

CS FOR HOUSE BILL NO. 113(HES) am

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Amended: 4/12/01

Offered: 3/22/01

Sponsor(s): REPRESENTATIVES GREEN, Dyson, McGuire

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

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

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

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

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

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

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

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

13 [AND]

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

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

18 * **Sec. 2.** AS 21.54.020 is repealed and reenacted to read:

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

25 (b) If a claim is not paid within 30 calendar days as required under (a) of this
 26 section, the health care insurer shall give notice of the specific items necessary for the
 27 claim to be adjudicated to the covered person and, if the claim was assigned or if the
 28 covered person elected direct payment under (e) of this section, to the provider of the
 29 hospital, nursing, medical, dental, or surgical services. Notice required under this
 30 subsection is required to be given by the date specified for payment of an indemnity
 31 under (a) of this section.

1 (c) If notice of the specific items necessary for a claim to be adjudicated is not
2 given as required in (b) of this section, the claim is presumed to be a clean claim, and
3 interest accrues beginning on the day following the day notice is due and shall be
4 added to the claim until the claim is paid. The rate of interest required under this
5 subsection is the maximum rate provided for the financing of premiums under
6 AS 06.40.120. If a claim made is only partially covered under the insurance contract,
7 the interest accrued shall be based on the amount of the claim that is covered under the
8 contract.

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

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

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

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

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

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

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

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

19 (k) In this section,

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

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

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

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

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

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

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