

AMENDED IN SENATE MAY 10, 2005
AMENDED IN SENATE APRIL 11, 2005

SENATE BILL

No. 634

Introduced by Senator Speier

February 22, 2005

An act to ~~amend Section 10604~~ *add Section 511.4 to the Business and Professions Code, and to amend Section 10123.12 of, and to add Section 10133.66 to, the Insurance Code, relating to health insurance.*

LEGISLATIVE COUNSEL'S DIGEST

SB 634, as amended, Speier. Health insurance: claims practices.

Existing law provides for regulation of health insurers by the Insurance Commissioner. Existing law, known as the Health Care Providers Bill of Rights, imposes certain requirements and prohibitions on the relationship between providers of health care services and health insurers relative to alternative rates of payment made by insurers on behalf of covered insureds. Existing law also requires health insurance *and self-insured employee welfare benefit plan* disclosure forms to be provided to insureds *and enrollees*, and requires those disclosure forms to contain specified information.

This bill would impose additional requirements on health insurers that enter into contracts with health care providers relative to the processing and payment of claims *including requiring the disclosure of specified information in electronic format to providers annually and, additionally, upon a contracted provider's request. The bill would also require a contracting agent to disclose such specified information in electronic format to providers annually and upon a contracted provider's written request.* The bill would ~~also~~ require the health insurance policy *or self-insured employee welfare benefit plan* disclosure forms to insureds *and enrollees* to contain the nature and

extent of the financial liability that is or may be incurred by the insured, *enrollee*, or his or her family, where care is furnished by a provider that does not have a contract with the insurer *or plan* to provide services at an alternative rate of payment.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:

3 (a) The billing by providers and the handling of claims by
4 insurers are essential components of the health care delivery
5 process.

6 (b) Health maintenance organizations and preferred provider
7 organizations regulated by the Department of Managed Health
8 Care are subject to regulations to prevent unfair payment
9 practices against health care providers. Preferred provider
10 organizations and other entities regulated by the Department of
11 Insurance are not subject to many of these regulations, leaving
12 providers and their patients without similar protections.

13 (c) To ensure the appropriate payment of claims and consistent
14 regulation of overpayment of health care services by third-party
15 payors, this act extends many of the current protections afforded
16 by the Legislature to providers who deliver care to health care
17 service plan enrollees to those who deliver care to insureds.

18 *SEC. 2. Section 511.4 is added to the Business and*
19 *Professions Code, to read:*

20 *511.4. (a) A contracting agent, as defined in paragraph (2)*
21 *of subdivision (d) of Section 511.1, shall beginning July 1, 2006,*
22 *prior to contracting, annually thereafter on or before the*
23 *contract anniversary date, and, in addition, upon the contracted*
24 *provider's written request, disclose to contracting providers all*
25 *of the following information in an electronic format:*

26 *(1) The amount of payment for each service to be provided*
27 *under the contract, including any fee schedules or other factors*
28 *or units used in determining the fees for each service, shall be*
29 *disclosed on the Internet or on written request by the health*
30 *insurer or the entity that contracts with providers. To the extent*
31 *that reimbursement is made pursuant to a specified fee schedule,*

1 *the contract shall incorporate that fee schedule by reference,*
2 *including the year of the schedule. For any proprietary fee*
3 *schedule, the contract shall include sufficient detail that payment*
4 *amounts related to that fee schedule can be accurately predicted.*

5 *(2) The detailed payment policies and rules and nonstandard*
6 *coding methodologies used to adjudicate claims, which shall,*
7 *unless otherwise prohibited by state law, do all of the following:*

8 *(A) When available, be consistent with Current Procedural*
9 *Terminology (CPT), and standards accepted by nationally*
10 *recognized medical societies and organizations, federal*
11 *regulatory bodies, and major credentialing organizations.*

12 *(B) Clearly and accurately state what is covered by any global*
13 *payment provisions for both professional and institutional*
14 *services, any global payment provisions for all services*
15 *necessary as part of a course of treatment in an institutional*
16 *setting, and any other global arrangements, such as per diem*
17 *hospital payments.*

18 *(C) At a minimum, clearly and accurately state the policies*
19 *regarding all of the following:*

20 *(i) Consolidation of multiple services or charges and payment*
21 *adjustments due to coding changes.*

22 *(ii) Reimbursement for multiple procedures.*

23 *(iii) Reimbursement for assistant surgeons.*

24 *(iv) Reimbursement for the administration of immunizations*
25 *and injectable medications.*

26 *(v) Recognition of CPT modifiers.*

27 *(b) The information disclosures required by this section shall*
28 *be in sufficient detail and in an understandable format that does*
29 *not disclose proprietary trade secret information or violate*
30 *copyright law or patented processes, so that a reasonable person*
31 *with sufficient training, experience, and competence in claims*
32 *processing can determine the payment to be made according to*
33 *the terms of the contract.*

34 *(c) A contracting agent may disclose the fee schedules*
35 *mandated by this section through the use of a Web site, so long*
36 *as it provides written notice to the contracted provider at least 45*
37 *days prior to implementing a Web site transmission format or*
38 *posting any changes to the information on the Web site.*

39 *SEC. 3. Section 10123.12 of the Insurance Code is amended*
40 *to read:*

1 10123.12. Every ~~disability~~ *health* insurer, including those
 2 insurers ~~which that~~ contract for alternative rates of payment
 3 pursuant to Section 10133, and every self-insured employee
 4 welfare benefit plan, ~~which that~~ will affect the choice of
 5 physician, hospital, or other health care providers shall include
 6 within its disclosure form and within its evidence or certificate of
 7 coverage a statement clearly describing how participation in the
 8 policy or plan may affect the choice of physician, hospital, or
 9 other health care providers, and *describing the nature and extent*
 10 *of the financial liability that is, or that may be, incurred by the*
 11 *insured, enrollee, or covered dependents if care is furnished by a*
 12 *provider that does not have a contract with the insurer or plan to*
 13 *provide service at alternative rates of payment pursuant to*
 14 *Section 10133. The form shall clearly inform prospective*
 15 *insureds or plan enrollees that participation in the policy or plan*
 16 *will affect the person's choice in this regard by placing the*
 17 *following statement in a conspicuous place on all material*
 18 *required to be given to prospective insureds or plan enrollees*
 19 *including promotional and descriptive material, disclosure forms,*
 20 *and certificates and evidences of coverage:*

21 PLEASE READ THE FOLLOWING INFORMATION SO
 22 YOU WILL KNOW FROM WHOM OR WHAT GROUP OF
 23 PROVIDERS HEALTH CARE MAY BE OBTAINED

24 It is not the intent of this section to require that the names of
 25 individual health care providers be enumerated to prospective
 26 *insureds or enrollees.*

27 If a ~~disability~~ *health* insurer providing coverage for hospital,
 28 medical, or surgical expenses provides a list of facilities to
 29 patients or contracting providers, the insurer shall include within
 30 the provider listing a notification that *insureds or enrollees* may
 31 contact the insurer in order to obtain a list of the facilities with
 32 which the ~~disability~~ *health* insurer is contracting for subacute
 33 care and/or transitional inpatient care.

34 ~~SEC. 2.~~

35 *SEC. 4.* Section 10133.66 is added to the Insurance Code, to
 36 read:

37 10133.66. A health insurer ~~that enters into contracts with a~~
 38 ~~provider to provide services at alternative rates of payment~~
 39 ~~pursuant to Section 10133, whether directly or through any entity~~

1 ~~that contracts with providers on its behalf, shall~~ *shall* comply
2 with all the following:

3 (a) Deadlines shall not be imposed for the receipt of a claim
4 *from a professional provider who submits a claim on behalf of an*
5 *insured or pursuant to a professional provider's contract with a*
6 *health insurer* that is less than ~~180~~ 90 days for contracted
7 providers and ~~360~~ 180 days for noncontracted providers after the
8 date of service, except as required by any state or federal law or
9 regulation. If a health insurer is not the primary payor under
10 coordination of benefits, the insurer shall not impose a deadline
11 for submitting supplemental or coordination of benefits claims to
12 any secondary payor that is less than ~~180~~ 90 days from the date
13 of payment or date of contest, denial, or notice from the primary
14 payor. A health insurer, ~~whether directly or through any entity~~
15 ~~that contracts with providers on its behalf~~, that denies a claim
16 because it was filed beyond the claim filing deadline shall, upon
17 provider's demonstration of good cause for the delay, accept and
18 adjudicate the claim according to Section 10123.13 or
19 10123.147, whichever is applicable. This subdivision shall not
20 alter or affect any rights providers may have under any
21 applicable statute of limitations or antiforfeiture provisions
22 available under the laws of the State of California.

23 (b) Reimbursement requests for the overpayment of a claim
24 shall not be made, including requests made pursuant to Section
25 10123.145, unless a written request for reimbursement is sent to
26 the provider within 365 days of the date of payment on the
27 overpaid claim. The written notice shall clearly identify the
28 claim, the name of the patient, and the date of service, and shall
29 include a clear explanation of the basis upon which it is believed
30 the amount paid on the claim was in excess of the amount due,
31 including interest and penalties on the claim. The 365-day time
32 limit shall not apply if the overpayment was caused in whole or
33 in part by fraud or misrepresentation on the part of the provider.

34 (c) The receipt of each claim shall be identified and
35 acknowledged, whether or not complete, and the recorded date of
36 receipt shall be disclosed in the same manner as the claim was
37 submitted or provided through an electronic means, by telephone,
38 Web site, or another mutually agreeable accessible method of
39 notification, by which the provider may readily confirm the

1 insurer's receipt of the claim and the recorded date of receipt-as
2 follows:

3 ~~(1) In the case of an electronic claim, identification and~~
4 ~~acknowledgment shall be provided within two working days of~~
5 ~~the date of receipt of the claim by the office designated to receive~~
6 ~~the claim.~~

7 ~~(2) In the case of a paper claim, identification and~~
8 ~~acknowledgment shall be provided within 15 working days of the~~
9 ~~date of receipt of the claim by the office designated to receive the~~
10 ~~claim.~~

11 If a claimant submits a claim to a health insurer, ~~or any entity~~
12 ~~that contracts with providers on its behalf~~, using a claims
13 clearinghouse, its identification and acknowledgment to the
14 clearinghouse within the timeframes set forth in ~~paragraph (1) or~~
15 ~~(2), whichever is applicable~~, *above* shall constitute compliance
16 with this section.

17 (d) ~~Beginning January~~ *July* 1, 2006, prior to contracting,
18 annually thereafter on or before the contract anniversary date,
19 and in addition, upon the contracted provider's written request,
20 the health insurer ~~or the entity that contracts with providers~~ shall
21 disclose to contracting providers all of the following information
22 in an electronic format:

23 (1) The amount of payment for each service to be provided
24 under the contract, including any fee schedules or other factors or
25 units used in determining the fees for each service, shall be
26 disclosed on the Internet or on written request by the health
27 insurer or the entity that contracts with providers. To the extent
28 that reimbursement is made pursuant to a specified fee schedule,
29 the contract shall incorporate that fee schedule by reference,
30 including the year of the schedule. For any proprietary fee
31 schedule, the contract shall include sufficient detail that payment
32 amounts related to that fee schedule can be accurately predicted.

33 (2) The detailed payment policies and rules and nonstandard
34 coding methodologies used to adjudicate claims, that shall,
35 unless otherwise prohibited by state law do all of the following:

36 (A) When available, be consistent with Current Procedural
37 Terminology (CPT), and standards accepted by nationally
38 recognized medical societies and organizations, federal
39 regulatory bodies, and major credentialing organizations.

1 (B) Clearly and accurately state what is covered by any global
2 payment provisions for both professional and institutional
3 services, any global payment provisions for all services necessary
4 as part of a course of treatment in an institutional setting, and any
5 other global arrangements such as per diem hospital payments.

6 (C) At a minimum, clearly and accurately state the policies
7 regarding all of the following:

8 (i) Consolidation of multiple services or charges, and payment
9 adjustments due to coding changes.

10 ~~(ii)~~

11 (ii) Reimbursement for multiple procedures.

12 (iii) Reimbursement for assistant surgeons.

13 (iv) Reimbursement for the administration of immunizations
14 and injectable medications.

15 (v) Recognition of CPT modifiers.

16 The information disclosures required by this section shall be in
17 sufficient detail and in an understandable format that does not
18 disclose proprietary trade secret information or violate copyright
19 law or patented processes, so that a reasonable person with
20 sufficient training, experience, and competence in claims
21 processing can determine the payment to be made according to
22 the terms of the contract.

23 A health insurer, ~~whether directly or through any entity that~~
24 ~~contracts with providers on its behalf~~, may disclose the fee
25 schedules mandated by this section through the use of a Web site
26 so long as it provides written notice to the contracted provider at
27 least 45 days prior to implementing a Web site transmission
28 format or posting any changes to the information on the Web
29 site.

30 ~~SEC. 3. Section 10604 of the Insurance Code is amended to~~
31 ~~read:~~

32 ~~10604. The disclosure form shall include the following~~
33 ~~information, in concise and specific terms, relative to the~~
34 ~~disability insurance policy:~~

35 ~~(a) The applicable category or categories of coverage provided~~
36 ~~by the policy, from among the following:~~

37 ~~(1) Basic hospital expense coverage.~~

38 ~~(2) Basic medical-surgical expense coverage.~~

39 ~~(3) Hospital confinement indemnity coverage.~~

40 ~~(4) Major medical expense coverage.~~

- 1 ~~(5) Disability income protection coverage.~~
2 ~~(6) Accident only coverage.~~
3 ~~(7) Specified disease or specified accident coverage.~~
4 ~~(8) Such other categories as the commissioner may prescribe.~~
5 ~~(b) The principal benefits and coverage of the disability~~
6 ~~insurance policy.~~
7 ~~(c) The exceptions, reductions, and limitations that apply to~~
8 ~~such policy.~~
9 ~~(d) A summary, including a citation of the relevant contractual~~
10 ~~provisions, of the process used to authorize or deny payments for~~
11 ~~services under the coverage provided by the policy including~~
12 ~~coverage for subacute care, transitional inpatient care, or care~~
13 ~~provided in skilled nursing facilities. This subdivision shall only~~
14 ~~apply to policies of disability insurance that cover hospital,~~
15 ~~medical, or surgical expenses.~~
16 ~~(e) The full premium cost of such policy.~~
17 ~~(f) Any copayment, coinsurance, or deductible requirements~~
18 ~~that may be incurred by the insured or his family in obtaining~~
19 ~~coverage under the policy.~~
20 ~~(g) The nature and extent of the financial liability that is, or~~
21 ~~that may be, incurred by the insured or his or her family where~~
22 ~~care is furnished by a provider that does not have a contract with~~
23 ~~the insurer to provide service at alternative rates of payment~~
24 ~~pursuant to Section 10133.~~
25 ~~(h) The terms under which the policy may be renewed by the~~
26 ~~insured, including any reservation by the insurer of any right to~~
27 ~~change premiums.~~
28 ~~(i) A statement that the disclosure form is a summary only,~~
29 ~~and that the policy itself should be consulted to determine~~
30 ~~governing contractual provisions.~~