SB-1008 Health insurance: dental services: reporting and disclosures. (2017-2018)

Date Published: 10/01/2018 09:00 PM

Senate Bill No. 1008

CHAPTER 933

An act to amend Sections 1363 and 1367.004 of, and to add Section 1363.04 to, the Health and Safety Code, and to amend Section 10112.26 of, and to add Section 10603.04 to, the Insurance Code, relating to dental services.

[Approved by Governor September 29, 2018. Filed with Secretary of State September 29, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1008, Skinner. Health insurance: dental services: reporting and disclosures.

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 provides for the regulation of health insurers by the Department of Insurance.

The federal Patient Protection and Affordable Care Act requires a health insurance issuer issuing health insurance coverage to comply with minimum medical loss ratios and to provide an annual rebate to each insured if the medical loss ratio of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified.

Existing law requires a health care service plan or health insurer to provide certain disclosures of the benefits, services, and terms of a contract or policy.

This bill would require a health care service plan or a health insurer that issues, sells, renews, or offers a health care service plan contract or insurance policy that covers dental services in California, in addition to any other applicable disclosure requirements, to utilize a uniform benefits and coverage disclosure matrix, with specified contents. The bill would require the Department of Managed Health Care and the Department of Insurance to develop the uniform benefits and disclosure matrix in consultation with stakeholders. The bill would require the Department of Managed Health Care and the Department of Insurance to implement the bill's provisions relating to the benefits and coverage disclosure matrix through emergency regulations, as specified. The benefits and coverage disclosure matrix requirements would take effect for plan or policy years on and after January 1, 2021, or 12 months after adoption of the emergency regulations, whichever occurs later.

Existing law requires a health care service plan or health insurer that issues, sells, renews, or offers a specialized health care service plan contract or health insurance policy covering dental services, no later than September 30, 2015, and each year thereafter, to file a report known as the Medical Loss Ratio (MLR) annual report, with the Department of Managed Health Care or the Department of Insurance, respectively, that is organized by market and product type.

This bill would require the MLR annual report to be filed with the Department of Managed Health Care or the Department of Insurance by July 31 of each year. The bill would require the respective department to post a health care service plan's or health insurer's MLR annual report on its Internet Web site within 45 days after receiving the report. The bill would authorize the

respective departments to issue guidance to specialized health care service plans and health insurers regarding compliance with these provisions until regulations are adopted.

Because a willful violation of these 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.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1363 of the Health and Safety Code is amended to read:

1363. (a) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(b) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.

(K) Chemical dependency services.

(L) Home health services.

(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(3) (A) A health care service plan contract subject to Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15), shall satisfy the requirements of this subdivision by providing the uniform summary of benefits and coverage required under Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15) and any rules or regulations issued thereunder. A health care service plan that issues the uniform summary of benefits referenced in this paragraph shall do both of the following:

(i) Ensure that all applicable benefit disclosure requirements specified in this chapter and in Title 28 of the California Code of Regulations are met in other health plan documents provided to enrollees under the provisions of this chapter.

(ii) Consistent with applicable law, advise applicants and enrollees, in a prominent place in the plan documents referenced in subdivision (a), that enrollees are not financially responsible in payment of emergency care services, in any amount that the health care service plan is obligated to pay, beyond the enrollee's copayments, coinsurance, and deductibles as provided in the enrollee's health care service plan contract.

(B) Commencing October 1, 2016, the uniform summary of benefits and coverage referenced in this paragraph shall constitute a vital document for the purposes of Section 1367.04. Not later than July 1, 2016, the department shall develop written translations of the template uniform summary of benefits and coverage for all language groups identified by the State Department of Health Care Services in all plan letters as of August 27, 2014, for translation services pursuant to Section 14029.91 of the Welfare and Institutions Code, except for any language group for which the United States Department of Labor has already prepared a written translation. Not later than July 1, 2016, the department shall make available on its Internet Web site written translations of the template uniform summary of benefits and coverage developed by the department, and written translations prepared by the United States Department of Labor, if available, for any language group to which this subparagraph applies.

(C) Subdivision (c) shall not apply to a health care service plan contract subject to subparagraph (A).

(4) A health care service plan may satisfy the requirements of this subdivision for the dental services offered under a contract subject to Section 1363.04 by providing the uniform benefit disclosure benefits and coverage disclosure matrix consistent with the requirements of that section.

(c) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(d) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(e) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(g) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(h) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(i) Subdivision (b) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare Program pursuant to Title XVIII and Title XIX of the federal Social Security Act.

SEC. 2. Section 1363.04 is added to the Health and Safety Code, to read:

1363.04. (a) For plan years on and after January 1, 2021, or 12 months after regulations are adopted under subdivision (f), whichever occurs later, a health care service plan that issues, sells, renews, or offers a contract that covers dental services in this state, in addition to any other applicable disclosure requirements, shall utilize a uniform benefits and coverage disclosure matrix,

which shall be developed by the department, in conjunction with the Department of Insurance, and in consultation with stakeholders. At a minimum, the benefits and coverage disclosure matrix shall require the health care service plan to make available all of the following information relating to covered dental services, together with the corresponding copayments or coinsurance and limitations:

(1) The annual overall plan deductible.

(2) The annual benefit limit.

(3) Coverage for the following categories:

(A) Preventive and diagnostic services.

(B) Basic services.

(C) Major services.

(D) Orthodontia services.

(4) Dental plan reimbursement levels and estimated enrollee cost share for services.

(5) Waiting periods.

(6) Examples to illustrate coverage and estimated enrollee costs of commonly used benefits. The examples shall include at least one service from each of the following categories listed in paragraph (3):

(A) Preventive and diagnostic services.

(B) Basic services.

(C) Major services.

(b) All plans, solicitors, and representatives of a plan that issue, sell, renew, or offer a health care plan contract that covers dental services shall, when presenting any plan contract for examination or sale to an individual prospective plan member, make available to the individual a properly completed benefits and coverage disclosure matrix, as prescribed by the director pursuant to this section for each dental plan examined or sold.

(c) In the case of group contracts for dental services, the completed benefits and coverage disclosure matrix and evidence of coverage shall be made available to the contractholder upon delivery of the completed health care service plan agreement.

(d) Group contractholders shall make available the completed benefits and coverage disclosure matrix to all persons eligible to be a subscriber under the group contract at the time those persons are offered the dental plan. If the individual group members are offered a choice of dental plans, separate matrices shall be made available for each dental plan offered. Each group contractholder shall also make available copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(e) The health care service plan offering a dental product in the individual, small, or large group market shall make available the benefits and coverage disclosure matrix to all individuals newly enrolling for coverage, experiencing a special enrollment event, and renewing coverage, and shall make available the benefits and coverage disclosure matrix to all other enrollees upon request.

(f) (1) The department shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement this section. The department shall consult with the Department of Insurance in adopting the emergency regulations, as appropriate. The adoption of regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted pursuant to this section shall not be subject to the review and approval of the Office of Administrative Law. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 120 days unless the adopting agency complies with all of the provisions of Chapter 3.5 (commencing with Section 11340) as required by subdivision (c) of Section 11346.1 of the Government Code.

(g) This section does not apply to Medi-Cal dental managed care contracts authorized under Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 1367.004 of the Health and Safety Code is amended to read:

1367.004. (a) A health care service plan that issues, sells, renews, or offers a contract covering dental services shall file a report with the department by July 31 of each year, which shall be known as the MLR annual report. The MLR annual report shall be organized by market and product type and shall contain the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The department shall post a health care service plan's MLR annual report on its Internet Web site within 45 days after receiving the report.

(b) The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. As applicable, all terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with Section 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If the director decides to conduct a financial examination, as described in Section 1382, because the director finds it necessary to verify the health care service plan's representations in the MLR annual report, the department shall provide the health care service plan with a notification 30 days before the commencement of the financial examination.

(d) The health care service plan shall have 30 days from the date of notification to electronically submit to the department all requested records, books, and papers specified in subdivision (a) of Section 1381. The director may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.

(e) The department shall make available to the public all of the data provided to the department pursuant to this section.

(f) This section does not apply to a health care service plan contract issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(g) The department may issue guidance to specialized health care service plans subject to this section regarding compliance with this section. The guidance shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), and shall be effective only until the department adopts regulations pursuant to that act. The department shall consult with the Department of Insurance in issuing the guidance specified in this section.

SEC. 4. Section 10112.26 of the Insurance Code is amended to read:

10112.26. (a) A health insurer that issues, sells, renews, or offers a policy covering dental services shall file a report with the department, by July 31 of each year, which shall be known as the MLR annual report. The MLR annual report shall be organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The department shall post a health insurer's MLR annual report on its Internet Web site within 45 days after receiving the report.

(b) The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. As applicable, all terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and Part 158 (commencing with Section 158.101) of Title 45 of the Code of Federal Regulations.

(c) If the commissioner decides to conduct an examination, as described in Section 730, because the commissioner finds it necessary to verify the health insurer's representations in the MLR annual report, the department shall provide the health insurer with a notification 30 days before the commencement of the examination.

(d) The health insurer shall have 30 days from the date of notification to electronically submit to the department all requested records, books, and papers specified in subdivision (a) of Section 733. The commissioner may extend the time for a health insurer to comply with this subdivision upon a finding of good cause.

(e) The department shall make available to the public all of the data provided to the department pursuant to this section.

(f) This section does not apply to an insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(g) This section does not apply to disability insurance for covered benefits in the single specialized area of dental-only health care that pays benefits on a fixed benefit, cash payment only basis.

(h) The department may issue guidance to health insurers of specialized health insurance policies subject to this section regarding compliance with this section. The guidance shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), and shall be effective only until the department adopts regulations pursuant to that act. The department shall consult with the Department of Managed Health Care in issuing the guidance specified in this section.

SEC. 5. Section 10603.04 is added to the Insurance Code, to read:

10603.04. (a) For policy years on and after January 1, 2021, or 12 months after regulations are adopted under subdivision (f), whichever occurs later, a health insurer that issues, sells, renews, or offers a policy that covers dental services in this state, in addition to any other applicable disclosure requirements, shall use a uniform benefits and coverage disclosure matrix, which shall be developed by the department, in conjunction with the Department of Managed Health Care, and in consultation with stakeholders. At a minimum, the benefits and coverage disclosure matrix shall require the health insurer to make available all of the following relating to covered dental services, together with the corresponding copayments or coinsurance and limitations:

(1) The annual overall policy deductible.

(2) The annual benefit limit.

(3) Coverage for the following categories:

(A) Preventive and diagnostic services.

(B) Basic services.

(C) Major services.

(D) Orthodontia services.

(4) Dental policy reimbursement levels and estimated insured cost share for service.

(5) Waiting periods.

(6) Examples to illustrate coverage and estimated insured costs of commonly used benefits. The examples shall include at least one service from each of the following categories listed in paragraph (3):

(A) Preventive and diagnostic services.

(B) Basic services.

(C) Major services.

(b) All health insurers, solicitors, and representatives of a health insurer that issue, sell, renew, or offer a policy that covers dental services shall, when presenting any policy for examination or sale to an individual prospective insured, make available to the individual a properly completed benefits and coverage disclosure matrix, as prescribed by the commissioner pursuant to this section for each dental policy examined or sold.

(c) In the case of group policies for dental services, the completed disclosures and coverage matrix and evidence of coverage shall be made available to the policyholder upon delivery of the completed policy for dental insurance.

(d) Group policyholders shall make available the completed benefits and coverage disclosure matrix to all persons eligible to be a policyholder under the group policy at the time those persons are offered the dental insurance. If the individual group members are offered a choice of dental policies, separate benefits and coverage disclosure matrices shall be made available for each dental policy offered. Each group policyholder shall also make available copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all policyholders insured under the group policy.

(e) The health insurer offering a policy that covers dental services in the individual, small, or large group market shall make available the benefits and coverage disclosure matrix to all individuals newly enrolling for coverage, experiencing a special enrollment event, and renewing coverage, and shall make available the benefits and coverage disclosure matrix to all other insureds upon request.

(f) (1) The department shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement this section. The department shall consult with the Department of

Managed Health Care in adopting the emergency regulations, as appropriate. The adoption of regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted pursuant to this section shall not be subject to the review and approval of the Office of Administrative Law. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 120 days unless the adopting agency complies with all of the provisions of Chapter 3.5 (commencing with Section 11340) as required by subdivision (c) of Section 11346.1 of the Government Code.

(g) This section does not apply to Medi-Cal dental managed care contracts authorized under Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 6. 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.