ASSEMBLY BILL No. 562

Introduced by Assembly Member Cook

February 25, 2009

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

LEGISLATIVE COUNSEL'S DIGEST

AB 562, as introduced, Cook. Health care coverage: report of claim information.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance.

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

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

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

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

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

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

Article 12. Reporting of Claims Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) In a written report.

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

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

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

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

(2) Total premiums paid by month.

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

(A) An employee only.

(B) An employee with dependents only.

(C) An employee with a spouse only.

(D) An employee with a spouse and dependents.

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

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

(A) A unique identifying number, characteristic, or code for the individual.

(B) The amounts paid during the 12-month period.

(C) The dates on which health care services were provided during the 12-month period.

(D) The applicable procedure codes and diagnosis codes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 7.5. Reporting of Claims Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) In a written report.

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

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

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

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

(2) Total premiums paid by month.

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

(A) An employee only.

(B) An employee with dependents only.

(C) An employee with a spouse only.

(D) An employee with a spouse and dependents.

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

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

(A) A unique identifying number, characteristic, or code for the individual.

(B) The amounts paid during the 12-month period.

(C) The dates on which health care services were provided during the 12-month period.

(D) The applicable procedure codes and diagnosis codes.

(6) For claims that are not part of the report described by paragraphs (1) to (5), inclusive, a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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