

AMENDED IN SENATE AUGUST 16, 1999
AMENDED IN ASSEMBLY APRIL 27, 1999
AMENDED IN ASSEMBLY APRIL 15, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL

No. 735

Introduced by Assembly Member Knox

February 24, 1999

An act to amend Sections 1371 and 1399.55 of the Health and Safety Code, and to amend Section 10123.13 of the Insurance Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 735, as amended, Knox. Health care service plans: late payments: penalty.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans administered by the Commissioner of Corporations. Under existing law, willful violation of any of these provisions is punishable as either a felony or a misdemeanor.

Existing law requires a health care service plan, and a health care service plan that is a health maintenance organization, to reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 or 45 days, respectively, after receipt of the claim, unless the claim is contested. Existing law provides that if an uncontested claim is not reimbursed within these time

periods, interest shall accrue at the rate of 10% per annum beginning with the first calendar day after the 30- or 45-working-day period. Existing law requires that the contested portion of the claim be identified and specific reasons given.

This bill would change the interest rate from 10% to ~~13%~~ 18% per annum on claims or portions thereof that are neither contested nor denied, *and would enact penalties for failure to pay these claims when required.* This bill would require that notice that a claim is being contested or denied identify the contested or denied portion, provide the specific reasons for contesting or denying and additional information concerning the objection and other information.

The bill would, in connection with the foregoing provisions, make it a misdemeanor to attest in writing to any matter an individual knows to be false.

Since a willful violation of the provisions applicable to health care service plans is a crime, this bill would impose a state-mandated local program.

Existing law requires every insurer issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses to reimburse claims no later than 30 days after receipt, and provides that interest accrues at the rate of 10% per annum on uncontested claims that are not reimbursed.

This bill would change the interest rate from 10% to 18% per annum on claims or portions thereof that are neither contested nor denied, and would enact penalties for failure to pay these claims when required.

This bill would require the reimbursement of each complete claim or portion no later than 30 days after receipt and require that the notice that a claim is being contested or denied identify the portion being contested or denied, provide specific reasons, explain the basis of the objection, and include other information.

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 of the Health and Safety
2 Code is amended to read:
3 1371. (a) A health care service plan, including a
4 specialized health care service plan, shall reimburse each
5 complete claim or any portion of any claim, whether in
6 state or out of state, as soon as practical, but no later than
7 30 working days after receipt of the complete claim by the
8 health care service plan, or if the health care service plan
9 is a health maintenance organization, 45 working days
10 after receipt of the complete claim by the health care
11 service plan. However, a health care service plan may
12 contest or deny a claim, or any portion thereof, by
13 notifying the provider, in writing, that the claim is
14 contested or denied, within 30 working days after receipt
15 of the claim by the health care service plan, or if the
16 health care service plan is a health maintenance
17 organization, 45 working days after receipt of the claim
18 by the health care service plan. The notice that a claim,
19 or portion thereof, is being contested or denied shall
20 identify the portion of the claim that is contested or
21 denied, the specific reasons for contesting or denying the
22 claim, or portion thereof, an explanation of the basis for
23 the objection, the name, address, and telephone number
24 of the person to contact for additional information
25 concerning the objection, and a clear description of the
26 specific information needed from the provider in order
27 to ~~pay~~ *reconsider* the claim. A health care service plan
28 shall not delay payment of any uncontested portion of a
29 claim for reconsideration of a contested portion of that
30 claim. ~~A health care service plan requesting additional~~
31 ~~information, including copies of medical records, from a~~
32 ~~provider shall reimburse the provider for copies at the~~
33 ~~rates specified in Section 123110.~~ *If a health care service*



1 *plan or its agent requests or requires copies of a patient's*
2 *medical records for use in determining a claim's payment*
3 *for an authorized course of treatment, the plan or its*
4 *agent shall reimburse the health care provider for those*
5 *copies at the rates specified in Section 123110. For*
6 *purposes of this section, "authorized" means that the plan*
7 *agreed with the provider that the patient needed the*
8 *course of treatment. A plan shall not request or require*
9 *that any entity not holding a license under this chapter*
10 *comply with this section.*

11 (b) If a complete claim or portion thereof, that is
12 neither contested nor denied is not reimbursed by
13 delivery to the provider's address of record within the
14 respective 30 or 45 working days after receipt, ~~the health~~
15 ~~care service plan shall pay the provider's full billed~~
16 ~~charges for each claim or portion thereof, and interest~~
17 *interest shall accrue at the rate of 13 18 percent per*
18 *annum beginning with the first calendar day after the 30-*
19 ~~or 45-working-day~~ *45-working day period. The interest*
20 *due shall automatically be included in the payment made*
21 *to the provider, without requiring a request by the*
22 *provider.*

23 (c) For the purposes of this section, a claim, or portion
24 thereof, is reasonably contested only ~~where~~ *if the plan has*
25 *not received a ~~completed claim~~ complete claim or the*
26 *additional information required by contract, or there is*
27 *evidence of fraud. A claim from a provider shall be*
28 *deemed complete upon submission of a completed*
29 *HCFA-1500 form or its electronic equivalent. A claim*
30 *from an institutional provider shall be deemed complete*
31 *upon submission of a completed UB-92 form or its*
32 *electronic equivalent, or in any other format adopted by*
33 *the National Uniform Billing Committee or its electronic*
34 *equivalent. If a plan requires providers to provide*
35 *additional information, the plan shall specifically disclose*
36 *each additional requirement in each provider contract.*
37 *Any requirement shall be reasonable and relevant.*
38 *Additional information requirements shall not be*
39 *changed during the term of a contract.*



1 ~~(d) This section shall not apply to claims about which~~
2 ~~there is evidence of fraud or misrepresentation, or in~~
3 ~~instances where the plan has not been granted reasonable~~
4 ~~access to information under the provider's control. A plan~~
5 ~~shall specify, in a written notice sent to the provider~~
6 ~~within the respective 30 or 45 working days of receipt of~~
7 ~~a claim, why and which, if any, of these exceptions applies~~
8 ~~to a claim.~~

9 ~~(e)~~

10 (d) If a claim or portion thereof is contested on the
11 basis that the plan has not received ~~all information a~~
12 *complete claim or the additional information specified in*
13 *subdivision (c)* reasonably necessary to determine payer
14 liability for the claim or portion thereof and notice has
15 been provided pursuant to this section, then the plan shall
16 have 30 working days or, if the health care service plan is
17 a health maintenance organization, 45 working days after
18 receipt of this additional information to complete
19 reconsideration and, if the claim is not denied,
20 reimbursement of the claim. If a claim, or portion thereof,
21 undergoing reconsideration is not reimbursed by
22 delivery to the provider's address of record within the
23 respective 30 or 45 working days after receipt of the
24 additional information, ~~the plan shall pay the provider's~~
25 ~~full billed charges for each claim, or portion thereof, and~~
26 interest shall accrue at the rate of ~~13~~ 18 percent per
27 annum beginning with the first calendar day after the 30-
28 or 45-working day period. The interest due shall
29 automatically be included in the payment made to the
30 provider without requiring a request by the provider.

31 ~~(f)~~

32 (e) *If a complete claim or a portion thereof is not*
33 *denied, contested, or paid, by delivery to the provider's*
34 *address of record within 90 working days after receipt,*
35 *the plan shall pay a penalty of 30 percent of the total*
36 *amount of the claim, but the provider shall not be entitled*
37 *to the interest amount described in subdivision (b). The*
38 *penalties and interest due shall automatically be paid to*
39 *the provider, without requiring a request by the*
40 *provider.*



1 (f) If a complete claim is not denied, contested, or
2 paid, by delivery to the provider's address of record
3 within 120 working days after receipt, the plan shall pay
4 the amount of the claim plus a penalty equal to one time
5 the total dollar amount of the claim. The provider shall
6 not be entitled to the interest amount described in
7 subdivision (b). The penalties and interest due shall
8 automatically be paid to the provider, without requiring
9 a request by the provider.

10 (g) For the purposes of subdivisions (e) and (f), there
11 shall be a rebuttable presumption that a claim was
12 submitted to the plan if a provider attests in writing and
13 under penalty of perjury that a claim or group of claims
14 was sent to a plan, or the plan's designee, by mail or
15 another delivery service, or was submitted electronically.
16 The provider shall provide written documentation of the
17 dates and manner in which each claim was submitted to
18 the plan. A person who attests in writing, as described in
19 this subdivision, to any matter that he or she knows to be
20 false is guilty of a misdemeanor and shall be punished
21 upon conviction by imprisonment for not more than six
22 months in a county jail, by a fine of not more than one
23 thousand dollars (\$1,000), or by both that imprisonment
24 and fine.

25 (h) A health care service plan, including a specialized
26 health care service plan, shall make capitation payments
27 on a date certain each month. If a capitation payment, or
28 portion thereof, is not made by a health plan pursuant to
29 the due date in a provider's contract, interest shall accrue
30 at the rate of 18 percent per annum beginning with the
31 first calendar day after the payment due date. The
32 interest due shall automatically be included in the
33 capitation payment made to the provider, without
34 requiring a request by the provider.

35 (i) If a capitation payment, or portion thereof, is more
36 than 90 working days overdue, the plan shall pay a penalty
37 of 30 percent of the total amount due, but the provider
38 shall not be entitled to the interest amount described in
39 subdivision (h). Any interest and penalties due shall



1 automatically be paid to the provider, without requiring
2 a request by the provider.

3 (j) If a capitation payment, or portion thereof, is more
4 than 120 working days overdue, the plan shall pay the
5 amount of the capitation payment due plus a penalty
6 equal to one time the total dollar amount of the capitation
7 payment due. The provider shall not be entitled to the
8 interest amount described in subdivision (h). Any
9 interest and penalties due shall automatically be paid to
10 the provider, without requiring a request by the
11 provider.

12 (k) Health care service plan risk pool payments or
13 capitation withhold settlements shall be made at least
14 quarterly, with final payments to be made no later than
15 90 working days after the close of the contract period.
16 Payments made later than 90 working days after the close
17 of the contract period shall accrue interest at a rate of 18
18 percent per annum beginning with the first calendar date
19 after the due date. Any interest due shall automatically be
20 paid to the provider or provider organization, without
21 requiring a request by the provider.

22 (l) If health care service plan risk pool payments or
23 capitation withhold settlements, or any portion thereof,
24 are more than 90 working days overdue, the health plan
25 shall pay a penalty of 30 percent of the total amount due,
26 but the provider shall not be entitled to the interest
27 amount described in subdivision (k). Any interest and
28 penalties due shall automatically be paid to the provider,
29 without requiring a request by the provider.

30 (m) If health care service plan risk pool payments or
31 capitation withhold settlements, or any portion thereof,
32 are more than 120 working days overdue, the plan shall
33 pay the payment due plus a penalty equal to one time the
34 total dollar amount of the payment due. The provider
35 shall not be entitled to the interest amount described in
36 subdivision (k). Any interest and penalties due shall
37 automatically be paid to the provider, without requiring
38 a request by the provider.

39 (n) All health care service plans shall disclose in
40 contracts with participating providers, the provider



1 payment adjudication rules and the amount of payment
2 for each and every service to be provided under the
3 contract with participating providers. These disclosures
4 shall include, at a minimum, either a complete fee
5 schedule for each and every service to be provided under
6 the contract or the unit value and applicable conversion
7 factor for each and every service provided under the
8 contract. In addition, where applicable, plans shall
9 disclose precisely what is covered by any global payment
10 provisions, including, but not limited to, the time period
11 encompassed by any provision and all policies regarding
12 multiple procedure payments. Contracts providing for
13 capitation payments meet this requirement provided
14 they specify the amount to be paid per member per
15 month, any deductions which may be made, the
16 information used to calculate provider payments, and
17 that the capitation payment shall commence upon the
18 patient's enrollment in the health plan. These disclosures
19 shall also be made for each and every health plan product
20 line with the product line specifically identified
21 (including Medicare, Medi-Cal, Healthy Families, AIM,
22 Champus, PPO, or HMO).

23 ~~(g)~~

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

29 (p) (1) *Any professional provider, except emergency*
30 *physicians and emergency departments, may, in*
31 *accordance with paragraph (2), utilize an alternative*
32 *dispute resolution procedure or bring an action in a court*
33 *of competent jurisdiction for an order requiring a plan to*
34 *comply with this section. The court or arbitrator shall*
35 *order a plan to pay the penalties described in this section*
36 *and attorneys' fees and costs to any professional provider,*
37 *except emergency physicians, found to be damaged by*
38 *the plan's noncompliance with this section. The remedies*
39 *provided under this section are not exclusive, and shall be*
40 *in addition to any other remedies provided by law.*



1 (2) Arbitration of a violation of this section shall
2 commence within 120 days of the plan's receipt of a
3 demand for arbitration by a professional health care
4 provider permitted to bring an action pursuant to this
5 subdivision. If, after the 120-day period, arbitration has
6 not commenced, the professional health care provider
7 shall be entitled to seek redress from a court pursuant to
8 this section.

9 SEC. 2. Section 1399.55 of the Health and Safety Code
10 is amended to read:

11 1399.55. Health care service plans shall, upon
12 rejecting a claim from a health care provider or a patient,
13 disclose the specific rationale used in determining why
14 the claim was rejected and the additional information
15 required in Section 1371. Nothing in this section is
16 intended to expand or restrict the ability of a health care
17 provider or a patient from having health care coverage
18 approved in advance of services.

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

21 10123.13. (a) Every insurer issuing group or
22 individual policies of disability insurance that covers
23 hospital, medical, or surgical expenses, including those
24 telemedicine services covered by the insurer as defined
25 in subdivision (a) of Section 2290.5 of the Business and
26 Professions Code, shall reimburse each complete claim or
27 any portion of any claim, whether in state or out of state,
28 for those expenses as soon as practical, but no later than
29 30 working days after receipt of the complete claim by the
30 insurer. However, an insurer may contest or deny a claim
31 or any portion thereof by notifying the provider, in
32 writing, that the claim is contested or denied, within 30
33 working days after receipt of the claim by the insurer.
34 The notice that a claim is being contested or denied shall
35 identify the portion of the claim that is contested or
36 denied, the specific reasons for contesting or denying the
37 claim, or portion thereof, an explanation of the basis for
38 the objection, the name, address, and telephone number
39 of the person to contact for additional information
40 concerning the objection, and a clear description of the



1 specific information needed from the provider in order
2 to ~~pay~~ *reconsider* the claim. An insurer shall not delay
3 payment of any uncontested portion of a claim for
4 reconsideration of a contested portion of that claim.

5 ~~An insurer requesting additional information,~~
6 ~~including copies of medical records, from a provider shall~~
7 ~~reimburse the provider for copies at the rates specified in~~
8 ~~Section 123110 of the Health and Safety Code.~~

9 *If an insurer or its agent requests or requires copies of*
10 *a patient's medical records in determining a claim's*
11 *payment for an authorized course of treatment, the*
12 *insurer or its agent shall reimburse the health care*
13 *provider for those copies at the rates specified in Section*
14 *123110 of the Health and Safety Code. For purposes of this*
15 *section, "authorized" means that the insurer agreed with*
16 *the provider that the patient needed the course of*
17 *treatment.*

18 (b) If a complete claim or portion thereof that is
19 neither contested nor denied is not reimbursed by
20 delivery to the provider's address of record within 30
21 working days after receipt, ~~the insurer shall pay the~~
22 ~~provider's full billed charges for each claim or portion~~
23 ~~thereof and~~ interest shall accrue at the rate of ~~13~~ 18
24 percent per annum beginning with the first calendar day
25 after the ~~30-working-day~~ 30-working day period. The
26 interest shall automatically be included in the payment to
27 the provider, without requiring a request by the claimant.

28 (c) For purposes of this section, a claim, or portion
29 thereof, is reasonably contested ~~when~~ if the insurer has
30 not received a ~~completed claim~~ *complete claim or the*
31 *additional information required by contract, or there is*
32 *evidence of fraud. A claim from a provider shall be*
33 *deemed complete upon submission of a completed*
34 *HCFA-1500 form or its electronic equivalent. A claim*
35 *from an institutional provider shall be deemed complete*
36 *upon submission of a completed UB-92 form or its*
37 *electronic equivalent, or in any other format adopted by*
38 *the National Uniform Billing Committee or its electronic*
39 *equivalent. If an insurer requires providers to provide*
40 *additional information, the insurer must specifically*



1 *disclose the additional information requirements in each*
2 *provider contract. Any requirements shall be reasonable*
3 *and relevant. Additional information requirements shall*
4 *not be changed during the term of a contract.*

5 ~~(d) This section shall not apply to claims about which~~
6 ~~there is evidence of fraud or misrepresentation, or in~~
7 ~~instances where the insurer has not been granted~~
8 ~~reasonable access to information under the provider's~~
9 ~~control. An insurer shall specify, in a written notice sent~~
10 ~~to the provider within the respective 30 or 45 working~~
11 ~~days of receipt of a claim, why and which, if any, of these~~
12 ~~exceptions applies to a claim.~~

13 ~~(e)~~

14 (d) If a claim or portion thereof is contested on the
15 basis that the insurer has not received ~~all information a~~
16 *complete claim or the additional information specified in*
17 *subdivision (c)* necessary to determine payer liability for
18 the claim or portion thereof and notice has been provided
19 pursuant to this section, then the insurer shall have 30
20 working days after receipt of this additional information
21 to complete reconsideration and, if the claim is not
22 denied, reimbursement of the claim.

23 If a claim, or portion thereof, undergoing
24 reconsideration is not reimbursed by delivery to the
25 provider's address of record within the respective 30- or
26 45-working days after receipt of the additional
27 ~~information, the insurer shall pay the provider's full billed~~
28 ~~charges for each claim, or portion thereof, and interest~~
29 *information, interest* shall accrue at the rate of ~~13~~ 18
30 percent per annum beginning with the first calendar day
31 after the 30- or 45-working day period. The interest due
32 shall automatically be included in the payment made to
33 the provider without requiring a request by the provider.

34 ~~(f)~~

35 (e) *If a complete claim or a portion thereof is not*
36 *denied, contested, or paid, by delivery to the provider's*
37 *address of record within 90 working days after receipt,*
38 *the insurer shall pay a penalty of 30 percent of the total*
39 *amount of the claim, but the provider shall not be entitled*
40 *to the interest amount described in subdivision (b). The*



1 *penalties and interest due shall automatically be paid to*
2 *the provider, without requiring a request by the*
3 *provider.*

4 *(f) If a complete claim is not denied, contested, or*
5 *paid, by delivery to the provider's address of record*
6 *within 120 working days after receipt, the insurer shall*
7 *pay the amount of the claim plus a penalty equal to one*
8 *time the total dollar amount of the claim. The provider*
9 *shall not be entitled to the interest amount described in*
10 *subdivision (b). The penalties and interest due shall*
11 *automatically be paid to the provider, without requiring*
12 *a request by the provider.*

13 *(g) All insurers shall disclose in contracts with*
14 *participating providers, the provider payment*
15 *adjudication rules and the amount of payment for each*
16 *and every service to be provided under the contract with*
17 *participating providers. These disclosures shall include, at*
18 *a minimum, either a complete fee schedule for each and*
19 *every service to be provided under the contract or the*
20 *unit value and applicable conversion factor for each and*
21 *every service provided under the contract. In addition,*
22 *where applicable, insurers shall disclose precisely what is*
23 *covered by any global payment provisions, including, but*
24 *not limited to, the time period encompassed by any*
25 *provision and all policies regarding multiple procedure*
26 *payments. These disclosures shall also be made for each*
27 *and every insurer product line with the product line*
28 *specifically identified (including Medicare, Medi-Cal,*
29 *Healthy Families, AIM, Champus, PPO, or HMO).*

30 ~~*(g)*~~

31 *(h) The obligation of the insurer to comply with this*
32 *section shall not be deemed to be waived when the*
33 *insurer requires its contracting entities to pay claims for*
34 *covered services.*

35 *(i) (1) Any professional provider, except emergency*
36 *physicians and emergency departments, may, in*
37 *accordance with paragraph (2), bring an arbitration*
38 *action or bring an action in a court of competent*
39 *jurisdiction for an order requiring an insurer to comply*
40 *with this section. The court or arbitrator shall order an*



1 insurer to pay the penalties described in this section and
2 attorneys' fees and costs to any professional provider
3 found to be damaged by the insurer's noncompliance
4 with this section. The remedies provided under this
5 section are not exclusive, and shall be in addition to any
6 other remedies provided by law.

7 (2) Arbitration of a violation of this section shall
8 commence within 120 days of the insurer's receipt of a
9 demand for arbitration by a professional health care
10 provider permitted to bring an action pursuant to this
11 subdivision. If, after the 120-day period, arbitration has
12 not commenced, the professional health care provider
13 shall be entitled to seek redress from a court pursuant to
14 this section.

15 SEC. 4. No reimbursement is required by this act
16 pursuant to Section 6 of Article XIII B of the California
17 Constitution because the only costs that may be incurred
18 by a local agency or school district will be incurred
19 because this act creates a new crime or infraction,
20 eliminates a crime or infraction, or changes the penalty
21 for a crime or infraction, within the meaning of Section
22 17556 of the Government Code, or changes the definition
23 of a crime within the meaning of Section 6 of Article
24 XIII B of the California Constitution.

