

AMENDED IN SENATE AUGUST 7, 2000

AMENDED IN SENATE JULY 3, 2000

AMENDED IN SENATE JUNE 15, 2000

AMENDED IN SENATE MAY 18, 2000

AMENDED IN SENATE AUGUST 26, 1999

AMENDED IN SENATE AUGUST 18, 1999

AMENDED IN SENATE JUNE 9, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL

No. 1455

Introduced by Assembly Member Scott
(Principal coauthor: Assembly Member Knox)
(Coauthors: Assembly Members Bock, Machado, and
Washington)
(Coauthors: Senators Figueroa, Hughes, and Speier)

February 26, 1999

An act to add Section 1371.9 to the Health and Safety Code, relating to health care service plans.

LEGISLATIVE COUNSEL'S DIGEST

AB 1455, as amended, Scott. Health care service plans: *plan unfair—trade or business—practices payment patterns: provider fraudulent billing.*

The Knox-Keene Health Care Service Plan Act of 1975 provides for the regulation and licensure of health care

service plans by the Department of Managed Care, ~~effective no later than July 1, 2000, or earlier pursuant to an executive order of the Governor,~~ and makes the willful violation of the provisions of this act a crime. Under existing law, the director of the department is required to administer and enforce the act and is provided with certain powers in this respect, including the power to conduct investigations affecting the interests of plans, subscribers, enrollees, and the public; to audit the books and records of plans; to hold public hearings;; to issue subpoenas;; to take testimony;; and to compel the production of books, papers, documents, and other evidence.

This bill would authorize a plan enrollee, an enrollee's representative, or an enrollee's provider to petition the director to investigate an allegation that a health care service plan has engaged in an ~~unfair trade or business practice~~ *payment pattern*, as defined, in its reimbursement of a provider of health care services and would ~~require~~ *permit* the director, as he or she deems necessary, to investigate the allegation, conduct a hearing or an audit, and subpoena witnesses and documents to determine whether the plan committed an ~~unfair trade or business practice~~ *payment pattern*. This bill would authorize the director to annually audit a health care service plan that he or she determines has committed an ~~unfair trade or business practice~~ *payment pattern*, as specified, to verify whether it engaged in further ~~unfair trade or business practices~~ *payment patterns*. This bill would authorize the director to require a plan found as a result of this audit to have engaged in that ~~practice pattern~~ to make specified claims reimbursements to providers and would provide that a provider would remain liable for ~~overbillings~~ *fraudulent billing*.

This bill would authorize a contracting health care service plan to petition the director to investigate allegations that a provider has engaged in ~~fraudulent overbilling and billing~~. *The bill would permit the director, as he or she deems necessary, to investigate the allegation, conduct a hearing or an audit, and subpoena witnesses and documents to determine whether the provider has engaged in a pattern, practice, or scheme of fraudulent billing. The bill would*



require the director to report his or her findings to the appropriate regulatory agency.

Because this bill would add to the act specified reimbursement provisions for plans found during these audits to have committed further unfair trade or business practices, a willful violation of which would be a crime, this bill would expand the scope of an existing crime and thereby would impose a state-mandated local program.

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 1371.9 is added to the Health and
2 Safety Code, to read:

3 1371.9. (a) An enrollee, an enrollee’s representative,
4 or an enrollee’s provider may petition the director to
5 investigate an allegation that a health care service plan
6 has engaged in an unfair ~~trade or business practice~~
7 *payment pattern*, as defined in this section, in its
8 reimbursement of a provider.

9 ~~(b) An unfair trade or business practice includes all of~~
10 ~~the following:~~

11 ~~(1) A pattern, practice, or scheme that results in a~~
12 ~~failure to reimburse a provider within the timeframes set~~
13 ~~forth in Section 1371.~~

14 ~~(2) A pattern, practice, or scheme to delay, deny, or~~
15 ~~otherwise reduce the reimbursement amount of a~~
16 ~~provider’s claim for administrative errors or omissions of~~
17 ~~a nonsubstantive, technical, or clerical nature.~~

18 ~~(3) A pattern, practice, or scheme to delay the~~
19 ~~reconciliation of risk based reimbursement arrangements~~
20 ~~with providers.~~



1 (b) An unfair payment pattern, as used in this section,
2 means any of the following:

3 (1) Engaging in inappropriate patterns of reviewing,
4 approving, handling, processing, or paying claims,
5 including, but not limited to, policies, requirements, or
6 procedures that result in delayed payment.

7 (2) Engaging in inappropriate patterns of lowering
8 payment, or nonpayment, of legitimate claims, including
9 a pattern of retrospective, rather than concurrent,
10 review that results in the denial of part or all of a claim.

11 (3) Repeated failure to pay uncontested portions of a
12 claim within the timeframes set forth in Section 1371,
13 1371.1, or 1371.35.

14 (c) After receipt of a petition to investigate an
15 allegation of an unfair ~~trade or business practice~~ payment
16 pattern by a health care service plan, the director ~~shall~~
17 may, as the director deems necessary, ~~as authorized by~~
18 ~~Section 1346~~, investigate; audit; conduct a hearing
19 pursuant to Section 1397; subpoena witnesses; take
20 testimony; compel the production of books, papers,
21 documents; ~~and~~, and collect other evidence to obtain
22 information required to determine whether or not ~~a the~~
23 health care service plan has engaged in an unfair ~~trade or~~
24 ~~business practice~~ payment pattern.

25 (d) If the director determines that a health care
26 service plan has engaged in an unfair payment pattern as
27 specified in subdivision (b), the director may require the
28 plan for a period of three years from the date of the
29 director's determination, or for a shorter period
30 prescribed by the director, to reimburse the provider the
31 total amount of the allowable charges for each claim
32 submitted by the provider, or the full plan-provider
33 contract amount, whichever is greater, within 30 days of
34 the plan's receipt of each of the provider's claims.

35 (e) The director may issue an order directing a health
36 care service plan to cease and desist from engaging in any
37 unfair payment pattern determined by the director.

38 (f) In addition to any other powers or remedies
39 available to the director, the director may annually audit
40 each health care service plan that has previously been



1 determined by the director to have engaged in an unfair
2 ~~trade or business practice~~, for a period not to exceed five
3 ~~payment pattern for a period not to exceed three years~~
4 from the date of the director's determination, or for a
5 shorter period prescribed by the director, in order to
6 verify that the plan has not engaged in further unfair
7 ~~trade or business practices~~ *payment patterns*.
8 Notwithstanding any other powers or remedies available
9 to the director, if the director determines that a health
10 care service plan has engaged in an unfair trade or
11 business practice, the director may require the plan to
12 reimburse the total amount of the allowable charges of
13 each claim submitted by a provider or the full
14 plan-provider contract amount within 30 days of the
15 plan's receipt of the provider's claim, for a period not to
16 exceed five years from the date of the director's
17 determination, or for a shorter period prescribed by the
18 director. The director may also issue an order directing
19 a health care service plan to cease and desist from
20 engaging in any unfair trade or business practice, as
21 determined by the director. Nothing in this section shall
22 be construed as affecting the director's authority
23 pursuant to Article 7 (commencing with Section 1386) or
24 Article 8 (commencing with Section 1390).

25 (e)

26 (g) After a final determination that a health care
27 service plan has engaged in an unfair ~~trade or business~~
28 ~~practice~~ *payment pattern*, and during a period where a
29 health care service plan is required to reimburse ~~a the~~
30 provider either the total amount of the allowable charges
31 of each claim submitted by ~~a the~~ provider or the full
32 plan-provider contract amount, ~~a the~~ provider shall
33 remain liable for ~~overbilling~~ *fraudulent billing*. After
34 exhausting all available administrative and civil
35 remedies, and upon a final determination that ~~a the~~
36 provider has ~~overbilled~~ *fraudulently billed* a health care
37 service plan, the provider shall repay the health ~~plan~~
38 ~~within 30~~ *care service plan within seven* days of the final
39 determination.

40 (f)



1 (h) Nothing in this section shall be construed as
 2 affecting the director's authority pursuant to Article 7
 3 (commencing with Section 1386) or Article 8
 4 (commencing with Section 1390).

5 (i) The enforcement remedies provided in this section
 6 are not exclusive and shall not limit or preclude the use
 7 of any other criminal, civil, or administrative remedy
 8 otherwise available.

9 ~~(g)~~

10 (j) Upon petition of a contracting health care service
 11 plan, the director ~~shall investigate allegations that may,~~
 12 *as the director deems necessary, investigate; audit;*
 13 *conduct a hearing pursuant to Section 1397; subpoena*
 14 *witnesses; take testimony; compel the production of*
 15 *books, papers, documents, and collect other evidence, to*
 16 *determine whether a provider has engaged in a pattern,*
 17 *practice, or scheme of fraudulent ~~overbilling and billing.~~*
 18 *The director shall report his ~~for~~ or her findings to the*
 19 *appropriate regulatory agency.*

20 ~~(h)~~

21 (k) In addition to any other authority granted to the
 22 director or department, the director is authorized to
 23 study and evaluate other methods that may be available
 24 to enforce the law relating to unfair ~~trade or business~~
 25 ~~practices~~ *payment patterns* and may promulgate
 26 regulations pertaining to those methods.

27 ~~(i)~~

28 (l) The penalties set forth in this section shall not
 29 preclude, suspend, affect, or impact any other duty, right,
 30 responsibility, or obligation under a statute or under a
 31 contract between a health care service plan and a
 32 provider.

33 ~~(j)~~

34 (m) A health care service plan may not delegate any
 35 statutory responsibility or liability under this section.

36 SEC. 2. No reimbursement is required by this act
 37 pursuant to Section 6 of Article XIII B of the California
 38 Constitution because the only costs that may be incurred
 39 by a local agency or school district will be incurred
 40 because this act creates a new crime or infraction,



1 eliminates a crime or infraction, or changes the penalty
2 for a crime or infraction, within the meaning of Section
3 17556 of the Government Code, or changes the definition
4 of a crime within the meaning of Section 6 of Article
5 XIII B of the California Constitution.

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