SB-368 Health care coverage: deductibles and out-of-pocket expenses. (2021-2022)

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Senate Bill No. 368

CHAPTER 602

An act to add Section 1367.0061 to the Health and Safety Code, and to add Section 10112.291 to the Insurance Code, relating to health care coverage.

[Approved by Governor October 06, 2021. Filed with Secretary of State October 06, 2021.]

LEGISLATIVE COUNSEL'S DIGEST

SB 368, Limón. Health care coverage: deductibles and out-of-pocket expenses.

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. A willful violation of the act is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets limits on the amount of the deductible and out-of-pocket expenses that may be included in specified health care service plan contracts and health insurance policies.

This bill, for a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2022, in the individual or group market, would require the health care service plan or health insurer to monitor an enrollee's or insured's accrual balance toward their annual deductible and out-of-pocket maximum, if any. The bill would require a health care service plan or health insurer to provide an enrollee or insured with their accrual balance toward their annual deductible and out-of-pocket maximum for every month in which benefits were used, as specified. The bill would require a health care service plan or health insurer to establish and maintain a system that allows an enrollee or insured to request their most up-to-date accrual balances from their health care service plan or health insurer at any time. The bill would require accrual updates to be mailed to enrollees unless the enrollee has elected to opt out of mailed notice and elected to receive the accrual update electronically, as specified. The bill would require a health care service plan or health insurer to notify enrollees and insureds of their rights under the bill, as specified. The bill would require a contracted entity to which a health care service plan or health insurer has delegated claims payment functions to comply with the requirements of the bill, as specified. Because a willful violation of the bill's provisions by a health care service plan 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 1367.0061 is added to the Health and Safety Code, immediately following Section 1367.006, to read:

1367.0061. (a) For a health care service plan contract issued, amended, or renewed on or after July 1, 2022, in the individual or group market, a health care service plan shall monitor an enrollee's accrual toward their annual deductible, if any, for covered benefits, as set forth in this section and any regulations promulgated by the department.

(1) A health care service plan shall provide an enrollee with their accrual balance toward their annual deductible for every month in which benefits were used and until the accrual balance equals the full deductible amount.

(2) A health care service plan subject to this section shall establish and maintain a system that allows an enrollee to request their most up-to-date accrual balance toward their annual deductible from their health care service plan at any time.

(3) If the health care service plan contract includes more than one annual deductible for an enrollee, then this section applies to each deductible.

(b) For a health care service plan contract issued, amended, or renewed on or after July 1, 2022, in the individual or group market, a health care service plan shall monitor an enrollee's accrual toward their annual out-of-pocket maximum, if any, for covered benefits, as set forth in this section and any regulations promulgated by the department.

(1) A health care service plan shall provide an enrollee with their accrual balance toward their annual out-of-pocket maximum for every month in which benefits were used and until the accrual balance equals the full out-of-pocket maximum.

(2) A health care service plan subject to this section shall establish and maintain a system that allows an enrollee to request their most up-to-date accrual balance toward their annual out-of-pocket maximum from their health care service plan at any time.

(c) Accrual updates shall be mailed to enrollees unless the enrollee has elected to opt out of mailed notice and elected to receive the accrual update electronically, or unless the enrollee has previously opted out of mailed notices.

(1) Enrollees who have opted out of receiving mailed notice may opt back in at any time.

(2) Accrual updates may be included with evidence of benefit statements.

(d) A health care service plan shall notify enrollees of their rights pursuant to this section, including, but not limited to, how to request information and how to opt out of mailed notices and elect to instead receive their accrual update electronically, in the manner set forth by the department. The department may issue guidance regarding implementation of, and compliance with, this subdivision. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 1340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2027. The department shall consult with stakeholders in developing guidance pursuant to this subdivision.

(e) If a health care service plan delegates claims payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, then the delegated entity shall comply with the requirements of this section. A health care service plan shall specify by contract the delegated entity's responsibilities and shall monitor the delegated entity to ensure compliance with this section. Notwithstanding delegation pursuant to this subdivision, the health care service plan shall remain responsible for compliance with this section.

SEC. 2. Section 10112.291 is added to the Insurance Code, immediately following Section 10112.29, to read:

10112.291. (a) For a health insurance policy issued, amended, or renewed on or after July 1, 2022, in the individual or group market, a health insurer shall monitor an insured's accrual toward their annual deductible, if any, for covered benefits, as set forth in this section and any regulations promulgated by the department.

(1) A health insurer shall provide an insured with their accrual balance toward their annual deductible for every month in which benefits were used and until the accrual balance equals the full deductible amount.

(2) A health insurer subject to this section shall establish and maintain a system that allows an insured to request their most up-to-date accrual balance toward their annual deductible from their health insurer at any time.

(3) If the health insurance policy includes more than one annual deductible for an insured, then this section applies to each deductible.

(b) For a health insurance policy issued, amended, or renewed on or after July 1, 2022, in the individual or group market, an insurer shall monitor an insured's accrual balance toward their annual out-of-pocket maximum, if any, for covered benefits, as set forth in this section and any regulations promulgated by the department.

(1) A health insurer shall provide an insured with their accrual balance toward their annual out-of-pocket maximum for every month in which benefits were used and until the accrual balance equals the full out-of-pocket maximum.

(2) A health insurer subject to this section shall establish and maintain a system that allows an insured to request their most up-to-date accrual balance toward their annual out-of-pocket maximum from their health insurer at any time.

(c) Accrual updates shall be mailed to an insured unless the insured has elected to opt out of mailed notice and elected to receive the accrual update electronically as allowed according to Section 38.6, or unless the insured has previously opted out of mailed notices.

(1) Insureds who have opted out of receiving mailed notice may opt back in at any time.

(2) Accrual updates may be included with evidence of benefit statements.

(d) A health insurer shall notify insureds of their rights pursuant to this section, including, but not limited to, how to request information and how to opt out of mailed notices and elect to instead receive their accrual update electronically, in the manner set forth by the department. The department may issue guidance regarding implementation of, and compliance with, this subdivision. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 1340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2027. The department shall consult with stakeholders in developing guidance pursuant to this subdivision.

(e) If a health insurer delegates claims payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with the requirements of this section. A health insurer shall specify by contract the delegated entity's responsibilities and shall monitor the delegated entity to ensure compliance with this section. Notwithstanding delegation pursuant to this subdivision, the health insurer shall remain responsible for compliance with this section.

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.