Senate Bill No. 1440

Passed the Senate August 31, 2008

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Secretary of the Senate

Passed the Assembly August 19, 2008

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2008, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Section 1378.1 to the Health and Safety Code, and to add Section 10113.11 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1440, Kuehl. Health care coverage: benefits.

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. Under existing law, a health care service plan is prohibited from expending for administrative costs, as defined, an excessive amount of the payments it receives for providing health care services to its subscribers and enrollees. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, the Insurance Commissioner is required to withdraw approval of an individual or mass-marketed policy of disability insurance if the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged, as specified.

This bill would require full service health care service plans and health insurers to expend on health care benefits no less than 85% of the aggregate dues, fees, premiums, and other periodic payments they receive with respect to plan contracts or policies issued, amended, or renewed on or after January 1, 2011, as specified. The bill would authorize those plans and insurers to assess compliance with this requirement by averaging their total costs across all plan contracts or insurance policies issued, amended, or renewed by them and their affiliated plans and insurers in California, except as specified. The bill would require those plans and insurers to annually, commencing January 1, 2011, provide written affirmation of compliance with the bill's requirements to the Department of Managed Health Care or the Department of Insurance, and would also require those plans and insurers to annually, commencing January 1, 2011, report to the Director of Managed Health Care or the Insurance Commissioner the medical

loss ratio of each individual and small group health care service plan product and health insurance policy form issued, amended, or renewed in California and to report the ratio when presenting a plan for examination or sale to any individual or group consisting of 50 or fewer individuals. The bill would authorize the Department of Managed Health Care to assess health care service plan compliance with these provisions in specified medical surveys and would also authorize the director of that department and the Insurance Commissioner to take specified actions if the director or commissioner determines that a plan or insurer has failed to comply with these provisions. The bill would require the departments to jointly adopt and amend regulations to implement these provisions, as specified.

Because a willful violation of the bill's requirements with respect to health care service plans 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.

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

SECTION 1. Section 1378.1 is added to the Health and Safety Code, to read:

1378.1. (a) Notwithstanding any other provision of law, on and after January 1, 2011, a full service health care service plan shall expend in the form of health care benefits no less than 85 percent of the aggregate dues, fees, premiums, and other periodic payments received by the plan. For purposes of this section, a full service health care service plan may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the plan the amount of income taxes or other taxes that the plan expensed.

(b) For purposes of this section, "health care benefits" shall include, but shall not be limited to, all of the following:

(1) Health care services that are either provided or reimbursed by the plan or its contracted providers as covered benefits to its enrollees and subscribers.

(2) The costs of programs or activities, including training and the provision of informational materials that are determined, as part of the regulations under subdivision (e), to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.

(3) Disease management expenses using cost-effective evidence-based guidelines.

(4) Payments to providers as risk pool payments of pay-for-performance initiatives.

(5) Plan medical advice by telephone.

(6) Prescription drug management programs.

(c) For purposes of this section, "health care benefits" shall not include administrative costs listed in Section 1300.78 of Title 28 of the California Code of Regulations in effect on January 1, 2007, agent and broker commission and solicitation costs associated with the issuance of individual and group health care service plan contracts, dividends, profits, stock options, assessments or fines levied by the Department of Managed Health Care, or administrative costs associated with existing or new regulatory requirements.

(d) To assess compliance with this section, a health care service plan may average its total costs across both of the following:

(1) All health care service plan contracts issued, amended, or renewed by the plan, or by its affiliated plans, in California, except those contracts described in subdivision (*l*).

(2) All health insurance policies issued, amended, or renewed in California by the plan's affiliated health insurers with a valid California certificate of authority, except those policies listed in subdivision (k) of Section 10113.11 of the Insurance Code.

(e) The department and the Department of Insurance shall jointly adopt and amend regulations to implement this section and Section 10113.11 of the Insurance Code to establish uniform reporting by health care service plans and health insurers of the information necessary to determine compliance with this section and Section 10113.11 of the Insurance Code. These regulations may include additional elements in the definition of "health care benefits" not identified in subdivision (b) in order to consistently operationalize

the requirements of this section among health care service plans and health insurers, but these regulatory additions shall be consistent with the legislative intent that a health care service plan expend at least 85 percent of the aggregate payments received by the plan, as provided in subdivision (a), on health care benefits.

(f) The department may exclude from the determination of compliance with the requirement of subdivision (a) any new health care service plan contracts for up to the first two years that these contracts are offered for sale in California, provided that the director determines that the new contracts are substantially different from the existing contracts being issued, amended, or renewed by the plan seeking the exclusion.

(g) Commencing January 1, 2011, and annually thereafter, a full service health care service plan licensed to operate in California shall provide written affirmation to the department that it meets the requirements of this section.

(h) Commencing January 1, 2011, a health care service plan subject to this section shall annually report to the director the medical loss ratio of each individual and small group health care service plan product issued, amended, or renewed by the plan in California. Every health care service plan and its employees or agents shall disclose this information when presenting a plan for examination or sale to any individual or the representative of a group consisting of 50 or fewer individuals.

(i) The department may assess compliance with this section in its periodic onsite medical survey conducted pursuant to Section 1380 or in nonroutine medical surveys, as appropriate.

(j) The director may disapprove a health care service plan's use of a plan contract, issue a fine or assessment against a health care service plan, suspend or revoke the license issued to a health care service plan under this chapter, or take any other action the director deems appropriate if the director determines that the plan has failed to comply with this section.

(k) Except as provided in subdivision (*l*), this section shall apply to all health care service plan contracts issued, amended, or renewed in California by a full service health care service plan on or after January 1, 2011.

(*l*) This section shall not apply to Medicare supplement plan contracts, administrative services-only contracts, or other similar administrative arrangements, or to coverage offered by specialized

health care service plans, including, but not limited to, ambulance, dental, vision, behavioral health, chiropractic, and naturopathic coverage.

SEC. 2. Section 10113.11 is added to the Insurance Code, to read:

10113.11. (a) Notwithstanding any other provision of law, on and after January 1, 2011, a health insurer shall expend in the form of health care benefits no less than 85 percent of the aggregate dues, fees, premiums, and other periodic payments received by the insurer. For purposes of this section, a health insurer may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the insurer the amount of income taxes or other taxes that the insurer expensed.

(b) For purposes of this section, "health care benefits" shall include, but shall not be limited to, all of the following:

(1) Health care services that are either provided or reimbursed by the insurer or its contracted providers as covered benefits to its policyholders and insureds.

(2) The costs of programs or activities, including training and the provision of informational materials that are determined, as part of the regulations under subdivision (e), to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.

(3) Disease management expenses using cost-effective evidence-based guidelines.

(4) Payments to providers as risk pool payments of pay-for-performance initiatives.

(5) Plan medical advice by telephone.

(6) Prescription drug management programs.

(c) For purposes of this section, "health care benefits" shall not include administrative costs listed in Section 1300.78 of Title 28 of the California Code of Regulations in effect on January 1, 2007, agent and broker commission and solicitation costs associated with the issuance of individual and group health insurance policies, dividends, profits, stock options, assessments or fines levied by the Department of Insurance, or administrative costs associated with existing or new regulatory requirements.

(d) To assess compliance with this section, a health insurer may average its total costs across both of the following:

(1) All health insurance policies issued, amended, or renewed by the insurer in California, except those policies listed in subdivision (k).

(2) All health care service plan contracts issued, amended, or renewed in California by the insurer's affiliated health care service plans licensed to operate in California, except those contracts described in subdivision (*l*) of Section 1378.1 of the Health and Safety Code.

(e) The department and the Department of Managed Health Care shall jointly adopt and amend regulations to implement this section and Section 1378.1 of the Health and Safety Code to establish uniform reporting by health care service plans and health insurers of the information necessary to determine compliance with this section and Section 1378.1 of the Health and Safety Code. These regulations may include additional elements in the definition of "health care benefits" not identified in subdivision (b) in order to consistently operationalize the requirements of this section among health care service plans and health insurers, but these regulatory additions shall be consistent with the legislative intent that a health insurer expend at least 85 percent of the aggregate payments received by the insurer, as provided in subdivision (a), on health care benefits.

(f) The department may exclude from the determination of compliance with the requirement of subdivision (a) any new health insurance policies for up to the first two years that these policies are offered for sale in California, provided that the commissioner determines that the new policies are substantially different from the existing policies being issued, amended, or renewed by the insurer seeking the exclusion.

(g) Commencing January 1, 2011, and annually thereafter, a health insurer holding a certificate of authority to do business in California shall provide written affirmation to the department that it meets the requirements of this section.

(h) Commencing January 1, 2011, a health insurer subject to this section shall annually report to the commissioner the medical loss ratio of each individual and small group health insurance policy form issued, amended, or renewed by the insurer in California. Every insurer and its employees or agents shall disclose the information when presenting a policy for examination or sale

to any individual or the representative of a group consisting of 50 or fewer individuals.

(i) The commissioner may disapprove a health insurer's use of a health insurance policy, revoke or suspend the certificate of authority of a health insurer, issue a fine or assessment against a health insurer, or take any other action the commissioner deems appropriate if the commissioner determines that the health insurer has failed to comply with this section.

(j) Except as provided in subdivision (k), this section shall apply to all health insurance policies issued, amended, or renewed in California on or after January 1, 2011.

(k) This section shall not apply to Medicare supplement policies, administrative services-only policies, or other similar administrative arrangements, short-term limited duration health insurance policies, vision-only, dental-only, behavioral health-only, or pharmacy-only policies, CHAMPUS-supplement or TRICARE-supplement insurance policies, or to hospital indemnity, hospital only, accident only, or specified disease insurance policies that do not pay benefits on a fixed benefit, cash payment only basis.

SEC. 3. 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.

Approved _____, 2008

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Governor