AMENDED IN SENATE DECEMBER 17, 2009

AMENDED IN SENATE MAY 28, 2009

SENATE BILL No. 316

Introduced by Senator Alquist

February 25, 2009

An act to ~~add Section 1378.1 to~~ *amend Section 1363 of* the Health and Safety Code, and to ~~add Section 10113.11 to~~ *amend Section 10607 of* the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 316, as amended, Alquist. Health care coverage: ~~benefits.~~ *disclosures.*

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. ~~Under existing law, a health care service plan is prohibited from expending for administrative costs, as defined, an excessive amount of the payments it receives for providing health care services to its subscribers and enrollees.~~ Existing law also provides for the regulation of ~~health~~ *disability* insurers by the Department of Insurance. ~~Under existing law, the Insurance Commissioner is required to withdraw approval of an individual or mass-marketed policy of disability insurance if the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged, as specified.~~ *Existing law requires health care service plans and disability insurers, and their employees or agents, when presenting a plan contract or policy for examination or sale to an individual purchaser or to the representative of a group consisting of 25 or fewer individuals, to make a written disclosure of the ratio of premium costs*

to health services paid, in the case of health care service plans, or of incurred claims to earned premiums, in the case of disability insurers, for the preceding year, as specified.

This bill would instead require that this disclosure be made when presenting a plan contract or policy for examination or sale to an individual purchaser or to the representative of a group consisting of 50 or fewer individuals. The bill would make other technical, nonsubstantive changes.

~~This bill would require full service health care service plans and health insurers to expend on health care benefits no less than 85% of the aggregate dues, fees, premiums, and other periodic payments they receive with respect to plan contracts or policies issued, amended, or renewed on or after January 1, 2013, as specified. The bill would authorize those plans and insurers to assess compliance with this requirement by averaging their total costs across all plan contracts or insurance policies issued, amended, or renewed by them and their affiliated plans and insurers in California, except as specified. The bill would require those plans and insurers to annually, commencing January 1, 2013, provide written affirmation of compliance with the bill's requirements to the Department of Managed Health Care or the Department of Insurance, and would also require those plans and insurers to annually, commencing January 1, 2013, report to the Director of the Department of Managed Health Care or the Insurance Commissioner the medical loss ratio of each individual and small group health care service plan product and health insurance policy form issued, amended, or renewed in California and to report the ratio when presenting a plan for examination or sale to any individual or group consisting of 50 or fewer individuals. The bill would authorize the Department of Managed Health Care to assess health care service plan compliance with these provisions in specified medical surveys, and would also authorize the director of that department and the Insurance Commissioner to take specified actions if the director or commissioner determines that a plan or insurer has failed to comply with these provisions, except as specified. The bill would require the departments to jointly adopt and amend regulations to implement these provisions, as specified.~~

Because a willful violation of the bill's requirements with respect to health care service plans would be 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. Section 1363 of the Health and Safety Code is amended to read:

1363. (a) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan *contract* in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan *contract*, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan *contract*.

(3) The full premium cost of the plan *contract*.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan *contract*.

(5) The terms under which the plan *contract* may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan *contract* or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(b) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the ~~plan's~~ *plan contract's* major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting ~~any~~ *a* plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan *contract* so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan *contract*. If the individual group members are offered a choice of ~~plans~~ *plan contracts*, separate disclosure forms shall be supplied for each plan *contract* available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the

plan shall, when presenting a plan *contract* for examination or sale to any individual purchaser or the representative of a group consisting of ~~25~~ *50* or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare program pursuant to Title XVIII and Title XIX of the Social Security Act.

SEC. 2. Section 10607 of the Insurance Code is amended to read:

10607. In addition to the other disclosures required by this chapter, every insurer and their employees or agents shall, when presenting a ~~plan~~ *policy* for examination or sale to any individual or the representative of a group consisting of ~~25~~ *50* or fewer individuals, disclose in writing the ratio of incurred claims to earned premiums (loss-ratio) for the insurer's preceding calendar year. ~~This section shall become operative on March 1, 1991, in order to allow insurers time to comply with its provisions.~~

~~SECTION 1. Section 1378.1 is added to the Health and Safety Code, to read:~~

~~1378.1. (a) Notwithstanding any other provision of law, on and after January 1, 2013, a full service health care service plan shall expend in the form of health care benefits no less than 85 percent of the aggregate dues, fees, premiums, and other periodic payments received by the plan. For purposes of this section, a full service health care service plan may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the plan the amount of income taxes or other taxes that the plan expensed.~~

~~(b) For purposes of this section, "health care benefits" shall include, but shall not be limited to, all of the following:~~

~~(1) Health care services that are either provided or reimbursed by the plan or its contracted providers as covered benefits to its enrollees and subscribers.~~

~~(2) The costs of programs or activities, including training and the provision of informational materials that are determined, as part of the regulations under subdivision (e), to improve the~~

~~provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.~~

~~(3) Disease management expenses using cost-effective evidence-based guidelines.~~

~~(4) Payments to providers as risk pool payments of pay-for-performance initiatives.~~

~~(5) Plan medical advice by telephone.~~

~~(6) Prescription drug management programs.~~

~~(c) For purposes of this section, "health care benefits" shall not include administrative costs listed in Section 1300.78 of Title 28 of the California Code of Regulations in effect on January 1, 2007, agent and broker commission and solicitation costs associated with the issuance of individual and group health care service plan contracts, dividends, profits, stock options, assessments or fines levied by the department, or administrative costs associated with existing or new regulatory requirements.~~

~~(d) To assess compliance with this section, a health care service plan may average its total costs across both of the following:~~

~~(1) All health care service plan contracts issued, amended, or renewed by the plan, or by its affiliated plans, in California, except those contracts described in subdivision (*l*).~~

~~(2) All health insurance policies issued, amended, or renewed in California by the plan's affiliated health insurers with a valid California certificate of authority, except those policies listed in subdivision (*l*) of Section 10113.11 of the Insurance Code.~~

~~(e) The department and the Department of Insurance shall jointly adopt and amend regulations to implement this section and Section 10113.11 of the Insurance Code to establish uniform reporting by health care service plans and health insurers of the information necessary to determine compliance with this section and Section 10113.11 of the Insurance Code. These regulations may include additional elements in the definition of "health care benefits" not identified in subdivision (b) in order to consistently operationalize the requirements of this section among health care service plans and health insurers, but these regulatory additions shall be consistent with the legislative intent that a health care service plan expend at least 85 percent of the aggregate payments received by the plan, as provided in subdivision (a), on health care benefits.~~

~~(f) The department may exclude from the determination of compliance with the requirement of subdivision (a) any new health~~

~~care service plan contracts for up to the first two years that these contracts are offered for sale in California, provided that the director determines that the new contracts are substantially different from the existing contracts being issued, amended, or renewed by the plan seeking the exclusion.~~

~~(g) Commencing January 1, 2013, and annually thereafter, a full service health care service plan licensed to operate in California shall provide written affirmation to the department that it meets the requirements of this section.~~

~~(h) Commencing January 1, 2013, a health care service plan subject to this section shall annually report to the director the medical loss ratio of each individual and small group health care service plan product issued, amended, or renewed by the plan in California. Every health care service plan and its employees or agents shall disclose this information when presenting a plan for examination or sale to any individual or the representative of a group consisting of 50 or fewer individuals.~~

~~(i) (1) The department may assess compliance with this section in its periodic onsite medical survey conducted pursuant to Section 1380 or in nonroutine medical surveys, as appropriate.~~

~~(2) The department shall not make an assessment of any health care service plan within the 12-month period after the date a plan has complied with the reporting requirements specified in subdivisions (g) and (h), unless the plan certifies that it failed to meet its medical loss ratio, or the department believes the plan's certification of its medical loss ratio is incorrect.~~

~~(j) The director may disapprove a health care service plan's use of a plan contract, issue a fine or assessment against a health care service plan, suspend or revoke the license issued to a health care service plan under this chapter, or take any other action the director deems appropriate if the director determines that the plan has failed to comply with this section.~~

~~(k) Except as provided in subdivision (*l*), this section shall apply to all health care service plan contracts issued, amended, or renewed in California by a full service health care service plan on or after January 1, 2013.~~

~~(*l*) This section shall not apply to Medicare supplement plan contracts, administrative services-only contracts, or other similar administrative arrangements, or to coverage offered by specialized health care service plans, including, but not limited to, ambulance,~~

~~dental, vision, behavioral health, chiropractic, and naturopathic coverage.~~

~~SEC. 2. Section 10113.11 is added to the Insurance Code, to read:~~

~~10113.11. (a) Notwithstanding any other provision of law, on and after January 1, 2013, a health insurer shall expend in the form of health care benefits no less than 85 percent of the aggregate dues, fees, premiums, and other periodic payments received by the insurer. For purposes of this section, a health insurer may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the insurer the amount of income taxes or other taxes that the insurer expensed.~~

~~(b) For purposes of this section, "health care benefits" shall include, but shall not be limited to, all of the following:~~

~~(1) Health care services that are either provided or reimbursed by the insurer or its contracted providers as covered benefits to its policyholders and insureds.~~

~~(2) The costs of programs or activities, including training and the provision of informational materials that are determined, as part of the regulations under subdivision (e), to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.~~

~~(3) Disease management expenses using cost-effective evidence-based guidelines.~~

~~(4) Payments to providers as risk pool payments of pay-for-performance initiatives.~~

~~(5) Plan medical advice by telephone.~~

~~(6) Prescription drug management programs.~~

~~(c) For purposes of this section, "health care benefits" shall not include administrative costs listed in Section 1300.78 of Title 28 of the California Code of Regulations in effect on January 1, 2007, agent and broker commission and solicitation costs associated with the issuance of individual and group health insurance policies, dividends, profits, stock options, assessments or fines levied by the department, or administrative costs associated with existing or new regulatory requirements.~~

~~(d) To assess compliance with this section, a health insurer may average its total costs across both of the following:~~

~~(1) All health insurance policies issued, amended, or renewed by the insurer in California, except those policies listed in subdivision (*l*).~~

~~(2) All health care service plan contracts issued, amended, or renewed in California by the insurer's affiliated health care service plans licensed to operate in California, except those contracts described in subdivision (*l*) of Section 1378.1 of the Health and Safety Code.~~

~~(e) The department and the Department of Managed Health Care shall jointly adopt and amend regulations to implement this section and Section 1378.1 of the Health and Safety Code to establish uniform reporting by health care service plans and health insurers of the information necessary to determine compliance with this section and Section 1378.1 of the Health and Safety Code. These regulations may include additional elements in the definition of "health care benefits" not identified in subdivision (b) in order to consistently operationalize the requirements of this section among health care service plans and health insurers, but these regulatory additions shall be consistent with the legislative intent that a health insurer expend at least 85 percent of the aggregate payments received by the insurer, as provided in subdivision (a), on health care benefits.~~

~~(f) The department may exclude from the determination of compliance with the requirement of subdivision (a) any new health insurance policies for up to the first two years that these policies are offered for sale in California, provided that the commissioner determines that the new policies are substantially different from the existing policies being issued, amended, or renewed by the insurer seeking the exclusion.~~

~~(g) Commencing January 1, 2013, and annually thereafter, a health insurer holding a certificate of authority to do business in California shall provide written affirmation to the department that it meets the requirements of this section.~~

~~(h) Commencing January 1, 2013, a health insurer subject to this section shall annually report to the commissioner the medical loss ratio of each individual and small group health insurance policy form issued, amended, or renewed by the insurer in California. Every insurer and its employees or agents shall disclose the information when presenting a policy for examination or sale~~

~~to any individual or the representative of a group consisting of 50 or fewer individuals.~~

~~(i) The department shall not make an assessment of any health insurer within the 12-month period after the date an insurer has complied with the reporting requirements specified in subdivisions (g) and (h), unless the insurer certifies that it failed to meet its medical loss ratio, or the department believes the insurer's certification of its medical loss ratio is incorrect.~~

~~(j) The commissioner may disapprove a health insurer's use of a health insurance policy, revoke or suspend the certificate of authority of a health insurer, issue a fine or assessment against a health insurer, or take any other action the commissioner deems appropriate if the commissioner determines that the health insurer has failed to comply with this section.~~

~~(k) Except as provided in subdivision (*l*), this section shall apply to all health insurance policies issued, amended, or renewed in California on or after January 1, 2013.~~

~~(*l*) This section shall not apply to Medicare supplement policies, administrative services-only policies, or other similar administrative arrangements, short-term limited duration health insurance policies, vision-only, dental-only, behavioral health-only, ambulance-only, chiropractic-only, naturopathic-only, or pharmacy-only policies, CHAMPUS-supplement or TRICARE-supplement insurance policies, or to hospital indemnity, hospital only, accident only, or specified disease insurance policies that do not pay benefits on a fixed benefit, cash payment only basis.~~

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.

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