ASSEMBLY BILL No. 1976

Introduced by Assembly Member Cook

February 17, 2010

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 1976, 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, 2011, require a health care service plan or health insurer that receives a written request for a written report of claim information from the group subscriber or group policyholder of a group health care service plan contract or health insurance policy issued by the plan or insurer, as specified, to provide that report to the subscriber or policyholder 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 after removing any individually identifiable information, as defined. The bill would prohibit the health care service plan or health insurer from disclosing any information protected under federal or state law. The bill would make a plan or insurer that fails to comply with these requirements subject to administrative penalties assessed by the departments.

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 Claim Information

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

(1) "Group health care service plan contract" means a group health care service plan contract other than a contract issued to a small employer, as defined in subdivision (*l*) of Section 1357.

(2) "Individually identifiable information" means both of the following:

(A) Individually identifiable health information, as defined in Section 160.103 of Title 45 of the Code of Federal Regulations.

(B) Medical information, as defined in Section 56.05 of the Civil Code.

(b) A reference to a federal statute or regulation under subdivision (a) refers to that statute or regulation as it existed on January 1, 2010, 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.

1399.852. (a) A health care service plan that receives a written request for a written report of claim information from the group subscriber of a group health care service plan contract issued by

the plan shall provide that report, consistent with the requirements of this section, to the group subscriber no later than 30 days after receipt of the request. The health care service plan shall not be required to provide a report under this subdivision regarding a particular group health care service plan contract more than twice in a 12-month period.

(b) A health care service plan 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 group subscriber.

(c) A report of claim information provided under this section shall contain all information available to the health care service plan 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 paragraph (5) and in subdivision (e). Except as provided in subdivision (d), the report required by this section shall include all of the following information, after removing any individually identifiable information:

(1) Aggregate paid claims experience by month, including, but not limited to, claims experience for medical, dental, and pharmacy benefits, including capitation costs or payments in the case of health maintenance organizations, as applicable. Twenty thousand dollars ($20,000) shall be used as the pooling point for aggregate reporting.

(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 twenty thousand dollars ($20,000) during the 12-month period preceding the date of the report. This report shall include both of the following related to the claims for that individual:

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

(B) The applicable procedure codes and diagnosis codes.

(d) A health care service plan shall not disclose any information in the report required under this section that the health care service plan 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).

(e) If a health care service plan receives a request under subdivision (a) after the date that coverage under the applicable group health care service plan contract has terminated, the report required under subdivision (a) shall contain all information available to the health care service plan for the period described in subdivision (c) preceding the date of termination of coverage or for the entire period of coverage, whichever period is shorter. The report shall include the information described in paragraphs (1) to (5), inclusive, of subdivision (c), but shall not include any individually identifiable health information.

(f) In order to be entitled to receive the report described in this section, a group subscriber shall request that report on or before the second anniversary of the date of termination of coverage under a group health care service plan contract issued by the health care service plan.

(g) A report of claim information provided under this section by or to a state or local agency, as defined in Section 6252 of the Government Code, 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.

1399.853. For purposes of this article, Sections 1374.8 and 1390 shall not apply.

1399.854. A health care service plan that fails to comply with this article is subject to administrative penalties assessed by the department subject to appropriate notice of, and opportunity for, a hearing in accordance with Section 1397.

1399.855. (a) This article applies only to a request for a written report of claim information made on or after July 1, 2011.

(b) This article shall not apply to specialized health care service plans.

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 Claim Information

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

(1) "Group health insurance policy" means a group health insurance policy other than a policy issued to a small employer, as defined in subdivision (w) of Section 10700.

(2) "Individually identifiable information" means both of the following:

(A) Individually identifiable health information, as defined in Section 160.103 of Title 45 of the Code of Federal Regulations.

(B) Medical information, as defined in Section 56.05 of the Civil Code.

(b) A reference to a federal statute or regulation under subdivision (a) refers to that statute or regulation as it existed on January 1, 2010, 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.

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

(b) A health insurer 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 group policyholder.

(c) A report of claim information provided under this section shall contain all information available to the health insurer 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 paragraph (5) and in subdivision (e). Except as provided in subdivision (d), the report required by this section shall include all of the following information, after removing any individually identifiable information:

(1) Aggregate paid claims experience by month, including, but not limited to, claims experience for medical, dental, and pharmacy benefits, including capitation costs or payments in the case of contracts with providers at alternative rates pursuant to Section 10133, as applicable. Twenty thousand dollars ($20,000) shall be used as the pooling point for aggregate reporting.

(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 twenty thousand dollars ($20,000) during the 12-month period preceding the date of the report. This report shall include both of the following related to the claims for that individual:

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

(B) The applicable procedure codes and diagnosis codes.

(d) A health insurer shall not disclose any information in the report required under this section that the health insurer 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).

(e) If a health insurer receives a request under subdivision (a) after the date that coverage under the applicable group health insurance policy has terminated, the report required under subdivision (a) shall contain all information available to the health insurer 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 (5), inclusive, of subdivision (c), but shall not include any individually identifiable health information.

(f) In order to be entitled to receive the report described in this section, a group policyholder shall request that report on or before the second anniversary of the date of termination of coverage under a group health insurance policy issued by the health insurer.

(g) A report of claim information provided under this section by or to a state or local agency, as defined in Section 6252 of the Government Code, 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.

10653. For purposes of this chapter, Section 791.27 shall not apply.

10654. A health insurer that fails to comply with this chapter is subject to administrative penalties assessed by the department subject to appropriate notice of, and opportunity for, a hearing.

10655. (a) This chapter applies only to a request for a written report of claim information made on or after July 1, 2011.

(b) This chapter shall not apply to specialized health insurance policies.

SEC. 3. The Legislature finds and declares that Sections 1 and 2 of this act, which add Section 1399.852 to the Health and Safety Code and Section 10652 to the Insurance Code, respectively, impose 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 personally identifiable health information, it is necessary to ensure that the reports provided pursuant to this act are kept confidential.

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