ASSEMBLY BILL No. 2410

Introduced by Assembly Member Dababneh

February 21, 2014

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2410, as introduced, Dababneh. Insurance: life and disability insurance.

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, and the insurer can request reasonable additional information about the claim. The provider is required to submit the relevant information requested to the insurer within 15 working days. 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.

This bill would instead require insurers to contest or deny a claim and request reasonable additional information within 45 calendar days after receipt of the claim, and require providers to submit the requested additional information to the insurer within 21 calendar days. This bill would also require insurers to pay the greater of $30 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 45 working days after receipt.

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 insurer issuing group or individual policies 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, whether in state or out of state, as soon as practical, but no later than ~~30 working~~ *45 calendar* days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within ~~30 working~~ *45 calendar* days after receipt of the complete claim by the insurer. The notice that a claim, or portion thereof, 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, 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 provide only the factual or legal basis for its reason to deny the claim. 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 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, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the ~~30 working~~ *45 calendar* days after receipt, the insurer shall pay the greater of ~~fifteen dollars ($15)~~ *thirty dollars ($30)* per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the ~~30-working~~ *45-calendar* day period. An insurer shall automatically include the ~~fifteen dollars ($15)~~ *thirty dollars ($30)* per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, 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~~ *45 calendar* 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~~ *45 calendar* days of receipt of the claim. However, if the insurer requests a copy of the emergency department report within the ~~30 working~~ *45 calendar* days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within ~~30 working~~ *45 calendar* 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~~ *45 calendar* days of receipt of the claim. The provider shall provide

the insurer reasonable relevant information within ~~15 working~~ *21 calendar* days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional ~~15 working~~ *21 calendar* 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 not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where 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~~ *45 calendar* days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the insurer shall have ~~30 working~~ *45 calendar* days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the ~~30 working~~ *45 calendar* days after receipt of the additional information, the insurer shall pay the greater of ~~fifteen dollars ($15)~~ *thirty dollars ($30)* per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the ~~30-working~~ *45-calendar* day period. An insurer shall automatically include the ~~fifteen dollars ($15)~~ *thirty dollars ($30)* per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) An insurer shall not delay payment on a claim from a physician or other 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 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 affect the rights or obligations of any person pursuant to Section 10123.13.

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

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