§ 1367.50. Disclosure of claims data to qualified entity

(a) No contract in existence or issued, amended, or renewed on or after January 1, 2013, between a health care service plan and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to an enrollee or subscriber of the health care service plan or beneficiaries of any self-funded health coverage arrangement administered by the health care service plan, to a qualified entity, as defined in Section 1395kk(e)(2) of Title 42 of the United States Code. All disclosures of data made under this section shall comply with all applicable state and federal laws for the protection of the privacy and security of the data, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

(b) For purposes of this section, the following definitions apply:

(1) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(2) "Provider" means a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, a hospice, a clinic, or a rehabilitation agency.

(3) "Supplier" means a physician and surgeon or other health care practitioner, or an entity that furnishes health care services other than a provider.

HISTORY:

Added Stats 2012 ch 869 § 2 (SB 1196), effective January 1, 2013.

§ 1367.51. Coverage of equipment and supplies for treatment of dia- betes; Prescription items; Outpatient self-management and training

(a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, and that covers hospital, medical, or surgical expenses shall include coverage for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription:

(1) Blood glucose monitors and blood glucose testing strips.
(2) Blood glucose monitors designed to assist the visually impaired.
(3) Insulin pumps and all related necessary supplies.
(4) Ketone urine testing strips.
(5) Lancets and lancet puncture devices.
(6) Pen delivery systems for the administration of insulin.
(7) Podiatric devices to prevent or treat diabetes-related complications.
(8) Insulin syringes.

(9) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

(b) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits shall include coverage for the following prescription items if the items are determined to be medically necessary:

(1) Insulin.

(2) Prescriptive medications for the treatment of diabetes.

(3) Glucagon.

(c) The copayments and deductibles for the benefits specified in subdivisions (a) and (b) shall not exceed those established for similar benefits within the given plan.

(d) Every plan shall provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable an enrollee to properly use the equipment, supplies, and medications set forth in subdivisions (a) and (b), and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the enrollee's participating physician. If a plan delegates outpatient self-management training to contracting providers, the plan shall require contracting providers to ensure that diabetes outpatient self-management training, education, and medical nutrition therapy are provided by appropriately licensed or registered health care professionals.

(e) The diabetes outpatient self-management training, education, and medical nutrition therapy services identified in subdivision (d) shall be provided by appropriately licensed or registered health care professionals as prescribed by a participating health care professional legally authorized to prescribe the service. These benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

(f) The copayments for the benefits specified in subdivision (d) shall not exceed those established for physician office visits by the plan.

(g) Every health care service plan governed by this section shall disclose the benefits covered pursuant to this section in the plan's evidence of coverage and disclosure forms.

(h) A health care service plan may not reduce or eliminate coverage as a result of the requirements of this section.

(i) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

HISTORY:

Added Stats 1999 ch 540 § 1 (SB 64). Amended Stats 2000 ch 1067 § 10 (SB 2094); Stats 2002 ch 791 § 6 (SB 842).