

**HOUSE BILL NO. 113**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

**BY REPRESENTATIVE GREEN**

**Introduced: 2/5/01**

**Referred: Labor and Commerce, Health, Education and Social Services**

**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4 **\* Section 1.** AS 21.54.020 is repealed and reenacted to read:

5 **Sec. 21.54.020. Required insurer payment for hospital and medical**  
6 **services.** (a) A health care insurer shall pay indemnities under a group health  
7 insurance policy or subscriber benefits under a group hospital or medical service  
8 subscriber contract, whether or not services were provided by participant providers, as  
9 follows:

10 (1) within 20 working days after receipt of a clean claim if the claim  
11 was submitted as a paper claim; or

12 (2) within 10 working days after receipt of a clean claim if the claim  
13 was submitted as an electronic claim.

14 (b) If a claim is not paid as required under (a) of this section, the health care

1 insurer shall give notice of the specific items necessary for the claim to be adjudicated  
2 to the covered person and, if the claim was assigned, to the provider of the hospital,  
3 nursing, medical, dental, or surgical services. Notice required under this subsection is  
4 required to be given by the date specified for payment of an indemnity under (a) of  
5 this section.

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

14 (d) A claim for which a health care insurer provides appropriate notice of a  
15 deficiency under (b) of this section must be paid within five working days after receipt  
16 of those items listed as being deficient. If payment is not made within five working  
17 days, the claim is presumed to be a clean claim, interest accrues at the rate allowed in  
18 (c) of this section, and the interest shall be added to the claim until the claim is paid.  
19 If a claim is only partially covered under the insurance contract, the interest accrued  
20 shall be based on the amount of the claim that is covered under the contract.

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

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

1 health care insurer must certify that the covered person has given written notice of  
 2 revocation to the provider of the service. Revocation of an election of direct claim  
 3 payment is not effective until the notice of revocation is received by the health care  
 4 insurer and the provider of the service, whichever date is later.

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

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

15 (i) Within 30 working days after the end of each calendar quarter, a health  
 16 care insurer shall file with the director a report that shows, for the previous calendar  
 17 quarter, the percentage of claims paid in this state during that quarter that meets the  
 18 time limits imposed under (a) and (d) of this section.

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

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

25 (l) In this section,

26 (1) "calendar quarter" has the meaning given in AS 23.20.520;

27 (2) "clean claim" means a claim that does not have a defect,  
 28 impropriety, or circumstance requiring special treatment that precludes timely  
 29 payment on the claim.

30 \* **Sec. 2.** AS 25.24.160(b) is amended to read:

31 (b) If a judgment under this section distributes benefits to an alternate payee

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

5 \* **Sec. 3.** AS 25.24.230(h) is amended to read:

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

11 \* **Sec. 4.** This Act takes effect January 1, 2002.