SENATE BILL No. 781

Introduced by Senator Allen

February 27, 2015

An act to amend Section 10123.147 of the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 781, as introduced, Allen. Health insurance: claims.

Exiting law requires insurers issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses to reimburse each complete claim, as specified, as soon as practical but no later than 30 working days after receipt of the complete claim. Within 30 working days after receipt of the claim, an insurer can contest or deny a claim, as specified. An insurer is required to pay the greater of $15 per year or interest, as specified, on a claim that is not contested or denied and that has not been delivered to the claimant within 30 working days after receipt. Existing law also authorizes the insurer to request reasonable additional information about the claim, and requires the service provider making the claim to submit the relevant information requested to the insurer within 15 working days. Existing law allows the insurer 30 working days after receipt of the additional information to reconsider the claim, and requires the insurer to pay the greater of $15 per year, or interest, as specified, on a claim that is undergoing reconsideration and that has not been delivered to the claimant within 30 working days after receipt of the additional information. Under existing law these requirements are not applicable to claims to which specified exceptions apply, and the insurer is required to give written notice to the provider if any of those exceptions apply within 30 working days of receipt of the claim.

This bill would require an insurer, under those circumstances, to instead pay to the claimant the greater of $25 per year or the interest, as specified.

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

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

SECTION 1. Section 10123.147 of the Insurance Code is amended to read:

10123.147. (a) ~~Every~~ *(1) An* insurer ~~issuing~~ *that issues a* group or individual ~~policies~~ *policy* of health insurance that covers hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse each complete claim, or portion ~~thereof,~~ *of a claim*, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the insurer. ~~However,~~

(2) However, an insurer may contest or deny a claim, or portion ~~thereof,~~ *of the claim*, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by the insurer. The notice that a claim, or portion ~~thereof,~~ *of a claim*, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion ~~thereof,~~ *of a claim*, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial, including the factual and legal basis known at that time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer ~~is required to~~ *shall* provide only the factual or legal basis for its reason to deny the claim. ~~The~~

(3) The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice required by this subdivision shall include a statement advising the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the

insured that either may seek review by the department of a claim that was contested or denied by the insurer and the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. ~~An~~

(4) An insurer may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the insurer pays those charges specified in subdivision (b).

(b) If a complete claim, or portion ~~thereof,~~ *of the claim,* that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt, the insurer shall pay the greater of ~~fifteen~~ *twenty-five* dollars ~~($15)~~ *($25)* per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period. An insurer shall automatically include the ~~fifteen~~ *twenty-five* dollars ~~($15)~~ *($25)* per year or interest due in the payment made to the claimant, without requiring a ~~request therefor.~~ *request.*

(c) *(1)* For the purposes of this section, a claim, or portion ~~thereof,~~ *of the claim,* is reasonably contested if the insurer has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. ~~However,~~

(2) However, if the insurer requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at

which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 working days of receipt of a written request that is clear and specific regarding the information sought. ~~If,~~

(3) If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section ~~shall~~ *does* not apply to ~~claims~~ *a claim* about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances ~~where~~ *that* the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 working days of receipt of the claim, ~~which,~~ *the exceptions,* if any, of these ~~exceptions applies~~ *that apply* to a claim.

(e) If a claim or portion ~~thereof~~ *of a claim* is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion ~~thereof,~~ *of the claim,* then the insurer shall have 30 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion ~~thereof,~~ *of a claim,* undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt of the additional information, the insurer shall pay the greater of ~~fifteen~~ *twenty-five* dollars ~~($15)~~ *($25)* per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period. An insurer shall automatically include the ~~fifteen~~ *twenty-five* dollars ~~($15)~~ *($25)* per year or interest due in the payment made to the claimant, without requiring a ~~request therefor.~~ *request.*

(f) An insurer shall not delay payment on a claim from a physician *and surgeon* or other *health care* provider to await the

submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the insurer's actions to resolve the claim, to the provider that submitted the claim.

(g) An insurer shall not request or require that a provider waive its rights pursuant to this section.

(h) This section ~~shall apply~~ *applies* only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 of the Health and Safety Code in the United States on or after September 1, 1999.

(i) This section ~~shall not be construed to~~ *does not* affect the rights or obligations of ~~any~~ *a* person pursuant to Section 10123.13.

(j) This section ~~shall not be construed to~~ *does not* affect a written agreement, if any, of a provider to submit bills within a specified time period.

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