AMENDED IN ASSEMBLY AUGUST 22, 2014

AMENDED IN ASSEMBLY AUGUST 18, 2014

AMENDED IN ASSEMBLY JUNE 30, 2014

AMENDED IN SENATE APRIL 10, 2014

SENATE BILL No. 1182

Introduced by Senator Leno

February 20, 2014

An act to amend ~~Sections 1374.8, 1385.03, and 1385.04 of the Health and Safety Code, and to amend Sections 791.27 and 10181.4 of the Insurance Code,~~ *Sections 1374.8 and 1385.07 of, and to add Section 1385.10 to, the Health and Safety Code, and to amend Sections 791.27 and 10181.7 of, and to add Section 10181.10 to, the Insurance Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1182, as amended, Leno. Health care coverage: rate review.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires the United States Secretary of Health and Human Services to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage in which health insurance issuers submit to the secretary and the relevant state, a justification for an unreasonable premium increase prior to implementation of the increase. 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. Existing law also provides for the regulation of health insurers by the Department of Insurance. For large group plan contracts and policies, existing law

requires a plan or insurer to file rate information with the appropriate department at least 60 days prior to implementing an unreasonable rate increase, as defined in PPACA. Existing law requires the plan or insurer to also disclose specified aggregate data with that rate filing.

This bill would require a health care service plan or health insurer to annually disclose additional aggregate claims data for all products sold in the large group market and to provide deidentified claims data at no charge to a large group purchaser that requests the information and meets specified conditions. The bill would specify that all disclosures of data to the large group purchaser made pursuant to these provisions is required to comply with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal Health Information Technology for Economic and Clinical Health Act, and the Confidentiality of Medical Information Act or the Insurance Information and Privacy Protection Act, as specified. The bill would prohibit a health care service plan or a health insurer from disclosing the contracted rates between the health care service plan or health insurer and a provider to a large group purchaser. This bill would specify that additional aggregate claims data disclosed to a large group purchaser by a health care service plan or health insurer is confidential and is prohibited from being made public by the department and exempt from disclosure under the California Public Records Act.

Existing law prohibits, with exceptions, a health care service plan or health insurer from releasing any information to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider covered by the plan unless authorized to do so by the employee.

This bill would exempt from the prohibition the release of relevant information for the purposes set forth in these provisions regarding a plan's or insurer's annual disclosure of aggregate data for all products sold in the large group market.

Because a willful violation of the bill's requirements by a health care services plan would be a crime, the bill would impose a state-mandated local program.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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.

~~Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires the United States Secretary of Health and Human Services to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage in which health insurance issuers submit to the secretary and the relevant state a justification for an unreasonable premium increase prior to implementation of the increase. 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. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer in the individual, small group, or large group markets to file rate information with the Department of Managed Health Care or the Department of Insurance. For individual and small group contracts and policies, existing law requires a plan or insurer to file rate information at least 60 days prior to implementing a rate change and requires a plan or insurer to disclose with each filing specified information by aggregate benefit category. Existing law allows a health care service plan that exclusively contracts with no more than 2 medical groups to provide or arrange for professional medical services for enrollees of the plan to meet this requirement by disclosing its actual trend experience for the prior year using benefit categories that are the same or similar to those used by other plans.~~

~~This bill would specify the benefit categories to be used for that purpose and would make other related changes.~~

~~For large group plan contracts and policies, existing law requires a plan or insurer to file rate information with the department at least 60 days prior to implementing an unreasonable rate increase, as defined in PPACA. Existing law requires the plan or insurer to also disclose specified aggregate data with that rate filing.~~

~~This bill would revise the aggregate information required to be provided with the rate filing described above, including, among other things, total earned premiums, total incurred claims, and average rate~~

~~of increase for the rate year. The bill would require a plan or insurer to disclose the methodologies used to develop base rates and other specified information, including, among other things, all of the base rates used for groups in the large group market and all of the factors used to adjust the base rates. The bill would also require a plan or insurer to provide additional aggregate information regarding rate changes for the large group market, including, among other things, the average monthly rate implemented during the prior year and the average rate change initially requested, as specified. The bill would require a plan or insurer, under certain circumstances, to annually disclose additional aggregate data for the large group market and to provide deidentified claims data at no charge to a large group purchaser that requests the information and meets specified conditions.~~

~~Existing law prohibits, with exceptions, a health care service plan or health insurer from releasing any information to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider covered by the plan unless authorized to do so by the employee.~~

~~This bill would exempt from the prohibition the release of relevant information for the purposes set forth in the provisions regarding the review of rate changes.~~

~~Because a willful violation of the bill's requirements by a health care service plan 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 1374.8 of the Health and Safety Code is amended to read:

1374.8. *(a)* A health care service plan shall not release any information to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider covered by the plan

unless authorized to do so by the employee. An insurer that has, pursuant to an agreement, assumed the responsibility to pay compensation pursuant to Article 3 (commencing with Section 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall not be considered an employer for the purposes of this section. ~~Nothing~~

(b) Nothing in this section prohibits a health care service plan from releasing relevant information described in this section for the purposes set forth in Chapter 12 (commencing with Section 1871) of Part 2 of Division 1 of the Insurance Code.

(c) Nothing in this section prohibits a health care service plan from releasing relevant information described in this section for the purposes set forth in Section 1385.10.

SEC. 2. Section 1385.07 of the Health and Safety Code is amended to read:

1385.07. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) *(1)* The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health care service plan and a ~~large~~ *provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10.*

(2) The contracted rates between a health care service plan and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). *Information provided to a large group purchaser pursuant to Section 1385.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).*

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the department, except as provided in subdivision (b). The information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health plan's actual costs, by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

SEC. 3. Section 1385.10 is added to the Health and Safety Code, to read:

1385.10. (a) (1) A health care service plan shall annually provide claims data at no charge to a large group purchaser if the large group purchaser requests the information and otherwise meets the requirements of this section.

(2) The health care service plan shall provide claims data that a qualified statistician has determined are deidentified so that the claims data do not identify or do not provide a reasonable basis from which to identify an individual. If the statistician is unable

to determine that the data has been deidentified, then the data that cannot be deidentified shall not be provided by the health care service plan to the large group purchaser. A health care service plan may provide the claims data in an aggregated form as necessary to comply with subdivisions (e) and (f).

(b) (1) As an alternative to providing claims data required pursuant to subdivision (a), the plan shall provide, at no charge to a large group purchaser, all of the following:

(A) Deidentified data sufficient for the large group purchaser to calculate the cost of obtaining similar services from other health plans and evaluate cost-effectiveness by service and disease category.

(B) Deidentified aggregated patient-level data on demographics, prescribing, encounters, inpatient services, outpatient services, and any other data that is comparable to what is required of the health plan to comply with risk adjustment, reinsurance, or risk corridors pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(C) Deidentified aggregated patient-level data used to experience rate the large group, including diagnostic and procedure coding and costs assigned to each service that the plan has available.

(2) The health care service plan shall obtain a formal determination from a qualified statistician that the data provided pursuant to this subdivision have been deidentified so that the data do not identify or do not provide a reasonable basis from which to identify an individual. The statistician shall certify the formal determination in writing and shall, upon request, provide the protocol used for deidentification to the department.

(c) Data provided pursuant to this section shall only be provided to a large group purchaser that meets both of the following conditions:

(1) Is able to demonstrate its ability to comply with state and federal privacy laws.

(2) Is a large group purchaser that is either an employer with an enrollment of greater than 1,000 covered lives or a multiemployer trust.

(d) Nothing in this section shall be construed to prohibit a plan and purchaser from negotiating the release of additional information not described in this section.

(e) All disclosures of data to the large group purchaser made pursuant to this section shall comply with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

(f) All disclosures of data to the large group purchaser made pursuant to this section shall comply with the Confidentiality of Medical Information Act (Chapter 1 (commencing with Section 56) of Part 2.6 of Division 1 of the Civil Code).

SEC. 4. Section 791.27 of the Insurance Code is amended to read:

791.27. *(a)* A disability insurer that provides coverage for hospital, medical, or surgical expenses shall not release any information to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider covered by the plan unless authorized to do so by the employee. An insurer that has, pursuant to an agreement, assumed the responsibility to pay compensation pursuant to Article 3 (commencing with Section 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall not be considered an employer for the purposes of this section. ~~Nothing~~

(b) Nothing in this section prohibits a disability insurer from releasing relevant information described in this section for the purposes set forth in Chapter 12 (commencing with Section 1871) of Part 2 of Division 1.

(c) Nothing in this section prohibits a disability insurer from releasing relevant information described in this section for the purposes set forth in Section 10181.10.

SEC. 5. Section 10181.7 of the Insurance Code is amended to read:

10181.7. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) *(1)* Any contracted rates between a health insurer and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health insurer and a ~~large~~ *provider shall not be disclosed by a health insurer to a large group purchaser that receives information pursuant to Section 10181.10.*

(2) The contracted rates between a health insurer and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). *Information provided to a large group purchaser pursuant to Section 10181.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).*

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health insurer shall, at a minimum, make the following information readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the department, except as provided in subdivision (b). The information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) An insurer's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) An insurer's actual costs, by aggregate benefit category to include, hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual policy trends

by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

SEC. 6. Section 10181.10 is added to the Insurance Code, to read:

10181.10. (a) (1) A health insurer shall annually provide claims data at no charge to a large group purchaser if the large group purchaser requests the information and otherwise meets the requirements of this section.

(2) The health insurer shall provide claims data that a qualified statistician has determined are deidentified so that the claims data do not identify or do not provide a reasonable basis from which to identify an individual. If the statistician is unable to determine that the data has been deidentified, then the data that cannot be deidentified shall not be provided by the health insurer to the large group purchaser. A health insurer may provide the claims data in an aggregated form as necessary to comply with subdivisions (e) and (f).

(b) (1) As an alternative to providing claims data required pursuant to subdivision (a), the insurer shall provide, at no charge to a large group purchaser, all of the following:

(A) Deidentified data sufficient for the large group purchaser to calculate the cost of obtaining similar services from other health insurers and plans and evaluate cost-effectiveness by service and disease category.

(B) Deidentified aggregated patient-level data on demographics, prescribing, encounters, inpatient services, outpatient services, and any other data that is comparable to what is required of the health insurer to comply with risk adjustment, reinsurance, or risk corridors pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(C) Deidentified aggregated patient-level data used to experience rate the large group, including diagnostic and procedure coding and costs assigned to each service that the insurer has available.

(2) The health insurer shall obtain a formal determination from a qualified statistician that the data provided pursuant to this

subdivision have been deidentified so that the data do not identify or do not provide a reasonable basis from which to identify an individual. The statistician shall certify the formal determination in writing and shall, upon request, provide the protocol used for deidentification to the department.

(c) Data provided pursuant to this section shall only be provided to a large group purchaser that meets both of the following conditions:

(1) Is able to demonstrate its ability to comply with state and federal privacy laws.

(2) Is a large group purchaser that is either an employer with an enrollment of greater than 1,000 covered lives or a multiemployer trust.

(d) Nothing in this section shall be construed to prohibit an insurer and purchaser from negotiating the release of additional information not described in this section.

(e) All disclosures of data to the large group purchaser made pursuant to this section shall comply with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

(f) All disclosures of data to the large group purchaser made pursuant to this section shall comply with the Insurance Information and Privacy Protection Act (Chapter 1 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code).

SEC. 7. The Legislature finds and declares that Section 2 of this act, which amends Section 1385.07 of the Health and Safety Code, and Section 5 of this act, which amends Section 10181.07 of the Insurance Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect the public's interest in access to high-quality health care coverage in the most efficient, cost-effective manner for those individuals who receive his or her health care coverage

through a large employer or multi-employer trust, it is necessary that additional aggregate data disclosed by a health care service plan or health insurer to a large group purchaser remain confidential.

SEC. 8. 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.

All matter omitted in this version of the bill appears in the bill as amended in the Assembly, August 18, 2014. (JR11)

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