

AMENDED IN ASSEMBLY AUGUST 27, 2014

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**

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**Introduced by Senator Leno**

February 20, 2014

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An act to amend 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.~~ *claims data.*

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.~~ *deidentified claims data to a large group purchaser.*

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.

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

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

1 SECTION 1. Section 1374.8 of the Health and Safety Code is  
2 amended to read:

3 1374.8. (a) A health care service plan shall not release any  
4 information to an employer that would directly or indirectly  
5 indicate to the employer that an employee is receiving or has  
6 received services from a health care provider covered by the plan  
7 unless authorized to do so by the employee. An insurer that has,  
8 pursuant to an agreement, assumed the responsibility to pay  
9 compensation pursuant to Article 3 (commencing with Section  
10 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall  
11 not be considered an employer for the purposes of this section.

12 (b) Nothing in this section prohibits a health care service plan  
13 from releasing relevant information described in this section for  
14 the purposes set forth in Chapter 12 (commencing with Section  
15 1871) of Part 2 of Division 1 of the Insurance Code.

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

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

21 1385.07. (a) Notwithstanding Chapter 3.5 (commencing with  
22 Section 6250) of Division 7 of Title 1 of the Government Code,  
23 all information submitted under this article shall be made publicly  
24 available by the department except as provided in subdivision (b).

25 (b) (1) The contracted rates between a health care service plan  
26 and a provider shall be deemed confidential information that shall  
27 not be made public by the department and are exempt from

1 disclosure under the California Public Records Act (Chapter 3.5  
2 (commencing with Section 6250) of Division 7 of Title 1 of the  
3 Government Code). The contracted rates between a health care  
4 service plan and a provider shall not be disclosed by a health care  
5 service plan to a large group purchaser that receives information  
6 pursuant to Section 1385.10.

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

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

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

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

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

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

37 (4) The amount of the projected trend attributable to the use of  
38 services, price inflation, or fees and risk for annual plan contract  
39 trends by aggregate benefit category, such as hospital inpatient,  
40 hospital outpatient, physician services, prescription drugs and other

1 ancillary services, laboratory, and radiology. A health plan that  
2 exclusively contracts with no more than two medical groups in the  
3 state to provide or arrange for professional medical services for  
4 the enrollees of the plan shall instead disclose the amount of its  
5 actual trend experience for the prior contract year by aggregate  
6 benefit category, using benefit categories that are, to the maximum  
7 extent possible, the same or similar to those used by other plans.

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

10 1385.10. (a) (1) A health care service plan shall annually  
11 provide claims data at no charge to a large group purchaser if the  
12 large group purchaser requests the information and otherwise meets  
13 the requirements of this section.

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

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

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

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

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

1 (2) The health care service plan shall obtain a formal  
2 determination from a qualified statistician that the data provided  
3 pursuant to this subdivision have been deidentified so that the data  
4 do not identify or do not provide a reasonable basis from which  
5 to identify an individual. *If the statistician is unable to determine*  
6 *that the data has been deidentified, the health care service plan*  
7 *shall not provide the data that cannot be deidentified to the large*  
8 *group purchaser.* The statistician shall ~~certify~~ *document* the formal  
9 determination in writing and shall, upon request, provide the  
10 protocol used for deidentification to the department.

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

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

16 (2) Is a large group purchaser that is either an employer with  
17 an enrollment of greater than 1,000 covered lives *and at least 500*  
18 *covered lives enrolled with the health care service plan providing*  
19 *the information* or a multiemployer ~~trust~~ *trust with an enrollment*  
20 *of greater than 500 covered lives and at least 250 covered lives*  
21 *enrolled with the health care service plan providing the*  
22 *information.*

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

26 (e) All disclosures of data to the large group purchaser made  
27 pursuant to this section shall comply with the federal Health  
28 Insurance Portability and Accountability Act of 1996 (Public Law  
29 104-191) and the federal Health Information Technology for  
30 Economic and Clinical Health Act, Title XIII of the federal  
31 American Recovery and Reinvestment Act of 2009 (Public Law  
32 111-5), and implementing regulations.

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

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

39 791.27. (a) A disability insurer that provides coverage for  
40 hospital, medical, or surgical expenses shall not release any

1 information to an employer that would directly or indirectly  
2 indicate to the employer that an employee is receiving or has  
3 received services from a health care provider covered by the plan  
4 unless authorized to do so by the employee. An insurer that has,  
5 pursuant to an agreement, assumed the responsibility to pay  
6 compensation pursuant to Article 3 (commencing with Section  
7 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall  
8 not be considered an employer for the purposes of this section.

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

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

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

18 10181.7. (a) Notwithstanding Chapter 3.5 (commencing with  
19 Section 6250) of Division 7 of Title 1 of the Government Code,  
20 all information submitted under this article shall be made publicly  
21 available by the department except as provided in subdivision (b).

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

30 (2) The contracted rates between a health insurer and a large  
31 group shall be deemed confidential information that shall not be  
32 made public by the department and are exempt from disclosure  
33 under the California Public Records Act (Chapter 3.5 (commencing  
34 with Section 6250) of Division 7 of Title 1 of the Government  
35 Code). Information provided to a large group purchaser pursuant  
36 to Section 10181.10 shall be deemed confidential information that  
37 shall not be made public by the department and shall be exempt  
38 from disclosure under the California Public Records Act (Chapter  
39 3.5 (commencing with Section 6250) of Division 7 of Title 1 of  
40 the Government Code).

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

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

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

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

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

20 (4) The amount of the projected trend attributable to the use of  
21 services, price inflation, or fees and risk for annual policy trends  
22 by aggregate benefit category, such as hospital inpatient, hospital  
23 outpatient, physician services, prescription drugs and other  
24 ancillary services, laboratory, and radiology.

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

27 10181.10. (a) (1) A health insurer shall annually provide  
28 claims data at no charge to a large group purchaser if the large  
29 group purchaser requests the information and otherwise meets the  
30 requirements of this section.

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

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

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

8 (B) Deidentified aggregated patient-level data on demographics,  
9 prescribing, encounters, inpatient services, outpatient services, and  
10 any other data that is comparable to what is required of the health  
11 insurer to comply with risk adjustment, reinsurance, or risk  
12 corridors pursuant to the federal Patient Protection and Affordable  
13 Care Act (Public Law 111-148), as amended by the federal Health  
14 Care and Education Reconciliation Act of 2010 (Public Law  
15 111-152), and any rules, regulations, or guidance issued thereunder.

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

19 (2) The health insurer shall obtain a formal determination from  
20 a qualified statistician that the data provided pursuant to this  
21 subdivision have been deidentified so that the data do not identify  
22 or do not provide a reasonable basis from which to identify an  
23 individual. *If the statistician is unable to determine that the data*  
24 *has been deidentified, the health insurer shall not provide the data*  
25 *that cannot be deidentified to the large group purchaser.* The  
26 statistician shall ~~certify~~ *document* the formal determination in  
27 writing and shall, upon request, provide the protocol used for  
28 deidentification to the department.

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

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

34 (2) Is a large group purchaser that is either an employer with  
35 an enrollment of greater than 1,000 covered lives *and at least 500*  
36 *covered lives enrolled with the health insurer providing the*  
37 *information* or a multiemployer ~~trust~~ *trust with an enrollment of*  
38 *greater than 500 covered lives and at least 250 covered lives*  
39 *enrolled with the health insurer providing the information.*

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

4 (e) All disclosures of data to the large group purchaser made  
5 pursuant to this section shall comply with the federal Health  
6 Insurance Portability and Accountability Act of 1996 (Public Law  
7 104-191) and the federal Health Information Technology for  
8 Economic and Clinical Health Act, Title XIII of the federal  
9 American Recovery and Reinvestment Act of 2009 (Public Law  
10 111-5), and implementing regulations.

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

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

25 In order to protect the public's interest in access to high-quality  
26 health care coverage in the most efficient, cost-effective manner  
27 for those individuals who receive ~~his or her~~ *their* health care  
28 coverage through a large employer or multi-employer trust, it is  
29 necessary that additional aggregate data disclosed by a health care  
30 service plan or health insurer to a large group purchaser remain  
31 confidential.

32 SEC. 8. No reimbursement is required by this act pursuant to  
33 Section 6 of Article XIII B of the California Constitution because  
34 the only costs that may be incurred by a local agency or school  
35 district will be incurred because this act creates a new crime or  
36 infraction, eliminates a crime or infraction, or changes the penalty  
37 for a crime or infraction, within the meaning of Section 17556 of  
38 the Government Code, or changes the definition of a crime within

1 the meaning of Section 6 of Article XIII B of the California  
2 Constitution.

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