



# Legislative Research Incorporated

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## *The Core Legislative History of*

California  
Statutes of 1989, Chapter 968  
Assembly Bill 865 – Wright

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## *Authentication of the Records and Table of Contents*

### Core Legislative History Research Report Regarding: California Statutes of 1989, Chapter 968, Assembly Bill 865 – Wright

I, Lisa Hampton, declare that this report includes:

- *Historical documents surrounding the adoption of the above enactment.* These documents were obtained by the staff of Legislative Research, Incorporated and are true and correct copies of the originals obtained from the designated official, public sources in California unless another source is indicated, with the following exceptions: In some cases, pages may have been reduced in size to fit an 8 ½” x 11” sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, paging and relevant identification have been inserted.

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- *A table of contents itemizing the documents.* This table of contents cites the sources of the documents.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct and that I could and would so testify in a court of law if called to be a witness.

Executed October 1, 2009, in Sacramento, California.

Lisa Hampton, Research Director

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*PRIMARY SOURCE RECORDS (UNPUBLISHED HARDCOPY): At least one official California source is cited for the primary source records provided in this report. Multiple copies may have been obtained from various sources (primarily State Archives, the state library system and/or legislative offices), but the clearest/most legible version was selected for this report.*

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# General Enactment History

Legislative Research Incorporated hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

**ASSEMBLY BILL**

**No. 865**

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**Introduced by Assembly Member Wright**

February 23, 1989

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---

An act to amend Sections 10123.13 and 11512.180 of the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 865, as introduced, Wright. Health insurance: claim reimbursement.

Existing law, with respect to policies of disability insurance, self-insured employee welfare benefit plans, and nonprofit hospital service plans provide for claim reimbursement as soon as practical but no later than 30 working days after receipt of the claim unless contested, except that if a nonprofit hospital service plan is a health maintenance organization, reimbursement is required 45 days after receipt, unless the claim is contested. A claimant is required to be notified in writing within 30 working days if his or her claim is contested.

This bill would require the notice that the claim is being contested to identify the portion of the claim that is contested and the specific reasons for contesting. It would also provide that if the claim is not reimbursed within the time limitation, interest shall accrue, 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:*

1 SECTION 1. Section 10123.13 of the Insurance Code  
2 is amended to read:

3 10123.13. Every insurer issuing group or individual  
4 policies of disability insurance and every self-insured  
5 employee welfare benefit plan which covers hospital,  
6 medical, or surgical expenses shall reimburse claims or  
7 any portion of any claim, whether in state or out of state,  
8 for such expenses, as soon as practical, but no later than  
9 30 working days after receipt of the claim by the insurer  
10 or plan unless the claim or portion thereof is contested by  
11 the insurer in which case the claimant shall be notified,  
12 in writing, within 30 working days. *The notice that a*  
13 *claim is being contested shall identify the portion of the*  
14 *claim that is contested and the specific reasons for*  
15 *contesting the claim.*

16 *If an uncontested claim is not reimbursed within 30*  
17 *working days after receipt, interest shall accrue at the*  
18 *rate of 10 percent per annum beginning with the first*  
19 *calendar day after the 30 working day period. If a claim*  
20 *is contested in error, interest shall accrue at the rate of 10*  
21 *percent per annum beginning with the first calendar day*  
22 *after the 30 working day period.*

23 As used in this section, a contested claim, or portion  
24 thereof, includes situations in which the insurer or plan  
25 has not received a completed claim and all information  
26 necessary to determine payer liability for the claim,  
27 including but not limited to, reports of investigations  
28 concerning fraud or misrepresentation, and necessary  
29 consents, releases, and assignments, or a claim on appeal.

30 SEC. 2. Section 11512.180 of the Insurance Code is  
31 amended to read:

32 11512.180. Every nonprofit hospital service plan that  
33 covers hospital, medical, or surgical expenses on a group  
34 or individual basis shall reimburse claims or any portion  
35 of any claim, whether in state or out of state, for such  
36 expenses, as soon as practical, but ~~no~~ *not* later than 30  
37 working days after receipt of the claim by the hospital  
38 service plan, or if the plan is a health maintenance

1 organization, 45 working days after receipt of the claim  
2 by the hospital service plan, unless the claim or portion  
3 thereof is contested by the plan in which case the  
4 claimant shall be notified, in writing, within 30 working  
5 days. *The notice that a claim is being contested shall*  
6 *identify the portion of the claim that is contested and the*  
7 *specific reasons for contesting the claim.*

8 *If an uncontested claim is not reimbursed within the*  
9 *respective 30 or 45 working days after receipt, interest*  
10 *shall accrue at the rate of 10 percent per annum*  
11 *beginning with the first calendar day after the 30 or 45*  
12 *working day period. If a claim is contested in error,*  
13 *interest shall accrue at the rate of 10 percent per annum*  
14 *beginning with the first calendar day after the 30 or 45*  
15 *working day period.*

16 As used in this section, a contested claim, or portion  
17 thereof, includes situations in which the plan has not  
18 received the completed claim and all information  
19 necessary to determine payer liability for the claim,  
20 including but not limited to, reports of investigations  
21 concerning fraud or misrepresentation, and necessary  
22 consents, releases, and assignments, or a claim on appeal.

O

AMENDED IN ASSEMBLY MAY 10, 1989

CALIFORNIA LEGISLATURE—1989-90 REGULAR SESSION

**ASSEMBLY BILL**

**No. 865**

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**Introduced by Assembly Member Wright**

February 23, 1989

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An act to amend Section 1371 of the Health and Safety Code, and to amend Sections 10123.13 and 11512.180 of the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 865, as amended, Wright. Health insurance: claim reimbursement.

Existing law, with respect to *health care service plans*, policies of disability insurance, self-insured employee welfare benefit plans, and nonprofit hospital service plans provide for claim reimbursement as soon as practical but no later than 30 working days after receipt of the claim unless contested, except that if a nonprofit hospital service plan or *health care service plan* is a health maintenance organization, reimbursement is required 45 days after receipt, unless the claim is contested. A claimant is required to be notified in writing within 30 working days if his or her claim is contested.

This bill would require the notice that the claim is being contested to identify the portion of the claim that is contested and the specific reasons for contesting. It would also provide that if the claim is not reimbursed within the time limitation, interest shall accrue, 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:*

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

3 1371. A health care service plan which covers  
4 hospital, medical, or surgical expenses shall reimburse  
5 claims or any portion of any claim, whether in state or out  
6 of state, for those expenses, as soon as practical, but no  
7 later than 30 working days after receipt of the claim by  
8 the health care service plan, or if the health care service  
9 plan is a health maintenance organization, 45 working  
10 days after receipt of the claim by the health care service  
11 plan, unless the claim or portion thereof is contested by  
12 the plan in which case the claimant shall be notified, in  
13 writing, within 30 working days. *The notice that a claim*  
14 *is being contested shall identify the portion of the claim*  
15 *that is contested and the specific reasons for contesting*  
16 *the claim.*

17 *If an uncontested claim is not reimbursed within the*  
18 *respective 30 or 45 working days after receipt, interest*  
19 *shall accrue at the rate of 10 percent per annum*  
20 *beginning with the first calendar day after the 30 or 45*  
21 *working day period. If a claim is contested in error,*  
22 *interest shall accrue at the rate of 10 percent per annum*  
23 *beginning with the first calendar day after the 30 or 45*  
24 *working day period.*

25 As used in this section, a contested claim, or portion  
26 thereof, includes situations in which the plan has not  
27 received the completed claim and all information  
28 necessary to determine payer liability for the claim,  
29 including, but not limited to, reports of investigations  
30 concerning fraud and misrepresentation, and necessary  
31 consents, releases, and assignments, or a claim on appeal.

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

34 10123.13. Every insurer issuing group or individual  
35 policies of disability insurance and every self-insured  
36 employee welfare benefit plan which covers hospital,  
37 medical, or surgical expenses shall reimburse claims or  
38 any portion of any claim, whether in state or out of state,

1 for such expenses, as soon as practical, but no later than  
2 30 working days after receipt of the claim by the insurer  
3 or plan unless the claim or portion thereof is contested by  
4 the insurer in which case the claimant shall be notified,  
5 in writing, within 30 working days. The notice that a  
6 claim is being contested shall identify the portion of the  
7 claim that is contested and the specific reasons for  
8 contesting the claim.

9 If an uncontested claim is not reimbursed within 30  
10 working days after receipt, interest shall accrue at the  
11 rate of 10 percent per annum beginning with the first  
12 calendar day after the 30 working day period. If a claim  
13 is contested in error, interest shall accrue at the rate of 10  
14 percent per annum beginning with the first calendar day  
15 after the 30 working day period.

16 As used in this section, a contested claim, or portion  
17 thereof, includes situations in which the insurer or plan  
18 has not received a completed claim and all information  
19 necessary to determine payer liability for the claim,  
20 including but not limited to, reports of investigations  
21 concerning fraud or misrepresentation, and necessary  
22 consents, releases, and assignments, or a claim on appeal.

23 ~~SEC. 2.~~

24 *SEC. 3.* Section 11512.180 of the Insurance Code is  
25 amended to read:

26 11512.180. Every nonprofit hospital service plan that  
27 covers hospital, medical, or surgical expenses on a group  
28 or individual basis shall reimburse claims or any portion  
29 of any claim, whether in state or out of state, for such  
30 expenses, as soon as practical, but not later than 30  
31 working days after receipt of the claim by the hospital  
32 service plan, or if the plan is a health maintenance  
33 organization, 45 working days after receipt of the claim  
34 by the hospital service plan, unless the claim or portion  
35 thereof is contested by the plan in which case the  
36 claimant shall be notified, in writing, within 30 working  
37 days. The notice that a claim is being contested shall  
38 identify the portion of the claim that is contested and the  
39 specific reasons for contesting the claim.

40 If an uncontested claim is not reimbursed within the

1 respective 30 or 45 working days after receipt, interest  
2 shall accrue at the rate of 10 percent per annum  
3 beginning with the first calendar day after the 30 or 45  
4 working day period. If a claim is contested in error,  
5 interest shall accrue at the rate of 10 percent per annum  
6 beginning with the first calendar day after the 30 or 45  
7 working day period.

8 As used in this section, a contested claim, or portion  
9 thereof, includes situations in which the plan has not  
10 received the completed claim and all information  
11 necessary to determine payer liability for the claim,  
12 including but not limited to, reports of investigations  
13 concerning fraud or misrepresentation, and necessary  
14 consents, releases, and assignments, or a claim on appeal.

O

AMENDED IN ASSEMBLY MAY 25, 1989

AMENDED IN ASSEMBLY MAY 10, 1989

CALIFORNIA LEGISLATURE—1989-90 REGULAR SESSION

**ASSEMBLY BILL**

**No. 865**

**Introduced by Assembly Member Wright**

February 23, 1989

---

An act to amend Section 1371 of the Health and Safety Code, and to amend Sections 10123.13 and 11512.180 of the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 865, as amended, Wright. Health insurance: claim reimbursement.

Existing law, with respect to health care service plans, policies of disability insurance, self-insured employee welfare benefit plans, and nonprofit hospital service plans provide for claim reimbursement as soon as practical but no later than 30 working days after receipt of the claim unless contested, except that if a nonprofit hospital service plan or health care service plan is a health maintenance organization, reimbursement is required 45 days after receipt, unless the claim is contested. A claimant is required to be notified in writing within 30 working days if his or her claim is contested.

This bill would require the notice that the claim is being contested to identify the portion of the claim that is contested and the specific reasons for contesting. It would also provide that if ~~the~~ *an uncontested* claim is not reimbursed within the time limitation, interest shall accrue, 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:*

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

3 1371. A health care service plan which covers  
4 hospital, medical, or surgical expenses shall reimburse  
5 claims or any portion of any claim, whether in state or out  
6 of state, for those expenses, as soon as practical, but no  
7 later than 30 working days after receipt of the claim by  
8 the health care service plan, or if the health care service  
9 plan is a health maintenance organization, 45 working  
10 days after receipt of the claim by the health care service  
11 plan, unless the claim or portion thereof is contested by  
12 the plan in which case the claimant shall be notified, in  
13 writing, within 30 working days. The notice that a claim  
14 is being contested shall identify the portion of the claim  
15 that is contested and the specific reasons for contesting  
16 the claim.

17 If an uncontested claim is not reimbursed within the  
18 respective 30 or 45 working days after receipt, interest  
19 shall accrue at the rate of 10 percent per annum  
20 beginning with the first calendar day after the 30 or 45  
21 ~~working day period. If a claim is contested in error,~~  
22 ~~interest shall accrue at the rate of 10 percent per annum~~  
23 ~~beginning with the first calendar day after the 30 or 45~~  
24 ~~working day period.~~

25 As used in this section, a contested claim, or portion  
26 thereof, includes situations in which the plan has not  
27 received the completed claim and all information  
28 necessary to determine payer liability for the claim,  
29 including, but not limited to, reports of investigations  
30 concerning fraud and misrepresentation, and necessary  
31 consents, releases, and assignments, or a claim on appeal.

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

34 10123.13. Every insurer issuing group or individual  
35 policies of disability insurance and every self-insured  
36 employee welfare benefit plan which covers hospital,  
37 medical, or surgical expenses shall reimburse claims or  
38 any portion of any claim, whether in state or out of state,

1 for such expenses, as soon as practical, but no later than  
2 30 working days after receipt of the claim by the insurer  
3 or plan unless the claim or portion thereof is contested by  
4 the insurer in which case the claimant shall be notified,  
5 in writing, within 30 working days. The notice that a  
6 claim is being contested shall identify the portion of the  
7 claim that is contested and the specific reasons for  
8 contesting the claim.

9 If an uncontested claim is not reimbursed within 30  
10 working days after receipt, interest shall accrue at the  
11 rate of 10 percent per annum beginning with the first  
12 calendar day after the 30 working day period. ~~If a claim  
13 is contested in error, interest shall accrue at the rate of 10  
14 percent per annum beginning with the first calendar day  
15 after the 30 working day period.~~

16 As used in this section, a contested claim, or portion  
17 thereof, includes situations in which the insurer or plan  
18 has not received a completed claim and all information  
19 necessary to determine payer liability for the claim,  
20 including but not limited to, reports of investigations  
21 concerning fraud or misrepresentation, and necessary  
22 consents, releases, and assignments, or a claim on appeal.

23 SEC. 3. Section 11512.180 of the Insurance Code is  
24 amended to read:

25 11512.180. Every nonprofit hospital service plan that  
26 covers hospital, medical, or surgical expenses on a group  
27 or individual basis shall reimburse claims or any portion  
28 of any claim, whether in state or out of state, for such  
29 expenses, as soon as practical, but not later than 30  
30 working days after receipt of the claim by the hospital  
31 service plan, or if the plan is a health maintenance  
32 organization, 45 working days after receipt of the claim  
33 by the hospital service plan, unless the claim or portion  
34 thereof is contested by the plan in which case the  
35 claimant shall be notified, in writing, within 30 working  
36 days. The notice that a claim is being contested shall  
37 identify the portion of the claim that is contested and the  
38 specific reasons for contesting the claim.

39 If an uncontested claim is not reimbursed within the  
40 respective 30 or 45 working days after receipt, interest

1 shall accrue at the rate of 10 percent per annum  
2 beginning with the first calendar day after the 30 or 45  
3 ~~working day period. If a claim is contested in error,~~  
4 ~~interest shall accrue at the rate of 10 percent per annum~~  
5 ~~beginning with the first calendar day after the 30 or 45~~  
6 ~~working day period.~~

7 As used in this section, a contested claim, or portion  
8 thereof, includes situations in which the plan has not  
9 received the completed claim and all information  
10 necessary to determine payer liability for the claim,  
11 including but not limited to, reports of investigations  
12 concerning fraud or misrepresentation, and necessary  
13 consents, releases, and assignments, or a claim on appeal.

O

AMENDED IN SENATE AUGUST 21, 1989

AMENDED IN ASSEMBLY MAY 25, 1989

AMENDED IN ASSEMBLY MAY 10, 1989

CALIFORNIA LEGISLATURE—1989-90 REGULAR SESSION

**ASSEMBLY BILL**

**No. 865**

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---

Introduced by Assembly Member Wright

February 23, 1989

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---

An act to amend Section 1371 of, *and to add Section 1371.1 to*, the Health and Safety Code, and to amend Sections 10123.13 and 11512.180 of, *and to add Sections 10123.14 and 11512.181 to*, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 865, as amended, Wright. Health insurance: claim reimbursement.

Existing law, with respect to health care service plans, policies of disability insurance, self-insured employee welfare benefit plans, and nonprofit hospital service plans provide for claim reimbursement as soon as practical but no later than 30 working days after receipt of the claim unless contested, except that if a nonprofit hospital service plan or health care service plan is a health maintenance organization, reimbursement is required 45 days after receipt, unless the claim is contested. A claimant is required to be notified in writing within 30 working days if his or her claim is contested.

This bill would require the notice ~~that~~ *specify whether* the claim is being contested *or denied and* to identify the portion of the claim that is contested and the specific reasons for contesting. It would also provide that if an uncontested claim *or uncontested portion of a claim* is not reimbursed, *as specified*, within the time limitation, interest shall accrue, as

specified.

*The bill would also require, in the case of overpayment to an institutional or professional provider, reimbursement to the insurer or health care service plan, within certain time limits.*

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

*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 health care service plan which covers  
4 hospital, medical, or surgical expenses shall reimburse  
5 claims or any portion of any claim, whether in state or out  
6 of state, for those expenses, as soon as practical, but no  
7 later than 30 working days after receipt of the claim by  
8 the health care service plan, or if the health care service  
9 plan is a health maintenance organization, 45 working  
10 days after receipt of the claim by the health care service  
11 plan, unless the claim or portion thereof is contested by  
12 the plan in which case the claimant shall be notified, in  
13 writing, *that the claim is contested or denied*, within 30  
14 working days. The notice that a claim is being contested  
15 shall identify the portion of the claim that is contested  
16 and the specific reasons for contesting the claim.

17 ~~If an uncontested claim is not reimbursed within the~~  
18 *If an uncontested claim, or uncontested portion of the*  
19 *claim, is not reimbursed by delivery to the claimants'*  
20 *address of record within the respective 30 or 45 working*  
21 *days after receipt, interest shall accrue at the rate of 10*  
22 *percent per annum beginning with the first calendar day*  
23 *after the 30 or 45 working day period.*

24 ~~As used in this section, a contested claim, or portion~~  
25 ~~thereof, includes situations in which the plan has not~~  
26 ~~received the completed claim and all information~~  
27 ~~necessary to determine payer liability for the claim,~~  
28 ~~including, but not limited to, reports of investigations~~  
29 ~~concerning fraud and misrepresentation, and necessary~~  
30 ~~consents, releases, and assignments, or a claim on appeal.~~

1     *For the purposes of this section, a claim, or portion*  
2 *thereof, is reasonably contested where the plan has not*  
3 *received the completed claim and all information*  
4 *necessary to determine payer liability for the claim.*  
5 *Information necessary to determine payer liability for the*  
6 *claim includes, but is not limited to, reports of*  
7 *investigations concerning fraud and misrepresentation,*  
8 *and necessary consents, releases, and assignments, a*  
9 *claim on appeal, or other information necessary for the*  
10 *plan to determine the medical necessity for the health*  
11 *care services provided.*

12     *SEC. 1.5. Section 1371.1 is added to the Health and*  
13 *Safety Code, to read:*

14     *1371.1. Whenever a health care service plan which*  
15 *covers hospital, medical, or surgical expenses determines*  
16 *that in reimbursing a claim for provider services an*  
17 *institutional or professional provider has been overpaid,*  
18 *and then notifies the provider in writing through a*  
19 *separate notice identifying the overpayment and the*  
20 *amount of the overpayment, the provider shall*  
21 *reimburse the health care service plan within 30 working*  
22 *days of receipt by the provider of the notice of*  
23 *overpayment unless the overpayment or portion thereof*  
24 *is contested by the provider in which case the health care*  
25 *service plan shall be notified, in writing, within 30*  
26 *working days. The notice that an overpayment is being*  
27 *contested shall identify the portion of the overpayment*  
28 *that is contested and the specific reasons for contesting*  
29 *the overpayment.*

30     *If the provider does not make reimbursement for an*  
31 *uncontested overpayment within 30 working days after*  
32 *receipt, interest shall accrue at the rate of 10 percent per*  
33 *annum beginning with the first calendar day after the 30*  
34 *working day period.*

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

37     *10123.13. Every insurer issuing group or individual*  
38 *policies of disability insurance and every self-insured*  
39 *employee welfare benefit plan which covers hospital,*  
40 *medical, or surgical expenses shall reimburse claims or*

1 any portion of any claim, whether in state or out of state,  
2 for such expenses, as soon as practical, but no later than  
3 30 working days after receipt of the claim by the insurer  
4 or plan unless the claim or portion thereof is contested by  
5 the insurer in which case the claimant shall be notified,  
6 in writing, *that the claim is contested or denied*, within  
7 30 working days. The notice that a claim is being  
8 contested shall identify the portion of the claim that is  
9 contested and the specific reasons for contesting the  
10 claim.

11 ~~If an uncontested claim is not reimbursed within 30~~  
12 *If an uncontested claim, or uncontested portion of the*  
13 *claim, is not reimbursed by delivery to the claimants'*  
14 *address of record within 30* working days after receipt,  
15 interest shall accrue at the rate of 10 percent per annum  
16 beginning with the first calendar day after the 30 working  
17 day period.

18 ~~As used in this section, a contested claim, or portion~~  
19 ~~thereof, includes situations in which the insurer or plan~~  
20 ~~has not received a completed claim and all information~~  
21 ~~necessary to determine payer liability for the claim,~~  
22 ~~including but not limited to, reports of investigations~~  
23 ~~concerning fraud or misrepresentation, and necessary~~  
24 ~~consents, releases, and assignments, or a claim on appeal.~~

25 *For purposes of this section, a claim, or portion thereof,*  
26 *is reasonably contested where the insurer or plan has not*  
27 *received a completed claim and all information necessary*  
28 *to determine payer liability for the claim. Information*  
29 *necessary to determine liability for the claims includes,*  
30 *but is not limited to, reports of investigations concerning*  
31 *fraud and misrepresentation, and necessary consents,*  
32 *releases, and assignments, a claim on appeal, or other*  
33 *information necessary for the insurer or plan to*  
34 *determine the medical necessity for the health care*  
35 *services provided to the claimant. This section does not*  
36 *apply to self-insured employee welfare benefit plans if*  
37 *the provisions are in conflict with the Employee*  
38 *Retirement Income Security Act of 1974 (29 U.S.C.A. Sec.*  
39 *1001 et seq.).*

40 *SEC. 2.5. Section 10123.14 is added to the Insurance*

1 Code, to read:

2 10123.14. Whenever an insurer issuing group or  
3 individual policies of disability insurance or a self-insured  
4 employee welfare benefit plan which covers hospital,  
5 medical, or surgical expenses determines that in  
6 reimbursing a claim for provider services an institutional  
7 or professional provider has been overpaid, and then  
8 notifies the provider in writing through a separate notice  
9 identifying the overpayment and the amount of the  
10 overpayment, the provider shall reimburse the insurer or  
11 self-insured welfare benefit plan within 30 working days  
12 of receipt by the provider of the notice of overpayment  
13 unless the overpayment or portion thereof is contested  
14 by the provider in which case the insurer or self-insured  
15 welfare benefit plan shall be notified, in writing, within  
16 30 working days. The notice that an overpayment is being  
17 contested shall identify the portion of the overpayment  
18 that is contested and the specific reasons for contesting  
19 the overpayment.

20 If the provider does not make reimbursement for an  
21 uncontested overpayment within 30 working days after  
22 receipt, interest shall accrue at the rate of 10 percent per  
23 annum beginning with the first calendar day after the 30  
24 working day period.

25 This section does not apply to overpayments by  
26 self-insured employee welfare benefit plans which are  
27 not subject to Section 10123.13.

28 SEC. 3. Section 11512.180 of the Insurance Code is  
29 amended to read:

30 11512.180. Every nonprofit hospital service plan that  
31 covers hospital, medical, or surgical expenses on a group  
32 or individual basis shall reimburse claims or any portion  
33 of any claim, whether in state or out of state, for such  
34 expenses, as soon as practical, but not later than 30  
35 working days after receipt of the claim by the hospital  
36 service plan, or if the plan is a health maintenance  
37 organization, 45 working days after receipt of the claim  
38 by the hospital service plan, unless the claim or portion  
39 thereof is contested by the plan in which case the  
40 claimant shall be notified, in writing, that the claim is

1 *contested or denied*, within 30 working days. The notice  
2 that a claim is being contested shall identify the portion  
3 of the claim that is contested and the specific reasons for  
4 contesting the claim.

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

12 ~~As used in this section, a contested claim, or portion~~  
13 ~~thereof, includes situations in which the plan has not~~  
14 ~~received the completed claim and all information~~  
15 ~~necessary to determine payer liability for the claim,~~  
16 ~~including but not limited to, reports of investigations~~  
17 ~~concerning fraud or misrepresentation, and necessary~~  
18 ~~consents, releases, and assignments, or a claim on appeal.~~

19 *For purposes of this section, a claim, or portion thereof,*  
20 *is reasonably contested where the plan has not received*  
21 *the completed claim and all information necessary to*  
22 *determine payer liability for the claim. Information*  
23 *necessary to determine liability includes, but is not*  
24 *limited to, reports of investigations concerning fraud and*  
25 *misrepresentation, and necessary consents, releases, and*  
26 *assignments, a claim on appeal, or other information*  
27 *necessary for the insurer to determine the medical*  
28 *necessity for the health care services provided to the*  
29 *claimant.*

30 *SEC. 3.5. Section 11512.181 is added to the Insurance*  
31 *Code, to read:*

32 *11512.181. Whenever a nonprofit hospital service*  
33 *plan which covers hospital, medical, or surgical expenses*  
34 *determines that in reimbursing a claim for provider*  
35 *services an institutional or professional provider has been*  
36 *overpaid, and then notifies the provider in writing*  
37 *through a separate notice identifying the overpayment*  
38 *and the amount of the overpayment, the provider shall*  
39 *reimburse the nonprofit hospital service plan within 30*  
40 *working days of receipt by the provider of the notice of*

1 *overpayment unless the overpayment or portion thereof*  
2 *is contested by the provider in which case the nonprofit*  
3 *hospital service plan shall be notified, in writing, within*  
4 *30 working days. The notice that an overpayment is being*  
5 *contested shall identify the portion of the overpayment*  
6 *that is contested and the specific reasons for contesting*  
7 *the overpayment.*

8 *If the provider does not make reimbursement for an*  
9 *uncontested overpayment within 30 working days after*  
10 *receipt, interest shall accrue at the rate of 10 percent per*  
11 *annum beginning with the first calendar day after the 30*  
12 *working day period.*

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AMENDED IN SENATE AUGUST 30, 1989

AMENDED IN SENATE AUGUST 21, 1989

AMENDED IN ASSEMBLY MAY 25, 1989

AMENDED IN ASSEMBLY MAY 10, 1989

CALIFORNIA LEGISLATURE—1989-90 REGULAR SESSION

**ASSEMBLY BILL**

**No. 865**

**Introduced by Assembly Member Wright**

**February 23, 1989**

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An act to amend Section 1371 of, and to add Section 1371.1 to, the Health and Safety Code, and to amend Sections 10123.13 and 11512.180 of, and to add Sections 10123.14 and 11512.181 to, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 865, as amended, Wright. Health insurance: claim reimbursement.

Existing law, with respect to health care service plans, policies of disability insurance, ~~self-insured employee welfare benefit plans~~, and nonprofit hospital service plans provide for claim reimbursement as soon as practical but no later than 30 working days after receipt of the claim unless contested, except that if a nonprofit hospital service plan or health care service plan is a health maintenance organization, reimbursement is required 45 days after receipt, unless the claim is contested. A claimant is required to be notified in writing within 30 working days if his or her claim is contested.

This bill would require the notice specify whether the claim is being contested or denied and to identify the portion of the claim that is contested and the specific reasons for contesting. It would also provide that if an uncontested claim ~~or uncontested portion of a claim~~ is not reimbursed, as specified,

within the time limitation, interest shall accrue, as specified.

The bill would also require, in the case of overpayment to an institutional or professional provider, reimbursement to the insurer or health care service plan, within certain time limits.

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

*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 health care service plan which covers  
4 hospital, medical, or surgical expenses shall reimburse  
5 claims or any portion of any claim, whether in state or out  
6 of state, for those expenses, as soon as practical, but no  
7 later than 30 working days after receipt of the claim by  
8 the health care service plan, or if the health care service  
9 plan is a health maintenance organization, 45 working  
10 days after receipt of the claim by the health care service  
11 plan, unless the claim or portion thereof is contested by  
12 the plan in which case the claimant shall be notified, in  
13 writing, that the claim is contested or denied, within 30  
14 working days *after receipt of the claim by the health care*  
15 *service plan, or if the health care service plan is a health*  
16 *maintenance organization, 45 working days after receipt*  
17 *of the claim by the health care service plan.* The notice  
18 that a claim is being contested shall identify the portion  
19 of the claim that is contested and the specific reasons for  
20 contesting the claim.

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

27 For the purposes of this section, a claim, or portion  
28 thereof, is reasonably contested where the plan has not  
29 received the completed claim and all information  
30 necessary to determine payer liability for the claim, *or*

1 *has not been granted reasonable access to information*  
2 *concerning provider services.* Information necessary to  
3 determine payer liability for the claim includes, but is not  
4 limited to, reports of investigations concerning fraud and  
5 misrepresentation, and necessary consents, releases, and  
6 assignments, a claim on appeal, or other information  
7 necessary for the plan to determine the medical necessity  
8 for the health care services provided.

9 SEC. 1.5. Section 1371.1 is added to the Health and  
10 Safety Code, to read:

11 1371.1. Whenever a health care service plan which  
12 covers hospital, medical, or surgical expenses determines  
13 that in reimbursing a claim for provider services an  
14 institutional or professional provider has been overpaid,  
15 and then notifies the provider in writing through a  
16 separate notice identifying the overpayment and the  
17 amount of the overpayment, the provider shall  
18 reimburse the health care service plan within 30 working  
19 days of receipt by the provider of the notice of  
20 overpayment unless the overpayment or portion thereof  
21 is contested by the provider in which case the health care  
22 service plan shall be notified, in writing, within 30  
23 working days. The notice that an overpayment is being  
24 contested shall identify the portion of the overpayment  
25 that is contested and the specific reasons for contesting  
26 the overpayment.

27 If the provider does not make reimbursement for an  
28 uncontested overpayment within 30 working days after  
29 receipt, interest shall accrue at the rate of 10 percent per  
30 annum beginning with the first calendar day after the 30  
31 working day period.

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

34 10123.13. Every insurer issuing group or individual  
35 policies of disability insurance ~~and every self-insured~~  
36 ~~employee welfare benefit plan~~ which covers hospital,  
37 medical, or surgical expenses shall reimburse claims or  
38 any portion of any claim, whether in state or out of state,  
39 for such expenses, as soon as practical, but no later than  
40 30 working days after receipt of the claim by the insurer

1 ~~or plan~~ unless the claim or portion thereof is contested by  
2 the insurer in which case the claimant shall be notified,  
3 in writing, that the claim is contested or denied, within  
4 30 working days *after receipt of the claim by the insurer.*  
5 The notice that a claim is being contested shall identify  
6 the portion of the claim that is contested and the specific  
7 reasons for contesting the claim.

8 If an uncontested claim ; ~~or uncontested portion of the~~  
9 ~~claim;~~ is not reimbursed by delivery to the claimants'  
10 address of record within 30 working days after receipt,  
11 interest shall accrue at the rate of 10 percent per annum  
12 beginning with the first calendar day after the 30 working  
13 day period.

14 For purposes of this section, a claim, or portion thereof,  
15 is reasonably contested where the insurer ~~or plan~~ has not  
16 received a completed claim and all information necessary  
17 to determine payer liability for the claim , *or has not been*  
18 *granted reasonable access to information concerning*  
19 *provider services.* Information necessary to determine  
20 liability for the claims includes, but is not limited to,  
21 reports of investigations concerning fraud and  
22 misrepresentation, and necessary consents, releases, and  
23 assignments, a claim on appeal, or other information  
24 necessary for the insurer ~~or plan~~ to determine the  
25 medical necessity for the health care ~~services provided to~~  
26 ~~the claimant.~~ ~~This section does not apply to self/insured~~  
27 ~~employee welfare benefit plans if the provisions are in~~  
28 ~~conflict with the Employee Retirement Income Security~~  
29 ~~Act of 1974 (29 U.S.C.A. Sec. 1001 et seq.); services~~  
30 *provided to the claimant.*

31 SEC. 2.5. Section 10123.14 is added to the Insurance  
32 Code, to read:

33 10123.14. Whenever an insurer issuing group or  
34 individual policies of disability insurance ~~or a self/insured~~  
35 ~~employee welfare benefit plan~~ which covers hospital,  
36 medical, or surgical expenses determines that in  
37 reimbursing a claim for provider services an institutional  
38 or professional provider has been overpaid, and then  
39 notifies the provider in writing through a separate notice  
40 identifying the overpayment and the amount of the

1 overpayment, the provider shall reimburse the insurer ~~or~~  
2 ~~self/insured welfare benefit plan~~ within 30 working days  
3 of receipt by the provider of the notice of overpayment  
4 unless the overpayment or portion thereof is contested  
5 by the provider in which case the insurer ~~or self/insured~~  
6 ~~welfare benefit plan~~ shall be notified, in writing, within  
7 30 working days. The notice that an overpayment is being  
8 contested shall identify the portion of the overpayment  
9 that is contested and the specific reasons for contesting  
10 the overpayment.

11 If the provider does not make reimbursement for an  
12 uncontested overpayment within 30 working days after  
13 receipt, interest shall accrue at the rate of 10 percent per  
14 annum beginning with the first calendar day after the 30  
15 working day period.

16 ~~This section does not apply to overpayments by~~  
17 ~~self/insured employee welfare benefit plans which are~~  
18 ~~not subject to Section 10123.13.~~

19 SEC. 3. Section 11512.180 of the Insurance Code is  
20 amended to read:

21 11512.180. Every nonprofit hospital service plan that  
22 covers hospital, medical, or surgical expenses on a group  
23 or individual basis shall reimburse claims or any portion  
24 of any claim, whether in state or out of state, for such  
25 expenses, as soon as practical, but not later than 30  
26 working days after receipt of the claim by the hospital  
27 service plan, or if the plan is a health maintenance  
28 organization, 45 working days after receipt of the claim  
29 by the hospital service plan, unless the claim or portion  
30 thereof is contested by the plan in which case the  
31 claimant shall be notified, in writing, that the claim is  
32 contested or denied, within 30 working days *after receipt*  
33 *of the claim by the nonprofit hospital service plan, or if*  
34 *the plan is a health maintenance organization, 45 working*  
35 *days after receipt of the claim by the nonprofit hospital*  
36 *service plan.* The notice that a claim is being contested  
37 shall identify the portion of the claim that is contested  
38 and the specific reasons for contesting the claim.

39 If an uncontested claim ; ~~or uncontested portion of the~~  
40 ~~claim,~~ is not reimbursed by delivery to the claimants'

1 address of record within the respective 30 or 45 working  
2 days after receipt, interest shall accrue at the rate of 10  
3 percent per annum beginning with the first calendar day  
4 after the 30 or 45 working day period.

5 For purposes of this section, a claim, or portion thereof,  
6 is reasonably contested where the plan has not received  
7 the completed claim and all information necessary to  
8 determine payer liability for the claim, *or has not been*  
9 *granted reasonable access to information concerning*  
10 *provider services*. Information necessary to determine  
11 liability includes, but is not limited to, reports of  
12 investigations concerning fraud and misrepresentation,  
13 and necessary consents, releases, and assignments, a  
14 claim on appeal, or other information necessary for the  
15 insurer to determine the medical necessity for the health  
16 care services provided to the claimant.

17 SEC. 3.5. Section 11512.181 is added to the Insurance  
18 Code, to read:

19 11512.181. Whenever a nonprofit hospital service  
20 plan which covers hospital, medical, or surgical expenses  
21 determines that in reimbursing a claim for provider  
22 services an institutional or professional provider has been  
23 overpaid, and then notifies the provider in writing  
24 through a separate notice identifying the overpayment  
25 and the amount of the overpayment, the provider shall  
26 reimburse the nonprofit hospital service plan within 30  
27 working days of receipt by the provider of the notice of  
28 overpayment unless the overpayment or portion thereof  
29 is contested by the provider in which case the nonprofit  
30 hospital service plan shall be notified, in writing, within  
31 30 working days. The notice that an overpayment is being  
32 contested shall identify the portion of the overpayment  
33 that is contested and the specific reasons for contesting  
34 the overpayment.

35 If the provider does not make reimbursement for an  
36 uncontested overpayment within 30 working days after  
37 receipt, interest shall accrue at the rate of 10 percent per  
38 annum beginning with the first calendar day after the 30  
39 working day period.

AMENDED IN SENATE SEPTEMBER 11, 1989

AMENDED IN SENATE AUGUST 30, 1989

AMENDED IN SENATE AUGUST 21, 1989

AMENDED IN ASSEMBLY MAY 25, 1989

AMENDED IN ASSEMBLY MAY 10, 1989

CALIFORNIA LEGISLATURE—1989-90 REGULAR SESSION

**ASSEMBLY BILL**

**No. 865**

*chapter 968*

**Introduced by Assembly Member Wright**

February 23, 1989

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An act to amend Section 1371 of, and to add Section 1371.1 to, the Health and Safety Code, and to amend Sections 10123.13 and 11512.180 of, and to add Sections ~~10123.14~~ *10123.145* and 11512.181 to, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 865, as amended, Wright. Health insurance: claim reimbursement.

Existing law, with respect to health care service plans, policies of disability insurance, and nonprofit hospital service plans provide for claim reimbursement as soon as practical but no later than 30 working days after receipt of the claim unless contested, except that if a nonprofit hospital service plan or health care service plan is a health maintenance organization, reimbursement is required 45 days after receipt, unless the claim is contested. A claimant is required to be notified in writing within 30 working days if his or her claim is contested.

This bill would require the notice specify whether the claim is being contested or denied and to identify the portion of the

claim that is contested and the specific reasons for contesting. It would also provide that if an uncontested claim is not reimbursed, as specified, within the time limitation, interest shall accrue, as specified.

The bill would also require, in the case of overpayment to an institutional or professional provider, reimbursement to the insurer or health care service plan, within certain time limits.

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

*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 health care service plan which covers  
4 hospital, medical, or surgical expenses shall reimburse  
5 claims or any portion of any claim, whether in state or out  
6 of state, for those expenses, as soon as practical, but no  
7 later than 30 working days after receipt of the claim by  
8 the health care service plan, or if the health care service  
9 plan is a health maintenance organization, 45 working  
10 days after receipt of the claim by the health care service  
11 plan, unless the claim or portion thereof is contested by  
12 the plan in which case the claimant shall be notified, in  
13 writing, that the claim is contested or denied, within 30  
14 working days after receipt of the claim by the health care  
15 service plan, or if the health care service plan is a health  
16 maintenance organization, 45 working days after receipt  
17 of the claim by the health care service plan. The notice  
18 that a claim is being contested shall identify the portion  
19 of the claim that is contested and the specific reasons for  
20 contesting the claim.

21 If an uncontested claim is not reimbursed by delivery  
22 to the claimants' address of record within the respective  
23 30 or 45 working days after receipt, interest shall accrue  
24 at the rate of 10 percent per annum beginning with the  
25 first calendar day after the 30 or 45 working day period.

26 For the purposes of this section, a claim, or portion  
27 thereof, is reasonably contested where the plan has not

1 received the completed claim and all information  
2 necessary to determine payer liability for the claim, or  
3 has not been granted reasonable access to information  
4 concerning provider services. Information necessary to  
5 determine payer liability for the claim includes, but is not  
6 limited to, reports of investigations concerning fraud and  
7 misrepresentation, and necessary consents, releases, and  
8 assignments, a claim on appeal, or other information  
9 necessary for the plan to determine the medical necessity  
10 for the health care services provided.

11 SEC. 1.5. Section 1371.1 is added to the Health and  
12 Safety Code, to read:

13 1371.1. Whenever a health care service plan which  
14 covers hospital, medical, or surgical expenses determines  
15 that in reimbursing a claim for provider services an  
16 institutional or professional provider has been overpaid,  
17 and then notifies the provider in writing through a  
18 separate notice identifying the overpayment and the  
19 amount of the overpayment, the provider shall  
20 reimburse the health care service plan within 30 working  
21 days of receipt by the provider of the notice of  
22 overpayment unless the overpayment or portion thereof  
23 is contested by the provider in which case the health care  
24 service plan shall be notified, in writing, within 30  
25 working days. The notice that an overpayment is being  
26 contested shall identify the portion of the overpayment  
27 that is contested and the specific reasons for contesting  
28 the overpayment.

29 If the provider does not make reimbursement for an  
30 uncontested overpayment within 30 working days after  
31 receipt, interest shall accrue at the rate of 10 percent per  
32 annum beginning with the first calendar day after the 30  
33 working day period.

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

36 10123.13. Every insurer issuing group or individual  
37 policies of disability insurance which covers hospital,  
38 medical, or surgical expenses shall reimburse claims or  
39 any portion of any claim, whether in state or out of state,  
40 for such expenses, as soon as practical, but no later than

1 30 working days after receipt of the claim by the insurer  
2 unless the claim or portion thereof is contested by the  
3 insurer in which case the claimant shall be notified, in  
4 writing, that the claim is contested or denied, within 30  
5 working days after receipt of the claim by the insurer.  
6 The notice that a claim is being contested shall identify  
7 the portion of the claim that is contested and the specific  
8 reasons for contesting the claim.

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

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

27 SEC. 2.5. Section ~~10123.14~~ 10123.145 is added to the  
28 Insurance Code, to read:

29 ~~10123.14.~~

30 10123.145. Whenever an insurer issuing group or  
31 individual policies of disability insurance which covers  
32 hospital, medical, or surgical expenses determines that in  
33 reimbursing a claim for provider services an institutional  
34 or professional provider has been overpaid, and then  
35 notifies the provider in writing through a separate notice  
36 identifying the overpayment and the amount of the  
37 overpayment, the provider shall reimburse the insurer  
38 within 30 working days of receipt by the provider of the  
39 notice of overpayment unless the overpayment or  
40 portion thereof is contested by the provider in which case

1 the insurer shall be notified, in writing, within 30 working  
2 days. The notice that an overpayment is being contested  
3 shall identify the portion of the overpayment that is  
4 contested and the specific reasons for contesting the  
5 overpayment.

6 If the provider does not make reimbursement for an  
7 uncontested overpayment within 30 working days after  
8 receipt, interest shall accrue at the rate of 10 percent per  
9 annum beginning with the first calendar day after the 30  
10 working day period.

11 SEC. 3. Section 11512.180 of the Insurance Code is  
12 amended to read:

13 11512.180. Every nonprofit hospital service plan that  
14 covers hospital, medical, or surgical expenses on a group  
15 or individual basis shall reimburse claims or any portion  
16 of any claim, whether in state or out of state, for such  
17 expenses, as soon as practical, but not later than 30  
18 working days after receipt of the claim by the hospital  
19 service plan, or if the plan is a health maintenance  
20 organization, 45 working days after receipt of the claim  
21 by the hospital service plan, unless the claim or portion  
22 thereof is contested by the plan in which case the  
23 claimant shall be notified, in writing, that the claim is  
24 contested or denied, within 30 working days after receipt  
25 of the claim by the nonprofit hospital service plan, or if  
26 the plan is a health maintenance organization, 45 working  
27 days after receipt of the claim by the nonprofit hospital  
28 service plan. The notice that a claim is being contested  
29 shall identify the portion of the claim that is contested  
30 and the specific reasons for contesting the claim.

31 If an uncontested claim is not reimbursed by delivery  
32 to the claimants' address of record within the respective  
33 30 or 45 working days after receipt, interest shall accrue  
34 at the rate of 10 percent per annum beginning with the  
35 first calendar day after the 30 or 45 working day period.

36 For purposes of this section, a claim, or portion thereof,  
37 is reasonably contested where the plan has not received  
38 the completed claim and all information necessary to  
39 determine payer liability for the claim, or has not been  
40 granted reasonable access to information concerning

1 provider services. Information necessary to determine  
2 liability includes, but is not limited to, reports of  
3 investigations concerning fraud and misrepresentation,  
4 and necessary consents, releases, and assignments, a  
5 claim on appeal, or other information necessary for the  
6 insurer to determine the medical necessity for the health  
7 care services provided to the claimant.

8 SEC. 3.5. Section 11512.181 is added to the Insurance  
9 Code, to read:

10 11512.181. Whenever a nonprofit hospital service  
11 plan which covers hospital, medical, or surgical expenses  
12 determines that in reimbursing a claim for provider  
13 services an institutional or professional provider has been  
14 overpaid, and then notifies the provider in writing  
15 through a separate notice identifying the overpayment  
16 and the amount of the overpayment, the provider shall  
17 reimburse the nonprofit hospital service plan within 30  
18 working days of receipt by the provider of the notice of  
19 overpayment unless the overpayment or portion thereof  
20 is contested by the provider in which case the nonprofit  
21 hospital service plan shall be notified, in writing, within  
22 30 working days. The notice that an overpayment is being  
23 contested shall identify the portion of the overpayment  
24 that is contested and the specific reasons for contesting  
25 the overpayment.

26 If the provider does not make reimbursement for an  
27 uncontested overpayment within 30 working days after  
28 receipt, interest shall accrue at the rate of 10 percent per  
29 annum beginning with the first calendar day after the 30  
30 working day period.

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## Assembly Bill No. 865

### CHAPTER 968

An act to amend Section 1371 of, and to add Section 1371.1 to, the Health and Safety Code, and to amend Sections 10123.13 and 11512.180 of, and to add Sections 10123.145 and 11512.181 to, the Insurance Code, relating to insurance.

[Approved by Governor September 29, 1989. Filed with Secretary of State September 29, 1989.]

#### LEGISLATIVE COUNSEL'S DIGEST

AB 865, Wright. Health insurance: claim reimbursement.

Existing law, with respect to health care service plans, policies of disability insurance, and nonprofit hospital service plans provide for claim reimbursement as soon as practical but no later than 30 working days after receipt of the claim unless contested, except that if a nonprofit hospital service plan or health care service plan is a health maintenance organization, reimbursement is required 45 days after receipt, unless the claim is contested. A claimant is required to be notified in writing within 30 working days if his or her claim is contested.

This bill would require that the notice specify whether the claim is being contested or denied and to identify the portion of the claim that is contested and the specific reasons for contesting. It would also provide that if an uncontested claim is not reimbursed, as specified, within the time limitation, interest shall accrue, as specified.

The bill would also require, in the case of overpayment to an institutional or professional provider, reimbursement to the insurer or health care service plan, within certain time limits.

*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 which covers hospital, medical, or surgical expenses 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 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.

SEC. 1.5. Section 1371.1 is added to the Health and Safety Code, to read:

1371.1. Whenever a health care service plan which covers hospital, medical, or surgical expenses determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the health care service plan within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the health care service plan shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

If the provider does not make reimbursement for an uncontested overpayment 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.

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.

SEC. 2.5. Section 10123.145 is added to the Insurance Code, to read:

10123.145. Whenever an insurer issuing group or individual policies of disability insurance which covers hospital, medical, or surgical expenses determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the insurer within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the insurer shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

If the provider does not make reimbursement for an uncontested overpayment 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.

SEC. 3. Section 11512.180 of the Insurance Code is amended to read:

11512.180. Every nonprofit hospital service plan that covers hospital, medical, or surgical expenses on a group or individual basis shall reimburse claims or any portion of any claim, whether in state or out of state, for such expenses, as soon as practical, but not later than 30 working days after receipt of the claim by the hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the hospital 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

nonprofit hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the nonprofit hospital 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 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 liability 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.

SEC. 3.5. Section 11512.181 is added to the Insurance Code, to read:

11512.181. Whenever a nonprofit hospital service plan which covers hospital, medical, or surgical expenses determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the nonprofit hospital service plan within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the nonprofit hospital service plan shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

If the provider does not make reimbursement for an uncontested overpayment 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.

VOLUME 1  
CALIFORNIA LEGISLATURE  
AT SACRAMENTO  
1989-90 REGULAR SESSION  
1989-90 FIRST EXTRAORDINARY SESSION

ASSEMBLY FINAL HISTORY

SYNOPSIS OF  
ASSEMBLY BILLS, CONSTITUTIONAL AMENDMENTS, CONCURRENT,  
JOINT, AND HOUSE RESOLUTIONS

Assembly Convened December 5, 1988

Recessed December 6, 1988	Reconvened January 3, 1989
Recessed March 16, 1989	Reconvened March 27, 1989
Recessed July 20, 1989	Reconvened August 21, 1989
Recessed September 15, 1989	Reconvened November 4, 1989
Recessed November 4, 1989	Reconvened January 3, 1990
Recessed April 5, 1990	Reconvened April 16, 1990
Recessed July 28, 1990	Reconvened August 6, 1990

Adjourned September 1, 1990  
Adjourned Sine Die November 30, 1990

Legislative Days..... 264

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HON WILLIE L BROWN  
*Speaker*

HON MIKE ROOS  
*Speaker pro Tempore*

HON THOMAS HANNIGAN  
*Majority Floor Leader*

HON. JACK O'CONNELL  
*Assistant Speaker pro Tempore*

HON. ROSS JOHNSON  
*Minority Floor Leader*

*Compiled Under the Direction of*  
R. BRIAN KIDNEY  
*Chief Clerk*

GUNVOR L ENGLE  
*History Clerk*

## A.B. No. 865—Wright.

An act to amend Section 1371 of, and to add Section 1371 1 to, the Health and Safety Code, and to amend Sections 10123.13 and 11512 180 of, and to add Sections 10123 145 and 11512 181 to, the Insurance Code, relating to insurance

1989

- Feb 23—Read first time. To print.
- Feb 24—From printer. May be heard in committee March 26
- Mar 2—Referred to Com. on FIN. & INS.
- May 10—From committee chairman, with author's amendments: Amend, and re-refer to Com. on FIN. & INS Read second time and amended
- May 11—Re-referred to Com. on FIN & INS
- May 24—From committee Amend, and do pass as amended (Ayes 18. Noes 0 ) (May 23)
- May 25—Read second time and amended. Ordered returned to second reading.
- May 26—Read second time To third reading
- June 7—Read third time, passed, and to Senate (Ayes 64 Noes 1 Page 2312 )
- June 7—In Senate Read first time To Com on RLS for assignment
- June 15—Referred to Com on INS , CL & CORPS
- Aug. 21—From committee chairman, with author's amendments Amend, and re-refer to committee Read second time, amended, and re-referred to Com on INS , CL & CORPS
- Aug 29—From committee: Amend, and do pass as amended (Ayes 6 Noes 0 )
- Aug 30—Read second time, amended, and to third reading
- Sept 8—To inactive file - Senate Rule 29
- Sept 11—From inactive file Read second time, amended, and to third reading.
- Sept 13—Read third time, passed, and to Assembly (Ayes 26 Noes 2 Page 3904.)
- Sept 13—In Assembly Concurrence in Senate amendments pending
- Sept 14—Senate amendments concurred in. To enrollment. (Ayes 75 Noes 0 Page 4924 )
- Sept 19—Enrolled and to the Governor at 1 p m
- Sept. 29—Approved by the Governor
- Sept 29—Chaptered by Secretary of State - Chapter 968, Statutes of 1989

## A.B. No. 866—Floyd (Senator Dills, coauthor).

An act to amend Section 6253 of, and to add Section 6269 to, the Government Code, relating to public information.

1989

- Feb 23—Read first time. To print
- Feb 24—From printer May be heard in committee March 26
- Mar 2—Referred to Com on G O
- Mar 27—From committee chairman, with author's amendments Amend, and re-refer to Com. on G O Read second time and amended
- Mar 28—Re-referred to Com on G O
- April 5—In committee Hearing postponed by committee.

1990

- Jan. 3—From committee chairman, with author's amendments Amend, and re-refer to Com on G O Read second time and amended
- Jan 4—Re-referred to Com on G O
- Jan 8—Joint Rule 61 suspended
- Jan 17—In committee Set, first hearing. Hearing canceled at the request of author
- Jan 30—From committee Filed with the Chief Clerk pursuant to Joint Rule 56 Died pursuant to Art. IV, Sec. 10(a) of the Constitution.



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To Gov

JACK I. HORTON  
ALAN MACKAY  
CHIEF DEPUTIES

JAMES L. ASHFORD  
JERRY L. SABBETT  
STANLEY M. LOURIMORE  
JOHN T. STUDBAKER  
JAMES WING

DAVID D. ALVES  
JOHN A. CORZINE  
C. DAVID DICKERSON  
ROBERT CULLEN DUFFY  
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# Legislative Counsel of California

BION M. GREGORY

Sacramento, California

September 25, 1989

Honorable George Deukmejian  
Governor of California  
Sacramento, CA 95814

Assembly Bill No. 805

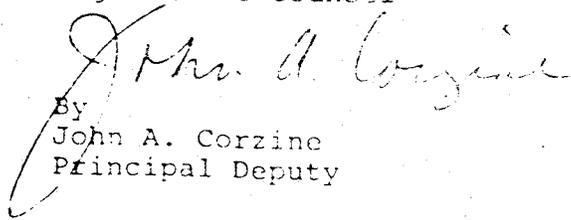
Dear Governor Deukmejian:

Pursuant to your request, we have reviewed the  
above-numbered bill authored by Assembly Member Wright  
and, in our opinion, the title and form are sufficient and  
the bill, if chaptered, will be constitutional. The digest  
on the printed bill as adopted correctly reflects the views  
of this office.

Very truly yours,

Bion M. Gregory  
Legislative Counsel

By  
John A. Corzine  
Principal Deputy



JAC:wld

Two copies to Honorable Cathie Wright  
pursuant to Joint Rule 34.

GERALD ROSS ADAMS  
MARTIN L. ANDERSON  
PAUL ANTELLA  
DANA B. APRILS  
CHARLES C. ASBILL  
JOE J. AYALA  
RANSOME P. BEAULIE  
DANIEL P. BOYER  
ANSELMO L. BUDD  
SILVER J. BURTON  
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MICHAEL J. KLOTZEN  
L. DOUGLAS KENNEDY  
S. LYONS KLEIN  
VICTOR KODOLSKI  
EVE S. KROTTENBER  
DIANA G. LIM  
RONALD I. LOPEZ  
KIRK S. LOUIS  
ANTHONY P. MARQUEZ  
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MARY SHAW  
WILLIAM K. STARR  
MARK FRANKLIN TERRY  
JEFF THOMAS  
MICHAEL H. UPPSON  
RICHARD B. WEISSBERG  
DANIEL A. WETZMAN  
THOMAS D. WHELAN  
JANA T. WHITTINGTON  
DOBRA J. WILSON  
CHRISTOPHER ZIMMER  
DEPUTIES

**ENROLLED BILL REPORT**

AGENCY		BILL NUMBER
HEALTH AND WELFARE AGENCY		AB 865
DEPARTMENT OR COMMISSION		AUTHOR
HEALTH		Wright

SUMMARY

Assembly Bill (AB) 865 requires health care service plans licensed under the Knox-Keene Act, insurance plans which provide disability insurance, and nonprofit hospital insurance plans licensed under the Insurance Code to pay a 10 percent per annum interest rate on uncontested claims not paid to their contracting providers within 30 to 45 working days, based on the type of plan. The bill also requires these plans to identify the portions of claims which are being contested and to state specific reasons for contesting the claim.

Background

AB 865 is sponsored by the California Association of Hospitals and Health Systems (CAHHS). The CAHHS sees a need to insure that health care plans pay their uncontested claims on time, and to compensate providers when payment is late.

Vote

	<u>Policy</u>	<u>Fiscal</u>	<u>Floor</u>
<u>Assembly</u>	18-0	N/A	64-1
<u>Senate</u>	6-0	N/A	26-2

Specific Findings

The Department of Health Services has opposed AB 865 because the bill requires plans to pay a ten percent per annum interest rate on uncontested claims, not paid to their contracting providers, without regard to current market interest rates and injects legislatively imposed penalties in what is essentially a business matter. The Department also saw a possibility that under AB 865 health care service plan costs would increase in a manner which could not be addressed by Medi-Cal in compensating plans operating under Medi-Cal contracts. Consequently, AB 865 could make the Medi-Cal contracting program less attractive to contractors. The health care service plan industry has not opposed this bill, however, and the Department of Corporations (DOC) (which licenses plans under the Knox-Keene Act) has taken a position of neutral on the bill. Since the industry has not opposed this bill, it is reasonable to presume that it will not generate significant costs for plans or place the plans in a disadvantageous position, relative to their transactions with providers. Consequently, the Department's concerns for Medi-Cal contractors are no longer at issue and the Department should defer to the industry position on the bill.

Pros and Cons

Pros: AB 865 creates monetary incentives for health care service plans to pay uncontested claims to their providers on time. This will help to eliminate provider cash flow problems.

7/24/89-1589  
RECOMMENDATION

Defer to Department of Corporations

DEPARTMENT DIRECTOR	DATE	AGENCY SECRETARY
<i>[Signature]</i>	9/16/89	<i>[Signature]</i>

DH-74 (3-74)

Cons: AB 865 injects statutory penalties in . . . t is essentially a business dispute.

Regulations

None.

Statutorily Mandated Report

None.

Fiscal Impact

None to the Department of Health Services.

Recommendation

Defer to the position of the Department of Corporations.

Since the health care service plan industry has not opposed AB 865, it is doubtful that the bill will impose significant costs or other disadvantages on the plans. This addresses the Department of Health Services concerns for Medi-Cal contractors.

Contact Person: Joseph A. Kelly

Work Phone: 327-1103

Home Phone: 1-663-4942

# ENROLLED BILL REPORT

Business, Transportation and Housing Agency

DEPARTMENT INSURANCE	AUTHOR WRIGHT	BILL NUMBER
SUBJECT HEALTH INSURANCE: CLAIM REIMBURSEMENT		AB 865

### SUMMARY

Requires the written notice to claimants, which is required when a claim is contested, to identify the portion of the claim which is at issue, and give specific reasons for contesting; provides for an interest penalty for late payment of uncontested claims and a time limit for repayment in the event a claim is overpaid.

### SPONSOR

This bill is sponsored by the California Association of Hospitals and Health Systems, although the author has a strong interest in the bill. Contact Jamie Kahn, 5-7676, in Assemblywoman Wright's office.

### IMPACT ASSESSMENT

Existing law requires insurers and health plans to notify a claimant in writing within 30 or 45 working days (depending on the type of organization) if a claim is being contested.

This bill would require the notice to identify the portion of the claim which is being contested, and to specify the reasons therefor.

This bill also enacts an interest penalty for late payment of uncontested claims, and provides that a lack of necessary information concerning a claim constitutes reasonable grounds to contest.

This bill also establishes notice requirements and a 30 day time limit for the return of amounts overpaid by payors to providers.

RECOMMENDATION

DEPARTMENT

DATE

AGENCY

ARGUMENT PRO

This bill is supported by a number of health providers.

Supporters contend, and this department's consumer services division agrees, that the notices required by existing law are inadequate because they do not provide the claimant with any information other than the fact that the claim is contested. The various payors have generally not included any reasons or specifications in the written notices.

Unless the claimant is placed on notice concerning the deficiencies in a claim, there is no reasonable opportunity to attempt to cure the problem, and satisfy the payor.

The interest penalty applies only to uncontested claims, and is needed to enforce existing law which requires payment to be made in either 30 or 45 days, depending on who the payor is.

ARGUMENT CON

(No formal opposition).

The interest penalty provision could have a counterproductive impact. If a payor is late in making payments, it may be a result of, or indication of, financial difficulties. Penalties will only exacerbate any such problems, and result in losses to claimants.

The requirement to specify reasons for contesting a claim may create difficulties in cases of suspected fraud.

RECOMMENDATION

The Department of Insurance recommends that the Governor SIGN AB 865.

EXPERT: ROXANI GILLESPIE  
ATSS: 8 597-9624

4.

ENROLLED BILL REPORT.

DEPARTMENT <b>CORPORATIONS</b>	AUTHOR <b>Wright</b>	JF:jw BILL NUMBER <b>AB 865</b>
SUBJECT <b>Health Insurance Claim Reimbursement</b>		

SUMMARY

Would: 1) require health care service plans, insurers and nonprofit hospital service plans to identify any portion of the claim that is contested and specify the reasons therefore; 2) specify circumstances when a claim is "reasonably contested"; 3) provide for 10 percent per annum interest on claims not timely paid; 4) add a new section providing for 10 percent per annum interest on overpayments not reimbursed to the HCSPs by providers in a timely manner.

SPONSOR

The bill is sponsored by the California Association of Hospitals and Health Systems.

IMPACT ASSESSMENT

The bill will impact the Knox-Keene Health Care Service Plan Act ("Knox-Keene") and various provisions of the Insurance Code. The interest of the Department of Corporations in the bill is limited to its impact on the Knox-Keene Act. The Department defers to the Department of Insurance on the balance of the bill.

Current law sets a deadline for payment of providers claims. In the case of federally licensed health maintenance organizations ("HMOs") which are also licensed as HCSPs, the deadline is 45 working days; for other HCSPs, payment is due in 30 working days. The bill retains those limitations, but, in addition, provides that if the statutory deadline is not met, interest shall accrue at the rate of 10 per cent per annum beginning with the first calendar day after the applicable period.

These penalties will not apply to contested claims. HCSPs must notify claimants within 30 working days after receipt of the claim (45 in the case of HMOs) if a claim is contested and identify the portion being contested and specify the reasons therefore.

The bill provides that a claim 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.

RECOMMENDATION

SIGN

Department Christine W. Bender Date 9-20-89 Agency

CHRISTINE W. BENDER  
Commissioner of Corporations

If an HCSP determines that an institutional or professional provider has been overpaid and notifies the provider of the overpayment in writing, the provider has 30 working days to pay back the overpayment or contest it, specifying the reasons. If a provider fails to make reimbursement for an uncontested overpayment after the 30-day period has expired, interest shall accrue at the rate of 10 percent per annum.

ARGUMENTS PRO AND CON

PRO: Proponents argue HCSPs and insurers delay payment of provider payments beyond the statutory deadline in order to collect extra interest on money which will be used to pay claims. They believe requiring HCSPs to pay interest if they do delay will encourage prompt payment.

CON: Failure to pay providers in a timely manner is sometimes a sign of financial troubles in HCSPs. Adding interest to the amount due will merely exacerbate those troubles.

RECOMMENDATION:

The Department of Corporations recommends the Governor SIGN this bill. To the extent the bill encourages timely payment of providers, it will result in continued accessibility and continuity of care for patients. Providers who aren't paid soon drop out of the provider network, disrupting the continuity of care to patients and leaving them without access to health care services.

+

# ENROLLED BILL REPORT

Analyst: Barry Hacker  
 Tel: 326-3689  
 Home Tel: 652-5947

<b>AGENCY:</b> STATE AND CONSUMER SERVICES AGENCY	<b>BILL NUMBER:</b> <div style="text-align: right;">AB 865</div>
<b>DEPARTMENT, BOARD OR COMMISSION:</b> PUBLIC EMPLOYEES' RETIREMENT SYSTEM	<b>AUTHOR:</b> <div style="text-align: right;">Wright</div>

**SUMMARY**

1 Description

**BACKGROUND**

- 2 History
- 3 Purpose
- 4 Sponsor
- 5 Current Practice
- 6 Implementation
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- 23 Absorption of Costs
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**RECOMMENDATION JUSTIFICATION**

- 38 Support
- 39 Oppose
- 40 Neutral
- 41 No Position
- 42 If Amended

**SUMMARY**

This bill would require that employee welfare benefit plans and nonprofit hospital services plans notice a claimant within 30 working days (or 45 days if the plan is a health maintenance organization) that a claim is being contested, identify the portion of the claim that is contested and specific reasons in contesting. This bill specifically exempts self-insured employee welfare benefit plans such as PERS-CARE. It would also provide that, if a noncontested or erroneously contested claim is not reimbursed within the time limitation (30 working days), interest shall accrue at the rate of 10% per annum beginning with the first calendar day after the 30 or 45 working-day period.

**BACKGROUND**

History. This bill is sponsored by the California Hospital Association. PERS has taken a support position on the bill.

Section 10123.13 of the Insurance Code requires insurers to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim by insurer unless the claim or portion thereof is contested. If contested, the claimant shall be notified in writing within 30 working days. The current PERS-Care self-insured plan requires that 85% properly completed claims will be processed in ten working days as reflected in a performance clause within the contract with the claims administrator.

This bill would require interest to be paid on uncontested claims not reimbursed within 30 or 45 working days after receipt.

The definition of a contested claim, or portion thereof, includes situations in which the insurer or plan has not received a completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim or appeal.

**FISCAL IMPACT ON STATE BUDGET**

Unknown. However, savings accrued by hospitals either through increased cash flows or by reducing the cash conversion cycle will ultimately be passed on to the consumer, i.e., PERS health program.

**VOTE:**

	Assembly	Partisan	Senate
	Y N	R D	
Floor:	Aye 75 No 0	( ) to ( )	Floor: Aye 26 No 2
Policy Committee:	Aye 18 No 0	( ) to ( )	Policy Committee: Aye 6 No 0
Fiscal Committee:	Aye 10 No 0	( ) to ( )	Fiscal Committee: Aye 5 No 0

**RECOMMENDATION TO GOVERNOR:**

SIGN    
  VETO    
  DEFER TO OTHER AGENCY

EXECUTIVE OFFICER: [Signature]    
 DATE: 9/19/89    
 AGENCY SECRETARY: [Signature]

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REPLY TO

SACRAMENTO ADDRESS  
STATE CAPITOL  
P.O. BOX 942849  
SACRAMENTO, CA 94249-0001  
(916) 445-7876

DISTRICT ADDRESS  
250 EAST EASY STREET, SUITE 7  
SUN VALLEY, CA 93085  
(805) 522-2920



# Assembly California Legislature

**CATHIE WRIGHT**  
MEMBER OF THE ASSEMBLY  
THIRTY-SEVENTH DISTRICT  
VICE-CHAIRWOMAN  
UTILITIES & COMMERCE

COMMITTEES  
ENVIRONMENTAL SAFETY  
AND TOXIC MATERIALS  
FINANCE & INSURANCE  
RULES  
UTILITIES & COMMERCE  
WAYS AND MEANS  
JT COMMITTEE ON  
QUINCENTENNIAL OF THE  
VOYAGES OF COLUMBUS  
COMMISSION ON STATUS  
OF WOMEN  
SELECT COMMISSION ON  
GANG VIOLENCE

September 20, 1989

The Honorable George Deukmejian  
Governor, State of California  
State Capitol  
Sacramento, CA 95814

Dear Governor:

This letter is to request your approval of Assembly Bill 865 relative to health insurance reimbursements.

This bill was sponsored by the California Association of Hospitals and Health Systems to simply require insurers to pay 10 percent interest on claims that are not paid within 30 days.

Current law requires insurers to reimburse claims within 30 days or 45 days for HMO's (Health Maintenance Organizations). The purpose of Assembly Bill 865 is to encourage compliance with this law by providing a deterrent for those who currently disregard it.

This bill also requires that claims being contested include the reason for contesting and the portion being contested.

After a number of negotiating sessions and a lot of compromising, the insurance companies are now neutral on AB 865. This bill is supported by the California Medical Association along with a number of medical care providers throughout the state.

I have received favorable reaction from my district for this bill and would very much appreciate your favorable consideration.

Sincerely,

CATHIE WRIGHT



## Legislative Research Incorporated

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# Author's File Materials

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STATEMENT FOR ASSEMBLY BILL 865

ASSEMBLY BILL 865 WILL SIMPLY REQUIRE INSURERS TO PAY 10 PERCENT INTEREST ON CLAIMS THAT ARE NOT PAID WITHIN 30 DAYS.

CURRENT LAW REQUIRES INSURERS TO REIMBURSE CLAIMS WITHIN 30 DAYS OR 45 DAYS FOR HMO'S (HEALTH MAINTENANCE ORGANIZATIONS). THE PURPOSE OF AB 865 IS ENCOURAGE COMPLIANCE WITH CURRENT LAW BY PROVIDING A DETERRENT FOR THOSE WHO DISREGARD CURRENT LAW.

THE BILL ALSO REQUIRES THAT CLAIMS BEING CONTESTED, INCLUDE THE REASON FOR CONTESTING AND THE PORTION BEING CONTESTED.

**STATEMENT ON AMENDMENTS TO ASSEMBLY BILL 865**

THE AMENDMENTS TO ASSEMBLY BILL 865 ARE NONSUBSTANTIVE AND MERELY DOUBLE JOIN THIS BILL WITH SENATE BILL 439 (ROBBINS) IN ORDER TO RESOLVE ANY POSSIBLE CHAPTERING OUT PROBLEMS.

STATEMENT ON AMENDMENTS TO ASSEMBLY BILL 865

THESE AMENDMENTS ARE TECHNICAL AND MERELY CLARIFY THAT THE POINT IN TIME AT WHICH THE 30 DAYS COMMENCES IS AFTER RECEIPT OF THE CLAIM BY THE HEALTH CARE SERVICE PLAN. THIS AMENDMENT RESPONDS TO A SUGGESTION MADE THE COMMITTEE STAFF.

THE OTHER AMENDMENTS CLARIFY THAT THE PROVISIONS OF THIS BILL DO NOT APPLY TO SELF INSURED EMPLOYEE WELFARE BENEFIT PLANS SINCE THESE PLANS ARE COVERED BY ERISA (THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974).

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THE BILL ALSO REQUIRES THAT CLAIMS BEING CONTESTED, INCLUDE THE REASON FOR CONTESTING AND THE PORTION BEING CONTESTED.

IN RESPONSE TO THE ANALYSIS, I WOULD LIKE TO OFFER AN AMENDMENT TO ELIMINATE LANGUAGE WHICH REFERS TO CLAIMS WHICH ARE CONTESTED IN ERROR. SPECIFICALLY, ON PAGE 2, ON LINE 21 ELIMINATE THE LAST SENTENCE. ON PAGE 3, LINE 12, ELIMINATE THE LAST SENTENCE. ON PAGE 4, LINE 4, ELIMINATE THE LAST SENTENCE.

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REPLY TO:

- SACRAMENTO ADDRESS  
STATE CAPITOL  
P.O. BOX 942849  
SACRAMENTO, CA 94249-0001  
(916) 445-7676
- DISTRICT ADDRESS  
250 EAST EASY STREET, SUITE 7  
SIMI VALLEY, CA 93065  
(805) 522-2920



# Assembly California Legislature

**CATHIE WRIGHT**

MEMBER OF THE ASSEMBLY  
THIRTY-SEVENTH DISTRICT

VICE-CHAIRWOMAN  
UTILITIES & COMMERCE

COMMITTEES  
ENVIRONMENTAL SAFETY  
AND TOXIC MATERIALS  
FINANCE & INSURANCE  
RULES  
UTILITIES & COMMERCE  
WAYS AND MEANS  
JT. COMMITTEE ON  
QUINCENTENNIAL OF THE  
VOYAGES OF COLUMBUS  
COMMISSION ON STATUS  
OF WOMEN  
SELECT COMMISSION ON  
GANG VIOLENCE

January 22, 1990

## MEMORANDUM

TO: LEGISLATIVE COUNSEL

FROM: ASSEMBLYWOMAN CATHIE WRIGHT

SUBJECT: LEGISLATIVE COUNSEL ORAL OPINION ON AB 865

Attached is a copy of Assembly Bill 865 (Chapter 968) which went into effect on January 1, 1990. Since that time, there has been some concern raised as to the application of this bill; therefore, I would appreciate an oral opinion on the following questions:

Throughout AB 865, coverage refers specifically to hospital, medical, or surgical expenses. Could this reference also imply and include coverage for pharmacy services?

Although AB 865 only makes reference to the term provider coverage and reimbursement, does that also allow the insured (who submits his/her own claim instead of the hospital or doctor) to be reimbursed under the same conditions?

Do the provisions of AB 865, apply to workers' compensation claims?

Thank you for your prompt attention and assistance in clarifying these points. If there are any questions, please contact Jamie Khan in my office at 445-7676.

Jack I. Horton  
Ann Mackey  
Chief Deputies  
James L. Ashford  
Jerry L. Bassett  
John T. Studebaker  
Jimmie Wing  
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Christopher Zirkle  
Principal Deputies

State Capitol, Suite 3021  
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# Legislative Counsel of California

BION M. GREGORY

Sacramento, California

April 1, 1991

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Thomas D. Whelan  
Belinda Whitsett  
Debra J. Zidich

Deputies

Honorable Cathie Wright  
3126 State Capitol

Insurance - #2565

Dear Mrs. Wright:

## QUESTION NO. 1

Do the timely payment provisions of Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code, apply to pharmacy services under a policy or plan that covers hospital, medical, or surgical expenses?

## OPINION NO. 1

The timely payment provisions of Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code, apply to pharmacy services under a policy or plan that covers hospital, medical, or surgical expenses.

## ANALYSIS NO. 1

Chapter 968 of the Statutes of 1989 (hereafter Chapter 968) operates, with respect to health care service plans, policies of disability insurance, and nonprofit hospital service plans, that cover hospital, medical, or surgical expenses. It requires,<sup>1</sup> where a claim for reimbursement by a provider is being

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<sup>1</sup> Chapter 968 also requires, in the case of overpayment to an institutional or professional provider, reimbursement to the health care service plan, disability insurer, or nonprofit hospital service plan, within certain time limits (Sec. 1371.1, H. & S.C., and Secs. 10123.145 and 11512.181, Ins. C.). However, this opinion does not involve a discussion of those provisions.

contested by the plan or the insurer, that a claim reimbursement notice specify whether the claim is being contested or denied and the identification of the portion of the claim that is contested and the specific reasons for contesting the claim. It also provides that if an uncontested claim is not reimbursed within the specified claim reimbursement period, interest shall accrue (Sec. 1371, H. & S.C. and Secs. 10123.13 and 11512.180, Ins. C.). An example of the language in question added by Chapter 968 is that contained in Section 11512.80 of the Insurance Code, with respect to nonprofit hospital service plans, which was amended to read as follows:

"11512.180. Every nonprofit hospital service plan that covers hospital, medical, or surgical expenses on a group or individual basis shall reimburse claims or any portion of any claim, whether in state or out of state, for such expenses, as soon as practical, but not later than 30 working days after receipt of the claim by the hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the hospital 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 nonprofit hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the nonprofit hospital 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 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 liability 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." (New language emphasized.)

The question raised is whether language, as used in the sections under discussion amended by Chapter 968 include coverage for pharmacy services. It could be argued, that, with respect to health care service plans and disability insurers, since pharmacy services are not specifically mentioned as one of the types of health services covered (see Sec. 1345, H. & S.C. re: health care service plans and Sec. 10176, Ins. C. re: disability insurers), those services should not be covered by the timely payment provisions under discussion. On the other hand, nonprofit hospital service plans may cover drugs and medicines (Sec. 11493, Ins. C.), and there are no express restrictions upon the provision of pharmacy services in the provisions relating to health care service plans and disability insurers. Thus, pharmacy coverage may be provided to plan subscribers and insureds pursuant to contractual agreement with providers as a part of the covered hospital, medical, or surgical expense coverage provided in the contract with plan subscribers and insureds. The term "medical expenses" may be used as a generic term used to refer to health services generally (see, e.g., Palmer v. State Farm Fire & Gas Co. (Fla.), 489 So. 2d 147; Miller v. Johnson (Pa.), 436 A. 2d 1187).

In the context in which the term "hospital, medical, or surgical" is used in the sections under discussion, we discern no legislative intent to limit that term to particular providers of health care services provided under a policy or plan that covers hospital, medical, or surgical expenses. Moreover, we are informed that the Department of Insurance, the administrative agency charged with the enforcement of the Insurance Code provisions amended by Chapter 968 (see Sec. 12921, Ins. C.), interprets those code sections broadly to include coverage for pharmacy services. The courts accord great weight to the contemporaneous administrative construction of a statute by an agency entrusted with its enforcement (Mueller v. MacBan, 62 Cal. App. 3d 258, 271), and it will be followed if not clearly erroneous (Shelor v. City of Lodi, 23 Cal. 2d 647, 655).

Therefore, it is our opinion that the timely payment provisions of Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code, apply to pharmacy services provided under a policy or plan that covers hospital, medical, or surgical expenses.

QUESTION NO. 2

Does Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code authorize a health care service plan subscriber, an insured, or a nonprofit hospital service plan subscriber who submits his or her own claims to be reimbursed under the same conditions as a claim submitted by a provider of health care services?

OPINION NO. 2

Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code authorize a health care service plan subscriber, an insured, or a nonprofit health care service plan subscriber who submits his or her own claims to be reimbursed under the same conditions as a claim submitted by a provider of health care services.

ANALYSIS NO. 2

Section 10123.13 of the Insurance Code<sup>2</sup> which was amended by Chapter 968, states, in pertinent part, as follows:

"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. . . ."

(Emphasis added.)

The language of Section 10123.13 contains no limitation or restriction upon the usual and ordinary definition of a "claim" or "claimant" (claimant, "one who asserts a right or title" Webster's Third International Dictionary, p. 414). It is our understanding that an individual insured covered by a policy of disability insurance may assign to a health care provider his or her right to file the claim and receive reimbursement under the terms of the policy, but in the absence of such an arrangement

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<sup>2</sup> The language contained in the amendment to Section 10123.13 parallels the language contained in the other code sections under discussion.

certainly a claim for reimbursement for payments made to a provider for covered services would be made directly to the insurer. The same option appears to be contemplated by Section 11493 of the Insurance Code as respects nonprofit hospital service plans (see subds. (b) and (c), Sec. 11493, Ins. C.). While health care service plans as a rule operate as direct providers of health care services for a prepaid or periodic charge (see subd. (f), Sec. 1345, H. & S.C), the definition of "health care services plan" contained in Section 1345 of the Health and Safety Code includes those persons who undertake to "reimburse any part of the cost of such services" in return for that charge. Thus, we think a health care service plan subscriber who seeks to be reimbursed by the plan for hospital, medical, or surgical expenses also may submit these claims directly to the plan.

We, therefore, think that a reasonable construction of the statutes affected by Chapter 968 containing this "claimant" language includes the individual plan subscriber or insured. In this regard, we are informed that the Department of Insurance interprets this provision similarly and views those provisions of Chapter 968 in question over which it has jurisdiction as requiring an insured who submits his or her own claim to be reimbursed under the same conditions as if the claim were submitted by a health care provider of health care services.

In conclusion, Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code authorize a health care service plan subscriber, an insured, or a nonprofit health care service plan subscriber who submits his or her own claims to be reimbursed under the same conditions as a claim submitted by a provider of health care services.

QUESTION NO. 3

Does Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code apply to workers' compensation claims?

OPINION NO. 3

Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code do not apply to workers' compensation claims.

ANALYSIS NO. 3

The California workers' compensation law is contained in Division 4 (commencing with Section 3200) and Division 4.5 (commencing with Section 6100) of the Labor Code, and generally speaking, provides a system of workers' compensation for employees

Honorable Cathie Wright - p. 6 - #2565

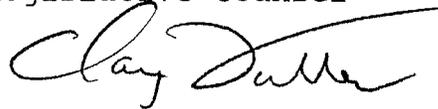
injured in the course and scope of their employment. Workers' compensation insurance is not disability insurance and it is not a nonprofit hospital service plan or a health care service plan (see Sec. 109, Ins. C.).

By its very terms, the provisions of Chapter 968 are made applicable only with respect to group and individual health care service plans (Secs. 1371 and 1371.1, H. & S.C.), disability insurance (Secs. 10123.13 and 10123.145, Ins. C.), and nonprofit hospital service plans (Secs. 11512.180 and 11512.181, Ins. C.).

In conclusion, Section 1371 of the Health and Safety Code, and Sections 10123.13 and 11512.180 of the Insurance Code do not apply to workers' compensation claims.

Very truly yours,

Bion M. Gregory  
Legislative Counsel



By  
Clay Fuller  
Deputy Legislative Counsel

CF:dfb



JIC  
TREATMENT  
CENTERS  
OF AMERICA

April 6, 1989

Honorable Cathie Wright  
State Capitol, Room 3126  
Sacramento, CA 95814

APR 10 1989

Dear Assemblywoman Wright:

Re: AB 865

Reasonably prompt claims payment for services rendered by health facilities is essential to their financial viability. Your requirements that there be specific reasons for contesting any portion of a claim plus an interest surcharge when reimbursement is not received within the statutory time limitation should facilitate the process and has our SUPPORT.

Sincerely,

Herbert Dorken, Ph.D.

cc: Mr. Elliott Sainer  
Members Finance and Insurance Committee

Corporate Offices  
LifePLUS Plaza  
6441  
Coldwater Canyon  
North Hollywood  
CA 91606  
818/769-3915

JK



# Association of California Life Insurance Companies

BRENT A. BARNHART  
ASSOCIATE COUNSEL

May 1, 1989

MAY 2 1989

Assemblywoman Cathie Wright  
Member, California State Assembly  
State Capitol  
Sacramento, California 95814

Re: AB 865  
OPPOSE

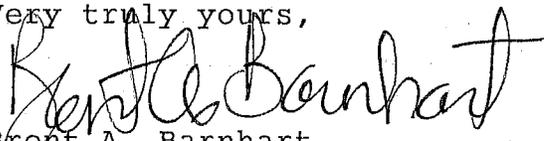
Dear Assemblywoman Wright:

The Association of California Life Insurance Companies (ACLIC) respectfully opposes AB 865, which would: (1) Compel health plans to notify providers of the specific portion of a claim for health care services which is being contested, and (2) Would require the payment of interest where a claim is not reimbursed within the statutory 30-day time limit for paying claims..

As presently written, the bill addresses only one side of claims payment controversies. No consideration should be given to imposing additional burdens upon health insurers and health maintenance organizations (HMO's) until equal consideration is given to compelling providers to supply payors with sufficient information to justify their claims. Under current practice, many hospitals deny payors access to evidence which substantiates their claims for payment for services.

Only when all such payment issues are addressed should legislation move forward which adds further provisions to the law which compels accelerated payment of providers.

Very truly yours,

  
Brent A. Barnhart  
Associate Counsel

BB/0069b

cc: Members, Assembly Finance & Insurance Committee  
Ken Cooley, Principal Consultant

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WESTERN GROWERS ASSOCIATION

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STREET ADDRESS: 17620 FITCH STREET • IRVINE, CALIFORNIA 92714  
MAILING ADDRESS: P.O. BOX 2130 • NEWPORT BEACH, CALIFORNIA 92658  
TELEPHONE 714/863-1000      TELEX: IRIN 182-266

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May 12, 1989

The Honorable Cathie Wright  
Room 3126, State Capitol  
Sacramento, CA 94249-0001

RE:            AB 865

Dear Assemblymember Wright:

Western Growers Association had reviewed your AB 865 upon introduction, and advised your staff as to our concerns with the provisions of the bill. As AB 865 has now been set in committee, we would like to once again voice our concerns in the hope that a satisfactory resolution to meet our concerns can be made.

Western Growers Assurance Trust is a self-insured employee welfare benefit entity. As such, WGAT enters into contracts which define the terms of payment whether it might be discounts for early payment, partial payment pending audit, etc. The provisions of AB 865 do not recognize such contracts, and would impose interest costs without justification.

WGAT routinely holds back a portion of the bill pending an audit of hospital charges. We have found that more often than not there is some overcharge on hospital billings, and that an overcharge is even more likely when a death occurs during hospitalization.

Based on the above, Western Growers Association would request an amendment which would recognize contracts which define payment responsibilities and exempt such from the interest provisions contained in AB 865.

Sincerely,

KATHLEEN R. MANNION  
Director, Governmental Affairs

KRM/seg



# California Medical Association

221 Main Street, P.O. Box 7690, San Francisco, CA 94120-7690 (415) 541-0900

Reply to: 925 L Street, Suite 1150 · Sacramento 95814 · (916) 444-5532

May 12, 1989

MAY 15 1989

The Honorable Burt Margolin  
State Capitol, Room 4117  
Sacramento, CA 95814

RE: AB 865 (Wright)  
CMA Position: SUPPORT

Dear Assemblyman Margolin:

The California Medical Association has taken a "SUPPORT" position on AB 865 (Wright) which is set for hearing on May 15, 1989, in the Assembly Health and Workers' Insurance Subcommittee.

This bill would strengthen the current delayed payments law by requiring insurers to notify claimants of the specific portion of a claim that is being contested and the reason for contesting that portion. It would also provide that if the claim is not reimbursed within the time limitation, interest shall accrue at the rate of 10% per annum.

This bill will help both patients and providers to receive duly-owed payments and proper explanations for delays. This is a severe problem that needs to be addressed.

For the above reasons, the California Medical Association strongly supports AB 865 and urges your "AYE" vote.

Sincerely,

Carol A. Lee  
Associate Director  
Government Relations

cc: The Honorable Patrick Johnston, Chairman  
Assembly Finance and Insurance Committee  
The Honorable Cathie Wright  
Ken Cooley, Committee Consultant  
Peter Conlin, Republican Caucus Consultant  
Dennis Flatt, California Association of  
Hospitals and Health Systems

CL5.11

CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS



May 15, 1989

Honorable Jack O'Connell  
Assembly Finance and Insurance  
Subcommittee on Health and  
Workers' Insurance  
State Capitol, Room 2141  
Sacramento, CA 95814

1050 20th Street  
P.O. Box 1100  
Sacramento, CA  
95812-1100  
916.443.7401

Dear Assemblyman O'Connell: *Jack*

On behalf of the California Association of Hospitals and Health Systems (CAHHS), I wish to inform you of our support of Assembly Bill 865 (Wright).

Existing law requires insurers to reimburse provider claims within thirty days unless the claim is contested. Currently, there is no prescribed penalty for late payment. As a result, payments are often late.

Assembly Bill 865 provides that a ten percent penalty shall be added to claims that are not reimbursed within the thirty-day time frame. The bill does not impair the insurers current ability to contest a claim when there is a reason to do so.

We urge your "aye" vote on AB 865. Thank you.

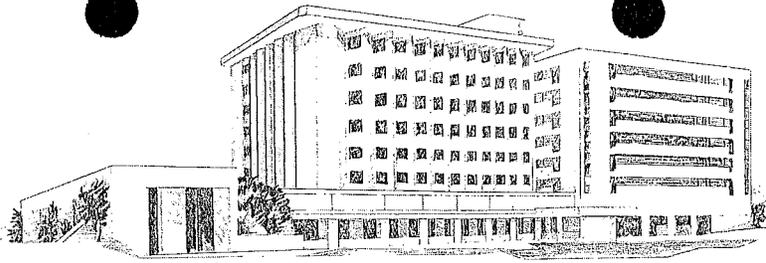
Yours truly,

Dennis O. Flatt  
Vice President  
Government Relations

DOF:tm

cc: Honorable Members and Consultant  
Assembly Finance and Insurance Subcommittee  
on Health and Workers' Insurance





## Centinela Hospital Medical Center

a nonprofit medical facility

Official Hospital for the 1984 Olympic Games

MAY 22 1989

May 18, 1989

The Honorable Cathie Wright  
California State Assembly  
P. O. Box 942849  
Sacramento, CA 94249-0001

Dear Assemblywoman <sup>Cathie</sup> Wright:

A letter on behalf of your bill AB865, as attached, was sent to all members of the Finance and Insurance Committee.

Hope all goes well.

Sincerely,

Leona H. Egeland  
Director of Government  
and Community Relations

LHE:khl

Enclosure

Ltr.100



Sutter Health

*JK*

Central Billing Office

2800 L Street  
Sacramento  
California 95816

Telephone  
(916) 733-8855  
FAX 733-3837

May 19, 1989

MAY 23 1989

The Honorable Cathie Wright  
Assembly Finance and Insurance Committee  
Room 3126, State Capitol  
Sacramento, CA 95814

Dear Ms. Wright:

On behalf of the California Association of Hospitals and Health Systems (CAHHS), I wish to inform you of our support of Assembly Bill 865 (Wright).

Existing law requires insurers to reimburse provider claims within thirty days unless the claim is contested. Currently, there is no prescribed penalty for late payment. As a result, payments are often late.

Assembly Bill 865 provides that a ten percent penalty shall be added to claims that are not reimbursed within the thirty-day time frame. The bill does not impair the insurers current ability to contest a claim when there is a reason to do so.

We urge your "aye" vote on AB 865. Thank you.

Yours truly,

Charles K. Van Slyter  
Sr. Vice President  
Sacramento Division  
Sutter Health

PKVS:lp

cc: Honorable Members and Consultant  
Assembly Finance and Insurance Subcommittee  
on Health and Workers' Insurance

VHA.  
Member of  
Voluntary Hospitals  
of America, Inc.

CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS



May 22, 1989

MAY 22 1989

Honorable Cathie Wright  
Assembly Finance and Insurance Committee  
Room 3126, State Capitol  
Sacramento, CA 95814

MAY 22 1989

P.O. Box 1100  
Sacramento, CA  
95812-1100  
916.443.7401

Dear Assemblywoman Wright:

On behalf of the California Association of Hospitals and Health Systems (CAHHS), I wish to inform you of our support of Assembly Bill 865 (Wright).

Existing law requires insurers to reimburse provider claims within thirty days unless the claim is contested. Currently, there is no prescribed penalty for late payment. As a result, payments are often late.

Assembly Bill 865 provides that a ten percent penalty shall be added to claims that are not reimbursed within the thirty-day time frame. The bill does not impair the insurers current ability to contest a claim when there is a reason to do so.

We urge your "aye" vote on AB 895. Thank you.

Yours truly,

Dennis O. Flatt  
Vice President  
Government Relations

DOF:tm

cc: Honorable Members and Consultant  
Assembly Finance and Insurance Committee





MAY 24 1989

May 22, 1989

Handwritten initials, possibly "DK", in black ink.

The Honorable Cathie Wright  
Assembly Finance and Insurance Committee  
Room 3126, State Capitol  
Sacramento, CA 95814

Dear Assemblywoman Wright:

Please support AB 865 (Wright) when it comes before the Assembly Finance and Insurance Committee on May 23rd.

This bill would put "teeth" into existing law by requiring that third party payers provide written notice to hospitals of any contested portions of a claim, including the reasons for contesting, and would impose a 10% interest penalty on late payment of uncontested claims. On average, our Blue Cross and other commercial carriers are taking in excess of sixty (60) days.

We urge your support of AB 865.

Sincerely,

A large, stylized handwritten signature in black ink, appearing to read "David Haray".

David Haray  
Director  
Business Services

JUN 12 1989

May 27, 1989

Honorable Members Assembly Finance and Insurance Committee

As a long time hospital Patient Accounts Manager I urge you to vote "Yes" on AB 865 (Wright).

Hospitals carry outstanding receivables from insurance companies for an average currently over ninety (90) days. Yet existing law requires insurers to reimburse provider claims within thirty days unless claim is contested. Assembly Bill 865 provides a ten percent penalty and that the provider be notified if a claim is being contested and to identify specifically which portion of claim is being contested.

Millions of dollars will flow into our overburdened, underpaid hospital system by passage of this bill and at no additional cost to patients or tax payers.

Please vote "Aye" on AB 865 (Wright).

Sincerely,

*Carol Altmann, CMPA*

Carol Altmann  
Director Business Services



**SAN JOSE  
MEDICAL  
CENTER**  
675 East Santa Clara Street  
San Jose, CA 95112  
(408) 998-3212

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**HEALTH  
DIMENSIONS  
INCORPORATED**

---

ST. SAMARITAN HOSPITAL  
SANTA CLARA VALLEY  
SAN JOSE MEDICAL CENTER  
WHEELER HOSPITAL  
SOUTH VALLEY HOSPITAL (1989)  
HEALTH ADVANTAGE  
HEALTH ADVANTAGE VENTURES



May 30, 1989

MAY 31 1989

The Honorable Cathie Wright  
California State Assembly  
State Capitol  
Sacramento, California 95814

RE: AB 865 -- SUPPORT

Dear Assembly Member Wright:

The California Association of Catholic Hospitals is pleased to support your AB 865 as an important measure to improve claims processing between health care providers and insurance companies.

Imposing time limits on processing of uncontested portions of claims recognizes the growing cash flow problems many health care providers are encountering. This rationalizes the payment process to preclude an insurer from holding up payment on a major claim due to a disagreement about a relatively minor portion of the claim.

Sincerely,

A handwritten signature in cursive script that reads "Gayle Ensign".

Gayle H. Ensign  
President

A handwritten signature in cursive script that reads "Bill".

William E. Barnaby  
Legislative Advocate

GHE:WEB/lc

California Association of Catholic Hospitals

1121 L Street, Suite 409 • Sacramento, CA 95814 • (916) 444-3386 • FAX (916) 444-6836



# Association of California Life Insurance Companies

BRENT A. BARNHART  
ASSOCIATE COUNSEL

May 31, 1989

JUN 1 1989

Honorable Cathie Wright  
Member, California State Assembly  
State Capitol  
Sacramento, CA 95814

Re: AB 865 OPPOSE

Dear Cathie:

The Association of California Life Insurance Companies (ACLIC) respectfully opposes AB 865, which would: (1) Compel health plans to notify providers of the specific portion of a claim for health care services which is being contested, and (2) Would require the payment of interest where a claim is not reimbursed within the statutory 30-day time limit for paying claims.

As presently written, the bill addresses only one side of claims payment controversies. No consideration should be given to imposing additional burdens upon health insurers and health maintenance organizations (HMO's) until equal consideration is given to compelling providers to supply payors with sufficient information to justify their claims. Under current practice, many hospitals deny payors access to evidence which substantiates their claims for payment for services.

Only when all such payment issues are addressed should legislation move forward which adds further provisions to the law which compels accelerated payment of providers.

Very truly yours,

Brent A. Barnhart

BB:gj  
0100b



Health Insurance Association of America

JUN 21 1989

June 19, 1989

*return to JAK*

Honorable Cathie Wright  
Assemblywoman  
District 37  
California State Assembly  
State Capitol  
Sacramento, California 95814

Dear Cathie:

Thank you very much for taking time out of your very busy schedule on June 15 to meet with the regarding suggested amendments to AB-865 and AB-2474. If after reviewing the materials I left with you, you have any questions or would like further information on the issues raised, please do not hesitate to contact me.

I look forward to working out the differences between the insurance industry and the provider community at joint meetings to be held later this summer.

If you feel it would be beneficial for you or any of your staff to have a claims demonstration similar to the one held last year at Tom Allen's office at Principal Financial Group, please do not hesitate to let me know. I would appreciate advance notice and several alternative dates.

Sincerely,

Jan Andrea Meisels  
Deputy Director

JAM:mlp

cc: Brent Barnhart  
Tom Allen

**Bellwood**  
**Health**  
**Center**

17800 Woodruff Avenue  
Bellflower, California 90706

(213) 925-9913  
(714) 952-3463

June 26, 1989

JUN 29 1989

Mr. Sal Bianco, Consultant  
Senate IC&C Committee  
State Capitol, Room 5122  
Sacramento, CA 95814

Dear Sal:

RE: AB 865 Wright

Reasonably prompt claims payment for services rendered by health facilities is essential to their financial viability. Accordingly, we SUPPORT this bill.

Cordially,

  
Herbert Dörken, Ph.D.

cc: Hon.C.Wright  
Mr.D.Topper,Paracelsus  
Mr.J.Sharp,Bellwood



TREATMENT  
CENTERS  
OF AMERICA

June 26, 1989

JUN 29 1989

Mr. Sal Bianco, Consultant  
Senate IC&C Committee  
State Capitol, Room 5122  
Sacramento, CA 95814

Dear Sal:

RE: AB 865 Wright

Reasonably prompt claims payment for services rendered by health facilities is essential to their financial viability. Accordingly, we SUPPORT this bill.

Cordially,

Herbert Dörken, Ph.D.

cc: Hon.C.Wright  
Ms.E.A.Rose,TCA

Corporate Offices  
LifePLUS Plaza  
6441  
Coldwater Canyon  
North Hollywood  
CA 91606  
818/769-3915



# Association of California Life Insurance Companies

BRENT A. BARNHART  
COUNSEL & SECRETARY

July 10, 1989

JUL 11 1989

Assemblywoman Cathie Wright  
Member, California State Assembly  
State Capitol  
Sacramento, California 95814

Re: AB 865 & AB 2474  
OPPOSE

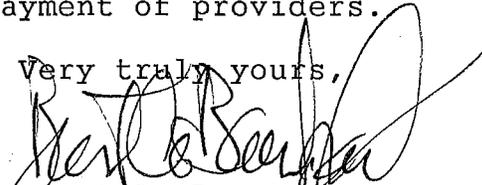
Dear Assemblywoman Wright:

The Association of California Life Insurance Companies (ACLIC) respectfully opposes AB 865, which would: (1) Compel health plans to notify providers of the specific portion of a claim for health care services which is being contested, and (2) Would require the payment of interest where a claim is not reimbursed within the statutory 30-day time limit for paying claims. We also oppose AB 2474, which would compel insurers to pay "major" portions of claims when there is justification solely for contesting a "lesser" portion of a claim..

As presently written, the bill addresses only one side of claims payment controversies. No consideration should be given to imposing additional burdens upon health insurers and health maintenance organizations (HMO's) until equal consideration is given to compelling providers to supply payors with sufficient information to justify their claims. Under current practice, many hospitals deny payors access to evidence which substantiates their claims for payment for services.

Only when all such payment issues are addressed should legislation move forward which adds further provisions to the law which compels accelerated payment of providers.

Very truly yours,



Brent A. Barnhart  
Associate Counsel

BAB:ip  
0069b

cc: All Members, Senate ICC Committee  
Sal Bianco, Consultant, Senate I.C.C. Committee



UC DAVIS MEDICAL CENTER  
2315 STOCKTON BOULEVARD  
SACRAMENTO, CALIFORNIA 95817

July 25, 1989

JUL 27 1989

Jamie Kahn  
Legislative Aide  
Office of Assemblywoman Wright  
California State Assembly  
State Capitol, Room 3126  
Sacramento, California 95814

RE: AB 865

Dear Jamie:

I recently learned from an insurance industry lobbyist that if AB 865 becomes law, the insurance industry plans to "comply" in a manner which I believe circumvents the intention of this bill.

The insurance industry plans to notify the patient, rather than the health care provider, of the portion of the claim being contested and the specific reasons for contesting the claim. The insurance industry also plans to pay any accrued interest to the patient rather than to the health care provider.

As you probably know, there are basically two different ways in which an insured patient's bills can be paid by his/her insurance company. The more common way is for the physician or hospital to send the bill directly to the insurance company. The insurance company then sends the payment directly to the physician or hospital. The patient is not required to act as a "middleman" and is not bothered with any paperwork.

An alternative method is for the provider to send the bill to the patient. The patient must pay the bill, and then submit a form to his/her insurance company requesting that the insurance company send him/her a check for the amount of the bill. This method is less common because: (1) it inconveniences the patient with paperwork; (2) it delays the payment process unnecessarily; and (3) many patients do not have enough cash to pay these bills and then wait six weeks or so until the insurance company reimburses them.

The spirit of this bill seems to be that when the provider bills the insurance company directly, provider (not just that patient) should be notified if the insurance company is contesting the claim and the specific reasons therefore. When the provider bills the insurance company directly, the provider should receive any interest which accrues as a result of the insurance company's payment delay.

Jamie Kahn  
July 25, 1989  
Page 2

In those cases in which the patient pays the provider directly and then requests the insurance company to reimburse him or her directly, the patient should receive any accrued interest occasioned by the insurance company's delay. I believe that in these cases, both the health care provider and the patient should be notified if a claim is contested and the specific reasons therefore.

I have enclosed a copy of AB 865 with suggested revisions noted in red ink. I would be most happy to discuss this matter with you over the phone (453-3584) or in person. Please feel free to contact me if I can be of any assistance to you whatsoever.

Sincerely,



Lois J. Richardson, Manager  
Contracts & Affiliations

LJR:dmm

Enclosure

cc: Jason Barr )  
Randi Harry ) (w/o enclosure)  
Kathy Lawrence )  
Doug Sjoberg )

AUG 2 1989



July 31, 1989

Cathy Wright  
Assembly Member  
250 East Easy Street  
Suite #7  
Simi Valley, CA 93065

RE: Assembly Bill No. 865

Dear Cathy Wright:

I have reviewed AB 865 which regulates timely reimbursement to providers of healthcare. You are to be commended for your efforts in dealing with a problem the hospitals and other medical facilities have been coping with for a number of years. However, I am not certain if change will be affected with the current wording of the bill.

Traditionally insurance companies including Blue Cross & Blue Shield do not consider receipting a claim until said claim is keypunched into their computer system. Several hours after reviewing the Bill a Blue Cross representative was in my office and he acknowledged the existence of AB 865 but stated the claims would sit in their "mailroom" or "keypunch room" for up to 30 days before being keyed into their system. I phoned other insurance companies and received the same response. Obviously this defeats the intent and purpose of the bill.

In the climate of healthcare, cash flow is paramount in order to stop cost passing, borrowing, adding staff to follow-up on claims, etc. I plan to direct my staff to send all claims that are in excess of \$2,000. to third party payors by certified mail. I will then be forced to test "receipting" in the courts. I hope you would consider more clearly defining "receipting" of a claim in AB No. 865.

Thanking you in advance for your continued efforts.

Sincerely,

*David E. Secor*  
David E. Secor  
Business Manager  
Mercy Medical Center

Clairmont Heights  
P.O. Box 6009  
Redding, CA 96099-6009  
(916) 225-6000

A Division of Catholic Healthcare West



**CONTRA COSTA  
HEALTH PLAN**

595 Center Avenue  
Suite 100  
Martinez, California 94553  
415 646-2920

August 1, 1989

State Assemblywoman Cathie Wright  
District 37  
3126 State Capitol  
Sacramento, CA 95814

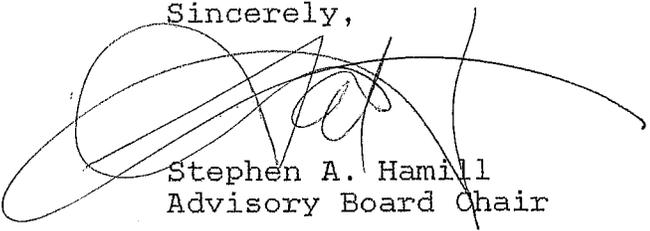
AUG 11 1989

Dear Ms Wright:

The Contra Costa Health Plan Advisory Board, at its meeting last week, unanimously voted to oppose your Bill, A.B. 865, as presently written. We are concerned that the monetary penalties for not paying claims within 45 days may place an undue burden on our County sponsored, Federally qualified, HMO.

Although Contra Costa Health Plan generally pays its claims well within the 45 day period, there are times when situations beyond its control extends its claims processing time. As part of county government, Contra Costa Health Plan is subject to County-wide hiring freezes which can impede the ability of the Health Plan and/or other county agencies to process the claims and cut the checks within 45 days. We are concerned that Contra Costa Health Plan's present ability to serve a broad spectrum of County residents (Medi-Cal, Medicare, County employees, private individuals, small businesses and the County Medically Indigent) may be adversely affected by A.B. 865.

Sincerely,



Stephen A. Hamill  
Advisory Board Chair

SAH:BB:smp

cc: Senator Daniel Boatwright

AFFORDABLE CARE PLUS SERVICE



# California Medical Association

221 Main Street, P.O. Box 7690, San Francisco, CA 94120-7690 (415) 541-0900

Reply to: 925 L Street, Suite 1150 · Sacramento 95814 · (916) 444-5532  
August 7, 1989

Brent A. Barnhart  
Association of California  
Life Insurance Companies  
1400 K Street, Suite 208  
Sacramento, CA 95814

AUG 9 1989

RE: AB 865 (Wright)

Dear Brent:

The California Medical Association has reviewed your proposed amendments to AB 865.

First, we do not believe the definition of "claimant" is adequate. Section 10123.13 notes that if ". . . the claim or portion thereof is contested by the insurer in which the case the claimant shall be notified . . ." If the physician submitted the claim on an assigned basis, would he then, for the purposes of that section, be the claimant? If he were not, then an information gap would result if the patient did not promptly notify the physician of the denial. It needs to be made clear that the physician will be notified of the contested claim on assigned claims.

Sections 10123.13(c)(1) and 11512.180(c)(1) should be changed to read: "Within 30 working days of receipt of the notice." This makes the language consistent with requirements on insurers and will protect physicians from insurers who may date a notice a few weeks earlier than it was actually mailed. The other proposed amendments appear to acceptable to the CMA.

We still have not received the language of an amendment which would require providers to repay overbillings within 30 days. I would appreciate this language as soon as possible so that we can comment on it.

Sincerely,

  
Carol A. Lee

cc: Assemblywoman Cathie Wright  
Gib Kingren, Blue Shield  
Joe Criscione, Kaiser Foundation Health Plan  
Dennis Flatt, California Association of Hospitals and Health Systems  
Barbara Donaldson

\*>CAL>CAL8.7c

AUG 21 1989



FREDERICK J. TAUGHER  
1100 11th Street, Suite 311  
Sacramento, California 95814  
Telephone 916 441 0702

August 21, 1989

Hon. Alan Robbins  
Senate Insurance Claims & Corporations Committee  
State Capitol, Room 5114  
Sacramento, California 95814

Dear Alan:

Assembly Bill 865 (Wright) is scheduled for consideration by the Senate Insurance, Claims & Corporations Committee on Wednesday, August 23. On behalf of our client, the Alliance for Health Care Cost Containment, we urge you to **VOTE NO** on **AB 865**.

On its surface, AB 865 appears to be a reasonable bill. It requires health insurers and H.M.O.s to give written notification specifying the portion of a claim that is contested and the reason for contesting. Further, the bill requires the payment of 10% interest on all uncontested claims not paid within 30 days (45 days for H.M.O.s).

Our client believes legitimate charges should be paid promptly. However, claims are often contested by insurers because the claimant has not provided, or refuses to provide, sufficient information to justify the claim. Unless AB 865 is appropriately amended to squarely place responsibility on providers to submit adequate information to justify claims, we believe the bill should be defeated. A rush by insurers to pay questionable claims will only aggravate problems associated with the availability and affordability of adequate health insurance.

Sincerely,



Frederick J. Taugher

August 21, 1989

AUG 23 1989

Honorable Alan Robbins  
Chair, Senate Insurance Claims & Corporations Committee  
State Capitol, Room 5114  
Sacramento, CA 95814

Re: State Farm's Opposition to AB 865

Dear Senator Robbins:

I am writing to express State Farm's opposition to AB 865.

AB 865 requires insurers providing disability insurance and specified employee welfare benefit plans to pay interest at a rate of 10% per annum on all claims which are not reimbursed within 30 days.

There are many reasons why it may take longer than 30 days to verify a claim. One problem frequently faced by insurers is that hospitals fail to provide the information necessary to substantiate a claim. Hospitals have resisted efforts to guarantee insurers a right of access to that information in a timely fashion. While insurers have an obligation to pay covered claims which are supported with adequate documentation, they also have a duty to other policy holders not to pay a claim which is unsubstantiated.

AB 865 as it is presently written is an unbalanced approach which would impose severe penalties on insurers without entitling them to access to the information needed to verify a claim.

Sincerely,



G. DIANE COLBORN  
Attorney at Law

GDC\vlr  
cc: Committee Members  
vr\ltr\ar0821.sf3



AUG 21 1989

FREDERICK J. TAUGHER

August 21, 1989

1100 11th Street, Suite 311  
Sacramento, California 95814  
Telephone 916 441 0702

Hon. Cathie Wright  
California State Assembly  
State Capitol, Room 3126  
Sacramento, California 95814

Dear Cathie:

Our client, the Alliance for Health Care Cost Containment, has taken an OPPOSE position to your Assembly Bill 865.

For your information, I have enclosed a copy of the letter which we have sent to each member of the Senate Insurance, Claims & Corporations Committee.

Sincerely,



Frederick J. Taugher

Enclosure

AUG 21 1989



FREDERICK J. TAUGHER

August 21, 1989

1100 11th Street, Suite 311  
Sacramento, California 95814  
Telephone 916 441 0702

Hon. Alan Robbins  
Senate Insurance Claims & Corporations Committee  
State Capitol, Room 5114  
Sacramento, California 95814

Dear Alan:

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Sincerely,

A handwritten signature in black ink, appearing to read "Fred Taugher", written over a horizontal line.

Frederick J. Taugher

WESTERN GROWERS ASSOCIATION



STREET ADDRESS: 17620 FITCH STREET • IRVINE, CALIFORNIA 92714  
MAILING ADDRESS: P.O. BOX 2130 • NEWPORT BEACH, CALIFORNIA 92658  
TELEPHONE 714/863-1000 TELEEX: IRIN 182-266

SEP 1 1989

August 31, 1989

The Honorable Cathie Wright  
Room 3126, State Capitol  
Sacramento, CA 94249-0001

RE: AB 865 -- Removal of Opposition

Dear Assemblymember *Cathie* Wright:

Western Growers Association is pleased to advise you that the August 30, 1989 amendments to AB 865 have resolved our concerns with your measure.

We appreciate the cooperation of your staff and the sponsor in addressing our concerns relative to self-insured employee benefit plans.

Sincerely,

*Kathy*  
KATHLEEN R. MANNION  
Director, Government Affairs

KRM/seg

JACK I. HORTON  
ANN MACKAY  
CHIEF DEPUTIES

JAMES L. ASHFORD  
JERRY L. BASSETT  
STANLEY M. LOURIMORE  
JOHN T. STUDEBAKER  
JIMMIE WING

DAVID D. ALVES  
JOHN A. CORZINE  
C. DAVID DICKERSON  
ROBERT CULLEN DUFFY  
ROBERT D. GRONKE  
SHERWIN C. MACKENZIE, JR.  
TRACY O. POWELL II  
MARGUERITE ROTH  
PRINCIPAL DEPUTIES

3021 STATE CAPITOL  
SACRAMENTO, CA 95814  
(916) 445-3057

8011 STATE BUILDING  
107 SOUTH BROADWAY  
LOS ANGELES, CA 90012  
(213) 620-2550  
TELECOPIER: 916-324-6311

# Legislative Counsel of California

BION M. GREGORY

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MARTIN L. ANDERSON  
PAUL ANTILLA  
DANA S. APPLING  
CHARLES C. ASBILL  
JOE J. AYALA  
RANEENE P. BELISLE  
DIANE F. BOYER  
AMELIA I. BUDD  
EILEEN J. BUXTON  
HENRY J. CONTRERAS  
EMILIA CUTRER  
BEN E. DALE  
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CLINTON J. DEWITT  
FRANCES S. DORBIN  
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HARVEY J. FOSTER  
CLAY FULLER  
ALVIN D. GRESS  
BALDEV S. HEIR  
THOMAS R. HEUER  
MICHAEL J. KERSTEN  
L. DOUGLAS KINNEY  
S. LYNNE KLEIN  
VICTOR KOZIELSKI  
EVE B. KROTINGER  
DIANA G. LIM  
ROMULO I. LOPEZ  
KIRK S. LOUIE  
ANTHONY P. MARQUEZ  
JAMES A. MARSALA  
FRANCISCO A. MARTIN  
PETER MELNICOE  
ROBERT G. MILLER  
JOHN A. MOGER  
VERNE L. OLIVER  
EUGENE L. PAINE  
MICHAEL B. SALERNO  
MARY SHAW  
WILLIAM K. STARK  
MARK FRANKLIN TERRY  
JEFF THOM  
MICHAEL H. UPSON  
RICHARD B. WEISBERG  
DANIEL A. WEITZMAN  
THOMAS D. WHELAN  
JANA T. WHITGROVE  
DEBRA J. ZIDICH  
CHRISTOPHER ZIRKLE  
DEPUTIES

Sacramento, California

September 25, 1989

Honorable George Deukmejian  
Governor of California  
Sacramento, CA 95814

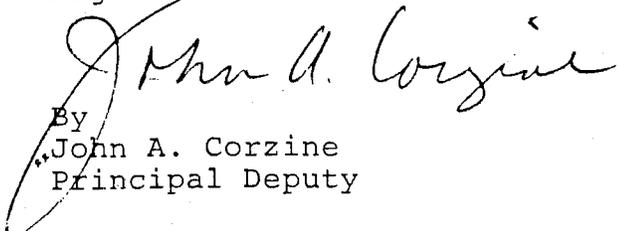
Assembly Bill No. 865

Dear Governor Deukmejian:

Pursuant to your request, we have reviewed the above-numbered bill authored by Assembly Member Wright and, in our opinion, the title and form are sufficient and the bill, if chaptered, will be constitutional. The digest on the printed bill as adopted correctly reflects the views of this office.

Very truly yours,

Bion M. Gregory  
Legislative Counsel

  
By  
John A. Corzine  
Principal Deputy

JAC:wld

Two copies to Honorable Cathie Wright,  
pursuant to Joint Rule 34.

Suite 1500  
1925 Century Park East  
Los Angeles, CA 90067-2790  
213 551-5600  
Facsimile: 213 551-5757

**TPF&C**

*a Towers Perrin company*

November 22, 1989

Asemblewoman Cathie Wright  
State Capitol  
Room 3126  
Sacramento, California 95814

NOV 28 1989 Done 11/28 ST

The Honorable Ms. Wright:

I am interested in your AB 865, and I would like to have a copy sent to my office.

Sincerely,

*Michael Lew*

Michael Lew

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, Wright.

General Subject: Health insurance: claim reimbursement.

Existing law, with respect to policies of disability insurance, self-insured employee welfare benefit plans, and nonprofit hospital service plans provide for claim reimbursement as soon as practical but no later than 30 working days after receipt of the claim unless contested, except that if a nonprofit hospital service plan is a health maintenance organization, reimbursement is required 45 days after receipt, unless the claim is contested. A claimant is required to be notified in writing within 30 working days if his or her claim is contested.

This bill would require the notice that the claim is being contested to identify the portion of the claim that is contested and the specific reasons for

contesting. It would also provide that if the claim is not reimbursed within the time limitation, interest shall accrue, as specified.

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

50549

**AUTHOR'S COPY**

FEB 16 1989

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RECORD #

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RN 89 003091

PAGE NO. 1

An act to amend Sections 10123.13 and 11512.180 of  
the Insurance Code, relating to insurance.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 10123.13 of the Insurance Code is amended to read:

10123.13. Every insurer issuing group or individual policies of disability insurance and every self-insured employee welfare benefit plan 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 or plan unless the claim or portion thereof is contested by the insurer in which case the claimant shall be notified, in writing, within 30 working days. 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 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. If a claim is contested in error, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30 working day period.

As used in this section, a contested claim, or portion thereof, includes situations in which the insurer or plan has not received a completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

SEC. 2. Section 11512.180 of the Insurance Code is amended to read:

11512.180. Every nonprofit hospital service plan that covers hospital, medical, or surgical expenses on a group or individual basis 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 not later than 30 working days after receipt of the claim by the hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the hospital service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, within 30 working days. 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 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. If a claim is contested in error, 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.

As used in this section, a contested claim, or portion thereof, includes situations in which the plan has not received the completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

SECTION 1. Section 10123.13 of the Insurance Code is amended to read:

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If an uncontested claim is not reimbursed 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.

(a) ~~[As used in]~~ For the purposes of this section, a ~~[contested]~~ claim, or portion thereof, ~~[includes situations in which]~~ is reasonably contested where the insurer or plan 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 payer liability for the claim," includes but is ~~[including but]~~ not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

(b) For the purposes of this section, "claimant" means the insured person who is entitled to make a claim for health care services under a contract with the insurer.

(c) For the purposes of this section "reasonable access to information concerning provider services" means that providers shall allow insurer verification of billings for health care services provided a claimant, under the following terms and conditions:

(1) Upon written notice from an insurer, providers shall agree to permit insurer review of provider information which supports a billing, within 30 working days of the notice.

(2) Providers shall not impose fees for accessing information which supports a billing other than reasonable costs of using reproduction equipment, or use of a telephone system for outside-of-facility telephone calls.

SECTION 2. Section 11512.180 of the Insurance Code is amended to read:

11512.180. Every nonprofit hospital service plan that covers hospital, medical, or surgical expenses on a group or individual basis shall reimburse claims or any portion of any claim, whether in state or out of state, for such expenses, as soon as practical, but not later than 30 working days after receipt of the claim by the hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the hospital service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified that the claim is contested or denied within 30 working days[.], or if the plan is a health maintenance organization, within 45 working days.

If an unconstested claim is not reimbursed 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.

(a) ~~[As used in]~~ For the purposes of this section, a [contested] claim, or portion thereof, [includes situations in which] is reasonably contested where the plan has not received the completed claim and been granted reasonable access to 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 [including but] not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

(b) For the purposes of this section, "claimant" means the subscriber who is entitled to make a claim for health care services under a contract with the plan.

(c) For the purposes of this section, "reasonable access to information concerning provider services" means that providers shall allow insurer verification of billings for health care services provided a claimant, under the following terms and conditions:

(1) Upon written notice from an insurer, providers shall agree to permit insurer review of provider information which supports a billing, within 30 working days of the notice.

(2) Providers shall not impose fees for accessing information which supports a billing other than reasonable costs of using reproduction equipment, or use of a telephone system for outside-of-facility telephone calls.

#0091b

Proposed Legislation Concerning  
Penalties for the Health Insurance  
Claims Reimbursement Penalties

SECTION 1. Section 10123.13 of the Insurance Code is amended to read:

10123.13. Every insurer issuing group or individual policies of disability insurance and every self-insured employee welfare benefit plan 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 or plan unless the claim or portion thereof is contested by the insurer in which case the claimant shall be notified, in writing, within 30 working days. The notice that a claim is being contested must identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If a claim that is not contested is not reimbursed 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. If a claim is contested in error, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30 working day period.

As used in this section, a contested claim, or portion thereof, includes situations in which the insurer or plan has not received a completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

SECTION 2. Section 11512.180 of the Insurance Code is amended to read:

11412.180 Every nonprofit hospital service plan that covers hospital, medical, or surgical expenses on a group or individual basis shall reimburse claims or any portion of any claim, whether in state or out of state, for such expenses, as soon as practical, but not later than 30 working days after receipt of the claim by the hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the hospital service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, within 30 working days. The notice that a claim is being contested must identify the portion of the claim that is contested and the specific reasons for contesting the claim.

Proposed Amendments to AB 865  
As Introduced February 23, 1989

Proposed additional section

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

1371. A health care service plan which covers hospital, medical, or surgical expenses 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 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, within 30 working days. 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 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. If a claim is contested in error, 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.

As used in this section, a contested claim, or portion thereof, includes situations in which the plan has not received the completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

ACLIC Revision of Sections 10123.13 & 11512.180 in AB 865:

~~[As used in]~~ For the purposes of this section, a ~~[contested]~~ claim, or portion thereof, ~~[includes situations in which]~~ is reasonably contested where the insurer or plan 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 payer liability for the claim" includes but is ~~[including but]~~ not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

#0158b

Amendments to AB 865 as Amended August 21, 1989  
Author's Amendments

Amendment 1

Page 2, line 14, before the period insert:

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

Amendment 2

Page 3, lines 38-39, delete:

and every self-insured employee welfare benefit plan

Amendment 3

Page 4, line 4, delete:

or plan

Amendment 4

Page 4, line 7, before the period insert:

after receipt of the claim by the insurer

Amendment 5

Page 4, line 26, delete:

or plan

Amendment 6

Page 4, line 33, delete:

or plan

Amendment 7

Page 4, lines 35-39, delete:

This section does not apply to self-insured employee welfare benefit plans if the provisions are in conflict with the Employee Retirement Income Security Act of 1974 (29 U.S.C.A. Sec. 1001 et seq.).

Amendment 8

Page 5, lines 3-4, delete:

or a self-insured employee welfare benefit plan

Amendment 9

Page 5, lines 10-11, delete:

or self-insured welfare benefit plan

Amendment 10

Page 5, lines 14-15, delete:

or self-insured welfare benefit plan

Amendment 11

Page 5, lines 25-27, delete:

This section does not apply to overpayments by self-insured employee welfare benefit plans which are not subject to Section 10123.13.

Amendment 12

Page 6, line 1, before the period insert:

after receipt of the claim by the nonprofit hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the nonprofit hospital service plan

AUG 17 1989

81037  
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89229 18:01  
RN 89 022062 PAGE NO. 1

**Substantive**

AMENDMENTS TO ASSEMBLY BILL NO. 865  
AS AMENDED IN ASSEMBLY MAY 25, 1989

Amendment 1

In line 1 of the title, after "of" insert:

, and to add Section 1371.1 to,

Amendment 2

In line 2 of the title, after "of" insert:

, and to add Sections 10123.14 and 11512.181 to,

Amendment 3

On page 2, line 13, after the comma insert:

that the claim is contested or denied,

Amendment 4

On page 2, strike out line 17 and insert:

If an uncontested claim, or uncontested portion of the claim, is not reimbursed by delivery to the claimants' address of record within the

Amendment 5

On page 2, strike out lines 25 to 31, inclusive, and insert:

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. 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.

SEC. 1.5. Section 1371.1 is added to the Health and Safety Code, to read:

1371.1. Whenever a health care service plan which covers hospital, medical, or surgical expenses determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing

through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the health care service plan within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the health care service plan shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

If the provider does not make reimbursement for an uncontested overpayment 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.

Amendment 6

On page 3, line 5, after the comma insert:

that the claim is contested or denied,

Amendment 7

On page 3, strike out line 9, and insert:

If an uncontested claim, or uncontested portion of the claim, is not reimbursed by delivery to the claimants' address of record within 30

Amendment 8

On page 3, strike out lines 16 to 22, inclusive, and insert:

For purposes of this section, a claim, or portion thereof, is reasonably contested where the insurer or plan has not received a completed claim and all information necessary to determine payer liability for the claim. 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 or plan to determine the medical necessity for the health care services provided to the claimant. This section does not apply to self-insured employee welfare benefit plans if the provisions are in conflict with the Employee Retirement Income Security Act of 1974 (29 U.S.C.A. Sec.

1001 et seq.).

SEC. 2.5. Section 10123.14 is added to the Insurance Code, to read:

10123.14. Whenever an insurer issuing group or individual policies of disability insurance or a self-insured employee welfare benefit plan which covers hospital, medical, or surgical expenses determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the insurer or self-insured welfare benefit plan within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the insurer or self-insured welfare benefit plan shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

If the provider does not make reimbursement for an uncontested overpayment 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.

This section does not apply to overpayments by self-insured employee welfare benefit plans which are not subject to Section 10123.13.

Amendment 9

On page 3, line 35, after the second comma insert:

that the claim is contested or denied,

Amendment 10

On page 3, strike out line 39, and insert:

If an uncontested claim, or uncontested portion of the claim, is not reimbursed by delivery to the claimants' address of record within the

Amendment 11

On page 4, strike out lines 7 to 13, inclusive, and insert:

For 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. Information necessary to determine liability 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.

SEC. 3.5. Section 11512.181 is added to the Insurance Code, to read:

11512.181. Whenever a nonprofit hospital service plan which covers hospital, medical, or surgical expenses determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the nonprofit hospital service plan within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the nonprofit hospital service plan shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

If the provider does not make reimbursement for an uncontested overpayment 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.

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54684  
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MAY 25 1989

*Wright*

MAY 19 1989

*DPAA (18-0)  
MAY 19 5/13/89*

89139 19:12  
RN 89 016507 PAGE NO. 1

AMENDMENTS TO ASSEMBLY BILL NO. 865  
AS AMENDED IN ASSEMBLY MAY 10, 1989

**Substantive**

Amendment 1

On page 2, strike out lines 21 to 23, inclusive

Amendment 2

On page 3, line 12, strike out "If a claim"  
strike out lines 13 to 15, inclusive

Amendment 3

On page 4, strike out lines 4 to 6, inclusive

- 0 -

MAY 08 1989

86996  
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RN 89 015198

89128 11:28  
PAGE NO. 1

**Substantive**

AMENDMENTS TO ASSEMBLY BILL NO. 865

Amendment 1

In line 1 of the title, after "to" insert:

amend Section 1371 of the Health and Safety Code, and to

Amendment 2

On page 2, line 1 after "SECTION 1." insert:

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

1371. A health care service plan which covers hospital, medical, or surgical expenses 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 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, within 30 working days. 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 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. If a claim is contested in error, 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.

As used in this section, a contested claim, or portion thereof, includes situations in which the plan has not received the completed claim and all information necessary to determine payer liability for the claim, including, but not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

SEC. 2.

Amendment 3

On page 2, line 30, strike out "SEC. 2." and insert:

86996  
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89128 11:28  
RN 89 015198 PAGE NO. 2

SEC. 3.

- 0 -

56813  
RECORD #

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SEP 05 1989

89248 15:43

RN 89 023716 PAGE NO. 1

**Nonsubstantive**

AMENDMENTS TO ASSEMBLY BILL NO. 865  
AS AMENDED IN SENATE AUGUST 30, 1989

Amendment 1

In line 3 of the title, strike out "10123.14"  
and insert:

10123.145

Amendment 2

On page 4, line 31, strike out "10123.14" and  
insert:

10123.145

Amendment 3

On page 4, line 33, strike out "10123.14." and  
insert:

10123.145.

- 0 -

problems. Although I don't pretend to have all the answers. I have made some observations and had some successes which may be useful.

extend their hours when other employees are sick or on vacation.

Another important tool we could all

## Delta Dental

(continued from page one)

(h) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(i) "Person" means any person, individual, firm, association, organization, partnership, business trust, foundation labor organization, corporation, public agency, or political subdivision of the state.

(n) "Specialized health care service plan contract" means a contract for health services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for such in return for a prepaid or periodic charge paid by or on behalf of such subscribers or enrollees for the cost of provided services.

(o) "Subscriber" means the person who is responsible for payment to a plan or whose employment or other status, except

for family dependency, is the basis for eligibility for membership in the plan.

(p) Unless the context indicates otherwise, "plan" refers to health care service plans and specialized health care service plans."

It would appear that Section 1345 (p) would void Delta's Service Benefit Contract "subcontractor" concept by definition. Furthermore, Section 1343.5 seems to place the burden proof on Delta to the validity of many of its activities.

### S 1346 Powers of commissioner

The commissioner shall administer and enforce the provisions of this chapter. He or she shall have the following powers:

(a) Recommend and propose the enactment of such legislation as necessary to protect and promote the interests of the public, subscribers, enrollees, and providers of health care service plans in the State of California.

(b) Provide information to federal and state legislative committees and executive agencies concerning plans.

Michael McKeever, D.D.S.  
Editorial Board  
Santa Clara County Dental Society

(c) Assist, advise and cooperate with federal-state-local agencies and officials to protect and promote the interests of plans, subscribers, enrollees and the public.

(d) Study, investigate, research, analyze matters affecting the interests of plans, subscribers, enrollees, and the public.

(e) Hold public hearings, subpoena witnesses, take testimony, compel the production of books, papers, documents, and other evidence, and call upon other state agencies for information to implement the purposes, and enforce the provisions of this chapter.

(f) Conduct audits and examinations of the books and records of plans and other persons subject to this chapter.

(g) Promote and establish standards of ethical conduct for the administration of plans and undertake activities to encourage responsibility in the promotion and sale of plan contracts and the enrollment of subscribers or enrollees in such plans.

(j) Advise the Governor on all matters affecting the interests of plans, subscribers, enrollees, and the public.

### S 1368 Grievance System

(a) Every plan shall establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations which shall insure adequate consideration of enrollee grievances and rectification when appropriate.

(b) Every plan shall inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. Such information shall include the location and telephone number where grievances may be submitted.

ADA and CDA are now organized jointly and can better serve young practitioners. If you have any questions or suggestions please call Alyson at 498-3381.

(c) Every plan shall provide forms for complaints to be given to subscribers and enrollees who wish to register written complaints. The forms used by plans licensed pursuant to Section 1353 shall be approved by the commissioner in advance as to format.

(d) The plan shall keep in its files all copies of complaints, and the responses thereto, for a period of five years.

### S 1369 Public Policy of plan, participation by subscribers and enrollees; sufficient compliance

"Every plan licensed pursuant to Section 1353 shall establish procedures to permit subscribers and enrollees to participate in establishing the public policy of the plan. For purposes of this section, public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public.

Compliance with the requirements of the Health Maintenance Organization Act of 1973 (42 U.S.C. S 300e et seq.) shall be deemed sufficient compliant with this section."

It would take another article to explain how many Mack trucks could travel side by side, to pass through the loop-hole established by stating this last paragraph, that suggests Section 300e of the HMO Act of 1973, is "...sufficient compliance..." "...to assure the comfort, dignity, and convenience of patients...."

The Health and Safety Code/Knox-Keene Act (and the Insurance Code) were amended by Legislative action in a State Assembly bill know as AB-4206.

Effective 1/1/87, the California Health

(continued on next page)



## BITS & BYTES

Helping people with their computer needs is what I do best.

For the past several months I have had the pleasure of working with the HDS staff resolving computer productivity problems. Specifically, tuning their equipment to cope with modern speeds and software, with very little expense to the Society.

My aim is not to sell computers but to provide service and assistance to those who must or want to compute. Many of us already have computers and are happily computing. But some of us would like to get more out of computing or don't know where to start. That's where I come in! I specialize in computer services, information management and hardware.

## Your Connection . . .

**DIRECTORS**

Ronald Surdi, DDS • 548-5720  
 Alyson Emery, DDS • 498-3381  
 Richard Matsueda, DDS • 323-0689  
 Michael Winter, DDS • 941-8218

**RECRUITMENT/RETENTION**

James Bettinger, DDS  
 860-1333

**MEMBERSHIP APPLICATION REVIEW**

Oscar Domodon, DMD  
 426-6591

**ETHICS**

Douglas Wall, DDS  
 597-7751

**PEER REVIEW**

George Papazian, DDS  
 420-1512

**DENTAL CARE**

Robert Gregg, DDS  
 860-6587

**LEGISLATION**

Lawrence Stark, DMD  
 436-8294

**Philip Solomon, DDS**

423-7996

**PROFESSIONAL RELATIONS**

Douglas Emery, DDS  
 498-3381

**GPR**

Larry Hall, DDS  
 424-1217

**DENTAL HEALTH/MARKETING**

Steve Vergara, DDS  
 323-2367

**PROGRAMS**

Mark Garlington, DDS  
 597-2471

**Charles Joseph, DDS**

431-4200

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 421-3336

**TRUSTEE / BY-LAWS**

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 493-2403

**TRUSTEE**

James Loos, DDS  
 421-8883

**EDITOR**

Robert Brundin, DDS  
 320-3240

**MEMBERS-AT-LARGE**

J. Michael Cahan, DDS • 438-9994

Dentists are under no obligation to purchase unsolicited merchandise or pay for its return to the supplier, says ADA Associate General Counsel Mary Logan.

Dentists who receive unsolicited items should inform the supplier they didn't order the merchandise and that it should be removed at once from the dental office. "If you use the merchandise or keep it without notifying the supplier, you will be obligated to pay for it," Ms. Logan said.

To prevent such occurrences, the ADA Council on Dental Materials, Instruments and Equipment suggests dentists:

- specify one person to handle orders;
- request an invoice number from anyone calling about a previously placed order;
- make sure office personnel are aware of orders placed;
- screen incoming calls for their purpose;
- make all orders in writing and have all verbal orders confirmed in writing;
- have office personnel ask for the records of orders that appear to be suspicious deliveries or unordered items; and
- check incoming items against orders before paying for them.

**Delta Dental... continued from page four**

& Safety Code was amended with regards to prompt claims payment. Code Sec. 1371 reads, "A health care service plan (Delta) which covers hospital (oral surgery), medical, or surgical (dental surgery) 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 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, within 30 working days." The Dept. of Corporations is responsible for enforcing compliance with this law.

Delta's attorneys have stated this law does not technically apply to them, but they have no wish to dispute the point, and are doing "their best" to comply with the law. However, AB-4206 is very specific in clarifying that the law does apply to Delta. AB-4206 also amends Health & Safety Code Sec.1375.1 (c), stating, "For the purposes of this section, 'covered health care services' means health care services under *all* plan contracts."

Too often to the detriment of patients and dentists, Delta has been inefficient and inaccurate in their claims processing procedures with respect to AB-4206. Helpfully, Assembly Member Cathie Wright, (R-Simi Valley) has introduced AB-865. ~~If passed, this law would allow the charging of interest for uncontested claims that are not reimbursed within 30 working days (45 calendar days). The annual percentage rate (APR) will be 10 percent and will accrue beginning with the 31st working day (or the first working day after 45 calendar days).~~

Next month I will present federal laws, regulations and agencies that apply to Delta Dental, but as you will see, there will still be some overlap in accountability.

**Continuing Education Seminar**

Saturday, February 10, 1990  
 Ramada Renaissance Hotel  
 111 E. Ocean Blvd. - Long Beach, CA

8:00 a.m. to 1:30 p.m.  
 Buffet Breakfast and  
 Continuing Education (5 units)  
 Cost: \$45.00

For registration information contact  
 Roz Mattson, RDH, 3478 Windsor Court,  
 Costa Mesa, CA 92626.

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## Continuing Ed Program

Tuesday

November 14, 1989

Golden Sails Hotel, Long Beach  
Registration 12:30 pm

Fees: Dentists - \$60.00  
Staff, Auxiliary - \$28.00

*\$5.00 late registration fee if  
reservations are made after  
Friday November 10, 1989*

### Our guest lecturer

...is a graduate of UCSF for his both his dental degree, 1967 and his M.S. in Oral Biology, 1970. Dr. Buemer received his degree in Oral Prosthodontics from UCLA in 1975. He is currently Professor and Chairman, Removable Prosthodontics and Director, Maxillofacial Prosthetic Clinic, UCLA School of Dentistry. He has authored 80 publications and two books. The latest book deals with clinical and laboratory systems of the Branemark implant system. Dr. Buemer organized the Osseointegrated Implant Program at UCLA, beginning in 1984.

## HDS WELL-BEING COMMITTEE

The HDS Well-Being Committee, an organization of dentists, is available to provide information, confidential assistance and support for anyone affected by alcohol or drug dependency. For information or assistance, please contact

213 / 424-1423

The first impression that a patient has of an office is over the phone. When patients have concerns they most often use the phone to voice their complaints. The office and more specifically the doctor, must respond to unhappy patients quickly and with compassion to assuage hurt feelings. A phone log should be kept so the doctor has the option of calling these patients at home. Patient frustrations increase when they are ignored. A short phone call by the doctor often defuses the most heated disagreement.

D. Ask the patient what they would suggest to rectify the situation.

E. Respond to the patient so that they feel their concerns are appreciated. If possible, comply with the patient's requests. An apology, a refund are small prices to pay for a patient's and ultimately a referral source's satisfaction.

*Editor's Note: Remember, communication is 90% listening. (Paula Perich, Assistant Executive Director, Membership and Marketing Services, ADA)*

## DELTA DENTAL DISCLOSED

# Accountability for Delta Dental & The Knox Keene Act

By Robert H. Gregg, DDS  
*Chairman, Dental Care Committee  
Member, HDS Writer's Council*

### Part three in a series

***This month continues the evaluation of state laws and agencies governing Delta Dental Plan of California.***

It seems the only way to get the message across that Knox-Keene is insufficient for regulating Delta Dental Plan, discouraging as this information may be, is to "tell it like it is."

Change will come about only if we sufficiently understand the problem and who is accountable, enough to make recommendations to Christine Bender, Commissioner of the Department of Corporations and the Legislature, as unpleasant as that may be. State Senator Alan Robbins (D-20) is Chairman of the Senate Standing Committee on Insurance, Claims, and Corporations.

The following illustrates the need for change in California laws. The California Insurance Code is contained in four

volumes that cover 2,722 pages, and includes 15,062 sections. The entire Knox-Keene Act is contained in a small chapter (Ch 2, 22.2) in one volume of the five volume Health and Safety Code. Knox-Keene covers 71 pages and includes 59 sections. As such, there are sufficient loop-holes, inadequacies, and poor language and grammar in Knox-Keene to make California State regulation and oversight of Delta Dental Plan very confusing, if not outright laughable.

The California Health and Safety Code SS1340-1399, has more interesting language the Harbor membership may wish to know:

### S 1342 Intent and Purpose of Legislature

"It is the intent and purpose of the Legislature to promote the delivery of health and medical care to the people of the state of California who enroll or subscribe for the services rendered by a health care service plan or specialized health care service plan by:

(e) Promoting effective representation of the interest of subscribers and enrollees."

Reports made to appropriate authorities remain confidential.

## RETRIBUTION

Section 11172 immunizes persons from civil and criminal liability for reporting, unless the person knowingly gave a false report.

## REPORT CHILD ABUSE TO:

1. County Probation Officer
2. Welfare Department
3. Department of Children and Family Services

Copies of pertinent California statutes are available by contacting the Harbor Dental Society office, (213) 595-6303.

*This information courtesy of  
Mr. Paul Lombardo,  
CDA General Counsel*

*Submitted by: Doug Wall, DDS  
Chairman, Ethics Committee*

## S 1343.5 Definitions; exemptions or exceptions; burden of proof

"In any proceeding...the burden of providing an exemption or exception from a definition is upon the person claiming it."

## S 1344 Rules, forms and orders; opinion; acts and omissions in good faith

"(b) The commissioner may honor requests from interested parties for interpretive opinions."

## S 1345 Definitions

(c) "Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan.

*(please turn to page four)*

## Delta Disclosed

(continued from page one)

"Insurance" is not what Delta wants to be perceived as doing. They would then be regulated by the Insurance Code and the Department of Insurance, which is relatively more able and willing to investigate consumer complaints, and has authority to enforce the insurance laws.

Insurance is defined in the California Civil Code, Title 11 and Insurance Code, Title 22. Both sections are identical in wording, "Insurance defined: Insurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from an unknown or contingent event." Even though Delta does nearly everything an insurance company does: collects premiums, assumes a contractual liability arising from an "unknown or contingent event," requires deductible and co-payments, processes ADA claim forms, requires "proof of loss," pays benefits to beneficiaries (or providers with a patient's assignment of benefits), maintains reserves for future claims and liabilities (\$130 million in fiscal '88 — as well as accumulate \$5.5 million in "excess revenues over expenses") and with the exception of not issuing stock to stockholders, conducts its business and operations just like an insurance company; Delta is technically not an "insurer," because Delta has not been fully scrutinized with respect to California Civil Code Title 11. Yet, in several other states, Delta is regulated by their Department of Insurance.

Thus, Delta of California escapes third-party payer oversight long established in our Department of Insurance. For example, the Insurance Code has stipulations for "unfair claims practices," and the Insurance Commissioner can issue orders and penalties to enforce these laws. The Knox-Keene Act has no such detailed stipulations for service plans, creating a great void in accountability in state statutes for Delta Dental regulations. There is no specific Knox-Keene Plan Commissioner, department, or extensive regulatory code as there is in the Department of Insurance. The Department of Corporations and the Department Commissioner were not originally designed, nor sufficiently staffed after Knox-Keene to oversee hundreds of Knox-Keene Plans, and do so effectively.

Next month continues our look at California state laws and agencies that are responsible for regulating Delta Plan (CDS).

## Freedom of expression

By the time this is read, the international brouhaha regarding Salman Rushdie's novel, *The Satanic Verses*, may well be over. But at the time of writing, the author is hiding in fear of his life, and the world, this time the literary world, is being held hostage by a religious zealot. All professionals, all educated people, in truth everyone who believes in freedom of speech, should be appalled by the recent spate of book burnings and staged riots in connection with the publication in England of *The Satanic Verses*. Academic freedom is part and parcel of our professional life and we should urge the professional organizations to which we belong to join in supporting the right of any person to write what they want, publish what they can, and read what they want.

When extremism rears its ugly head we all suffer. Whatever one's personal religious or political belief, burning books, and thus symbolically preventing others from reading books that express opinions distasteful to us as individuals, is simply wrong, dead wrong. In the United States we have witnessed the murder of an author, Henry Liu. An American citizen, Chinese by birth, Mr. Liu was killed by political enemies who, shall we say, lacked appreciation for his writings about his former homeland. Extremism that seeks to dictate what we may read or write is a corrupt expression of power. There is no doubt that

the death of Mr. Liu and the theft of the life of Mr. Rushdie will affect future authors and their willingness to freely express themselves. This is a real tragedy.

While it is unlikely that the sciences or treaties on professional and scientific matters in *Quintessence International* would invoke the Ayatollah's words are just as threatened in the world by the recent diabolical threats of Rushdie. In dental scientific publications we must be on guard not to let biases influence acceptance or rejection of certain papers. For example, we should publish some papers that show techniques and data that would be rejected in many publications in this country because the technique or data violate a folkloric belief that may have been a part of dental practice over the years. Rejection of a paper in *Quintessence International* made on the grounds that the paper's data or technique violates the religious or editor's belief, just like publication and sale of a book like *The Satanic Verses* must not be denied on the grounds that it offends some particular religious belief.

If we rejected papers that the scientific staff and reviewers found scientifically sound, but simply did not agree with philosophically, our value to the profession would decrease precipitously. We should not be a person who was offended by the publication of a book where to demand its

## YET ANOTHER OUTRAGE

### "Doctor, You charge more than the UCR "SO I WON'T PAY THE DIFFERENCE"

Reprinted courtesy: *Dental Business Today*, June 1989

Charles Kidd, Editor

In reading Del Webb's Insurance Newsletter I was stunned to see copies of correspondence sent to his patient by Aetna in which Aetna suggested that the patient not pay the difference between the doctor's fee and the amount indicated as UCR by the carrier.

In an industry known for its brazen and heavy handed tactics, this is not only the latest but the most outrageous infringement on the dentists' rights yet. What they are attempting to do is hold the dentists to a fee that they have never agreed to or even been informed of.

Now let's look at the same case as the new strategy developed by their client Navistar. You submit the same \$550 fee. You get the same carrier. But, this time the carrier writes to the patient and suggests to them that the UCR allowance of \$450 is more adequate and that they should pay 50 percent of \$450 or \$225. So this leaves you holding the bag for the entire difference between your UCR and Aetna's UCR fee. The insurer has adjusted your fee without your knowledge or permission by 18 percent.

I know this sounds hard to believe. I have seen copies of the correspondence. Here is word for word what Aetna says in the explanation of benefits:

# Harbor Dental Journal

HARBOR DENTAL SOCIETY • A COMPONENT OF THE CALIFORNIA DENTAL ASSOCIATION & THE AMERICAN DENTAL ASSOCIATION

SEPTEMBER 1989



CONTINUING  
EDUCATION  
PROGRAM

## Infectious Diseases and Infection Control

John Beierle, DDS

You and your dental team need to be current on the regulations concerning infection control as well as up-to-date information on the treatment of patients with infectious diseases.

**Mark your calendar!  
Don't miss our  
September 12, 1989  
Continuing Education  
Program!**

Our special guest speaker is John Beierle, D.D.S., Associate Professor, Medical Microbiology U.S.C. School of Dentistry, Department of Basic Sciences.



### HDS FACT FILE

Please join us on Tuesday,

September 12, 1989

Golden Sails Hotel • Long Beach

Registration begins at 12:30 pm

See your program flyer  
(mailed separately) for program  
agenda and reservation details.

## DENTI-CAL REFERRAL LINE

The Harbor Dental Society has installed a special telephone line to provide a recorded message of all HDS members who will accept Denti-cal patients in their offices. Please keep this telephone number handy for easy referral.

**(213- 595-5322)**

If you wish to be placed on this recorded message, please contact the HDS office.

### PART ONE IN A SERIES

## Delta Dental Disclosed...

By ROBERT H. GREGG, DDS  
*Chairman, Dental Care Committee*

Many dentists and patients are surprised to learn that Delta Dental Plan of California is not an insurance company. That's right! Delta (formerly California Dental Service...CDS) is not an insurance company under California and federal law. Therefore, they are not regulated by the Department of Insurance, and do not have to follow the guidelines of the insurance commissioner nor the laws of the California Insurance Code.

With Proposition 103 we have seen how insurance companies have thumbed their noses at the California voters. This is in spite of an entire department and volumes of insurance code law to regulate them. Well, what is Delta, and who is responsible for regulating them?

What Delta is, in general, is a *fiduciary*, like banks and insurance companies. A fiduciary is any party that manages money or property for another party and in whom the other has the legal right to place great trust and confidence. It is any relationship in which a party (Delta) is under a legal duty to act for the benefit of another party. A corporation (Delta) acting as a fiduciary is not permitted to make use of the relationship for its own corporate benefit. The courts carefully scrutinize any transaction between parties in fiduciary relationships, particularly if the dominant party profits at the expense of the party under his influence. Such a transaction is presumed to be fraudulent and void, and the court will strike it down unless the party who asserts that it is valid can clearly establish its fairness.

What Delta Dental is, specifically, is a "health care service plan" or "service corporation." Delta is not regulated by the California Insurance Code. The only mention a health plan receives in the Insurance Code is to exempt them. According to the Insurance Code of California, Section 740, "A health care service plan...shall not be subject to the provisions of this section."

Delta is such a health care service plan and is supposed to follow the laws as described in the California Health and Safety Code, Section 1340-1399, known as the Knox-Keene Health Care Service Plan Act of 1975.

These plans are often referred to as "Knox-Keene plans." Knox-Keene is the California law that regulates all HMOs and many PPOs. All Knox-Keene plans are regulated by the Department of Corporations and the California Securities Laws.

In case the point escaped you, Delta is a Preferred Provider Organization (PPO). Delta happens to have generous fee allowances for many procedures, but it is still a PPO.

The California Health and Safety Code, Section 1340-1399, and the Knox-Keene Health Care Service Plan Act of 1975 have some interesting language HDS members may wish to know:

#### Section 1342: Intent and Purpose of Legislature

"It is the intent and purpose of the Legislature to promote the delivery of health and medical care to the people of the state of California who enroll or subscribe for the services rendered by a health care service plan or specialized health care service plan by:

a. Assuring the continued role of the professional as the determiner of the patient's health needs which foster the traditional patient professional relationship of trust and confidence.

b. Assuring subscribers and enrollees are educated and informed on benefits and services available to enable a rational consumer choice in the marketplace.

c. Protecting the potential subscriber or enrollee from fraudulent solicitations, deceptive methods, misrepresentations, or practices."

#### Section 1377: Reimbursement, "fee-for-services" defined

"As used herein the term 'fee-for-services' refers to the situation where the amount of reimbursement paid by the plan to providers of service is determined by the amount and type of service rendered by the provider of service."

Next month I will write about some of the federal laws that regulate health care service plans and Delta Dental.

## The Golden Age: A Member's Forum

### Golden Age not the issue, but love of profession

Dentistry is like marriage in many ways. It takes a great amount of hard work, compromise and trust. If you're not in love with dentistry it will make your life miserable. It certainly is not for everybody!

But nobody ever promised a free and easy ride. That should have been obvious immediately after starting dental school. Like most things in life, you get out of dentistry approximately what you put in. I hear many of my friends say they hate dentistry, or it isn't worth the investment, time, frustration, etc. They think only dentists are subject to burn out, disappointments, lack of respect, hardship, and non-achievement of personal and business goals. Like the saying goes, "Life's a bitch, then you die." Probably the most interesting thing about these people is, while they seem to project a miserable attitude, they usually live in a big house in a nice area, have nice cars, work four days per week and take several vacation weeks per year.

At some point I think we have to stop and ask ourselves how much is enough? Will I ever be satisfied? Are my wants and needs in order?

(please turn to page 3)

## "Golden Image:" Is It Safe?

By DOUGLAS V. EMERY, DDS

Well, it seems that dentistry has had a continuing "painful" battle with its reputation. I can't say that I blame my patient's apprehension about the dental profession, after all, we don't do a lot to change the dental image to which the public is exposed. For instance, look at the dentists immortalized in the movies.

In the 1930's we had W.C. Fields starring in *The Dentists*. This is one of my personal favorites, probably because my Dad is so fond of Fields. In this film, Fields plays the stereotypical golf minded dentist who doesn't use anesthesia for extractions and ends up "pulling" the wrong tooth. For movie buffs it is quite an enjoyable film, but again one is left with the thought of Fields' patient squirming in the chair as his tooth is removed with Fields' knee in his chest.

In the 1970's our profession was blessed with *The Marathon Man*. If any film is to be correlated with dental phobia this is the one. To refresh your memory, this

film starred Dustin Hoffman and Laurence Olivier. Hoffman was the unfortunate "man in the wrong place at the wrong time" as he was repeatedly tortured by Olivier, an ex-Nazi dentist. In the film, Olivier did numerous pulpal exposures with a highspeed drill, as Hoffman produced some of Hollywood's finest blood-curdling screams. I get the hebe-jebes just thinking about this film; however, it does provide the classic film buff line as Olivier approaches Hoffman with his "drill" he utters the immortal words, "Is it safe?" (This is not a funny comment to make to someone who has seen this movie, if they are your patient.)

Finally, in the 1980's, dentists were given new attributes. *Little Shop Of Horrors* had Steve Martin as the dentist who not only inflicted gratifying pain to a masochistic patient, Bill Murray, he also inhaled enough nitrous oxide to asphyxiate himself. Another cinematic giant was *Compromising Positions*.

(please turn to page 2)

## DELTA DENTAL DISCLOSED

# Making Sense of California Dental Laws

By Robert H. Gregg, DDS  
Chairman, Dental Care Committee  
(part two in a series)

Last month's article explained that state laws governing Delta Dental Plan of California can be quite obscure, complex, and confusing. It is timely to report more on California laws.

To summarize, Delta Dental is a non-profit "health care service-plan." They are a Knox-Keene Plan as described in the California Health and Safety Code, and are regulated by the Department of Corporations, and not by Insurance Commissioner Roxani Gillespie or the Department of Insurance.

Delta Dental likes to make it clear that all they do is enter into contracts with employers and providers, and any similarity with an insurance company is incidental. Delta writes about its Service Benefit Concept, "Rather than insuring against dental claim expenses or 'losses' (as they are referred to by insurance companies), Delta contracts with purchasing groups to provide dental treatment. Delta then contracts with dentists for the provision of that treatment."

Translated during the Delta Dentist Forum held in Long Beach August 1, 1989, Delta representatives stated Delta

Dental Plan believes and acts as if they are the provider of treatment, and the Delta Participating Dentist is merely a "subcontractor" in some sort of secondary after-the-fact contracting! This is hardly the reality of Delta Dental's Confidential Fee Listing and Participating Dentist Agreement. Delta's contracts with dentists are completely separate and independent of a prior purchasing group contract. Otherwise, patients could not receive benefits for treatment at non-participating dentists' offices which they can and do.

It appears that Delta uses this "Service Benefit Concept" (SBC) to explain and justify their reimbursement decisions, as if SBC was part of California law. Again, the Health and Safety Code, Section 1377, defines fee-for-services to be, "...the amount paid by the plan to providers of service is determined...by the provider of the service." Who else but Delta (a service plan) did the Legislature intend to be "the plan"? How can Delta suggest they are the provider when the Health and Safety Code, Section 1342, **Intent and Purpose of Legislature** (a) states, "Assuring the continued role of the professional as the determiner of the patient's health needs..."?

This distinction between "insuring against losses" (to indemnify) and "purchasing contracts" in the Services Benefit Concept is also the critical difference that separates state regulatory responsibility for Delta. For-profit insurance companies indemnify against losses; "non-profit" health care service plans arrange contracts. This key distinction determines which state regulatory department (Corporations or Insurance) oversees Delta Dental Plan of California.

(please turn to page two)

## INFECTIOUS WASTE DISPOSAL

# Red bag everything (almost)

By P.L. Fan, Ph.D., Assoc. Secretary  
ADA Council on Dental Materials,  
Instruments and Equipment

Increased awareness of infectious diseases has caused federal, regional and local governments to enact legislation regarding disposal of infectious wastes.

Health care facilities and health care workers face a myriad of definitions of categories of wastes and methods for their disposal. Disposal of these waste items may, depending on the regulation,

(MMWR), August 27, 1987, the CDC stated "there is no epidemiologic evidence to suggest that most hospital waste is any more infectious than residential waste. Moreover, there is no epidemiologic evidence that hospital waste has caused disease in the community as a result of improper disposal. Therefore, identifying wastes for which special precautions are indicated is largely a matter of judgment about the relative risk of disease transmission."

## Chemical dependency: a dental family disease

By S. William Oberg  
Assistant Secretary  
Council on Dental Practice, ADA  
(conclusion to a four-part series)

The first three articles in this series have sought to acquaint you with the disease of chemical dependency, its consequences if not treated, and the denial and enabling behavior in the family that keep the sick person from getting help.

This series has also presented the positive messages of hope: chemical dependency is treatable. The unmanageable lives of those who are chemically dependent and those who want to help but can't, can be restored to sanity. A tough love approach must be used by family members, friends, office staff, colleagues, and significant others.

Q: If I think I know a dentist (or other member of the dental family) who is in trouble with alcohol or other drugs, what should I do?

A: If you think the person is in trouble, he or she probably is! You cannot afford to do nothing. Call the

PUBLIC EMPLOYEES' RETIREMENT SYSTEM  
1989-90 REGULAR SESSION  
BILL ANALYSIS

AB 865 (Wright)  
Original

PERS POSITION: SUPPORT  
(Staff Position  
Only)

SUMMARY

This bill would require that every self-insured employee welfare benefit plan and nonprofit hospital services plan notice a claimant within 30 working days that a claim is being contested, identify the portion of the claim that is contested and specific reasons in contesting. It would also provide that, if a noncontested or erroneously contested claim that is not reimbursed within the time limitation (30 working days), interest shall accrue at the rate of 10% per annum beginning with the first calendar day after the 30 working-day period.

BACKGROUND

Section 10123.13 of the Insurance Code requires insurers to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim by insurer unless the claim or portion thereof is contested. If contested, the claimant shall be notified in writing within 30 working days. The current PERS-Care self-insured plan requires that 85% properly completed claims will be processed in ten working days as reflected in a performance clause within the contract with the claims administrator.

This bill would expand Section 10123.13 to require:

- o Interest to be paid on uncontested claims not reimbursed within 30 working days after receipt.
- o Interest to be paid on claims contested in error beginning with the first calendar day after the 30 working-day period.

The definition of a contested claim, or portion thereof, includes situations in which the insurer or plan has not received a completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim or appeal.

FISCAL IMPACT ON STATE BUDGET

Unknown. However, savings accrued by hospitals either through increased cash flows or by reducing the cash conversion cycle will ultimately be passed on to the consumer, i.e., PERS health program.

BILL ANALYSIS  
Page 2  
Ab 865 (Wright)

RECOMMENDED POSITION AND COMMENTS

Support. The Legislative Counsel's Digest indicates that only self-insured employee welfare benefit plans and nonprofit hospital service plans are affected. The Digest should be changed to indicate that all profit and nonprofit hospital service plans and all profit and nonprofit health care service plans are affected by the bill. The bill should also amend Section 1371 of the Health and Safety Code to include the interest penalty for Health Care Service Plans.

PUBLIC EMPLOYEES' RETIREMENT SYSTEM  
1989-90 REGULAR SESSION  
BILL ANALYSIS

MAY 31 1989

AB 865 (Wright)  
as amended 5/10/89

PERS POSITION: SUPPORT

SUMMARY

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FISCAL IMPACT ON STATE BUDGET

Unknown. However, savings accrued by hospitals either through increased cash flows or by reducing the cash conversion cycle will ultimately be passed on to the consumer, i.e., PERS health program.

PUBLIC EMPLOYEES' RETIREMENT SYSTEM  
1989-90 REGULAR SESSION  
BILL ANALYSIS

AB 865 (Wright)  
as amended 5/25/89

PERS POSITION: SUPPORT

SUMMARY

This bill would require that every self-insured employee welfare benefit plan and nonprofit hospital services plan notice a claimant within 30 working days (or 45 days if the plan is a health maintenance organization) that a claim is being contested, identify the portion of the claim that is contested and specific reasons in contesting. It would also provide that, if a noncontested or erroneously contested claim that is not reimbursed within the time limitation (30 working days), interest shall accrue at the rate of 10% per annum beginning with the first calendar day after the 30 or 45 working-day period.

BACKGROUND

Section 10123.13 of the Insurance Code requires insurers to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim by insurer unless the claim or portion thereof is contested. If contested, the claimant shall be notified in writing within 30 working days. The current PERS-Care self-insured plan requires that 85% properly completed claims will be processed in ten working days as reflected in a performance clause within the contract with the claims administrator.

This bill would require interest to be paid on uncontested claims not reimbursed within 30 or 45 working days after receipt.

The definition of a contested claim, or portion thereof, includes situations in which the insurer or plan has not received a completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim or appeal.

FISCAL IMPACT ON STATE BUDGET

Unknown. However, savings accrued by hospitals either through increased cash flows or by reducing the cash conversion cycle will ultimately be passed on to the consumer, i.e., PERS health program.

## DEPARTMENT OF HEALTH SERVICES

714/744 P STREET  
SACRAMENTO, CA 95814

(916) 324-1003



AUG 10 1989

August 7, 1989

The Honorable Cathie Wright  
Member of the Assembly  
State Capitol, Room 3126  
Sacramento, CA 95814

Dear Ms. Wright:

OPPOSITION OF ASSEMBLY BILL 865 (MAY 25, 1989 VERSION)

I regret to inform you that the Department opposes Assembly Bill (AB) 865, May 25, 1989 version. AB 865 still requires health care service plans licensed under the Knox-Keene Act to pay a ten percent per annum interest rate on uncontested claims not paid to their contracting providers. This will still increase prepaid health plan (PHP) costs in a manner which is detrimental to the interest of the Medi-Cal managed care objectives and which could make the Medi-Cal contracting program less attractive to contractors.

The bill still arbitrarily sets a ten percent per annum interest rate on late payments to providers by PHPs without regard to current rates of return in the market place and inappropriately uses government to intervene in what is essentially a business dispute.

If you have any questions regarding the Department's opposition to AB 865, please contact me at 324-1003.

Sincerely,

A handwritten signature in cursive script that reads "Mary J. Griffin".

Mary J. Griffin  
Acting Deputy Director  
External Affairs



Legislative Office  
P.O. Box 942705  
Sacramento, CA 94229-2705  
(916) 326-3689

JK

April 13, 1989

Honorable Cathie Wright  
California State Assembly  
State Capitol, Room 3126  
Sacramento, CA 95814

APR 13 1989

Dear Assemblywoman Wright:

Re: AB 865

Attached is an analysis of your Assembly Bill 865. PERS staff is recommending a support position on this bill to our Board of Administration.

I am available to work with you and your staff.

Sincerely,

BARRY HACKER  
Chief, Legislative Services

BH:mg

Attachment

Assembly Republican Committee vote

ER&CA -- 5/17/89

(7-1) Noes: Pringle

Abs.: Baker, Mountjoy, Woodruff

Consultant: Margaret Heagney/Chris Jones

49-1

AB 865 (Wright) -- HEALTH INSURANCE: CLAIM REIMBURSEMENT

Version: 5/25/89

Vice-chairman: Pat Nolan

Recommendation: Support

Vote: Majority

Summary: Existing law establishes certain deadlines which health-care service plans must meet in paying claims and/or contesting claims. This bill provides that any delinquent claim-payment must be made with interest and requires that any notice that a claim is being contested specify which particular portion is being contested and list the reasons for that action. Fiscal effect: no appropriation.

Supported by: Treatment Centers of America. Opposed by: none known. Governor's position: not known.

Comments: Specific and reasonable consumer-protection provisions. Interest on late claims payments represents the lost opportunity value of money withheld improperly. Specificity in noticing that a claim is being contested will focus the issue and could eliminate some red tape.

Assembly Republican Committee vote

Finance and Insurance -- 5/31/89

(18-0) Ayes: All Republicans except

Abs.: Statham

Consultant: Peter Conlin

AB 888 (La Follette) -- HOUSEHOLD HAZARDOUS WASTE MANAGEMENT

Version: 5/31/89

Lead Republican: Doris Allen

Recommendation: Support

Vote: Majority

Summary: Requires county hazardous waste management plans to include a household hazardous waste management (collection, recycling and disposal) program at the next review after Jan. 1, 1990. After approval, the program must be implemented. A county would be responsible for household haz. waste in unincorporated areas, and cities would be responsible in incorporated areas.

Requires the Waste Management Board to assist local agencies

JACK I. HORTON  
ANN MACKEY  
CHIEF DEPUTIES

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# Legislative Counsel of California

BION M. GREGORY

August 30, 1989

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DEPUTIES

Honorable Cathie Wright ✓

A.B. 865 - Conflict

Supplemental

The above measure, introduced by you, which is now set for hearing in the Senate Insurance, Claims and Corporations Committee

appears to be in conflict with the following other measure(s):

A.B. 1311 - Filante  
A.B. 2474 - Wright

S.B. 439 - Robbins

*new bill* →  
*reg. bill* →  
*double joined* →

ENACTMENT OF THESE MEASURES IN THEIR PRESENT FORM MAY GIVE RISE TO A SERIOUS LEGAL PROBLEM WHICH PROBABLY CAN BE AVOIDED BY APPROPRIATE AMENDMENTS.

WE URGE YOU TO CONSULT OUR OFFICE IN THIS REGARD AT YOUR EARLIEST CONVENIENCE.

Very truly yours,  
BION M. GREGORY  
LEGISLATIVE COUNSEL

Committee  
named above  
Each lead author  
concerned



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# Assembly Policy Committee Materials

Legislative Research Incorporated hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

ASSEMBLY COMMITTEE ON FINANCE AND INSURANCE

Patrick Johnston, Chairman

BACKGROUND INFORMATION REQUEST

Measure: AB 865

Author : Assemblywoman Wright

1. Origin of the bill:

- a. Who is the source of the bill? What person, organization, or governmental entity requested introduction?

Dennis Flatt - 443-7401

Calif. Assoc. of Hospitals & Health Systems

- b. Has a similar bill been before either this session or a previous session of the legislature? If so, please identify the session, bill number and disposition of the bill.

not known

- c. Has there been an interim committee report on the bill? If so, please identify the report.

not known

2. What is the problem or deficiency in the present law which the bill seeks to remedy?

This bill will require insurers to pay interest at the rate of  
10 percent per annum if an uncontested claim is not reimbursed within  
30 working days.

3. Please attach copies of any background material in explanation of the bill, or state where such material is available for reference by committee staff.

4. Please attach copies of letters of support or opposition from any group, organization, or governmental agency who has contacted you either in support or opposition to the bill.

attached

5. If you plan substantive amendments to this bill prior to hearing, please explain briefly the substance of the amendments to be prepared.

amendments will include plans covered under the Health and Safety Code

6. List the witnesses you plan to have testify.

RETURN THIS FORM TO: ASSEMBLY COMMITTEE ON FINANCE AND INSURANCE  
Phone 445-9160

OFFICE COPY  
DO NOT REMOVE

AB 865

Date of Hearing: May 15, 1989

FINANCE AND INSURANCE SUBCOMMITTEE ON  
HEALTH AND WORKERS' INSURANCE

Burt Margolin, Chairman

AB 865 (Wright) - As Amended: May 10, 1989

SUBJECT

Should various insurers and health care plans be required to pay interest on claims which are not reimbursed within the time required by law?

DIGEST

Existing law requires health care service plans, disability insurers, self-insured employee welfare benefit plans covering hospital, medical or surgical expenses, and nonprofit hospital service plans to notify claimants in writing within 30 working days after receiving a claim which is contested. (Health maintenance organizations have 45 working days to give notice.)

This bill would:

- 1) Require affected insurers and plans to identify the portion of the claim that is contested and the reasons for contesting.
- 2) Require the insurers and plans to pay interest of 10% per annum for claims not reimbursed within the 30 or 45-day period and for those contested in error.

FISCAL EFFECT

None

COMMENTS

- 1) NEED FOR THE BILL. The sponsor of this measure indicates that there is widespread disregard for the current law requiring reimbursement of claims within 30 or 45 working days. This is said to happen because there is no effective sanction for violations. The bill seeks to cure this problem by requiring interest to be paid when the deadlines are missed.
- 2) OPPOSITION. Opponents assert that hospitals frequently fail to provide needed information quickly enough to permit compliance with the deadlines. On the other hand, the providers assert that it is difficult to deal with the different plans and insurers because they use different formats,

- continued -

AB 865  
Page 1

require different information, and operate on different schedules. In addition, the sponsor points out that the insurers can contest a claim based on inadequate documentation and avoid the deadlines altogether.

- 3; CLAIMS CONTESTED IN ERROR. The bill would require interest to be paid when claims are contested in error. The meaning of this provision is not entirely clear. If an insurer contests a claim because the documentation provided is really inadequate and the claim is subsequently determined to deserve payment, has the claim been contested in error? If so, is this a fair apportionment of fault? If not, what does "contested in error" mean?

SPONSOR: California Association of Hospitals and Health Systems

SUPPORT: Treatment Centers of America  
Bellwood Health Center

OPPOSITION: Association of California Life Insurance Companies

Diane Griffiths  
445-7440  
ashwi

AB 865  
Page 2

OFFICE COPY  
DO NOT REMOVE

AB 865

ASSEMBLY THIRD READING

AB 865 (Wright) - As Amended: May 25, 1989

ASSEMBLY ACTIONS:

COMMITTEE FIN. & INS. VOTE 18-0 COMMITTEE \_\_\_\_\_ VOTE \_\_\_\_\_

Ayes:

Ayes:

Nays:

Nays:

DIGEST

Existing law requires health care service plans, disability insurers, self-insured employee welfare benefit plans covering hospital, medical or surgical expenses, and nonprofit hospital service plans to notify claimants in writing within 30 working days after receiving a claim which is contested. (Health maintenance organizations have 45 working days to give notice.)

This bill:

- 1) Requires affected insurers and plans to identify the portion of the claim that is contested and the reasons for contesting.
- 2) Requires the insurers and plans to pay interest of 10% per annum for claims not reimbursed within the 30 or 45-day period.

FISCAL EFFECT

None

COMMENTS

- 1) The sponsor of this measure, California Association of Hospitals and Health Systems, indicates that there is widespread disregard for the current law requiring reimbursement of claims within 30 or 45 working days. This is said to happen because there is no effective sanction for violations. The bill seeks to cure this problem by requiring interest to be paid when the deadlines are missed.
- 2) Opponents assert that hospitals frequently fail to provide needed information quickly enough to permit compliance with the deadlines. On the other hand, the providers assert that it is difficult to deal with the different plans and insurers because they use different formats, require different information, and operate on different schedules. In addition, the sponsor points out that the insurers can contest a claim based on inadequate documentation and avoid the deadlines altogether.

Diane Griffiths  
445-7440  
6/1/89:ashwi

AB 865  
Page 1

THIRD READING

AB 865

Wright (R)

8/30/89 in Senate

Majority

64-1, p. 2312, 6/6/89

SUBJECT: Health insurance: claim reimbursement

SOURCE: California Association of Hospitals and Health Systems

DIGEST: This bill requires that insurers and plans pay an interest rate charge on uncontested health care claims which remain unpaid beyond a specific time period with commensurate requirements in overpayment situations.

ANALYSIS: Current law requires health care service plans, indemnity insurers, self-insured employee welfare benefit plans, and nonprofit hospital service plans to provide claim reimbursement as soon as practical but no later than 30 working day after claim receipt unless it is contested. For health maintenance organizations, which are either a nonprofit hospital service plan or a health care service plan, the timeframe period is 45 working days.

This bill requires every health care service plan, indemnity insurer, nonprofit hospital service plan, which provides either individual or group coverage, to be liable for the payment of interest at the rate of ten percent per annum on monies owed to a professional or institutional provider on any submitted claim which is uncontested.

If an uncontested claim is not reimbursed by delivering to the claimant's address the monies within 30 working days or within 45 working days with respect to a health maintenance organization, interest at ten percent per annum shall commence accrual.

CONTINUED

Regarding a claim, the claimant must be notified in writing within 30 working days that it is contested or denied. This notification shall identify the portion which is under dispute and the corresponding reasons. An entire or portion of a claim is defined as reasonably contested where the insurer or plan has not received a completed claim and all information necessary to determine liability for payment. The information includes matters of fraud, misrepresentation, consents, releases, assignments, claim on appeal, and medical necessity.

Regarding overpayments, if a provider is determined to be overpaid by a plan or insurer, a written notification on the particulars is required. The provider has 30 working days in which to reimburse the plan or insurer, unless it is contested. If contested, the plan or insurer must receive written notification of the specific details of contestability within 30 working days. A provider is subject to the identical interest penalty in cases where the overpayment for the uncontested portion of the claim is not received within a 30 working day period.

A health maintenance organization is defined as a nonprofit hospital service plan or a health care service plan.

FISCAL EFFECT: Appropriation: No Fiscal Committee: No Local: No

SUPPORT: (Verified 8/30/89)

California Association of Hospitals and Health Systems (source)  
Centinela Hospital Medical Center  
Treatment Centers of America  
Bellwood Health Center

OPPOSITION: (Verified 8/30/89)

Department of Health Services

ARGUMENTS IN SUPPORT: According to the Senate Insurance, Claims and Corporations Committee, analysis, the sponsor contends that this measure is needed because of widespread disregard for the existing statute requiring claim reimbursement within a specified time period. This is occurring because there is no effective sanction for violations. The bill's effort to cure this disregard is in the form of a sanction which provides for payment of interest on outstanding balances.

Proponents contend (1) reasonable prompt payment of claims is essential to professional provider financial viability; and, (2) with technological innovations in health care delivery, costs are mounting and the need for a good faith effort in claims payment is essential to maintain adequate cash flow for institutional providers.

The sponsor has met on a number of occasions with the opponents to resolve key differences. It appears that final resolution has not yet been attained over the issue of reasonable access to information concerning provider services, to wit financial audits, because of concern over possible "fishing expeditions" by insurers and plans in an audit review of the providers' claims.

CONTINUED

ARGUMENTS IN OPPOSITION: According to the Senate Insurance, Claims and Corporations Committee analysis, the opponents contend (1) the ten percent per annum interest rate is arbitrarily established without regard to current interest rate structures; (2) there is an inappropriate use of government, i.e. the Medi-Cal Program, to intervene in essentially a business dispute; (3) failure to pay an uncontested claim in the specified time period will have a detrimental impact on the Medi-Cal Program's managed care objective and result in loss of program contractors; and (4) without access to documents in a reasonable manner, which is essential for any payor to determine its liability, the use of the financial audit that has proven successful in this regard will be severely thwarted.

ASSEMBLY FLOOR VOTE:

DLW:lm 8/30/89 Senate Floor Analyses

CONTINUED

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# Bellwood Health Center

17800 Woodruff Avenue  
Bellflower, California 90706

(213) 925-9913  
(714) 952-3463

April 6, 1989

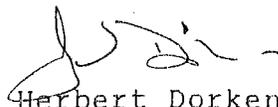
Honorable Cathie Wright  
State Capitol, Room 3126  
Sacramento, CA 95814

Dear Assemblywoman Wright:

Re: AB 865

Reasonably prompt claims payment for services rendered by health facilities is essential to their financial viability. Your requirements that there be specific reasons for contesting any portion of a claim plus an interest surcharge when reimbursement is not received within the statutory time limitation should facilitate the process and has our SUPPORT.

Sincerely,



Herbert Dorken, Ph.D.

cc: Mr. Joseph Sharp  
Members Finance and Insurance Committee



JIK  
TREATMENT  
CENTERS  
OF AMERICA

April 6, 1989

Honorable Cathie Wright  
State Capitol, Room 3126  
Sacramento, CA 95814

APR 10 1989

Dear Assemblywoman Wright:

Re: AB 865

Reasonably prompt claims payment for services rendered by health facilities is essential to their financial viability. Your requirements that there be specific reasons for contesting any portion of a claim plus an interest surcharge when reimbursement is not received within the statutory time limitation should facilitate the process and has our SUPPORT.

Sincerely,

Herbert Dorken, Ph.D.

cc: Mr. Elliott Sainer  
Members Finance and Insurance Committee

Corporate Offices  
LifePLUS Plaza  
6441  
Coldwater Canyon  
North Hollywood  
CA 91606  
818/769-3915



# Association of California Life Insurance Companies

JK

BRENT A. BARNHART  
ASSOCIATE COUNSEL

May 1, 1989

MAY 2 1989

Assemblywoman Cathie Wright  
Member, California State Assembly  
State Capitol  
Sacramento, California 95814

Re: AB 865  
OPPOSE

Dear Assemblywoman Wright:

The Association of California Life Insurance Companies (ACLIC) respectfully opposes AB 865, which would: (1) Compel health plans to notify providers of the specific portion of a claim for health care services which is being contested, and (2) Would require the payment of interest where a claim is not reimbursed within the statutory 30-day time limit for paying claims..

As presently written, the bill addresses only one side of claims payment controversies. No consideration should be given to imposing additional burdens upon health insurers and health maintenance organizations (HMO's) until equal consideration is given to compelling providers to supply payors with sufficient information to justify their claims. Under current practice, many hospitals deny payors access to evidence which substantiates their claims for payment for services.

Only when all such payment issues are addressed should legislation move forward which adds further provisions to the law which compels accelerated payment of providers.

Very truly yours,

Brent A. Barnhart  
Associate Counsel

BB/0069b

cc: Members, Assembly Finance & Insurance Committee  
Ken Cooley, Principal Consultant

MAY 15 1989



# California Medical Association

221 Main Street, P.O. Box 7690, San Francisco, CA 94120-7690 (415) 541-0900

Reply to: 925 L Street, Suite 1150 · Sacramento 95814 · (916) 444-5532

May 12, 1989

The Honorable Burt Margolin  
State Capitol, Room 4117  
Sacramento, CA 95814

RE: AB 865 (Wright)  
CMA Position: **SUPPORT**

Dear Assemblyman Margolin:

The California Medical Association has taken a "SUPPORT" position on AB 865 (Wright) which is set for hearing on May 15, 1989, in the Assembly Health and Workers' Insurance Subcommittee.

This bill would strengthen the current delayed payments law by requiring insurers to notify claimants of the specific portion of a claim that is being contested and the reason for contesting that portion. It would also provide that if the claim is not reimbursed within the time limitation, interest shall accrue at the rate of 10% per annum.

This bill will help both patients and providers to receive duly-owed payments and proper explanations for delays. This is a severe problem that needs to be addressed.

For the above reasons, the California Medical Association strongly supports AB 865 and urges your "AYE vote."

Sincerely,

Carol A. Lee  
Associate Director  
Government Relations

cc: The Honorable Patrick Johnston, Chairman  
Assembly Finance and Insurance Committee  
The Honorable Cathie Wright  
Ken Cooley, Committee Consultant  
Peter Conlin, Republican Caucus Consultant  
Dennis Flatt, California Association of  
Hospitals and Health Systems

CL5.11

MAY 15 1989

CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS



May 15, 1989

Honorable Burt Margolin, Chairman  
Assembly Finance and Insurance  
Subcommittee on Health and  
Workers' Insurance  
State Capitol, Room 4117  
Sacramento, CA 95814

1050 20th Street  
P.O. Box 1100  
Sacramento, CA  
95812-1100  
916.443.7401

Dear Assemblyman Margolin:

On behalf of the California Association of Hospitals and Health Systems (CAHHS), I wish to inform you of our support of Assembly Bill 865 (Wright).

Existing law requires insurers to reimburse provider claims within thirty days unless the claim is contested. Currently, there is no prescribed penalty for late payment. As a result, payments are often late.

Assembly Bill 865 provides that a ten percent penalty shall be added to claims that are not reimbursed within the thirty-day time frame. The bill does not impair the insurers current ability to contest a claim when there is a reason to do so.

We urge your "aye" vote on AB 865. Thank you.

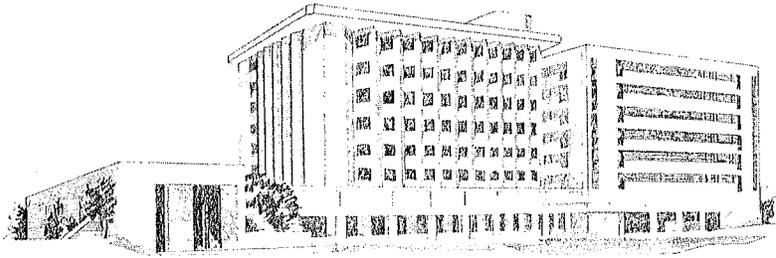
Yours truly,

Dennis O. Flatt  
Vice President  
Government Relations

DOF:tm

cc: Honorable Members and Consultant  
Assembly Finance and Insurance Subcommittee  
on Health and Workers' Insurance





MAY 22 1989

## Centinela Hospital Medical Center

a nonprofit medical facility

Official Hospital for the 1984 Olympic Games

May 18, 1989

RUSSELL S. STROMBERG  
PRESIDENT

The Honorable Burt Margolin  
California State Assembly  
P. O. Box 942849  
Sacramento, CA 94249-0001

Dear Assemblyman Margolin:

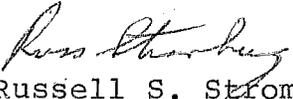
Assembly Bill 865 by Wright will soon be before the Finance and Insurance Committee. On behalf of Centinela Hospital Medical Center, I would respectfully ask that you consider an aye vote.

Hospitals are striving to provide state-of-the art services and technology in the face of mounting costs and growing numbers of uninsured patients. When uncontested claims are submitted to insurers, we expect a good faith effort on their part with regard to payment. The reality is, however, that payments are not made in a timely manner; that it is the exception not the rule that payments are received within a month.

Hospitals are reaching out to the legislature to help provide some leverage to sustain an adequate cash flow level. There is no valid reason for withholding payments for such unreasonable lengths of time.

Please pass AB865.

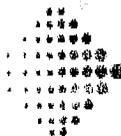
Sincerely,

  
Russell S. Stromberg  
President

RSS:khl

Mills Hospital  
100 South San Mateo Dr.  
San Mateo, CA 94401  
415-896-1400

Peninsula Hospital  
1783 El Camino Real  
Burlingame, CA 94010  
415-896-5400



Mills-Peninsula  
Hospitals

May 22, 1989

The Honorable Pat Johnston  
Room 4112, State Capitol  
Sacramento, CA 95814

Dear Honorable Johnston:

Please support AB 865 (Wright) when it comes before the Assembly  
Finance and Insurance Committee on May 23rd.

This bill would put "teeth" into existing law by requiring that  
third party payers provide written notice to hospitals of any  
contested portions of a claim, including the reasons for  
contesting, and would impose a 10% interest penalty on late  
payment of uncontested claims. On average, our Blue Cross and  
other commercial carriers are taking in excess of sixty (60) days.

We urge your support of AB 865.

Sincerely,

David Haray  
Director  
Business Services

*DPAA (18-0)*  
*5/23/89 MS/OS*

MAY 19 1989

54684  
RECORD #

30 BF:

89139 19:12  
RN 89 016507 PAGE NO. 1

AMENDMENTS TO ASSEMBLY BILL NO. 865  
AS AMENDED IN ASSEMBLY MAY 10, 1989

Substantive

Amendment 1

On page 2, strike out lines 21 to 23, inclusive

Amendment 2

On page 3, line 12, strike out "If a claim"  
strike out lines 13 to 15, inclusive

Amendment 3

On page 4, strike out lines 4 to 6, inclusive

- 0 -

*Sen. LaFollette*  
*5/10/89*

MAY 08 1989

86996  
RECORD #

20 BF:

89128 11:28  
RN 89 015198 PAGE NO. 1

**Substantive**

AMENDMENTS TO ASSEMBLY BILL NO. 865

Amendment 1

In line 1 of the title, after "to" insert:

amend Section 1371 of the Health and Safety Code, and to

Amendment 2

On page 2, line 1 after "SECTION 1." insert:

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

1371. A health care service plan which covers hospital, medical, or surgical expenses 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 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, within 30 working days. 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 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. If a claim is contested in error, 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.

As used in this section, a contested claim, or portion thereof, includes situations in which the plan has not received the completed claim and all information necessary to determine payer liability for the claim, including, but not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

SEC. 2.

Amendment 3

On page 2, line 30, strike out "SEC. 2." and insert:

86996  
RECORD #

40 BF:

89128 11:28  
RN 89 015198 PAGE NO. 2

SEC. 3.

- 0 -



Display 1989-1990 Votes - ROLL CALL

MEASURE: AB 865
DATE: 09/14/89
LOCATION: ASM. FLOOR
MOTION: AB 865 WRIGHT CONCURRENCE
(Ayes 75. Noes 0.) (PASS)

AYES
\*\*\*\*

- Allen, Bane, Burton, Chandler, Cortese, Elder, Ferguson, Frizzelle, Harvey, Hughes, Jones, Klehs, Lewis, Moore, O'Connell, Quackenbush, Sher, Vasconcellos, Wright, Areias, Bates, Calderon, Clute, Costa, Epple, Filante, Hannigan, Hauser, Isenberg, Katz, Lancaster, Margolin, Mountjoy, Peace, Roos, Speier, Maxine Waters, Wyman, Bader, Bentley, Campbell, Condit, Eastin, Farr, Frazee, Hansen, Hayden, Johnson, Kelley, Lempert, McClintock, Murray, Polanco, Roybal-Allard, Statham, Norman Waters, Willie Brown, Baker, Bronzan, Chacon, Connelly, Eaves, Felando, Friedman, Harris, Hill, Johnston, Killea, Leslie, Mojonnier, Nolan, Pringle, Seastrand, Tanner, Woodruff

NOES
\*\*\*\*

ABSENT, ABSTAINING, OR NOT VOTING
\*\*\*\*\*

- Dennis Brown, Floyd, La Follette, Tucker

MEASURE: AB 865
DATE: 09/13/89
LOCATION: SEN. FLOOR
MOTION: ASSEMBLY THIRD READING AB 865 WRIGHT BY ROBBINS
(Ayes 26. Noes 2.) (PASS)

AYES
\*\*\*\*

Display 1989-1990 Votes - ROLL CALL

Alquist	Bergeson	Boatwright	Campbell
Davis	Deddeh	Doolittle	Garamendi
Cecil Green	Leroy Greene	Keene	Kopp
Leonard	Maddy	Marks	Morgan
Nielsen	Robbins	Roberti	Rogers
Royce	Russell	Seymour	Torres
Vuich	Watson		

NOES  
\*\*\*\*

Presley                      Stirling

ABSENT, ABSTAINING, OR NOT VOTING  
\*\*\*\*\*

Ayala	Beverly	Craven	Dills
Bill Greene	Hart	Lockyer	McCorquodale
Mello	Montoya	Petris	Rosenthal

MEASURE: AB 865  
DATE: 08/23/89  
LOCATION: SEN. INS., CL. & CORPS.  
MOTION: Do pass as amended.  
(Ayes 6. Noes 0.) (PASS)

AYES  
\*\*\*\*

Davis	Doolittle	Keene	Montoya
Nielsen	Robbins		

NOES  
\*\*\*\*

ABSENT, ABSTAINING, OR NOT VOTING  
\*\*\*\*\*

Deddeh                      Cecil Green                      McCorquodale

MEASURE: AB 865  
DATE: 06/07/89  
LOCATION: ASM. FLOOR  
MOTION: AB 865 WRIGHT THIRD READING  
(Ayes 64. Noes 1.) (PASS)

AYES  
\*\*\*\*

Display 1989-1990 Votes - ROLL CALL

Allen	Areias	Bader	Baker
Bane	Bates	Bentley	Dennis Brown
Chandler	Clute	Condit	Connelly
Cortese	Costa	Eastin	Eaves
Epple	Farr	Ferguson	Filante
Frazee	Friedman	Frizzelle	Hannigan
Hansen	Harris	Harvey	Hauser
Hughes	Isenberg	Johnson	Johnston
Jones	Katz	Kelley	Killea
Klehs	La Follette	Lancaster	Lempert
Leslie	Lewis	McClintock	Mojonnier
Mountjoy	Murray	Nolan	O'Connell
Peace	Polanco	Pringle	Quackenbush
Roos	Roybal-Allard	Seastrand	Sher
Speier	Tanner	Tucker	Norman Waters
Woodruff	Wright	Wyman	Willie Brown

NOES  
\*\*\*\*

Floyd

ABSENT, ABSTAINING, OR NOT VOTING  
\*\*\*\*\*

Bronzan	Burton	Calderon	Campbell
Chacon	Elder	Felando	Hayden
Hill	Margolin	Moore	Statham
Vasconcellos	Maxine Waters		

MEASURE: AB 865  
DATE: 05/23/89  
LOCATION: ASM. FIN. & INS.  
MOTION: Do pass as amended.  
(Ayes 18. Noes 0.) (PASS)

AYES  
\*\*\*\*

Johnston	Bader	Bane	Bronzan
Dennis Brown	Chacon	Epple	Floyd
Katz	Lancaster	Lewis	Margolin
Moore	Nolan	O'Connell	Seastrand
Sher	Wright		

Display 1989-1990 Votes - ROLL CALL  
NOES  
\*\*\*\*

ABSENT, ABSTAINING, OR NOT VOTING  
\*\*\*\*\*

Farr

Statham

SUBCOMMITTEE ON Health and Workers' Insurance

Standing Committee on Finance and Insurance

Date of Hearing: May 15, 1989

BILL NO.	AB 360	AB 648	AB 865	AB 900
ACTION VOTED ON	RECOMMEND: DO PASS AS AMENDED	RECOMMEND: DO PASS TO WAYS AND MEANS	RECOMMEND: DO PASS AS AMENDED	RECOMMEND: DO PASS
	Aye : No	Aye : No	Aye : No	Aye : No
Margolin, Chair	X	X	X	X
Bader	X	X	X	X
Bronzan	X	X	X	X
Farr	X	X	X	X
Floyd	X	X	X	X
Johnston	X	X	X	X
Lancaster	X	X	X	X
Lewis	AB	X	X	AB
Moore	AB	X	X	X
O'Connell	X	X	X	X
Statham	AB	AB	AB	AB
	Ayes: 8 Noes: 0	Ayes: 9 Noes: 1	Ayes: 10 Noes: 0	Ayes: 7 Noes: 2

N.V. - Not voting

AB. - Absent

Received: \_\_\_\_\_

Burt Mungler

STATE OF CALIFORNIA  
OFFICE OF LEGISLATIVE COUNSEL

May 17, 1989

Honorable Cathie Wright

A.B. 865 - Conflict

The above measure, introduced by you, which is now set for hearing in the Assembly Finance and Insurance Committee

appears to be in conflict with the following other measure(s):

A.B. 2474 - Wright

**ENACTMENT OF THESE MEASURES IN THEIR PRESENT FORM MAY GIVE RISE TO A SERIOUS LEGAL PROBLEM WHICH PROBABLY CAN BE AVOIDED BY APPROPRIATE AMENDMENTS.**

**WE URGE YOU TO CONSULT OUR OFFICE IN THIS REGARD AT YOUR EARLIEST CONVENIENCE.**

Very truly yours,  
BION M. GREGORY  
LEGISLATIVE COUNSEL

cc: Committee  
named above  
Each lead author  
concerned



## Legislative Research Incorporated

1107 9th Street, Suite 220, Sacramento, CA 95814  
(800) 530.7613 · (916) 442.7660 · fax (916) 442.1529  
www.lrihistory.com · intent@lrihistory.com

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# Assembly Floor Analysis Materials

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CONCURRENCE IN SENATE AMENDMENTS

AB 865 (Wright) - As Amended: September 11, 1989

ASSEMBLY VOTE 64-1 ( June 7, 1989 ) SENATE VOTE ( September 13, 1989 )

Original Committee Reference: FIN. & INS.

DIGEST

Existing law requires health care service plans, disability insurers, self-insured employee welfare benefit plans covering hospital, medical or surgical expenses, and nonprofit hospital service plans to notify claimants in writing within 30 working days after receiving a claim which is contested. (Health maintenance organizations have 45 working days to give notice.)

As passed by the Assembly, this bill:

- 1) Would have required affected insurers and plans to identify the portion of the claim that is contested and the reasons for contesting.
- 2) Would have required the insurers and plans to pay interest of 10% per annum for claims not reimbursed within the 30 or 45-day period.

The Senate amendments:

- 1) Clarify that uncontested claims must be reimbursed by delivery to the claimants' address of record within the 30 or 45-day period.
- 2) Clarify that a claim is reasonably contested where the plan has not received the completed claim and all information necessary to determine the medical necessity for services provided, or where the plan has not been granted reasonable access to information concerning provider services.
- 3) Require providers to:
  - a) Reimburse plans for overpayments within 30 working days of receipt by the provider of a notice of overpayment unless the overpayment is contested by the provider within the 30 working days.
  - b) Pay interest at 10% per annum for overpayments not reimbursed within the 30-day period.

FISCAL EFFECT

None

Diane Griffiths  
445-7440  
9/14/89:ashwi



## Legislative Research Incorporated

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# Assembly Republican Caucus Materials

Legislative Research Incorporated hereby certifies that the accompanying record/s is/are true and correct copies of the original/s obtained from one or more official, public sources in California unless another source is indicated, with the following exceptions : In some cases, pages may have been reduced in size to fit an 8 ½" x 11" sized paper. Or, for readability purposes, pages may have been enlarged or cleansed of black marks or spots. Lastly, for ease of reference, paging and relevant identification have been inserted.

*2001 6/22/89*

<b>BILL ANALYSIS</b>	Author <b>Wright</b>	Bill Number <b>AB 865</b>
	Amendment Date <b>May 10, 1989</b>	
<i>THIS SECTION TO BE FILLED OUT BY OLL</i>		Sponsored By <b>California Hospital Association</b>
DMS Assignment <input type="checkbox"/> P <input type="checkbox"/> S <input checked="" type="checkbox"/> Other <i>0</i>	CC <i>EOD</i>	Hearing Date <i>/</i>
		Related Bills

Bill Summary

Assembly Bill (AB) 865 requires health care service plans licensed under the Knox-Keene Act, insurance plans which provide disability insurance, self-insured employee welfare benefit plans, and nonprofit hospital insurance plans licensed under the Insurance Code to pay a 10 percent per annum interest rate on uncontested claims not paid to their contracting providers within 30 or 45 working days, based on the type of plan. The bill also requires these plans to identify the portions of contested claims which are being contested and to state specific reasons for contesting the claim. This analysis was prepared on the long form because the May 10 version of the bill is the first version to include health care service plans and is therefore a major change requiring a full analysis. *The original bill was not analyzed by DHS.*

Legislative Background

AB 865 is sponsored by the California Association of Hospitals and Health Systems (CAHHS). The CAHHS sees a need to insure that health care plans pay their uncontested claims on time, and to compensate providers when payment is late.

Program Background

The Medi-Cal Program contracts with 12 prepaid health plans (PHPs) which are health care service plans licensed by Knox-Keene, to provide medical care services to approximately 240,000 Medi-Cal beneficiaries. Currently, Medi-Cal pays no interest on late payments to providers in either the PHP contracting program or the regular fee-for-service program.

Specific Findings and Analysis

AB 865 will impose new costs of doing business on PHPs. These added costs cannot be considered by the Department in setting Medi-Cal capitation rates. For this reason, the Bill's provisions conflict with the Department's objective of expanding managed care under the Medi-Cal Program. This could make the Medi-Cal PHP contracting program less attractive to contractors.

*MJA 6-21-89*

Position <b>Oppose</b>			<b>Governor's Office Use</b>	
Department Director <i>[Signature]</i>	Date <i>6/23/89</i>	Position Noted		
Agency Secretary <i>[Signature]</i>	Date <i>6/23/89</i>	Position Approved		
		Position Disapproved		
		By	Date	

This bill is also an effort to legislate matters between two parties to a contract to the benefit of one of the parties. In so doing, the bill would set a 10 per cent per annum interest rate on late payments to providers by health care service plans and place this rate in statute. This is arbitrary and inflexible and done without regard for the changeable nature of interest rates. The question of whether a PHP should pay interest on late claims to providers belongs in the contract negotiations between the plans and the providers. Should providers desire an interest penalty on late payments they can demand contract provisions which require it, or they can refuse to contract with the plan all together when the terms of their contracts do not comply with their needs.

It is the position of the Department that government must not determine where, when, or how one party must do business with another unless there is a legitimate State interest to protect the public through specific consumer and public health protections, to assure quality of care, or to require professionals and institutions to obtain necessary licenses.

#### Regulations Impact

None.

#### Statutorily Mandated Reports

None.

#### Fiscal Impact

AB 865 would require prepaid health plans to pay 10 per cent per annum interest on uncontested claims not paid within 30 or 45 days as specified. State Medi-Cal and federal Medicaid Program requirements do not allow for consideration of such costs in the establishment of Medi-Cal capitation rates paid to the plans. As a result, the plans contracting with Medi-Cal would have to absorb these costs.

#### Recommendations:

Oppose.

AB 865 increases PHP costs in a manner which is detrimental to the interest of the Medi-Cal managed care objectives and which could make the Medi-Cal PHP contracting less attractive to contractors. The bill also has the effect of legislating, to the advantage of one party to a contractual relationship, what should be a matter for contract negotiation between parties.

MA-11.c5

slm

06/09/89

BILL ANALYSIS (SHORT FORM)

THIS SECTION TO BE FILLED OUT BY OLL

DHS Assignment  
 P  S  Other

cc  
EDD

Hearing Date

Author  
Wright

Bill Number  
AB 865

Amendment Date  
May 25, 1989

SELECT ONE BOX:

No analysis required of this bill - not within scope of responsibility of the Department  
\_\_\_\_\_ Track for future amendments  
\_\_\_\_\_ Request to TOL (take off list)

Technical Amendment - No program for fiscal changes to existing program. Approved/Recommended position of \_\_\_\_\_

Minor Amendment \_\_\_\_\_ still valid.

Previously submitted approved/recommended position of oppose still valid.

\_\_\_\_\_ Change in approved/recommended position of \_\_\_\_\_ to \_\_\_\_\_

COMMENTS:

The May 25, 1989 amendment to Assembly Bill (As) 865 removes the provision in the bill which requires a ten percent per annum interest charge on claims which are contested in error by a health care service plan but leaves the interest charge on uncontested claims. This is a minor amendment and does not address the Department's concerns with the bill. The bill still increases prepaid health plan (PHP) costs in a manner which is detrimental to the interest of the Medi-Cal managed care objectives and which could make the Medi-Cal contracting program less attractive to contractors.

The bill still arbitrarily sets a ten percent per annum interest rate on late payments to providers by PHPs without regard to current rates of return in the marketplace and inappropriately uses government to intervene in what is essentially a business dispute. It is the position of the Department that government must not determine where, when, or how one party must do business with another unless there is a legitimate State interest to protect the public through specific consumer or public health protections, to assure quality of care, or to require professional institutions to obtain necessary licenses.

The Department's previous position of oppose is still valid.

Department \_\_\_\_\_ Date 6-29-89 Agency \_\_\_\_\_

Mary Puff

MA-4.06  
jk  
06/06/89

**LEGISLATIVE ANALYSIS**

JF:nd

DEPARTMENT <b>CORPORATIONS</b>	ARTICLE <b>Eight</b>	NUMBER <b>AB 865</b>
SUBJECT <b>Health insurance: claim reimbursement</b>		As Amended <b>5-10-89 &amp; 5-25-89</b>

**SUMMARY**

Would require health care service plans (HCSPs), as well as disability insurers and nonprofit hospital service plans, which are contesting a claim to identify the portion of the claim contested and specify the reasons. Would also provide for the accrual of interest at 10 percent per annum if the uncontested portion of the claim is not paid within a specified period.

**ANALYSIS**

**A. Detailed**

The interest of the Department of Corporations in this bill is limited to its impact on HCSPs, which are regulated by the Department under the Knox-Keene Health Care Service Plan Act of 1975. The Department defers to the Department of Insurance with regard to those portions of the bill affecting the Insurance Code.

Current law requires HCSPs to pay claims no later than 30 working days (45 working days for federally licensed health maintenance organizations) after receipt. This bill retains that limitation, but, in addition, provides that if that statutory deadline is not met in the case of uncontested claims, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the applicable 30 or 45 day period.

Current law requires HCSPs to notify claimants in writing within 30 working days if a claim or portion thereof is contested. This bill would require that notice to identify the portion of the claim that is contested and the specific reasons for contesting the claim.

**B. Cost**

There will be no cost to the Department of Corporations as a result of this bill. There could be a cost to health care service plans if they do not pay claims in a timely manner and this cost could be passed on to the public. It should be noted that the

DEPARTMENTS THAT MAY BE AFFECTED <b>Department of Insurance</b>		GOVERNOR'S OFFICE	
POSITION <b>NEUTRAL</b>	DEPARTMENT <b>CHRISTINE W. BENDER Commissioner of Corporations</b>	AGENCY <i>Original Signed by</i> <b>Janice Rogers Brown</b>	POSITION NOTED _____
DATE <i>Christine W. Bender</i> <b>6/23/89</b>	DATE <b>JUN 29 1989</b>		POSITION APPROVED _____
CC:			POSITION DISAPPROVED _____
			BY: _____ DATE _____

OP 500.297 (1/88)

interest would most likely occur on claims of HCSPs which do not pay on time because they are already experiencing financial difficulties. The accrual of interest would exacerbate those difficulties.

**HISTORY**

This bill is being sponsored by the California Association of Hospitals and Health Systems. A related bill is AB 2474. Neither the author nor the sponsor discussed this bill with the Department before it was introduced. The author's aide indicated one of the reasons for the bill is to discourage HCSPs and disability insurers from holding funds which should be paid to providers and claimants and indicated the intent of the amendments is to reinforce the existing deadlines and provide additional incentive for plans to meet those deadlines for payment.

The bill is supported by numerous hospitals which provide service to plans and disability insurers and depend on them for payment. It is being opposed by the Association of California Life Insurance Companies. No other support and opposition is known.

**REASONS FOR RECOMMENDATION**

The Department recommends a position of NEUTRAL on this bill because it will not impact the ability of the Department to regulate HCSPs under the Knox-Keene Act. While the 10 percent interest penalty may exacerbate the problems of fiscally troubled HCSPs, to the extent the bill will encourage compliance with the law and prompt payment of claims, it will preserve accessibility to health care services for enrollees because providers are more likely to see patients when they are confident of prompt payment.

PUBLIC EMPLOYEES' RETIREMENT SYSTEM  
1989-90 REGULAR SESSION  
BILL ANALYSIS

AB 865 (Wright)  
as amended 5/25/89

PERS POSITION: SUPPORT

SUMMARY

This bill would require that every self-insured employee welfare benefit plan and nonprofit hospital services plan notice a claimant within 30 working days (or 45 days if the plan is a health maintenance organization) that a claim is being contested, identify the portion of the claim that is contested and specific reasons in contesting. It would also provide that, if a noncontested or erroneously contested claim that is not reimbursed within the time limitation (30 working days), interest shall accrue at the rate of 10% per annum beginning with the first calendar day after the 30 or 45 working-day period.

BACKGROUND

Section 10123.13 of the Insurance Code requires insurers to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim by insurer unless the claim or portion thereof is contested. If contested, the claimant shall be notified in writing within 30 working days. The current PERS-Care self-insured plan requires that 85% properly completed claims will be processed in ten working days as reflected in a performance clause within the contract with the claims administrator.

This bill would require interest to be paid on uncontested claims not reimbursed within 30 or 45 working days after receipt.

The definition of a contested claim, or portion thereof, includes situations in which the insurer or plan has not received a completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim or appeal.

FISCAL IMPACT ON STATE BUDGET

Unknown. However, savings accrued by hospitals either through increased cash flows or by reducing the cash conversion cycle will ultimately be passed on to the consumer, i.e., PERS health program.



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# Senate Policy Committee Materials

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SENATOR ALAN ROBBINS, CHAIRMAN

ASSEMBLY BILL NO. 865 (Wright) As Amended August 21, 1989  
Health & Safety Code  
Insurance Code

Source: California Association of Hospitals & Health Systems  
Prior Legislation: AB 4206 (Peace) Chapter 957, Statutes of 1986  
Support: Centinela Hospital Medical Center  
Treatment Centers of America  
Bellwood Health Center  
Opposition: Association of California Life Insurance Companies  
Blue Shield of California  
Department of Health Services  
Interest: Department of Insurance  
Department of Corporations

**SUBJECT**

Requirement that insurers and plans pay an interest rate charge on uncontested health care claims which remained unpaid beyond a specific time period with commensurate requirements in overpayment situations.

**DIGEST**

1] **Description:** This bill requires every health care service plan, indemnity insurer, nonprofit hospital service plan, and a self-insured employee welfare benefit plan not subject to the Employee Retirement Insurance Security Act of 1974 (ERISA), which provides either individual or group coverage, to be liable for the payment of interest at the rate of ten percent per annum on monies owed to a professional or institutional provider on any portion of a submitted claim which is uncontested.

If an uncontested claim or the uncontested portion is not reimbursed by delivering to the claimant's address the monies within 30 working days or within 45 working days with respect to a health maintenance organization, interest at ten percent per annum shall commence accrual.

Regarding a claim, the claimant must be notified in writing within 30 working days that it is contested or denied. This notification shall identify the portion which is under dispute and the corresponding reasons. An entire or portion of a claim is defined as reasonably contested where the insurer or plan has not received a completed claim and all information necessary to determine liability for payment. The information includes matters of fraud, misrepresentation, consents, releases, assignments, claim on appeal, and medical necessity.

Regarding overpayments, if a provider is determined to be overpaid by a plan or insurer, a written notification on the particulars is required. The provider has 30 working days in which to reimburse the plan or insurer,

unless it is contested. If contested, the plan or insurer must receive written notification of the specific details of contestability within 30 working days. A provider is subject to the identical interest penalty in cases where the overpayment for the uncontested portion of the claim is not received within a 30 working day period.

A self-insured employee welfare benefit plan subject to ERISA is exempt from all of the provisions of this bill. A health maintenance organization is defined as a nonprofit hospital service plan or a health care service plan.

2] **Background:** Current law requires health care service plans, indemnity insurers, self-insured employee welfare benefit plans, and nonprofit hospital service plans to provide claim reimbursement as soon as practical but no later than 30 working day after claim receipt unless it is contested. For health maintenance organizations, which are either a nonprofit hospital service plan or a health care service plan, the timeframe period is 45 working days.

This requirement applies to either an in-state or out-of-state claim. A health care service plan must demonstrate to the Corporations Commissioner that a prompt payment or claim denial procedure meeting federal regulation exists as part of its operations.

Current law does not contain any monetary sanction to be assessed on any party involved in the submitted claim process.

**FISCAL EFFECT** Fiscal Committee: No

**STAFF COMMENTS**

The sponsor contends that this measure is needed because of widespread disregard for the existing statute requiring claim reimbursement within a specified time period. This is occurring because there is no effective sanction for violations. The bill's effort to cure this disregard is in the form of a sanction which provides for payment of interest on outstanding balances.

Proponents contend: 1) reasonable prompt payment of claims is essential to professional provider financial viability; and, 2) with technological innovations in health care delivery, costs are mounting and the need for a good faith effort in claims payment is essential to maintain adequate cash flow for institutional providers.

The sponsor has met on a number of occasions with the opponents to resolve key differences. It appears that final resolution has not yet been attained over the issue of reasonable access to information concerning

provider services, to wit financial audits, because of concern over possible "fishing expeditions" by insurers and plans in an audit review of the providers' claims.

The opponents contend: 1) the ten percent per annum interest rate is arbitrarily established without regard to current interest rate structures; 2) there is an inappropriate use of government, i.e. the Medi-Cal Program, to intervene in essentially a business dispute; 3) failure to pay an uncontested claim in the specified time period will have a detrimental impact on the Medi-Cal Program's managed care objective and result in loss of program contractors; 4) without access to documents in a reasonable manner, which is essential for any payor to determine its liability, the use of the financial audit that has proven successful in this regard will be severely thwarted.

In response to a suggestion by the Committee staff, the sponsor is preparing a technical amendment for submission by the author at the hearing. This amendment will clarify the point in time at which the 30 working day period commences for purposes of notifying the claimant in writing that a claim is contested or denied.

The sponsor is considering suggestions by Committee staff that should this measure be enacted future legislation should be developed to provide for an offset when a provider is owed money and liable for an overpayment involving the same insurer or plan. Further, future legislation may be needed to properly interface the solvency provisions of the Knox-Keene Health Care Service Plan Act of 1975 with situations where an overpayment exists between a plan whose tangible net equity may be of concern and there is a liability owing from a provider.

NOTE: Four author's amendments were adopted as follows:

1. Responded to committee staff suggestion that a time certain is needed to determine when the 30-day period commences for claimant notification of claim status.
2. Removed all references to a self-insured employee welfare benefit plan exempted from the provisions of the bill if it is exempt from ERISA.
3. Removed any penalty sanction on a portion of an uncontested claim.
4. Redefined reasonably contested to include reasonable access to information concerning provider services.

SAL BIANCO  
Consultant

ASSEMBLY BILL NO. 865

08/23/89

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Health Insurance Association of America

June 19, 1989

Mr. Salvatore Bianco  
Consultant  
Senate Insurance Claims and Corporations Committee  
State Capitol  
Sacramento, California 95814

Dear Sal:

Thank you very much for taking time out of your very busy schedule to meet with me on June 15 regarding concerns with AB-865 and AB-2474 regarding claims practices.

I would like to give you the opportunity to see a commercial health insurance company claims operation. Please contact me when you will be in the San Fernando Valley area so that I can set up a demonstration of claims payment for you. I would appreciate advance notice along with several alternate dates.

If after reviewing the materials I left with you, you have any questions or would like further information regarding the problems we've expressed, please do not hesitate to contact me.

Again, thank you very much for taking time out of your very busy schedule to meet with me.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jan", is written above the typed name.

Jan Andrea Meisels  
Deputy Director

JAM:mlp

cc: Brent Barnhart

# **Bellwood Health Center**

17800 Woodruff Avenue  
Bellflower, California 90706

(213) 925-9913  
(714) 952-3463

June 26, 1989

Mr. Sal Bianco, Consultant  
Senate IC&C Committee  
State Capitol, Room 5122  
Sacramento, CA 95814

Dear Sal:

RE: AB 865 Wright

Reasonably prompt claims payment for services rendered by health facilities is essential to their financial viability. Accordingly, we SUPPORT this bill.

Cordially,



Herbert Dörken, Ph.D.

cc: Hon.C.Wright  
Mr.D.Topper,Paracelsus  
Mr.J.Sharp,Bellwood



TREATMENT  
CENTERS  
OF AMERICA

June 26, 1989

Mr. Sal Bianco, Consultant  
Senate IC&C Committee  
State Capitol, Room 5122  
Sacramento, CA 95814

Dear Sal:

RE: AB 865 Wright

Reasonably prompt claims payment for services rendered by health facilities is essential to their financial viability. Accordingly, we SUPPORT this bill.

Cordially,

Herbert Dörken, Ph.D.

cc: Hon.C.Wright  
Ms.E.A.Rose,TCA

Corporate Offices  
LifePLUS Plaza  
6441  
Coldwater Canyon  
North Hollywood  
CA 91606  
818/769-3915



# Association of California Life Insurance Companies

BRENT A. BARNHART  
COUNSEL & SECRETARY

July 10, 1989

Assemblywoman Cathie Wright  
Member, California State Assembly  
State Capitol  
Sacramento, California 95814

Re: AB 865 & AB 2474  
OPPOSE

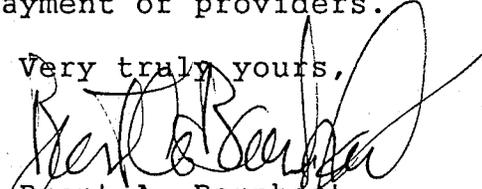
Dear Assemblywoman Wright:

The Association of California Life Insurance Companies (ACLIC) respectfully opposes AB 865, which would: (1) Compel health plans to notify providers of the specific portion of a claim for health care services which is being contested, and (2) Would require the payment of interest where a claim is not reimbursed within the statutory 30-day time limit for paying claims. We also oppose AB 2474, which would compel insurers to pay "major" portions of claims when there is justification solely for contesting a "lesser" portion of a claim..

As presently written, the bill addresses only one side of claims payment controversies. No consideration should be given to imposing additional burdens upon health insurers and health maintenance organizations (HMO's) until equal consideration is given to compelling providers to supply payors with sufficient information to justify their claims. Under current practice, many hospitals deny payors access to evidence which substantiates their claims for payment for services.

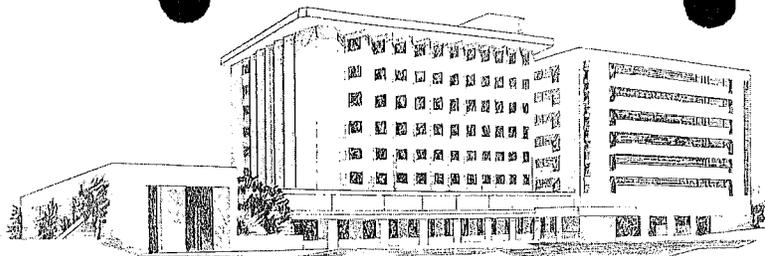
Only when all such payment issues are addressed should legislation move forward which adds further provisions to the law which compels accelerated payment of providers.

Very truly yours,

  
Brent A. Barnhart  
Associate Counsel

BAB:ip  
0069b

cc: All Members, Senate ICC Committee  
Sal Bianco, Consultant, Senate I.C.C. Committee



*File*

## Centinela Hospital Medical Center

a nonprofit medical facility

Official Hospital for the 1984 Olympic Games

RUSSELL S. STROMBERG  
PRESIDENT

July 27, 1989

The Honorable Alan Robbins  
California State Senate  
P. O. Box 942848  
Sacramento, CA 94248-0001

Dear Senator Robbins:

Assembly Bill 865 by Wright will soon be presented for a vote before the Senate Insurance, Claims & Corporations Committee. On behalf of Centinela Hospital Medical Center, I would respectfully ask that you consider an aye vote.

Hospitals are striving to provide state-of-the art services and technology in the face of mounting costs and growing numbers of uninsured patients. When uncontested claims are submitted to insurers, we expect a good faith effort on their part with regard to payment. The reality is, however, that payments are not made in a timely manner; that it is the exception not the rule that payments are received within a month.

Hospitals are reaching out to the legislature to help provide some leverage to sustain an adequate cash flow level. There is no valid reason for withholding payments for such unreasonable lengths of time.

Please pass AB865.

Sincerely,

Russell S. Stromberg  
President

RSS:khl

AB865



BLUE SHIELD  
of California

BLUE SHIELD PLAZA, TWO NORTH POINT, SAN FRANCISCO, CA  
Mailing Address: P.O. Box 7168, San Francisco, CA 94120-7168

21 August 1989

Senator Alan Robbins  
Room 5114, State Capitol  
Sacramento, CA 95814

Re: Assembly Bill 865 (Wright)

Dear Senator Robbins:

Blue Shield **opposes** AB 865 which is set for hearing before the Committee on Insurance, Claims & Corporations on August 23.

This bill requires health plans to pay "claims or any uncontested portion of any claim" within 30 working days after receipt of the claim, and notify the providers within the same time as to which parts of the claim are being contested and the specific reasons therefor. If an uncontested claim is not reimbursed within 30 working days after receipt, interest shall accrue at the rate of 10% per annum.

AB 865 is directed solely at insurance companies and health care service plans and establishes no requirements for hospital bills to reflect accurately the cost of the care received or to produce supporting information or to permit audits for verification. When over-payments have been verified, timely refunds should be required.

Blue Shield opposes AB 865 as it presently reads and urges your **NO** vote.

Sincerely,

Gibson Kingren

cc: Hon. Cathie Wright

CALIFORNIA PHYSICIANS' SERVICE  
A Statewide Health Care Service Plan

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JOSEPH MONTOYA

# California Legislature

## SENATE COMMITTEE ON INSURANCE, CLAIMS AND CORPORATIONS

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CHIEF CONSULTANT  
SAL BIANCO  
PRINCIPAL CONSULTANT  
LEAH CARTABRUNO  
ASSOCIATE CONSULTANT  
MAUREEN BROOKS  
COMMITTEE SECRETARY

ROOM 5122  
STATE CAPITOL  
SACRAMENTO, CA 95814  
(916) 445-0825

ALAN ROBBINS  
CHAIRMAN

September 5, 1989

MEMO

TO: AR  
FROM: SB  
RE: AB 865 (Wright)

Assemblywoman Wright's office asked if you would carry AB 865 on the Senate Floor. It will need to be amended to avoid a chaptering out problem with our SB 439 which is on the way to the Governor.

AB 865 is sponsored by the hospitals, and in its amended form has no opposition. The chaptering out amendments should be ready within the next few days.

Attached is a copy of the bill and ICC analysis.

- Yes, I will carry the bill for Wright.  
 No, Have her find another author.

SB/mv

Attachment

SUBMITTED BY Robbins

BILL AB 865

RN 89 023716

AUTHOR Wright

SENATE FLOOR AMENDMENTS  
Committee Analysis

SUBJECT OF BILL:

Health insurance.

Subject of Amendments:

Were these amendments discussed in committee? Yes

If so, did the committee defeat the amendments? No

Amendments are: Technical - Substantive - Re-write - New Bill  
(circle applicable description)

ANALYSIS:

These amendments double join the provisions of this bill with the provisions of SB 439 (Robbins) to prevent a chaptering out problem.

By Insurance, Claims & Corp / Sal Bianco  
Name of Committee Consultant

Received by SFA \_\_\_\_\_

Upon completion, please return to: Rick Rollens or David Wilkening  
Room 3189

rev. 9/88

File

# AB 865 Amendments

#1 On page 2, lines 18 & 19 ~~and page 3~~ strike "OR uncontested portion of the claim," <sup>OK</sup>

#2 On page 4, lines 12 & 13 strike "OR uncontested portion of the claim," <sup>OK</sup>

#3 On page 6, lines 6 & 7 strike "OR uncontested portion of the claim," <sup>OK</sup>

#4 See Insert (A)

#5 See Insert (B) I have noted where the language should be added.

Insert (A)

Amendments to AB 865 as Amended August 21, 1989  
Author's Amendments

Amendment 1 <sup>ok</sup>

Page 2, line 14, before the period insert:

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

Amendment 2 <sup>ok</sup>

Page 3, lines 38-39, delete:

and every self-insured employee welfare benefit plan

Amendment 3

Page 4, line 4, delete: <sup>ok</sup>

ok plan

Amendment 4 <sup>ok</sup>

Page 4, line 7, before the period insert:

after receipt of the claim by the insurer

Amendment 5 <sup>ok</sup>

Page 4, line 26, delete:

ok plan

Amendment 6 <sup>ok</sup>

Page 4, line 33, delete:

or plan

Amendment 7 <sup>ok</sup>

Page 4, lines 35-39, delete:

This section does not apply to self-insured employee welfare benefit plans if the provisions are in conflict with the Employee Retirement Income Security Act of 1974 (29 U.S.C.A. Sec. 1001 et seq.).

Amendment 8 <sup>ok</sup>

Page 5, lines 3-4, delete:

or a self-insured employee welfare benefit plan

Amendment 9 <sup>ok</sup>  
Page 5, lines 10-11, delete:

or self-insured welfare benefit plan

Amendment 10 <sup>ok</sup>  
Page 5, lines 14-15, delete:

or self-insured welfare benefit plan

Amendment 11 <sup>ok</sup>  
Page 5, lines 25-27, delete:

This section does not apply to overpayments by self-insured employee welfare benefit plans which are not subject to Section 10123.13.

Amendment 12 <sup>ok</sup>  
Page 6, line 1, before the period insert:

after receipt of the claim by the nonprofit hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the nonprofit hospital service plan

Insert (B)

ACLIC Revision of Sections 10123.13 & 11512.180 in AB 865:

~~[As used in]~~ For the purposes of this section, a ~~[contested]~~ claim, or portion thereof, ~~[includes situations in which]~~ is reasonably contested where the insurer or plan 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 payer liability for the claim" includes but is ~~[including but]~~ not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

#0158b

OK Page 3, line 4 20th "claim"  
OK Page 4, line 28 20th "claim"  
OK Page 6, line 22 20th "claim"

## DEPARTMENT OF HEALTH SERVICES

714/744 P STREET  
SACRAMENTO, CA 95814

(916) 324-1003

August 7, 1989

The Honorable Cathie Wright  
Member of the Assembly  
State Capitol, Room 3126  
Sacramento, CA 95814

Dear Ms. Wright:

## OPPOSITION OF ASSEMBLY BILL 865 (MAY 25, 1989 VERSION)

I regret to inform you that the Department opposes Assembly Bill (AB) 865, May 25, 1989 version. AB 865 still requires health care service plans licensed under the Knox-Keene Act to pay a ten percent per annum interest rate on uncontested claims not paid to their contracting providers. This will still increase prepaid health plan (PHP) costs in a manner which is detrimental to the interest of the Medi-Cal managed care objectives and which could make the Medi-Cal contracting program less attractive to contractors.

The bill still arbitrarily sets a ten percent per annum interest rate on late payments to providers by PHPs without regard to current rates of return in the market place and inappropriately uses government to intervene in what is essentially a business dispute.

If you have any questions regarding the Department's opposition to AB 865, please contact me at 324-1003.

Sincerely,

A handwritten signature in cursive script that reads "Mary J. Griffin".

Mary J. Griffin  
Acting Deputy Director  
External Affairs

18

OFFICE OF LEGISLATIVE COUNSEL

July 20, 1989

Honorable Cathie Wright

A.B. 865 - Conflict

The above measure, introduced by you, which is now set for hearing in the Senate Insurance, Claims and Corporations Committee ✓

appears to be in conflict with the following other measure(s):

A.B. 2474 - Wright

**ENACTMENT OF THESE MEASURES IN THEIR PRESENT FORM MAY GIVE RISE TO A SERIOUS LEGAL PROBLEM WHICH PROBABLY CAN BE AVOIDED BY APPROPRIATE AMENDMENTS.**

**WE URGE YOU TO CONSULT OUR OFFICE IN THIS REGARD AT YOUR EARLIEST CONVENIENCE.**

Very truly yours,  
BION M. GREGORY  
LEGISLATIVE COUNSEL

cc: Committee  
named above  
Each lead author  
concerned

STATEMENT FOR ASSEMBLY BILL 865

ASSEMBLY BILL 865 WILL SIMPLY REQUIRE INSURERS TO PAY 10 PERCENT INTEREST ON CLAIMS THAT ARE NOT PAID WITHIN 30 DAYS.

CURRENT LAW REQUIRES INSURERS TO REIMBURSE CLAIMS WITHIN 30 DAYS OR 45 DAYS FOR HMO'S (HEALTH MAINTENANCE ORGANIZATIONS). THE PURPOSE OF AB 865 IS ENCOURAGE COMPLIANCE WITH CURRENT LAW BY PROVIDING A DETERRENT FOR THOSE WHO DISREGARD CURRENT LAW.

THE BILL ALSO REQUIRES THAT CLAIMS BEING CONTESTED, INCLUDE THE REASON FOR CONTESTING AND THE PORTION BEING CONTESTED.

Problems from Payers Point of View

1. DELAYS IN AUDIT DATES
2. CHARGING FEE TO PROVE HOSPITAL BILL IS ACCURATE
3. DELAYS IN RESOLVING AUDITS
4. OBTAINING REFUNDS

5/26 to 6/12/86	CONFINED
2/23/87	\$40,663.75 BILL RECEIVED
2/26 to 3/3/87	PAID \$35,063.75 paid 86% of 5,600.00 (Pending Audit) total
3/6 and 4/6/87	AUTHORIZATION REQUESTED
5/4/87	AUTHORIZATION RECEIVED
5/11/87	AUDIT ORDERED
5/15 to 6/30/87	ATTEMPTS TO SCHEDULE AUDIT
6/4/87	AT HOSPITAL DEMAND, PAID \$4,381.00 LEAVING BALANCE OF \$1,219.00 (i.e. 98% of Bill)
8/20/87	AUDIT SCHEDULED 14 mos. post confinement 5 mos. post request
10/6/87	AUDIT COMPLETED AND AGREED TO \$2,284.49 IN UNDOCUMENTED CHARGES
10/8/87	REQUEST FOR OVERPAYMENT OF \$1,065.49
11/12/87	FOLLOW UP ON OVERPAYMENT
11/28/87	FOLLOW UP ON OVERPAYMENT
12/30/87	ATTORNEY BILL FOR \$3,500.00 hospital attny when they owed
12/31/87	RESPONDED ins. co.
1/8/88	FOLLOW UP ON OVERPAYMENT with CEO of hosp.
1/9/88	REFUND RECEIVED

HOSPITAL	Z	TOTAL CHARGES	\$79,000	( One Case)
2/13/87	-	4/15/87	DATES OF CONFINEMENT	
5/14/87			BILL RECEIVED IN CLAIM OFFICE	
5/20-26/87			BILL REVIEWED BY SUPERVISORS AND HEALTH CARE RESOURCES PERSONNEL	
6/4/87			\$45,561 OF BILL PAID WITH ADDITIONAL BENEFITS PAID ON SEPARATE DRAFT	
6/12/87			\$31,540.75 ADDITIONAL PAYMENT MADE FOR A TOTAL PAYMENT OF \$77,101.75 (98%)	
7/7/87			BILL SENT TO AUDIT COMPANY	
8/1/87			AUTHORIZATION UNACCEPTABLE TO HOSPITAL	
9/18/87				
10/1; 10/15; 11/4			FOLLOW-UPS TO MAKE AN APPOINTMENT	
1/4/88				
AS OF THE END OF FEBRUARY NO APPOINTMENT HAD BEEN SCHEDULED BY THE HOSPITAL ONE YEAR POST CONFINEMENT AND 8 MONTHS AFTER RECEIPT OF 98 % OF PAYMENT				
3/24/88			HOSPITAL GAVE APPROVAL FOR AUDIT 13 MONTHS AFTER BEGINNING OF CONFINEMENT AND 8 MONTHS AFTER INITIAL REQUEST	
5/12/88			AUDIT PERFORMED ON DATE SET BY HOSPITAL FOUND OVERPAYMENT OF \$3940	
5/27/88			REQUESTED REFUND STILL AWAITING REPLY	
PATIENT HAD TWO OTHER CONFINEMENTS AT SAME HOSPITAL DURING THIS TIME FRAME. INSURER WAITING FOR AUDIT APPROVAL FROM HOSPITAL FOR THOSE CONFINEMENTS				
2/1/89			RECEIVED REFUND FROM HOSPITAL 2 YEARS POST CONFINEMENT AND 19 MONTHS POST AUDIT REQUEST AND 8 MONTHS POST AUDIT	



DATA FROM INSURANCE COMPANY B :

HOSPITAL	Z	AUDITED \$12,291	SAVED \$7,063	CHARGES FEE FOR AUDIT	3-5 MONTH SCHED.
HOSPITAL	Y	AUDITED \$9,844	SAVED \$5,909	"	2-3 MONTH SCHED.
HOSPITAL	X	AUDITED \$7,557	SAVED \$4,614	"	30-45 DAYS SCHED.
HOSPITAL	V	AUDITED \$6,500	SAVED \$4,135	"	30 DAYS SCHED.
HOSPITAL	U	AUDITED \$9,803	SAVED \$6,688	"	3 - 4 MONTH SCHED
HOSPITAL	T	AUDITED \$8,327	SAVED \$4,739	"	30-45 DAYS SCHED

AVERAGE SAVINGS THROUGHOUT CALIFORNIA \$2.07 FOR EVERY DOLLAR AUDITED

AVERAGE REDUCED CHARGE AS A RESULT OF AUDIT/REVIEW \$977

HOSPITAL R AFTER FOUR MONTHS HOSPITAL NON RESPONSIVE TO INSURANCE COMPANY G's REQUEST FOR \$5,000 OVERPAYMENT--- INSURANCE COMPANY G SENT BILL TO COLLECTION - HOSPITAL REFUNDED OVERPAYMENT WITHIN TWO WEEKS

"SAVED" MEANS UNSUBSTANTIATED CHARGES

INSURANCE COMPANY E

FOURTH QUARTER 1987:	UNDER CHARGES	\$8,912.06
	OVER CHARGES	\$157,987.51

1988 AUDITS

INSURANCE COMPANY N

212 AUDITED CLAIMS CALIFORNIA

\$7,779,000 AUDITED

\$ 837,000 NET SAVINGS (Over and under charges netted out and cost of audit subtracted) \*

10.76% SAVINGS

INSURANCE COMPANY M

50 AUDITS  
( CALIFORNIA)

UNDER CHARGES AMOUNTED TO MORE THAN OVER CHARGES  
ON 13 AUDITS: OVER CHARGES AMOUNTED TO MORE THAN  
UNDER CHARGES ON 37 AUDITS

\$2,119,468.62 AUDITED

\$ 54, 495.69 NET SAVINGS \* See defination above

2.57% SAVINGS

INSURANCE COMPANY L

353 AUDITS CALIFORNIA

\$8,500,000 AUDITED

\$ 186,000 NET SAVINGS \* See defination above

2.19% SAVINGS

INSURANCE COMPANY K

111 CLAIMS CALIFORNIA

\$ 1,963,600 AUDITED

\$ 191,100 NET SAVINGS # Cost of audit not subtracted; cost is 1.5% of amount audited

9.7 % SAVINGS

1853 CLAIMS NATIONAL INCLUDING CALIFORNIA

\$33,154,000 AUDITED

\$ 2,256,000 AUDITED # see above for defination

6.8 % SAVINGS

SOME ADDITIONAL REASONS INSURANCE COMPANIES NEED ACCESS TO PATIENT MEDICAL CHARTS

INSURANCE COMPANY K

FRAUD INVESTIGATION	3918 CLAIMS	\$1,983,400	SAVINGS: \$1,810,000	91%
PREEXISTING INVESTIGATION	44989 CLAIMS	\$9,092,000	SAVINGS: \$8,384,200	92%
MEDICAL NECESSITY OF SERVICES	3188 CLAIMS	\$1,043,200	SAVINGS \$900,100	86%

SAVINGS DO NOT INCLUDE COST OF INVESTIGATION  
CLAIMS ARE NATIONAL INCLUDING THOSE IN CALIFORNIA

DANIEL FREEMAN  
HOSPITALS, INC  
DANIEL FREEMAN  
MARINA HOSPITAL  
DANIEL FREEMAN  
MEMORIAL HOSPITAL

A Cardiac Health Care Corp.  
6320 Arroyo Circle  
Los Angeles, CA 90045  
(213) 215-0919

0 9 0 3 2 4 6 0 0 5 3



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\* REMINDER TO ALL THIRD PARTY PAYORS

Please be advised that our credit policy allows for insurance companies to pay claims presented in a reasonable time frame.

After sixty days with no payment, we will immediately look to the patient/policy holder for payment in full. We would, therefore, appreciate your processing this claim within thirty days.

Our audit policy is the following:

- (1) An audit will not be scheduled until a minimum payment of at least eighty percent (80%) of charges is received by the hospital.
  - (a) If eighty percent (80%) of charges is received, the audit fee is \$200.00.
  - (b) If ninety percent (90%) of charges is received, the audit fee is \$100.00.
  - (c) If one hundred percent (100%) of charges is received, the audit fee is waived.

Please be advised that an audit status will not affect our existing credit policy as outlined above.

Please forward all payments to the lock box address of the facility that provided the service.

DANIEL FREEMAN MARINA HOSPITAL  
DEPARTMENT NO. 0253  
LOS ANGELES, CA 90084-0253

DANIEL FREEMAN MEMORIAL HOSPITAL  
DEPARTMENT NO. 0354  
LOS ANGELES, CA 90084-0354

# HOAG MEMORIAL HOSPITAL PRESBYTERIAN

301 NEWPORT BOULEVARD • BOX Y • NEWPORT BEACH, CALIFORNIA 92663 • PHONE (714) 645-8600

SUBJECT: AUDITS BY INSURANCE CARRIERS

The hospital is under no statutory or regulatory obligation to release patient medical records to an auditing entity. However, the hospital does recognize that an insurance carrier responsible for payment of the hospital bill has a legitimate interest in reviewing hospital patient records.

The hospital contends that it has a legitimate basis for charging an insurance carrier or its audit representative for all direct and indirect costs associated with conducting the audit. Costs may include, but are not limited to, the costs of all administrative and ancillary department personnel involved in the auditing process (which includes reauditing the insurance carrier's findings.) The fee for each audit is \$175.00. The fee is payable prior to release of the medical record.

Due to the significant reduction in cash flow that can occur when an audit is in progress, the hospital requires that 95% of the payable charges be paid prior to the release of the medical record.

Medical record audits require pre-arranged appointments with the Medical Audit Representative located in the Business Office.

An external auditor must remain in the Medical Records Department. Questions that may arise are to be directed to the Medical Audit Representative.

The external auditor must submit an itemized summary of the findings to the Medical Audit Representative.

The hospital will respond within 30 working days from the date the audit findings are received.

Review of the audit findings may be extended to include review of the entire charges. Unbilled charges will be added to the patient's bill. Overcharges will be deducted from the patient's bill.



MEDICAL CENTER  
101 THE CITY DRIVE  
ORANGE, CALIFORNIA 92668

INSURANCE AUDIT POLICY

1. Any account billed is subject to an independent audit per request of the insurance company involved.
- \* 2. The review of the medical record for audits is to be scheduled and conducted through the Audit Unit.
3. Proper authorization for release of information is mandatory to review the medical record.
4. A full focus audit will be conducted on each case by the Audit Unit. If the insurance auditor chooses not to review any particular area, the amount audited by the UCIMC representative will be considered final, and reported to the carrier as such.
5. In the event that an insurance audit is not completed within 30 days of notification, the patient's statement will be adjusted by the hospital's audit findings.
6. An exit interview will be conducted with each insurance auditor, during which a summary of agreed upon discrepancies, overcharges/undercharges, will be signed to formally close the case. UCIMC considers this to be a corrected, final billing to the insurance carrier.
7. At least 80% payment must be received and posted before the audit will be scheduled.
8. A \$150.00 fee will be collected at the time of audit. The audit fee will be waived if the bill has been paid in full within 60 days of the final billing date.
9. An offsite audit fee of \$250.00 will be assessed for each request. In addition, a \$40.00 per hour fee will be charged for the time necessary to photocopy and respond to offsite audit results. The \$250.00 must be received by the Audit Unit and 80% payment received by Patient Accounts before the chart will be forwarded to the photocopy company.

\*NOTES: To schedule Audits please contact Medical Correspondence at (714) 634-5670. If you have any further questions, please do not hesitate to contact Donna M. LaPorte, RN, Insurance Audit Coordinator, at (714) 937-7820.



# HOLY CROSS HOSPITAL

15031 RINALDI STREET • MISSION HILLS • CALIFORNIA 91345 • (818) 365-8051 (805) 255-3719

Metropolitan Life  
One City Blvd. West  
Suite 1200  
Orange, Calif. 92668

Date: Aug 25, 1987

Dear Linda Dempsey / Emerill Strong (auditor)

This letter is intended to acquaint you with Holy Cross Hospital's policy regarding insurance carrier audits. We would appreciate your scheduling audit appointments by contacting the Internal Auditor, Ms. Dorothy Lodge at 818-898-4504. The hospital expects that you reimburse us for 95% of billed charges prior to the audit, and within a reasonable and customary time period from the account billing date. Additionally, a \$125.00 fee is charged per audit, to compensate for hospital costs incurred in conducting the audit.

If you have any questions regarding Holy Cross Hospital's insurance audit policy, please contact me at 818-898-4508.

Sincerely,

Mary Ann Ray  
Manager of Patient Accounting

1100 WEST STEWART DRIVE, ORANGE, CALIFORNIA 92668 (714) 633-9111

FINANCIAL AUDITS

I. Policy governing insurance auditors:

1. All insurance and patient audits must be scheduled through the Consolidated Business Office. This office will coordinate the audits with Medical Records and the Department of Case Management.
2. Requests for insurance audits shall be handled on an appointment basis, on Tuesday, Wednesday and Thursday of each week from 8:00 AM to 4:00 PM. Requests by patients will be processed daily.
3. Written authorization to release information signed by the patient within six months of the hospitalization being audited according to the policies for release of medical record information set forth by Saint Joseph Hospital Medical Records Department is required. If the patient is legally incompetent or a minor child, authorization must be signed by parent or legal guardian. If the patient is deceased, authorization must be signed by spouse, next of kin, or executor of estate. Exceptions are made for substance abuse and psychiatric admissions, which are referenced in the policies and procedures of the Medical Records Department.
4. Each request to audit must specify the following information:
  - a. Patient full name.
  - b. Hospital identification number.
  - c. Admission and discharge date.
  - d. Specific charges to be audited.
  - e. Auditors name, phone number, address.
  - f. Audit company, phone number, address.
  - g. Patient's primary and secondary insurance provider.
5. All audits will be conducted on site and under the auspice of the Case Management Department with assistance from the Medical Records Department and Consolidated Business Office. If the auditor fails to complete an on-site review the patient remains responsible for all charges in dispute.



1100 WEST STEWART DRIVE, ORANGE, CALIFORNIA 92668 (714) 633-9111

FINANCIAL AUDITS Page 2

6. All disputed charges must be specifically identified and listed by item, quantity, unit price, and total charge per date of service.
7. All disputed, undocumented, or under-charged items will be identified in the audit process.
8. Audits will be completed on final charges only, for each individual admission.
9. Auditors must request a copy of the final charges from the insurance company.
10. To facilitate the completion of the audit process, Saint Joseph Hospital will provide a work place in the Medical Records Department, and/or the Case Management Office. At the conclusion of the audit an exit interview will be initiated by the Case Management Office for the resolving of disputed non-documented and under-charged items.
11. A statement detailing adjustments to be made to the final charges as originally billed must be forwarded to the Case Management Office within 10 working days following the completion of the audit. The statement must detail:
  - a. Date of Service
  - b. Area of Service
  - c. Total over and under-charges

In cases where this is not received Saint Joseph Hospital Case Management Office will forward results to the insurance carrier directly. It is the intent of Saint Joseph Hospital to immediately pursue resolution of the account at the time the audit results are forwarded to the insurance carrier. Any further delays in payment will result in the patient being notified of the outstanding balance responsibility.

Saint Joseph Hospital Case Management Office, upon receipt of the final statement reserves the right to file an appeal within 30 working days on any final statement that is determined to be incorrect, arbitrary or not in agreement with the exit conference.

1100 WEST STEWART DRIVE, ORANGE, CALIFORNIA 92668 (714) 633-9111

FINANCIAL AUDITS Page 3

12. All auditors must conduct themselves in a professional manner. Additionally, auditors may be placed on a probation for 30 days if behavior is not conducted in a professionally appropriate way. The insurance company will be notified immediately should such an incident occur.

The following situations will be considered non-professional:

- a. Auditors delayed greater than 30 minutes for a scheduled exit interview.
- b. Auditors not keeping their appointments requiring rescheduling, it is considered essential to cancel 24 hours before the appointment unless an emergency or lack of authorization.
- c. Auditors who are not able to follow the policies as defined in this document.

II. Fees

1. Audits will not be conducted unless 90% of the verified benefits have been paid within 45 days of the patient's billing.
2. Audits conducted on charges where 90% of the verified benefits have been paid within 45 days of the patient's discharge will be assessed a \$300 fee. Assessed fee must be received prior to audit.
3. Audits conducted on charges where 100% of the verified benefits have been paid within 45 days of the patient's discharge will have the fee waived.

III. Payment of Refunds on Completed Audits.

1. Balance of payment on completed audits is due within 30 days.
2. Overpayments as identified on completed audits will be refunded within 30 days of finalized audit results.

ATTN: Insurance Company Claims Processor(s)

PROVIDER AUDIT SERVICES has been contracted to perform charge audits on behalf of our client:

NORWALK COMMUNITY HOSPITAL

To accomplish this task, our Account Auditors perform a highly detailed comparison of the itemized bill to documentation contained in the patient's Medical Records.

In the event that such audits reveal missed charges, our company is authorized to bill these charges to the insurer on our client's behalf.

Should you have any questions regarding the additional charges billed on the attached claim, please contact:

Ms. Hilda Fried  
Special Accounts Representative  
PROVIDER AUDIT SERVICES

(213) 251-1460

Thank you for your cooperation.



Ms. Shella Welner  
Audit Programs Manager

100 WALK COMMUNITY HOSPITAL  
 3222 BLOOMFIELD AVE  
 100 WALK, CALIF.  
 713-863-4763

2 0001 770-200001 P 1985 151  
 5 BC/BS PROV. NO. 6 FEDERAL TAX NO. 7 MEDICARE NO. MEDICAID NO.  
 1155 9 0 5 0 2523563984 0502397 HSP400804 7000

PATIENT'S LAST NAME FIRST NAME INITIAL 11 PATIENT'S ADDRESS CITY STATE ZIP

2 BIRTH DATE 13 SEX 14 MS 15 DATE 16 HR. 17 TYPE 18 SRC 19 A.P.P. 20 D.H. 21 STAT 22 FROM 23 COV.D. 24 N-C.D. 25 C-ID. 26 L-R.D. 27

28 OCCURRENCE 29 OCCURRENCE 30 OCCURRENCE 31 OCCURRENCE 32 OCCURRENCE 33 OCCURRENCE SPAN  
 CD DATE CD DATE CD DATE CD DATE CD DATE CD DATE FROM THROUGH

CONDITION CODES BLOOD RECORD (PINTS) 44 SP PROG 45  
 36 37 38 39 40 FURN 41 REPL 42 NOT RP 43 DED. 44 SP PROG 45  
 46 VALUE 47 VALUE 48 VALUE 49 VALUE  
 CD AMT CD AMT CD AMT CD AMT

50 DESCRIPTION 51 R. CODE 52 S. UNITS 53 TOTAL CHARGES 54

PHARMACY	250	13	286.95	
MED-SUR SUPPLIES	270	28	1343.95	
LABORATORY OR (LAB)	300	6	171.00	
PATHOLOGY LAB OR. (PATH L)	310	1	28.00	
DIAGNOSTIC X-RAY	320	2	172.00	
DR SERVICES	360	6	1008.00	
ANESTHESIA	370	1	18.50	

ORIGINAL TOTAL CHARGES ... \$3028.40  
 METROPOLITAN LIFE PAID ON 2/17/89 .. \$1625.64  
 5/5/89 ADDITIONAL CHARGES DUE ..... \$326.79

SEE ATTACH BREAKDOWN OF ADDITIONAL CHARGES, COPY OF INSURANCE PAYMENT CHECK AND ASSIGNMENT.  
 THANK YOU  
 Hilda M. Fried  
 HILDA M. FRIED/jdb  
 SPECIAL ACCOUNTS REPRESENTATIVE  
 (213) 251-1460

ADDITIONAL CHARGES WERE RECENTLY AUDITED WITH MEDICAL RECORDS.

TOTAL CHARGES 001 3028.40

57 PAYER 58 REL. 59 AGG INFO 60 DEDUCTIBLE 61 CO-INSURANCE 62 EST. RESPONSIBILITY 63 PRIOR PAYMENTS 64 EST. AMOUNT DUE  
 METROPOLITAN ORANGE Y Y 3028.40

**DUE FROM PATIENT**

65 INSURED'S NAME 66 SEX 67 P.REL. 68 CERT.-SSN-HIC.-ID. NO. 69 GROUP NAME 70 INSURANCE GROUP NO.  
 METROPOLITAN

71 EID 72 ESC 73 EMPLOYER NAME 74 EMPLOYEE ID. 75 EMPLOYER LOCATION  
 AP 1

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS 77 PRIN. CODE 78 OTHER DIAGNOSES CODES 79 80 81  
 INGROWING NAIL; BEN NEO BONES ANKLE/FOOT 703.0 213.9

82 P.C. 83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS 84 PRINCIPAL PROCEDURE 85 OTHER PROCEDURE 86 OTHER PROCEDURE  
 9 LOC EXC BONE LESION NEC; NAIL REMOVAL 77.69 01/13 86.23 01/13

87 CD 88 APP. FROM 89 APP. THROUGH 90 GRC 91 TREATMENT AUTH. 92 ATTENDING PHYSICIAN ID 93 OTHER PHYSICIAN ID  
 CAE1440 PRYHARSKI, STEPHEN CAE1440 PRYHARSKI, STEPHEN

94 REMARKS METROPOLITAN ORANGE ATTN MEDICAL CLAIMS DEPT P.O. BOX 5518 ORANGE CA 92667  
 VERIFIED N-C. STAY DATES FROM THROUGH PR. PSC. D.  
 AMT. REIMBURSED N-PYM. CD APPROV. BY DATE APPROV.

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF  
 PROVIDER REPRESENTATIVE X H. Brown 96 DATE 1-24-89

CHAPMAN GENERAL HOSPITAL  
 2601 E CHAPMAN AVENUE  
 ORANGE CALIFORNIA 92669  
 (714-633-0011)

07-25-79

PATIENT CONTROL NUMBER

0-19833-7

111

10 PATIENT'S LAST NAME		FIRST NAME		INITIAL	11 PATIENT'S ADDRESS			CITY	STATE	ZIP
12 BIRTH DATE		13 SEX	14 MS	15 ADMISSION DATE			16 HR.	17 TYPE	18 SICK	19 A.M.
11-19-30		M		01-10-87			10			20 D.H.
21 STATE		22 STATEMENT COVERS PERIOD			23 COV. 2		24 N-C-D	25 C-10	26 L-1	27
01		01-10-87			02-03-87					
28 OCCURRENCE		29 OCCURRENCE		30 OCCURRENCE		31 OCCURRENCE		32 OCCURRENCE		
CO DATE		CO DATE		CO DATE		CO DATE		CO FROM THROUGH		
CO DATE		CO DATE		CO DATE		CO DATE		CO FROM THROUGH		
34		35 CONDITION CODES			36 BLOOD RECORD (PINTS)			37 SP		38
39		40			41			42		43
44		45			46			47		48
49		50			51			52		53
54		55			56			57		58
59		60			61			62		63
64		65			66			67		68
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84		85			86			87		88
89		90			91			92		93
94		95			96			97		98
99		100			101			102		103

01-27-87 LAB-ROUTINE CULTURE	4060		\$50.75
-1-20-28-87 LAB-SENSITIVITY	4060	\$41.75 X2=	83.50
01-15-87 CS-FOOT CRADLE	4050		11.35
1-16,21,22,23,27,28,31,2-1,2-87 CS-ISOLATION CHR.G.	4050	\$53.50 X10=	535.00
01-10,17,23,29X2,02-01-87 XR-PORTABLE EXAMS	4140	\$15.00 X6=	90.00
01-17,18,20,22,23,X2-87 PH-LASIX INJ.	4170	\$9.00 X6=	54.00
01-15,16-87 PH-SODIUM BICARBONATE	4170	\$34.85 X2=	69.70
01-23-X2-87 PH-MEZALIN INJ.	4170	\$55.90 X2=	111.80
01-27-87 RT-02 PER HR.	4180		5.00
01-11-87 CS-500 CC D5W	4050		28.00
01-20-87 CS-500 CC D5.2% NACL	4170		25.65
01-16X2,25-87 CS-1L D5.2%NACL	4050	\$32.50 X3=	97.50
01-15,16, 18,19-87 CS-INFUSION PUMP	4050	\$45.35 X4=	181.40
02-01-87 PH-LIDOCARICAIN INJ.	4170		28.90

**BENEFITS ASSIGNED**

PAY THIS AMOUNT ONLY \$1,372.55

CORRECT TOTAL \$40,026.98

57 PAYER		58 REF. 59 ASG. GEN.		60 DEDUCTIBLE		61 CO-INSURANCE		62 EST. RESPONSIBILITY		63 PRIOR PAYMENTS		64 EST. AMOUNT DUE					
A* METROPOLITAN LIFE INS CO																	
B																	
C																	
<b>DUE FROM PATIENT</b>																	
65 INSURED'S NAME				66 SEX		67 P. REL.		68 CERT. -SSN-HIC-ID. NO.		69 GROUP NAME		70 INSURANCE GROUP NO.					
A				M		01											
B																	
C																	
71 EID		72 ESC		73 EMPLOYER NAME				74 EMPLOYEE ID#		75 EMPLOYER LOCATION							
76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS						77 PRIN. CODE		78 OTHER DIAGNOSES CODES									
4280						2041		7990		5119		7895		5990			
82 P.C.		83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS				84 PRINCIPAL PROCEDURE		85 OTHER PROCEDURE		86 OTHER PROCEDURE							
9						3893		1/10/87		9925		1/10/87		8802			
87 CD		88 APP. FROM		89 APP. THROUGH		90 CAC.		91 TREATMENT AUTH.				92 ATTENDING PHYSICIAN ID.		93 OT-ER PHYSICIAN ID.			
								LUDLOW				WESTER		A			
94 REMARKS												95 VERIFIED N-C STAY DATES		96 FOR CREDITABLE USE ONLY			
METROPOLITAN LIFE INS CO.												FROM		THROUGH		P.C. O.	
GROUP HEALTH CLAIMS																	
P.O. BOX 5518												AUT. REIMBURSED		N-P.M. CD		APPROV. BY	
ORANGE, CA. 92667-0518																	

1-881-4 HOSPITAL REGIONAL  
 27700 MEDICAL CENTER  
 MISSION VIE CA 92691  
 714-364-1400

316877 131

5 BC/BS PROV. NO. 6 FEDERAL TAX NO. 7 MEDICARE NO. 8 MEDICAID NO. 9  
 0 0 0 4 2 7 651318323 2

PATIENT'S LAST NAME FIRST NAME INITIAL 11 PATIENT'S ADDRESS CITY STATE ZIP  
 HANLEY, PATRICIA A. 26522 AVE. VERONICA MISSION VIEJO CA 92691

2 BIRTH DATE 13 SEX 14 MS 15 DATE 16 HR. 17 TYPE 18 SRC 19 A.H. 20 D.H. 21 STAT 22 STATEMENT COVERS PERIOD 23 COV.D. 24 N.C.D. 25 C-I-D 26 L.R.D. 27  
 12-15-54 F W 01-20-89 20 3 1 13 01 01-20-89 01-21-89 FC = PT = F

29 OCCURRENCE		31 OCCURRENCE		33 OCCURRENCE SPAN	
DATE	CD	DATE	CD	FROM	THROUGH

3 DESCRIPTION 51 R. CODE 52 S UNITS 53 TOTAL CHARGES 54 55 56 PT AMT

DESCRIPTION	51 R. CODE	52 S UNITS	53 TOTAL CHARGES	54	55	56 PT AMT
PHARMACY		250	17	26825	26825	
IV THERAPY		260	5	14575	14575	
MED-SUR SUPPLIES		270	22	65700	65700	
LABORATORY OR (LAB)		300	2	6200	6200	
DR SERVICES		360	1	1900	1900	
RESPIRATORY SVC		410	1	3600	3600	
DELIVERY/LABOR		720	2	26200	26200	
OUTPATIENT/OTHER		509	1	28000	28000	
PLEASE NOTE CORRECTED ROOM FEE						
TOTAL CHARGE	001			1730 00	1730 00	

7 PAYER 58 REL. INFO. 59 ASG BEN. 60 DEDUCTIBLE 61 CO-INSURANCE 62 EST. RESPONSIBILITY 63 PRIOR PAYMENTS 64 EST. AMOUNT DUE  
 MET-ELECT #70# Y Y  
 AETNA XXXX X99 Y Y 1730 00 1730 00

**DUE FROM PATIENT**

15 INSURED'S NAME 66 SEX 67 P.REL. 68 CERT.-SSN-HIC-ID.NO. 69 GROUP NAME 70 INSURANCE GROUP NO.  
 F 1X 659780051 PAYOR # ROCKWELL INTER 0070989  
 M 02 06925031000 TRW INFORMATIO 60054 0132

71 EID 72 ESC 73 EMPLOYER NAME 74 EMPLOYEE ID. 75 EMPLOYER LOCATION  
 1 ROCKWELL INTERNATIONAL 569085453 EL SEGUNDO CA  
 1 TRW INFORMATION 557862689 ORANGE CA 92668

16 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS 77 PRIN. CODE 78 OTHER DIAGNOSES CODES 79 80 81  
 EXCESS FETAL GETH-DELIV ;HX-SKIN MALIGNANCY 636.61 V10.63

17 CD 18 APP. FROM 19 APP. THROUGH 20 GRC 21 TREATMENT AUTH. 22 ATTENDING PHYSICIAN ID. 23 OTHER PHYSICIAN ID.  
 STADLER EDWARD MD CA G023122 STADLER EDWARD MD CA G023122

24 REMARKS METROPOLITAN P.O. BOX 5518 ORANGE, CA 92613-5518  
 FROM VERIFIED N.C. STAY DATES THROUGH FOR INTERMEDIARY USE ONLY PR. PSC. D.  
 AMT. REIMBURSED N-PYM. CD APPROV. BY DATE APPROV.

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF  
 PROVIDER REPRESENTATIVE x s. Chacon 95 DATE 4/9/89

MISSION HOOP & HILL REGIONAL MEDICAL CENTER  
 27700 MEDICAL CENTER  
 MISSION, CA. 94901  
 714 364-1400  
 09042761402

3  
 HOSP. NO.

NO. OF BILL DATE OF PREV. BILL  
 1/26/89  
 IRS NUMBER 95-2691476

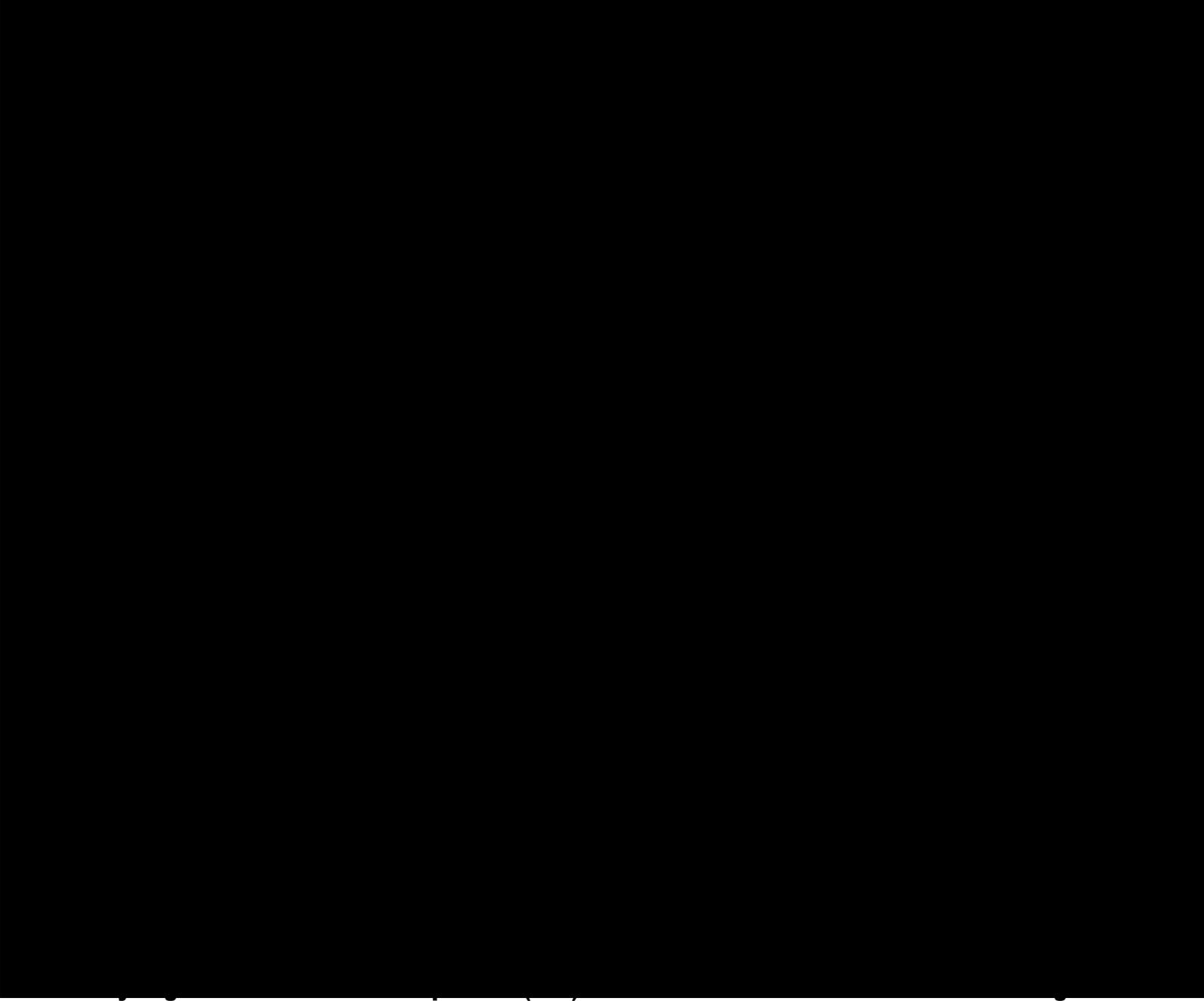
PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
[REDACTED]	316877	F		01/20/89	01/21/89	1

PAYER NAME AND ADDRESS	C.O.B.	INSURANCE COMPANY NAME	GROUP NO.	POLICY NUMBER
		1 MET-ELECT	W70#	659780051
		2 AETNA	A01#	06925031000
STADLER EDWARD MD				

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

AMOUNT OF PAYMENT \$

DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
LABOR R 1 DAYS							280.00



MISSION HOSPITAL REGIONAL  
 7700 MEDICAL CENTER  
 MISSION VIE CA 92691  
 14-360-1400

3 PATIENT CONTROL NUMBER  
 334177  
 131

5 BC/BS PROV. NO. 6 FEDERAL TAX NO. 7 MEDICARE NO. 8 MEDICAID NO.

9 PATIENT'S ADDRESS  
 20522 AVE. VERONICA MISSION VIEJO CA 92691

PATIENT'S LAST NAME  
 ANLEY, BOY-PATRICIA

13 SEX M 14 MS S 15 DATE 01-20-89 16 HR. 23 17 TYPE 4 18 SRC 1 19 A.H. 13 20 D.H. 01 21 STAT 01 22 STATE COV. D 23 N.C.D. 24 C.I.D. 25 L.R.D. 26 FC = 27 PT = B

DATE		OCCURRENCE		OCCURRENCE		OCCURRENCE SPAN	
DATE	CD	DATE	CD	DATE	CD	FROM	THROUGH

DESCRIPTION	51 P. CODE	52 S. UNITS	53 TOTAL CHARGES	54	55	56 PT AMT
PHARMACY	250	2	3000	3000		
ED-SUR SUPPLIES	270	9	23900	23900		
LABORATORY OR (LAB)	300	2	4605	4605		
TPATIENT/OTHER	509	1	22400	22400		
<b>TOTAL CHARGE</b>	<b>001</b>		<b>539 05</b>	<b>539 05</b>		

60 DEDUCTIBLE 61 CO-INSURANCE 62 EST RESPONSIBILITY 63 PRIOR PAYMENTS 64 EST. AMOUNT DUE

ET-ELECT 470# Y Y  
 ETNA 1A01# Y Y

539 05 539 05

**DUE FROM PATIENT**

INSURED'S NAME  
 ANLEY, BOY-PATRICIA

66 SEX F 67 03L 68 CERT.-SSN-HIC-ID NO. 659780051 69 GROUP NAME ROCKWELL INTER 70 INSURANCE GROUP NO. 0070989

M 03 06925031000 TRW INFORMATIO 60054 0132

72 ESC B 1 73 EMPLOYER NAME ROCKWELL INTERNATIONAL 74 EMPLOYEE ID. 569035453 75 EMPLOYER LOCATION EL SEGUNDO CA

A 1 TRW INFORMATION 557862689 ORANGE CA 92668

77 PRIN. CODE 78 79 80 81

77 PRIN. CODE V30.0 78 79 80 81

83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS 84 PRINCIPAL PROCEDURE 85 OTHER PROCEDURE

84 PRINCIPAL PROCEDURE CD DATE CD DATE CD DATE

PSRO UR DATA 91 TREATMENT AUTH. 92 ATTENDING PHYSICIAN ID. CA G035292 93 OTHER PHYSICIAN ID. CA G035292

88 APP. FROM 89 APP. THROUGH 90 GRC

CARRUTH JOHN MD CARRUTH JOHN MD

REMARKS  
 AETNA LIFE  
 101 W. BROADWAY #900  
 SAN DIEGO, CA 92101

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X S. Chacon 96 DATE 4/19/89

DATE OF BILL      DATE OF PREV. BILL

27700 MEDICAL CENTER  
MISSION, JO, CA.  
714 364-1400

691

2

HOSP. NO.

AL 01/26/89

IRS NUMBER 95-2691476

0 9 0 4 2 7 6 1 4 0 1

PATIENT NAME

PATIENT NUMBER

SEX

AGE

ADMISSION DATE

DISCHARGE DATE

DAYS

B

334177

M

01/20/89

01/21/89

1

C.O.B.

INSURANCE COMPANY NAME

GROUP NO.

POLICY NUMBER

1 MET-ELECT  
2 AETNA

W70#  
A01#

659780051  
06925031000

PATIENT NAME AND ADDRESS

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

AMOUNT OF PAYMENT \$

DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
SUMMARY OF CHARGES							
NURSERY 1DAY30	<del>XXXXXX</del>	<del>XXXXXX</del>	<del>XXXXXX</del>	224.00			
CENTRAL SUPPLY 4050		239.00	239.00				
LABORATORY 4060		46.05	46.05				
PHARMACY 4170		30.00	30.00				
<b>U-TOTAL OF CHARGES</b>		<b>539.05</b>	<b>539.05</b>				
		<del>XXXXXX</del>	<del>XXXXXX</del>				
PROFESSIONAL RADIOLOGIST FEES WILL BE BILLED SEPARATELY		539.05	539.05				
<b>TOTALS</b>		<del>XXXXXX</del>	<del>XXXXXX</del>				

PATIENT NUMBER  
334177

SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

PAY THIS AMOUNT      0.00

MISSION HOSPITAL REGIONAL MEDICAL CENTER  
MISSION VIEJO, CA.

C40

ADDENDUM

PALOMAR MEDICAL CENTER - ESCONDIDO, CA.

The ICU room rate at this facility is \$ 930.00 per day, a semi-private room is \$ 383.00 per day.

Trauma patients are charged, ICU \$ 2625.00 per day, semi-private \$ 1392.00 per day. The level of care is the same as that for any other ICU or semi-private patient.

This facility (from what we were told) makes these charges to try and offset their cost of operating a trauma unit, and to help pay for those trauma patients who cannot pay.

The basic trauma ER charge is \$ 2000.00. Each department then charges a flat fee of \$ 610.00 to respond to a trauma run, plus charges for each and every item used, tests and or treatments rendered.

The trauma coordinator also stated that the extra room rate was to help cover the costs of special rounds on these patients by various members of the trauma team (undocumented).

Had this not been a trauma patient the bill for room and board, would be reflected as below.

<u>TRAUMA</u>	<u>NON-TRAUMA</u>	<u>SAVINGS</u>
ICU \$ 5,250.00	\$ 1,860.00	\$ 3,390.00
SEMI 22,272.00	6,128.00	16,144.00
TOTAL: \$ <u>27,522.00</u>	\$ <u>7,808.00</u>	TOTAL SAVINGS <u>\$19,534.00</u>

OFFICE OF LEGISLATIVE COUNSEL

August 30, 1989

Honorable Cathie Wright

A.B. 865 - Conflict

Supplemental

The above measure, introduced by you, which is now set for hearing in the Senate Insurance, Claims and Corporations Committee ✓

appears to be in conflict with the following other measure(s):

- A.B. 1311 - Filante
- A.B. 2474 - Wright
- S.B. 439 - Robbins

**ENACTMENT OF THESE MEASURES IN THEIR PRESENT FORM MAY GIVE RISE TO A SERIOUS LEGAL PROBLEM WHICH PROBABLY CAN BE AVOIDED BY APPROPRIATE AMENDMENTS.**

**WE URGE YOU TO CONSULT OUR OFFICE IN THIS REGARD AT YOUR EARLIEST CONVENIENCE.**

Very truly yours,  
BION M. GREGORY  
LEGISLATIVE COUNSEL

cc: Committee  
named above  
Each lead author  
concerned



## Legislative Research Incorporated

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www.lrihistory.com · intent@lrihistory.com

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# Office of Senate Floor Analyses Materials

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THIRD READING

<b>SENATE RULES COMMITTEE</b>  Office of Senate Floor Analyses 1100 J Street, Suite 120 445-6614	Bill No.	AB 865
	Author:	Wright (R)
	Amended:	9/11/89 in Senate
	Vote Required:	Majority

Committee Votes:

Senate Floor Vote:

<b>COMMITTEE: INS/CLAIMS/CORPS</b>		
BILL NO.: <b>AB 865</b>		
DATE OF HEARING: <b>8-23-89</b>		
SENATORS:	AYE	NO
Davis	✓	
Deddeh		
Doolittle	✓	
Cecil Green		
Keene	✓	
McCorquodale		
Montoya	✓	
Nielsen (VC)	✓	
Robbins (Ch)	✓	
<b>TOTAL:</b>	<b>6</b>	<b>0</b>

Assembly Floor Vote: 64-1, p. 2312, 6/6/89

**SUBJECT:** Health insurance: claim reimbursement

**SOURCE:** California Association of Hospitals and Health Systems

**DIGEST:** This bill requires that insurers and plans pay an interest rate charge on uncontested health care claims which remain unpaid beyond a specific time period with commensurate requirements in overpayment situations.

Senate Floor Amendments of 9/11/89 double-join this bill with SB 439 (Robbins) to prevent a chaptering out problem.

**ANALYSIS:** Current law requires health care service plans, indemnity insurers, self-insured employee welfare benefit plans, and nonprofit hospital service plans to provide claim reimbursement as soon as practical but no later than 30 working day after claim receipt unless it is contested. For health maintenance organizations, which are either a nonprofit hospital service plan or a health care service plan, the timeframe period is 45 working days.

This bill requires every health care service plan, indemnity insurer, nonprofit hospital service plan, which provides either individual or group coverage, to be liable for the payment of interest at the rate of ten percent per annum on monies owed to a professional or institutional provider on any submitted claim which is uncontested.

If an uncontested claim is not reimbursed by delivering to the claimant's address the monies within 30 working days or within 45 working days with respect to a health maintenance organization, interest at ten percent per annum shall commence accrual.

CONTINUED

Regarding a claim, the claimant must be notified in writing within 30 working days that it is contested or denied. This notification shall identify the portion which is under dispute and the corresponding reasons. An entire or portion of a claim is defined as reasonably contested where the insurer or plan has not received a completed claim and all information necessary to determine liability for payment. The information includes matters of fraud, misrepresentation, consents, releases, assignments, claim on appeal, and medical necessity.

Regarding overpayments, if a provider is determined to be overpaid by a plan or insurer, a written notification on the particulars is required. The provider has 30 working days in which to reimburse the plan or insurer, unless it is contested. If contested, the plan or insurer must receive written notification of the specific details of contestability within 30 working days. A provider is subject to the identical interest penalty in cases where the overpayment for the uncontested portion of the claim is not received within a 30 working day period.

A health maintenance organization is defined as a nonprofit hospital service plan or a health care service plan.

**FISCAL EFFECT:** Appropriation: No Fiscal Committee: No Local: No

**SUPPORT:** (Verified (9/11/89)

California Association of Hospitals and Health Systems (source)  
Centinela Hospital Medical Center  
Treatment Centers of America  
Bellwood Health Center  
California Medical Association

**OPPOSITION:** (Verified 9/11/89)

Department of Health Services

**ARGUMENTS IN SUPPORT:** According to the Senate Insurance, Claims and Corporations Committee analysis, the sponsor contends that this measure is needed because of widespread disregard for the existing statute requiring claim reimbursement within a specified time period. This is occurring because there is no effective sanction for violations. The bill's effort to cure this disregard is in the form of a sanction which provides for payment of interest on outstanding balances.

Proponents contend (1) reasonable prompt payment of claims is essential to professional provider financial viability; and, (2) with technological innovations in health care delivery, costs are mounting and the need for a good faith effort in claims payment is essential to maintain adequate cash flow for institutional providers.

The sponsor has met on a number of occasions with the opponents to resolve key differences. It appears that final resolution has not yet been attained over the issue of reasonable access to information concerning provider services, to wit financial audits, because of concern over possible "fishing expeditions" by insurers and plans in an audit review of the providers' claims.

CONTINUED

**ARGUMENTS IN OPPOSITION:** According to the Senate Insurance, Claims and Corporations Committee analysis, the opponents contend (1) the ten percent per annum interest rate is arbitrarily established without regard to current interest rate structures; (2) there is an inappropriate use of government, i.e. the Medi-Cal Program, to intervene in essentially a business dispute; (3) failure to pay an uncontested claim in the specified time period will have a detrimental impact on the Medi-Cal Program's managed care objective and result in loss of program contractors; and (4) without access to documents in a reasonable manner, which is essential for any payor to determine its liability, the use of the financial audit that has proven successful in this regard will be severely thwarted.

**ASSEMBLY FLOOR VOTE:**

**ASSEMBLY BILL NO. 865 (Wright)**—An act to amend Section 1371 of the Health and Safety Code, and to amend Sections 10123.13 and 11512.180 of the Insurance Code, relating to insurance.

Bill read third time, and passed by the following vote:

**AYES—64**

Allen	Eppler	Jones	Peace
Areias	Farr	Katz	Polanco
Bader	Ferguson	Kelley	Pringle
Baker	Filante	Killea	Quackenbush
Bane	Frazee	Klehs	Roos
Bates	Friedman	La Follette	Roybal-Allard
Bentley	Frizzelle	Lancaster	Seastrand
Brown, Dennis	Hannigan	Lempert	Sher
Chandler	Hansen	Leslie	Speier
Clute	Harris	Lewis	Tanner
Condit	Harvey	McClintock	Tucker
Connelly	Hauser	Mojonnier	Waters, Norman
Cortese	Hughes	Mountjoy	Woodruff
Costa	Isenberg	Murray	Wright
Eastin	Johnson	Nolan	Wyman
Eaves	Johnston	O'Connell	Mr. Speaker

**NOES—1**

Floyd

Bill ordered transmitted to the Senate.

DLW:lm 9/11/89 Senate Floor Analyses



LRI