SENATE CS FOR CS FOR HOUSE BILL NO. 113(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 5/5/01
Referred: Rules

Sponsor(s): REPRESENTATIVES GREEN, Dyson, McGuire

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care insurance payments for hospital or medical services; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 21.06.110 is amended to read:

Sec. 21.06.110. Director's annual report. As early in each calendar year as is reasonably possible, the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose certificate of authority was surrendered, suspended, or revoked during the year and the cause of surrender, suspension, or revocation;

(3) the name of each insurer authorized to do business in this state

against which delinquency or similar proceedings were instituted and, if against an insurer domiciled in this state, a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipt and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance or the office of director;

(7) statistical information regarding health insurance, including the number of individual and group policies sold or terminated in the state; this paragraph does not authorize the director to require an insurer to release proprietary information; [AND]

(8) **the annual percentage of health claims paid in the state that meets the requirements of AS 21.54.020(a) and (d); and**

(9) other pertinent information and matters the director considers proper.

*** Sec. 2.** AS 21.54.020 is repealed and reenacted to read:

Sec. 21.54.020. Required insurer payment for hospital and medical services. (a) A health care insurer shall pay or deny indemnities under a group health insurance policy or subscriber benefits under a group hospital or medical service subscriber contract, whether or not services were provided by participant providers, within 30 calendar days after the health care insurer or a third-party administrator under contract with a health care insurer receives a clean claim.

(b) If a claim is not paid or is denied, the health care insurer shall give notice of the basis for denial or the specific items necessary for the claim to be adjudicated to the covered person and, if the claim was assigned or if the covered person elected direct payment under (e) of this section, to the provider of the hospital, nursing, medical, dental, or surgical services. Notice required under this subsection is required to be given within 30 calendar days after the health care insurer or third-party administrator receives the claim.

(c) For a claim that is made under this section on or after July 1, 2002, if notice of the specific items necessary for a claim to be adjudicated is not given as required in (b) of this section, the claim is presumed to be a clean claim, and interest accrues beginning on the day following the day notice is due and continues to accrue until the claim is paid. The rate of interest required under this subsection is the maximum rate provided for the financing of premiums under AS 06.40.120. If a claim made is only partially covered under the insurance contract, the interest accrued shall be based on the amount of the claim that is covered under the contract.

(d) A claim for which a health care insurer provides appropriate notice of a deficiency under (b) of this section must be paid within 30 days after receipt of the claim or 15 calendar days after receipt of those items listed as being deficient, whichever period is longer. For a claim that is made under this section on or after July 1, 2002, if payment is not made within the time period required under this subsection, the claim is presumed to be a clean claim, interest accrues at the rate allowed in (c) of this section, and the interest continues to accrue until the claim is paid. If a claim is only partially covered under the insurance contract, the interest accrued shall be based on the amount of the claim that is covered under the contract.

(e) Upon written request of a covered person, a health care insurer shall pay amounts due under (a), (b), (c), or (d) of this section directly to the provider of the hospital, nursing, medical, dental, or surgical services. The policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a group managed care plan under AS 21.07 or a health maintenance organization under AS 21.86. If the health care insurer makes a claim payment to the covered person after the covered person has given written notice electing direct payment to the provider of the service, the health care insurer shall also pay that amount to the provider of the service.

(f) A covered person may revoke an election of direct claim payment made under (e) of this section by giving written notice of the revocation to the health care insurer and to the provider of the service. The written notice of revocation to the health care insurer must certify that the covered person has given written notice of revocation to the provider of the service. Revocation of an election of direct claim

payment is not effective until the notice of revocation is received by the health care insurer and the provider of the service, whichever date is later.

(g) The right of the covered person to request payment of indemnities under a blanket health insurance policy directly to the provider of the services or to another person may be transferred by a qualified domestic relations order to a person who is not the covered person. Rights under the qualified domestic relations order do not take effect until the order is received by the health care insurer. In this subsection, "qualified domestic relations order" means an order or judgment in a divorce or dissolution action under AS 25.24 that designates a person to determine to whom indemnities for a covered person should be paid under a health insurance policy.

(h) This section does not prohibit a health care insurer from recovering an amount mistakenly paid to a provider or a covered person.

(i) For the purpose of this section, a claim shall be considered paid on the day payment is either mailed or transmitted electronically.

(j) If interest is required to be added to a claim under (c) or (d) of this section, the amount added may not be included when calculating an applicable cap on benefits payable to the covered person or other person claiming payments under the health insurance policy.

(k) Notwithstanding (c) and (d) of this section, a health care insurer is not required to pay interest due as a result of the application of (c) or (d) of this section if the amount of the interest is $1 or less.

(l) In this section,

(1) "clean claim" means a claim that does not have a defect, impropriety, or circumstance requiring special treatment that precludes timely payment on the claim;

(2) "group managed care plan" has the meaning given in AS 21.07.250.

*** Sec. 3.** AS 25.24.160(b) is amended to read:

(b) If a judgment under this section distributes benefits to an alternate payee under AS 14.25, AS 21.51.120(a), **AS 21.54.020(g)** [AS 21.54.020(c)], 21.54.050(c), AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the

requirements of a qualified domestic relations order under the definition of that phrase that is applicable to those provisions.

*** Sec. 4.** AS 25.24.230(h) is amended to read:

(h) If a judgment under this section distributes benefits to an alternate payee under AS 14.25, AS 21.51.120(a), **AS 21.54.020(g)** [AS 21.54.020(c)], 21.54.050(c), AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the requirements of a qualified domestic relations order under the definition of that phrase that is applicable to those provisions.

*** Sec. 5.** This Act takes effect January 1, 2002.