

AMENDED IN SENATE MAY 7, 2008
AMENDED IN SENATE APRIL 21, 2008
AMENDED IN SENATE APRIL 3, 2008

SENATE BILL

No. 1387

Introduced by Senator Padilla
(Coauthors: Senators Aanestad and Alquist)

February 21, 2008

An act to amend Section 1371.1 of the Health and Safety Code, and to amend ~~Sections 10123.145 and 10133.661~~ *Section 10123.145* of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1387, as amended, Padilla. ~~Health care~~ *Dental coverage: payment disputes; provider overpayments.*

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.

Under existing law, each contract between a health care service plan or a health insurer and a provider must contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism, as specified. Existing law requires a provider to reimburse a health care service plan or a health insurer for an overpayment within a specified period of time after receiving notice of the overpayment, unless that overpayment is contested by the provider. If an overpayment is contested, existing law requires that the plan or insurer be notified in writing within 30 days.

This bill would enact various provisions regarding overpayments by plans *and health insurers* providing dental coverage ~~and insurers issuing dental insurance policies~~. The bill would require that the overpayment notice sent by the plan or insurer contain specified information. In addition, the bill would specifically provide that an overpayment is contested if the provider has disputed the overpayment through the dispute resolution mechanism provided by the plan or insurer or if, within 30 calendar days following the conclusion of that mechanism, the provider has filed a written complaint regarding the alleged overpayment with the Department of Insurance or the Office of Provider Oversight, as applicable. The bill would require that a provider filing that written complaint notify the plan or insurer of the complaint in writing within a specified period of time *and would require the Department of Managed Health Care or the Department of Insurance to take specified actions with respect to the complaint*. The bill would also prohibit the plan or insurer from attempting to collect a contested overpayment until the conclusion of the dispute resolution mechanism and, if a complaint is filed, the receipt of the department's or commissioner's determination regarding the complaint.

Because a willful violation of the bill's provisions with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

~~Existing law authorizes an insured or health care provider to file a written complaint with the Department of Insurance with respect to the handling of a claim or other obligation under a health insurance policy by a health insurer or production agency, or with respect to the alleged misconduct by a health insurer or production agency, and requires the commissioner to, among other things, make a determination on the complaint within a specified period of time. Existing law requires the commissioner to notify the complainant of the final action taken on his or her complaint within 30 days of the final action.~~

~~This bill would instead require that the commissioner provide that notification within 10 days of the final action. The bill would also authorize insureds and health care providers to file complaints with respect to unresolved payment disputes, as defined.~~

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.
State-mandated local program: yes.

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

1 SECTION 1. Section 1371.1 of the Health and Safety Code is
2 amended to read:

3 1371.1. (a) Whenever a health care service plan, including a
4 specialized health care service plan, determines that in reimbursing
5 a claim for provider services an institutional or professional
6 provider has been overpaid, and then notifies the provider in
7 writing through a separate notice identifying the overpayment and
8 the amount of the overpayment, the provider shall reimburse the
9 health care service plan within 30 working days of receipt by the
10 provider of the notice of overpayment unless the overpayment or
11 portion thereof is contested by the provider in which case the health
12 care service plan shall be notified, in writing, within 30 working
13 days. The notice that an overpayment is being contested shall
14 identify the portion of the overpayment that is contested and the
15 specific reasons for contesting the overpayment.

16 If the provider does not make reimbursement for an uncontested
17 overpayment within 30 working days after receipt, interest shall
18 accrue at the rate of 10 percent per annum beginning with the first
19 calendar day after the 30 working day period.

20 (b) (1) This subdivision shall only apply to a health care service
21 plan contract covering dental services or a specialized health care
22 service plan contract covering dental services pursuant to this
23 chapter.

24 (2) The health care service plan's notice of overpayment shall
25 inform the provider how to access the plan's dispute resolution
26 mechanism offered pursuant to subdivision (h) of Section 1367.
27 The notice shall include the name and address to which the dispute
28 should be submitted and a statement that Section 1371.1 requires
29 a provider to reimburse the plan for an overpayment within 30
30 working days of receipt by the provider of the notice of
31 overpayment unless the provider contests the overpayment within
32 30 working days. The notice shall also include a statement that if
33 the provider does not make reimbursement of an uncontested
34 overpayment within 30 working days after receipt of the notice,
35 interest shall accrue at a rate of 10 percent per annum.

1 (3) For purposes of this subdivision, an overpayment shall be
2 considered contested if either of the following has occurred:

3 (A) The provider has disputed the overpayment through the
4 dispute resolution mechanism provided by the plan pursuant to
5 subdivision (h) of Section 1367.

6 (B) The provider has disputed the overpayment pursuant to the
7 plan’s dispute resolution mechanism, as described in paragraph
8 (A) and, within 30 calendar days following the conclusion of that
9 mechanism, has filed a written complaint *regarding the*
10 *overpayment* with the department’s Office of Provider Oversight,
11 and has notified the plan in writing of the complaint within 30
12 calendar days of filing the complaint.

13 (4) The department shall notify the complainant and the plan
14 of the receipt of a complaint filed pursuant to subparagraph (B) of
15 paragraph (3) within 10 working days of its receipt. The department
16 shall make a determination on the complaint within 60 calendar
17 days of its receipt, unless the department, in its discretion,
18 determines that additional time is reasonably necessary. The
19 department’s review shall focus solely on whether the overpayment
20 claimed is the result of the plan engaging in an unfair payment
21 pattern, as described in subdivision (c) of Section 1371.37. The
22 department shall notify the parties of the determination it makes
23 on a complaint within 10 calendar days of making that
24 determination.

25 (5) A plan may not attempt to collect a contested overpayment
26 from a provider until the conclusion of the plan’s dispute resolution
27 mechanism and, if the provider has filed a complaint with the
28 department’s Office of Provider Oversight pursuant to
29 subparagraph (B) of paragraph (3), the receipt of the department’s
30 determination pursuant to ~~this subdivision~~ *paragraph (4)*.

31 SEC. 2. Section 10123.145 of the Insurance Code is amended
32 to read:

33 10123.145. (a) Whenever an insurer issuing group or individual
34 policies of disability insurance which covers hospital, medical, or
35 surgical expenses determines that in reimbursing a claim for
36 provider services an institutional or professional provider has been
37 overpaid, and then notifies the provider in writing through a
38 separate notice identifying the overpayment and the amount of the
39 overpayment, the provider shall reimburse the insurer within 30
40 working days of receipt by the provider of the notice of

1 overpayment unless the overpayment or portion thereof is contested
2 by the provider in which case the insurer shall be notified, in
3 writing, within 30 working days. The notice that an overpayment
4 is being contested shall identify the portion of the overpayment
5 that is contested and the specific reasons for contesting the
6 overpayment.

7 If the provider does not make reimbursement for an uncontested
8 overpayment within 30 working days after receipt, interest shall
9 accrue at the rate of 10 percent per annum beginning with the first
10 calendar day after the 30 working day period.

11 (b) (1) This subdivision shall only apply to ~~disability insurers~~
12 ~~that issue a dental insurance policy pursuant to this part.~~ *a health*
13 *insurance policy covering dental services or a specialized health*
14 *insurance policy covering dental services.*

15 (2) The insurer's notice of overpayment shall inform the
16 provider how to access the insurer's dispute resolution mechanism
17 offered pursuant to subdivision (a) of Section 10123.137. The
18 notice shall include the name and address to which the dispute
19 should be submitted and a statement that Section ~~10123.137~~
20 *10123.145* requires a provider to reimburse the insurer for an
21 overpayment within 30 working days of receipt by the provider
22 of the notice of overpayment unless the provider contests the
23 overpayment within 30 working days. The notice shall also include
24 a statement that if the provider does not make reimbursement of
25 an uncontested overpayment within 30 working days after receipt
26 of the notice, interest shall accrue at a rate of 10 percent per annum.

27 (3) For purposes of this subdivision, an overpayment shall be
28 considered contested if either of the following have occurred:

29 (A) The provider has disputed the overpayment through the
30 dispute resolution mechanism provided by the insurer pursuant to
31 subdivision (a) of Section 10123.137.

32 (B) The provider has disputed the overpayment pursuant to the
33 insurer's dispute resolution mechanism, as described in
34 subparagraph (A) and, within 30 calendar days following the
35 conclusion of that mechanism, has filed a written complaint
36 regarding the overpayment with the department ~~pursuant to~~
37 ~~subdivision (c) of Section 10133.661,~~ and has notified the insurer
38 in writing of the complaint within 30 calendar days of filing the
39 complaint.

1 (4) The department shall notify the complainant and the insurer
 2 of the receipt of a complaint filed pursuant to subparagraph (B)
 3 of paragraph (3) within 10 working days of its receipt. The
 4 department shall make a determination on the complaint within
 5 60 calendar days of its receipt, unless the department, in its
 6 discretion, determines that additional time is reasonably necessary.
 7 The department shall notify the parties of the determination it
 8 makes on a complaint within 10 calendar days of making that
 9 determination.

10 ~~(4)~~

11 (5) An insurer may not attempt to collect a contested
 12 overpayment from a provider until the conclusion of the insurer's
 13 dispute resolution mechanism and, if the provider has filed a
 14 complaint with the commissioner pursuant to subdivision (c) of
 15 Section 10133.661, the receipt of notification of the final action
 16 taken on the complaint pursuant to subdivision (c) of Section
 17 10133.661. ~~complaint with the department pursuant to~~
 18 ~~subparagraph (B) of paragraph (3), the receipt of the department's~~
 19 ~~determination pursuant to paragraph (4).~~

20 SEC. 3. Section 10133.661 of the Insurance Code is amended
 21 to read:

22 ~~10133.661. On or before July 1, 2006, the commissioner,~~
 23 ~~pursuant to his or her authority under Section 12921.1, shall also~~
 24 ~~complete all of the following duties:~~

25 ~~(a) Provide announcements that inform health insurance~~
 26 ~~consumers and their health care providers of the department's~~
 27 ~~toll-free telephone number that is dedicated to the handling of~~
 28 ~~complaints and of the availability of the Internet Web page~~
 29 ~~established under this section, and the process to register a~~
 30 ~~complaint with the department and to submit an inquiry to it.~~

31 ~~(b) Establish an Internet Web page located on the department's~~
 32 ~~public Internet Web site dedicated exclusively to processing~~
 33 ~~complaints and inquiries relating to health insurance issues from~~
 34 ~~insureds and their health care providers. The Web page shall~~
 35 ~~provide insureds and their health care providers with information~~
 36 ~~concerning filing a complaint and making an inquiry concerning~~
 37 ~~a health insurer and, at a minimum, shall provide the following~~
 38 ~~information:~~

39 ~~(1) The department's toll-free telephone number.~~

40 ~~(2) A list of all health insurers licensed by the department.~~

1 ~~(3) Educational and informational guides for health insurance~~
 2 ~~consumers and health care providers describing their rights under~~
 3 ~~this code. The guides shall be easy to read and understand and~~
 4 ~~shall be made available to the public, including access on the~~
 5 ~~department’s Internet Web site.~~

6 ~~(4) A separate, standardized complaint form for health care~~
 7 ~~providers to file a complaint.~~

8 ~~(e) (1) An insured or health care provider may file a written~~
 9 ~~complaint with the department with respect to the handling of a~~
 10 ~~claim, an unresolved payment dispute, or other obligation under~~
 11 ~~a health insurance policy by a health insurer or production agency,~~
 12 ~~or with respect to the alleged misconduct by a health insurer or~~
 13 ~~production agency. The commissioner shall notify the complainant~~
 14 ~~of the receipt of the complaint within 10 business days of its~~
 15 ~~receipt. The commissioner shall make a determination on the~~
 16 ~~complaint within 60 calendar days of the date of its receipt, unless~~
 17 ~~the commissioner, in his or her discretion, determines that~~
 18 ~~additional time is reasonably necessary to fully and fairly evaluate~~
 19 ~~the complaint. The commissioner shall notify the complainant of~~
 20 ~~the final action taken on his or her complaint within 10 days of~~
 21 ~~the final action. The notification shall include a summary~~
 22 ~~explaining the commissioner’s reasons for the final action.~~

23 ~~(2) For purposes of this subdivision, “unresolved payment~~
 24 ~~dispute” means a payment dispute that remains unresolved at the~~
 25 ~~conclusion of the dispute resolution mechanism provided by the~~
 26 ~~insurer pursuant to subdivision (a) of Section 10123.137.~~

27 ~~SEC. 4.~~

28 ~~SEC. 3. No reimbursement is required by this act pursuant to~~
 29 ~~Section 6 of Article XIII B of the California Constitution because~~
 30 ~~the only costs that may be incurred by a local agency or school~~
 31 ~~district will be incurred because this act creates a new crime or~~
 32 ~~infraction, eliminates a crime or infraction, or changes the penalty~~
 33 ~~for a crime or infraction, within the meaning of Section 17556 of~~
 34 ~~the Government Code, or changes the definition of a crime within~~
 35 ~~the meaning of Section 6 of Article XIII B of the California~~
 36 ~~Constitution.~~

O