuer" has the same meaning as that term
 19 is defined in Section 160.103 of Title 45 of the Code of Federal
 20 Regulations.
- 21 (5) "Plan" means an employee welfare benefit plan, as defined
 22 in Section 1002(1) of Title 29 of the United States Code.
- 23 (6) "Plan administrator" means an administrator, as defined in
 24 Section 1002(16)(A) of Title 29 of the United States Code.
- 25 (7) "Plan sponsor" has the same meaning as that term is defined
 26 in Section 1002(16)(B) of Title 29 of the United States Code.

1 (8) “Political subdivision” means a county, municipality, school
2 district, special-purpose district, or other subdivision of state
3 government that has jurisdiction limited to a geographic portion
4 of the state.

5 (9) “Protected health information” has the same meaning as that
6 term is defined in Section 160.103 of Title 45 of the Code of
7 Federal Regulations.

8 (b) A reference to a federal statute or regulation under
9 subdivision (a) refers to that statute or regulation as it existed on
10 January 1, 2009, except that the director may, by rule, in
11 consultation with the Insurance Commissioner, adopt a definition
12 based on a later amended, enacted, or adopted federal statute or
13 regulation if the director determines that use of the later amended,
14 enacted, or adopted statute or regulation is consistent with the
15 purposes of this article and promotes regulatory consistency.

16 1399.851. (a) This article shall apply to a governmental entity
17 that enters into a contract with a health insurance issuer that results
18 in the health insurance issuer delivering, issuing for delivery, or
19 renewing a group health plan.

20 (b) For purposes of this chapter, a health insurance issuer shall
21 treat a governmental entity described in subdivision (a) as a plan
22 sponsor or plan administrator.

23 (c) A report of claim information provided under this section
24 to a governmental entity is confidential and exempt from public
25 disclosure under Chapter 3.5 (commencing with Section 6250) of
26 Division 7 of Title 1 of the Government Code.

27 1399.852. (a) A health insurance issuer that receives a written
28 request for a written report of claim information from a plan, plan
29 sponsor, or plan administrator with respect to a group health plan
30 issued by the issuer shall provide that report, consistent with the
31 requirements of this section, to the requesting party no later than
32 30 days after receipt of the request. The health insurance issuer
33 shall not be required to provide a report under this subdivision
34 regarding a particular employer or group health plan more than
35 twice in a 12-month period.

36 (b) A health insurance issuer shall provide the report of claim
37 information required pursuant to subdivision (a) by one of the
38 following means:

39 (1) In a written report.

1 (2) Through an electronic file transmitted by secure electronic
2 mail or a file transfer protocol site.

3 (3) By making the required information available through a
4 secure Internet Web site or Web portal accessible by the requesting
5 plan, plan sponsor, or plan administrator.

6 (c) A report of claim information provided under this section
7 shall contain all information available to the health insurance issuer
8 that is responsive to the request for the 36-month period preceding
9 the date of the report or the entire period of coverage, whichever
10 period is shorter, except as provided in paragraphs (5) and (6).
11 Except as provided in subdivisions (d) and (e), the report required
12 by this section shall include all of the following information:

13 (1) Aggregate paid claims experience by month, including, but
14 not limited to, claims experience for medical, dental, and pharmacy
15 benefits, as applicable.

16 (2) Total premiums paid by month.

17 (3) The total number of covered employees on a monthly basis
18 by coverage tier, including whether the coverage was for one of
19 the following:

20 (A) An employee only.
21 (B) An employee with dependents only.
22 (C) An employee with a spouse only.
23 (D) An employee with a spouse and dependents.

24 (4) The total dollar amount of claims pending as of the date of
25 the report.

26 (5) A separate description and individual claims report for any
27 individual whose total paid claims exceed fifteen thousand dollars
28 (\$15,000) during the 12-month period preceding the date of the
29 report. This report shall include all of the following information
30 related to the claims for that individual:

31 (A) A unique identifying number, characteristic, or code for the
32 individual.
33 (B) The amounts paid during the 12-month period.
34 (C) The dates on which health care services were provided
35 during the 12-month period.
36 (D) The applicable procedure codes and diagnosis codes.

37 (6) For claims that are not part of the report described by
38 paragraphs (1) to (5), inclusive, a statement describing
39 precertification requests for hospital stays of five days or longer

1 that were made during the 30-day period preceding the date of the
2 report.

3 (d) A health insurance issuer shall not disclose any information
4 in the report required under this section that the health insurance
5 issuer is prohibited from disclosing under another state or federal
6 law that imposes more stringent privacy restrictions than those
7 imposed under federal law under the Health Insurance Portability
8 and Accountability Act of 1996 (Public Law 104-191). In order
9 to withhold information in accordance with this subdivision, the
10 health insurance issuer shall do both of the following:

11 (1) Notify the plan, plan sponsor, or plan administrator
12 requesting the report that information is being withheld.

13 (2) Provide to the plan, plan sponsor, or plan administrator
14 requesting the report a list of categories of claim information that
15 the health insurance issuer has determined are subject to the more
16 stringent privacy restrictions under another state or federal law.

17 (e) A plan sponsor shall not receive protected health information
18 under paragraph (5) or (6) of subdivision (c) unless an appropriately
19 authorized representative of the plan sponsor makes a certification
20 to the health insurance issuer that is substantially similar to the
21 following:

22
23 “I hereby certify that the plan documents comply with the
24 requirements of 45 C.F.R. Section 164.504(f)(2) and that the plan
25 sponsor will safeguard and limit the use and disclosure of protected
26 health information that the plan sponsor may receive from the
27 group health plan to perform plan administration functions.”

28
29 (f) If a health insurance issuer receives a request under
30 subdivision (a) after the date that coverage under the applicable
31 group health plan has terminated, the report required under
32 subdivision (a) shall contain all information available to the health
33 insurance issuer that is responsive to the request for the period
34 described in subdivision (c) preceding the date of termination of
35 coverage or for the entire policy period, whichever period is
36 shorter. The report shall include the information described in
37 paragraphs (1) to (6), inclusive, of subdivision (c), but it shall not
38 include any protected health information required under paragraph
39 (5) or (6) of subdivision (c) unless a certification has been provided
40 in accordance with subdivision (e).

1 (g) In order to be entitled to receive the report described in this
2 section, a plan, plan sponsor, or plan administrator shall request
3 that report on or before the second anniversary of the date of
4 termination of coverage under a group health plan issued by the
5 health insurance issuer.

6 1399.853. (a) No later than 10 days after receiving the report
7 described in Section 1399.852, a plan, plan sponsor, or plan
8 administrator may make a written request to the health insurance
9 issuer for additional information regarding specified individuals
10 in accordance with this section.

11 (b) With respect to a request for additional information
12 concerning specified individuals for whom claims information
13 was provided under paragraph (5) of subdivision (c) of Section
14 1399.852, the health insurance issuer shall provide additional
15 information on the prognosis or recovery of the individual, if
16 available, and for individuals in active case management, the most
17 recent case management information relating to the claims for that
18 individual, including any future expected costs and treatment plans.

19 (c) The health insurance issuer shall respond to a request for
20 additional information under this section no later than 15 days
21 after the date of the request unless the requesting plan, plan
22 sponsor, or plan administrator agrees to a request for additional
23 time.

24 (d) The health insurance issuer shall not provide the information
25 described in this section unless a certification has been provided
26 in accordance with subdivision (e) of Section 1399.852.

27 1399.854. A health insurance issuer that releases information,
28 including, but not limited to, protected health information, in
29 accordance with this article shall not be in violation of a standard
30 of care. In addition, the health insurance issuer shall not be held
31 liable for civil damages resulting from, or subject to criminal
32 prosecution for, releasing that information in accordance with this
33 article.

34 1399.855. For purposes of this article, Sections 1374.8 and
35 1390 shall not apply.

36 1399.856. A health insurance issuer that fails to comply with
37 this article is subject to administrative penalties.

38 1399.857. This article applies only to a request for a written
39 report of claim information made on or after July 1, 2010.

1 SEC. 2. Chapter 7.5 (commencing with Section 10650) is added
2 to Part 2 of Division 2 of the Insurance Code, to read:

3
4 CHAPTER 7.5. REPORTING OF CLAIMS INFORMATION
5

6 10650. (a) For purposes of this chapter, except as provided in
7 subdivision (b), the following terms have the following meanings:

8 (1) "Employer" has the same meaning as that term is defined
9 in Section 1002(5) of Title 29 of the United States Code.

10 (2) "Governmental entity" means a state agency or political
11 subdivision of the state.

12 (3) "Group health plan" has the same meaning as that term is
13 defined in Section 160.103 of Title 45 of the Code of Federal
14 Regulations, except that the term does not include disability income
15 insurance or long-term care insurance.

16 (4) "Health insurance issuer" has the same meaning as that term
17 is defined in Section 160.103 of Title 45 of the Code of Federal
18 Regulations.

19 (5) "Plan" means an employee welfare benefit plan, as defined
20 in Section 1002(1) of Title 29 of the United States Code.

21 (6) "Plan administrator" means an administrator, as defined in
22 Section 1002(16)(A) of Title 29 of the United States Code.

23 (7) "Plan sponsor" has the same meaning as that term is defined
24 in Section 1002(16)(B) of Title 29 of the United States Code.

25 (8) "Political subdivision" means a county, municipality, school
26 district, special-purpose district, or other subdivision of state
27 government that has jurisdiction limited to a geographic portion
28 of the state.

29 (9) "Protected health information" has the same meaning as that
30 term is defined in Section 160.103 of Title 45 of the Code of
31 Federal Regulations.

32 (b) A reference to a federal statute or regulation under
33 subdivision (a) refers to that statute or regulation as it existed on
34 January 1, 2009, except that the commissioner may, by rule, in
35 consultation with the Director of Managed Health Care, adopt a
36 definition based on a later amended, enacted, or adopted federal
37 statute or regulation if the commissioner determines that use of
38 the later amended, enacted, or adopted statute or regulation is
39 consistent with the purposes of this chapter and promotes
40 regulatory consistency.

1 10651. (a) This chapter shall apply to a governmental entity
2 that enters into a contract with a health insurance issuer that results
3 in the health insurance issuer delivering, issuing for delivery, or
4 renewing a group health plan.

5 (b) For purposes of this chapter, a health insurance issuer shall
6 treat a governmental entity described in subdivision (a) as a plan
7 sponsor or plan administrator.

8 (c) A report of claim information provided under this section
9 to a governmental entity is confidential and exempt from public
10 disclosure under Chapter 3.5 (commencing with Section 6250) of
11 Division 7 of Title 1 of the Government Code.

12 10652. (a) A health insurance issuer that receives a written
13 request for a written report of claim information from a plan, plan
14 sponsor, or plan administrator with respect to a group health plan
15 issued by the issuer shall provide that report, consistent with the
16 requirements of this section, to the requesting party no later than
17 30 days after receipt of the request. The health insurance issuer
18 shall not be required to provide a report under this subdivision
19 regarding a particular employer or group health plan more than
20 twice in a 12-month period.

21 (b) A health insurance issuer shall provide the report of claim
22 information required pursuant to subdivision (a) by one of the
23 following means:

- 24 (1) In a written report.
- 25 (2) Through an electronic file transmitted by secure electronic
26 mail or a file transfer protocol site.
- 27 (3) By making the required information available through a
28 secure Internet Web site or Web portal accessible by the requesting
29 plan, plan sponsor, or plan administrator.

30 (c) A report of claim information provided under this section
31 shall contain all information available to the health insurance issuer
32 that is responsive to the request for the 36-month period preceding
33 the date of the report or the entire period of coverage, whichever
34 period is shorter, except as provided in paragraphs (5) and (6).
35 Except as provided in subdivisions (d) and (e), the report required
36 by this section shall include all of the following information:

- 37 (1) Aggregate paid claims experience by month, including, but
38 not limited to, claims experience for medical, dental, and pharmacy
39 benefits, as applicable.
- 40 (2) Total premiums paid by month.

- 1 (3) The total number of covered employees on a monthly basis
2 by coverage tier, including whether the coverage was for one of
3 the following:
- 4 (A) An employee only.
 - 5 (B) An employee with dependents only.
 - 6 (C) An employee with a spouse only.
 - 7 (D) An employee with a spouse and dependents.
- 8 (4) The total dollar amount of claims pending as of the date of
9 the report.
- 10 (5) A separate description and individual claims report for any
11 individual whose total paid claims exceed fifteen thousand dollars
12 (\$15,000) during the 12-month period preceding the date of the
13 report. This report shall include all of the following information
14 related to the claims for that individual:
- 15 (A) A unique identifying number, characteristic, or code for the
16 individual.
 - 17 (B) The amounts paid during the 12-month period.
 - 18 (C) The dates on which health care services were provided
19 during the 12-month period.
 - 20 (D) The applicable procedure codes and diagnosis codes.
- 21 (6) For claims that are not part of the report described by
22 paragraphs (1) to (5), inclusive, a statement describing
23 precertification requests for hospital stays of five days or longer
24 that were made during the 30-day period preceding the date of the
25 report.
- 26 (d) A health insurance issuer shall not disclose any information
27 in the report required under this section that the health insurance
28 issuer is prohibited from disclosing under another state or federal
29 law that imposes more stringent privacy restrictions than those
30 imposed under federal law under the Health Insurance Portability
31 and Accountability Act of 1996 (Public Law 104-191). In order
32 to withhold information in accordance with this subdivision, the
33 health insurance issuer shall do both of the following:
- 34 (1) Notify the plan, plan sponsor, or plan administrator
35 requesting the report that information is being withheld.
 - 36 (2) Provide to the plan, plan sponsor, or plan administrator
37 requesting the report a list of categories of claim information that
38 the health insurance issuer has determined are subject to the more
39 stringent privacy restrictions under another state or federal law.

1 (e) A plan sponsor shall not receive protected health information
2 under paragraph (5) or (6) of subdivision (c) unless an appropriately
3 authorized representative of the plan sponsor makes a certification
4 to the health insurance issuer that is substantially similar to the
5 following:

6
7 “I hereby certify that the plan documents comply with the
8 requirements of 45 C.F.R. Section 164.504(f)(2) and that the plan
9 sponsor will safeguard and limit the use and disclosure of protected
10 health information that the plan sponsor may receive from the
11 group health plan to perform plan administration functions.”
12

13 (f) If a health insurance issuer receives a request under
14 subdivision (a) after the date that coverage under the applicable
15 group health plan has terminated, the report required under
16 subdivision (a) shall contain all information available to the health
17 insurance issuer that is responsive to the request for the period
18 described in subdivision (c) preceding the date of termination of
19 coverage or for the entire policy period, whichever period is
20 shorter. The report shall include the information described in
21 paragraphs (1) to (6), inclusive, of subdivision (c), but it shall not
22 include any protected health information required under paragraph
23 (5) or (6) of subdivision (c) unless a certification has been provided
24 in accordance with subdivision (e).

25 (g) In order to be entitled to receive the report described in this
26 section, a plan, plan sponsor, or plan administrator shall request
27 that report on or before the second anniversary of the date of
28 termination of coverage under a group health plan issued by the
29 health insurance issuer.

30 10653. (a) No later than 10 days after receiving the report
31 described in Section 10652, a plan, plan sponsor, or plan
32 administrator may make a written request to the health insurance
33 issuer for additional information regarding specified individuals
34 in accordance with this section.

35 (b) With respect to a request for additional information
36 concerning specified individuals for whom claims information
37 was provided under paragraph (5) of subdivision (c) of Section
38 10652, the health insurance issuer shall provide additional
39 information on the prognosis or recovery of the individual, if
40 available, and for individuals in active case management, the most

1 recent case management information relating to the claims for that
2 individual, including any future expected costs and treatment plans.

3 (c) The health insurance issuer shall respond to a request for
4 additional information under this section no later than 15 days
5 after the date of the request unless the requesting plan, plan
6 sponsor, or plan administrator agrees to a request for additional
7 time.

8 (d) The health insurance issuer shall not provide the information
9 described in this section unless a certification has been provided
10 in accordance with subdivision (e) of Section 10652.

11 10654. A health insurance issuer that releases information,
12 including, but not limited to, protected health information, in
13 accordance with this chapter shall not be in violation of a standard
14 of care. In addition, the health insurance issuer shall not be held
15 liable for civil damages resulting from, or subject to criminal
16 prosecution for, releasing that information.

17 10655. For purposes of this chapter, Section 791.27 shall not
18 apply.

19 10656. A health insurance issuer that fails to comply with this
20 chapter is subject to administrative penalties.

21 10657. This chapter applies only to a request for a written
22 report of claim information made on or after July 1, 2010.