

Senate Bill No. 1478

CHAPTER 711

An act to amend Section 1371 of the Health and Safety Code, and to amend Section 10123.13 of the Insurance Code, relating to health coverage.

[Approved by Governor September 21, 1996. Filed with Secretary of State September 23, 1996.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1478, Solis. Health coverage: health care service plans and insurers.

Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are subject to licensure and regulation by the Department of Corporations. Existing law provides that a willful violation of the provisions governing health care service plans is subject to criminal sanction.

Existing law also provides for the licensure and regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan and an insurer that issues group or individual policies of disability insurance that covers hospital, medical, or surgical expenses to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim, unless the claim is contested.

This bill would provide that the obligation of the plan or insurer to comply with this requirement of reimbursement of claims shall not be waived when the plan requires its contracting entities to pay claims for covered services.

This bill would incorporate additional changes in Section 10123.13 of the Insurance Code, proposed by SB 1665, to be operative only if SB 1665 and this bill are both chaptered and become effective January 1, 1997, and this bill is chaptered last.

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

SECTION 1. Section 1371 of the Health and Safety Code is amended to read:

1371. A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by



the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30- or 45-working-day period.

For the purposes of this section, a claim, or portion thereof, is reasonably contested where the plan has not received the completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the plan to determine the medical necessity for the health care services provided.

If a claim or portion thereof is contested on the basis that the plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this section, then the plan shall have 30 working days or, if the health care service plan is a health maintenance organization, 45 working days after receipt of this additional information to complete reconsideration of the claim.

The obligation of the plan to comply with this section shall not be deemed to be waived when the plan requires its medical groups, independent practice associations, or other contracting entities to pay claims for covered services.

SEC. 2. Section 10123.13 of the Insurance Code is amended to read:

10123.13. Every insurer issuing group or individual policies of disability insurance which covers hospital, medical, or surgical expenses shall reimburse claims or any portion of any claim, whether in state or out of state, for such expenses, as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.



If an uncontested claim is not reimbursed by delivery to the claimants' address of record within 30 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

For purposes of this section, a claim, or portion thereof, is reasonably contested where the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant.

The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SEC. 3. Section 10123.13 of the Insurance Code is amended to read:

10123.13. Every insurer issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses, as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If an uncontested claim is not reimbursed by delivery to the claimants' address of record within 30 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

For purposes of this section, a claim, or portion thereof, is reasonably contested where the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant.



The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SEC. 4. Section 3 of this bill incorporates amendments to Section 10123.13 of the Insurance Code proposed by both this bill and SB 1665. It shall only become operative if (1) both bills are enacted and become effective on January 1, 1997, (2) each bill amends Section 10123.13 of the Insurance Code, and (3) this bill is enacted after SB 1665, in which case Section 2 of this bill shall not become operative.

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