

Senate Bill No. 1052

CHAPTER 575

An act to add Section 100503.1 to the Government Code, to amend Sections 1363.01 and 1368.016 of, and to add Section 1367.205 to, the Health and Safety Code, and to amend Section 10123.199 of, and to add Section 10123.192 to, the Insurance Code, relating to health care coverage.

[Approved by Governor September 25, 2014. Filed with
Secretary of State September 25, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1052, Torres. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act (Knox-Keene 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. Existing law also provides for the regulation of health insurers by the Department of Insurance. The Knox-Keene Act requires a health care service plan that provides prescription drug benefits and maintains one or more drug formularies to provide to members of the public, upon request, a copy of the most current list of prescription drugs on the formulary, as specified.

This bill would require a health care service plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies to post those formularies on its Internet Web site and update that posting with changes on a monthly basis. The bill would require the departments to jointly develop a standard formulary template by January 1, 2017, and would require plans and insurers to use that template to display formularies, as specified. The bill would make other related conforming changes. Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

Existing law establishes the California Health Benefit Exchange within state government, specifies the powers and duties of the board governing the Exchange, and requires the board to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers.

Existing law requires the board to determine the minimum requirements a health care service plan or health insurer must meet to be considered for participation in the Exchange and the standards and criteria for selecting qualified health plans to be offered through the Exchange that are in the best interests of qualified individuals and qualified small employers.

This bill would require the board of the Exchange to ensure that its Internet Web site provides a direct link to the formularies for each qualified health

plan offered through the Exchange that are posted by plans and insurers pursuant to the bill's provisions.

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 100503.1 is added to the Government Code, to read:

100503.1. The board shall ensure that the Internet Web site maintained under subdivision (c) of Section 100502 provides a direct link to the formulary, or formularies, for each qualified health plan offered through the Exchange that is posted by the carrier pursuant to Section 1367.205 of the Health and Safety Code or Section 10123.192 of the Insurance Code.

SEC. 2. Section 1363.01 of the Health and Safety Code is amended to read:

1363.01. (a) Every plan that covers prescription drug benefits shall provide notice in the evidence of coverage and disclosure form to enrollees regarding whether the plan uses a formulary. The notice shall be in language that is easily understood and in a format that is easy to understand. The notice shall include an explanation of what a formulary is, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

(b) Every plan that covers prescription drug benefits shall provide to members of the public, upon request, information regarding whether a specific drug or drugs are on the plan's formulary. Notice of the opportunity to secure this information from the plan, including the plan's telephone number for making a request of this nature and the Internet Web site where the formulary is posted under Section 1367.205, shall be included in the evidence of coverage and disclosure form to enrollees.

(c) Every plan shall notify enrollees, and members of the public who request formulary information, that the presence of a drug on the plan's formulary does not guarantee that an enrollee will be prescribed that drug by his or her prescribing provider for a particular medical condition.

SEC. 3. Section 1367.205 is added to the Health and Safety Code, to read:

1367.205. (a) In addition to the list required to be provided under Section 1367.20, a health care service plan that provides prescription drug benefits and maintains one or more drug formularies shall do all of the following:

(1) Post the formulary or formularies for each product offered by the plan on the plan's Internet Web site in a manner that is accessible and searchable by potential enrollees, enrollees, and providers.

(2) Update the formularies posted pursuant to paragraph (1) with any change to those formularies on a monthly basis.

(3) No later than six months after the date that a standard formulary template is developed under subdivision (b), use that template to display the formulary or formularies for each product offered by the plan.

(b) (1) By January 1, 2017, the department and the Department of Insurance shall jointly, and with input from interested parties from at least one public meeting, develop a standard formulary template for purposes of paragraph (3) of subdivision (a). In developing the template, the department and Department of Insurance shall take into consideration existing requirements for reporting of formulary information established by the federal Centers for Medicare and Medicaid Services. To the extent feasible, in developing the template, the department and the Department of Insurance shall evaluate a way to include on the template, in addition to the information required to be included under paragraph (2), cost-sharing information for drugs subject to coinsurance.

(2) The standard formulary template shall include the notification described in subdivision (c) of Section 1363.01, and as applied to a particular formulary for a product offered by a plan, shall do all of the following:

(A) Include information on cost-sharing tiers and utilization controls, including prior authorization or step therapy requirements, for each drug covered by the product.

(B) Indicate any drugs on the formulary that are preferred over other drugs on the formulary.

(C) Include information to educate enrollees about the differences between drugs administered or provided under a health care service plan's medical benefit and drugs prescribed under a health care service plan's prescription drug benefit and about how to obtain coverage information regarding drugs that are not covered under the plan's prescription drug benefit.

(D) Include information to educate enrollees that health care service plans that provide prescription drug benefits are required to have a method for enrollees to obtain prescription drugs not listed in the health plan drug formulary if the drugs are deemed medically necessary by a clinician pursuant to Section 1367.24.

(c) For purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under a health care service plan product and includes the drugs covered under the pharmacy benefit of the product.

SEC. 4. Section 1368.016 of the Health and Safety Code is amended to read:

1368.016. (a) A health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall, pursuant to subdivision (f) of Section 1368.015, include on its Internet Web site, or provide a link to, the following information:

(1) A telephone number that the enrollee or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.

(2) A link to prescription drug formularies posted pursuant to Section 1367.205, or instructions on how to obtain the formulary, as described in Section 1367.20.

(3) A detailed summary that describes the process by which the plan reviews and authorizes or approves, modifies, or denies requests for health care services as described in Sections 1363.5 and 1367.01.

(4) Lists of providers or instructions on how to obtain the provider list, as required by Section 1367.26.

(5) A detailed summary of the enrollee grievance process as described in Sections 1368 and 1368.015.

(6) A detailed description of how an enrollee may request continuity of care pursuant to subdivisions (a) and (b) of Section 1373.95.

(7) Information concerning the right, and applicable procedure, of an enrollee to request an independent medical review pursuant to Section 1374.30.

(b) Any modified material described in subdivision (a) shall be updated at least quarterly.

(c) The information described in subdivision (a) may be made available through a secured Internet Web site that is only accessible to enrollees.

(d) The material described in subdivision (a) shall also be made available to enrollees in hard copy upon request.

(e) Nothing in this article shall preclude a health care service plan from including additional information on its Internet Web site for applicants, enrollees or subscribers, or providers, including, but not limited to, the cost of procedures or services by health care providers in a plan's network.

(f) The department shall include on the department's Internet Web site a link to the Internet Web site of each health care service plan and specialized health care service plan described in subdivision (a).

(g) This section shall not apply to Medicare supplement insurance, Employee Assistance Programs, short-term limited duration health insurance, CHAMPUS-supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health care service plans, except behavioral health-only plans.

(h) This section shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with this section or Section 10123.199 of the Insurance Code.

SEC. 5. Section 10123.192 is added to the Insurance Code, to read:

10123.192. (a) A health insurer that provides prescription drug benefits and maintains one or more drug formularies shall do all of the following:

(1) Post the formulary or formularies for each product offered by the insurer on the insurer's Internet Web site in a manner that is accessible and searchable by potential insureds, insureds, and providers.

(2) Update the formularies posted pursuant to paragraph (1) with any change to those formularies on a monthly basis.

(3) No later than six months after the date that a standard formulary template is developed under subdivision (b), use that template to display the formulary or formularies for each product offered by the insurer.

(b) (1) By January 1, 2017, the department and the Department of Managed Health Care shall jointly, and with input from interested parties from at least one public meeting, develop a standard formulary template for purposes of paragraph (3) of subdivision (a). In developing the template, the department and Department of Managed Health Care shall take into consideration existing requirements for reporting of formulary information established by the federal Centers for Medicare and Medicaid Services. To the extent feasible, in developing the template, the department and the Department of Managed Health Care shall evaluate a way to include on the template, in addition to the information required to be included under paragraph (2), cost-sharing information for drugs subject to coinsurance.

(2) The standard formulary template shall include a notification that the presence of a drug on the insurer's formulary does not guarantee that an insured will be prescribed that drug by his or her prescribing provider for a particular medical condition. As applied to a particular formulary for a product offered by an insurer, the standard formulary template shall do all of the following:

(A) Include information on cost-sharing tiers and utilization controls, including prior authorization or step therapy requirements, for each drug covered by the product.

(B) Indicate any drugs on the formulary that are preferred over other drugs on the formulary.

(C) Include information to educate insureds about the differences between drugs administered or provided under a health insurer's medical benefit and drugs prescribed under a health insurer's prescription drug benefit and about how to obtain coverage information about drugs that are not covered under the health insurer's prescription drug benefit.

(D) Include information to educate insureds that health insurers that provide prescription drug benefits are required to have a method for insureds to obtain prescription drugs not listed in the health insurer's drug formulary if the drugs are deemed to be medically necessary by a clinician pursuant to Section 1367.24 of the Health and Safety Code, as required by clause (iv) of subparagraph (A) of paragraph (2) of subdivision (a) of Section 10112.27.

(c) The commissioner may adopt regulations as may be necessary to carry out the purposes of this section. In adopting regulations, the

commissioner shall comply with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) For purposes of this section, “formulary” means the complete list of drugs preferred for use and eligible for coverage under a health insurance product and includes the drugs covered under the pharmacy benefit of the product.

SEC. 6. Section 10123.199 of the Insurance Code is amended to read:

10123.199. (a) A health insurer that provides coverage for professional mental health services shall establish an Internet Web site. Each Internet Web site shall include, or provide a link to, the following information:

(1) A telephone number that the insured or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.

(2) A link to prescription drug formularies posted pursuant to Section 10123.192, or instructions on how to obtain formulary information.

(3) A detailed summary description of the process by which the insurer reviews and approves, modifies, or denies requests for health care services as described in Section 10123.135.

(4) Lists of providers or instructions on how to obtain a provider list as required by Section 10133.1.

(5) A detailed summary of the health insurer’s grievance process.

(6) A detailed description of how the insured may request continuity of care as described in Section 10133.55.

(7) Information concerning the right, and applicable procedure, of the insured to request an independent medical review pursuant to Section 10169.

(b) Except as otherwise specified, the material described in subdivision (a) shall be updated at least quarterly.

(c) The information described in subdivision (a) may be made available through a secured Internet Web site that is only accessible to the insured.

(d) The material described in subdivision (a) shall also be made available to insureds in hard copy upon request.

(e) Nothing in this article shall preclude an insurer from including additional information on its Internet Web site for applicants or insureds, including, but not limited to, the cost of procedures or services by health care providers in an insurer’s network.

(f) The department shall include on the department’s Internet Web site, a link to the Internet Web site of each health insurer described in subdivision (a).

(g) This section shall not apply to Medicare supplement insurance, Employee Assistance Programs, short-term limited duration health insurance, CHAMPUS-supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health insurance policies, except behavioral health-only policies.

(h) This section shall not apply to a health insurer that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its insureds, provided that the health insurer provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with this section or Section 1368.016 of the Health and Safety Code.

SEC. 7. 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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