

HB

225

HOUSE COMMITTEE REPORT

(7)
Date Referred: March 17, 1989

FURTHER REFERRALS: LABOR & COMMERCE

Date of Committee Action: 4/19/89

The HEALTH, EDUCATION, & SOCIAL SERVICES Committee considered: HB 225

HOUSE BILL NO. 225 [PAYMENT OF DISABILITY INSURANCE CLAIMS]
"An Act relating to payment of disability insurance claims."

RECOMMENDATIONS:

- [] be replaced with CS HB 225 (HESS) [] the same title
[] have attached amendment(s) [] a new title
[] do pass
[] do not pass
[] no recommendation
[] individual recommendations
[] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(S):
(Dept)

APPROVES PREVIOUS:

(Date/Dept)

- [] fiscal impact _____
[] zero fiscal note Commerce
[] zero with analysis _____

- [] fiscal note(s) _____
[] zero fiscal note(s) _____
[] zero fn/analysis _____

SIGNING DO PASS:

SIGNING:
(Check approp. column)

Mr. R. G. ...
J. Ellis

	Do Not Pass	No Rec	Amend
<u>Chris Davis</u>		<input checked="" type="checkbox"/>	
<u>[Signature]</u>		<input checked="" type="checkbox"/>	

J. Ellis
Chairman's signature

State of Alaska

Committees

CO-CHAIR, HOUSE JUDICIARY
VICE CHAIR, HOUSE LABOR AND COMMERCE
HOUSE HEALTH, EDUCATION
AND SOCIAL SERVICES



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(SESSION)

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ANCHORAGE, ALASKA 99501
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Representative Max F. Gruenberg, Jr.
District 11
Spenard, Upper Midtown Anchorage

April 12, 1989

MEMORANDUM

TO: Representative Johnny Ellis
Chair, House HESS Committee

FROM: Representative Max Gruenberg

RE: HB 225, Relating to Payment of Disability Insurance
Claims

HB 225 was drafted in response to concerns raised by the Alaska Dental Society. Under current law, patients that have received insurance payments that were supposed to be paid to a health care provider might not pay the bill. Under existing law, the health care provider would bear the cost rather than the insurance company, which mistakenly paid the patient.

Under HB 225 the insurance company loses the option (contained in current law) to disregard a patient's written instructions to pay the provider directly. In addition, the bill mandates that if an insurance company ignores the patient's directive, it remains liable to the provider.

These changes will make the insurance company, rather than the health care provider, bear the risk that a payment improperly sent to the patient will leave a medical bill unpaid.

An insurance company would retain the right to collect any amounts mistakenly paid to a patient from that person. Under current law a health care provider could collect from the patient in the same situation.

In addition to placing the risk of loss on the proper party, HB 225 adds a specific time limit within which medical bills must be paid.

Taken together, these changes in current law will make the Alaska insurance industry more responsive to consumers' needs and to their legitimate requests.

STATE OF ALASKA
THE LEGISLATURE

POORLY SHAPED
BUREAU ALASKA 928
907 465 1000

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

April 10, 1989

SUBJECT: Disability insurance claims - HB 225
TO: Representative Max Gruenberg
FROM: Michael F. Ford *MF*
Legislative Counsel

You have asked how the existing law under AS 21.51.120 and AS 21.54.020 is changed by HB 225. Existing law is changed by requiring payment of insurance claims 30 days after final billing, and by requiring that an insurer who pays the insured after receiving written notice that direct payment should be made to the service provider, must also make payment to the service provider. Finally, "dental" has been added to the list of service providers, in both sections of law.

I have also attached an amendment to HB 225 that will add "nursing" to the list of service providers, contained in AS 21.51.120. This term exists in present law and was inadvertently omitted in the repeal and reenactment of AS 21.51.-120.

Please contact me if you have further questions.

MF:kb
wkk3/084

Enclosure

A M E N D M E N T

OFFERED IN THE HOUSE

BY GRUENBERG

TO: HB 225

Page 1, line 22, after "hospital,"

Insert "nursing,"

A M E N D M E N T

OFFERED IN THE HOUSE

BY GRUENBERG

TO: HB 225

Page 2, line 13:

Delete "or blanket"

Page 2, after line 20:

Insert a new bill section to read:

"* Sec. 3. AS 21.54.050 is repealed and reenacted to read:

Sec. 21.54.050. PAYMENT OF BLANKET DISABILITY POLICY BENEFITS.
All benefits under a blanket disability policy shall be paid to (1) the person insured; (2) the designated beneficiary or beneficiaries of the person insured; (3) the estate of the person insured; (4) the parent, guardian, or other person actually supporting the person insured, if the person insured is a minor or otherwise not competent to give a valid release; or (5) the employer, if the entire cost of the insurance has been paid by the employer. An insurer may, and upon request of the covered person shall, within 30 days after receiving a proof of loss statement, pay benefits 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. If the insurer pays indemnities to the insured after the covered person has given the insurer written notice of an election of direct payment of indemnities to the provider of the service, the insurer shall also pay those indemnities to the provider

of the service."

Renumber the following bill section accordingly.

A M E N D M E N T

OFFERED IN THE HOUSE

BY GRUENBERG

TO: HB 225

Page 2, after line 20:

Insert a new bill section to read:

"* Sec. 3. AS 21.87.340 is amended to read:

Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

- (1) AS 21.03
- (2) AS 21.06
- (3) AS 21.09, except AS 21.09.090
- (4) AS 21.18.010
- (5) AS 21.18.030
- (6) AS 21.18.040
- (7) AS 21.18.120
- (8) AS 21.21.321
- (9) AS 21.36
- (10) AS 21.69.400
- (11) AS 21.69.520

- (12) AS 21.69.600, 21.69.620, and 21.69.630
- (13) AS 21.78
- (14) AS 21.90
- (15) AS 21.42.345 - 21.42.365
- (16) AS 21.89.040
- (17) AS 21.89.060;
- (18) AS 21.51.120."

Renumber the following bill section accordingly.

A M E N D M E N T

OFFERED IN THE HOUSE

BY GRUENBERG

TO: HB 225

Page 2, line 11:

Delete "insured"

Insert "covered person"

Page 2, line 17:

Delete "insured" in both instances

Insert "covered person" in both instances

A M E N D M E N T

OFFERED IN THE HOUSE

BY GRUENBERG

TO: HB 225

Page 1, line 21:

Delete "complete and final billing"

Insert "proof of loss statement"

Page 2, line 12:

Delete "complete and final billing"

Insert "proof of loss statement"

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 225
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____ Agency Affected: Commerce & Economic Dev.
Title: Payment of Disability Insurance BRU: Insurance
Claims
Sponsor: Gruenberg and Menard Components: _____
Requester: House HESS

EXPENDITURES / REVENUES : (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULLTIME	0	0	0	0	0	0
PARTTIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Prepared by: Paul Roller, Director
Division: Insurance

Phone: 465-2515
Date: 4-10-89

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development

Phone: 465-2500
Date: 4/10/89

Distribution (by preparer):

- Legislative Finance
- Legislative Sponsor
- Requester
- Office of Management and Budget
- Impacted Agency(ies)

page _____ of _____

Sec. 21.51.110. Time of payment of claims. There shall be a provision as follows:

"Time of Payment of Claims: Indemnities payable under this policy for a loss other than loss for which this policy provides a periodic payment, will be paid immediately upon receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof." (§ 1 ch 120 SLA 1966)

Sec. 21.51.120. Payment of claims. (a) There shall be a provision as follows:

"Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting the payment which shall be prescribed herein and effective at the time of payment. If no designation or provision is then effective, the indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to the estate. All other indemnities will be payable to the insured."

(b) The following provisions, or either of them, may be included with the provision in (a) of this section at the option of the insurer:

(1) "If an indemnity of this policy is payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount not exceeding \$ (insert an amount which shall not exceed \$1,000), to a relative by blood or connection by marriage of the insured or beneficiary who is considered by the insurer to be equitably entitled thereto. Payment made by the insurer in good faith under this provision shall fully discharge the insurer to the extent of the payment."

(2) "Subject to written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proof of the loss, be paid directly to the hospital or person rendering the services; and it is not required that the service be rendered by a particular hospital or person." (§ 1 ch 120 SLA 1966)

Sec. 21.51.130. Physical examination, autopsy. There shall be a provision as follows:

"Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law." (§ 1 ch 120 SLA 1966)

sidered representations and not warranties, and that a statement made for the purpose of effecting insurance may not void the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the insured person or the beneficiary of the insured person,

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group, a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits are payable; if dependents are included in the coverage, only one certificate need be issued for each family unit;

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy. (§ 1 ch 120 SLA 1966)

Collateral references. - Group medical and hospital service plan as constituting insurance. 167 ALR 323.

Sec. 21.54.020. Direct payment of hospital, medical services. A group disability policy may on request by the group policyholder provide that all or a portion of any indemnities provided by the policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid. (§ 1 ch 120 SLA 1966)

Sec. 21.54.030. Required provisions of blanket policies. An insurer authorized to write disability insurance in this state shall have the power to issue blanket disability insurance. A blanket policy may not be issued or delivered in this state unless a copy of the form of the policy has been filed in accordance with AS 21.42.120. Every blanket policy shall contain provisions which in the opinion of the director are at least as favorable to the policyholder and the individual insured as the following:

(1) a provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in the absence of fraud be considered a representation and not a warranty, and that no statements shall be used in defense to a claim under the policy, unless contained in a written application; the person, a beneficiary, or assignee, shall have the right to make written request to the

HB 225: An Act relating to payment of disability

This Act pertains to the payment of both group and individual disability insurance claims. It provides for a requirement that, when benefits are assigned to a medical care provider, the benefits must be paid within 30 days after receipt of a final and complete billing, and, if the insurer mistakenly pays the insured, then the insurer must also pay the medical care provider.

Section 1 - AS 21.52.120 - Individual Disability Contracts

Essentially, the repeal and reenactment of AS 21.51.120 does not change the existing law's intent. This section pertains to required contract provisions pertaining to payment of claims in individual disability insurance contracts. Two elements have been added in the situation when benefits have been assigned to a medical care provider:

1. payment must be made within 30 days after receipt of final and complete billing; and
2. if the insurer mistakenly pays benefits to the insured, it must also make payment to the medical care provider. It is assumed that the insurer is penalized for this mistake by the required double payment. Assumedly, both payments would tend to increase future rates.

It should be noted that this section does not create an irrevocable assignment and the insured could change his or her mind and request in writing that the insurer now pay direct to him or her (under AS 21.42.270 and AS 21.51.150). Furthermore, it should be noted that individual subscriber contracts issued by a hospital or medical service corporation that provide indemnity benefits would not be covered by this proposed change in the law.

Section 2 - AS 21.54.020 - Group Disability Contracts

Direct payment of benefits to medical care providers by insurers may provide for:

1. medical care providers not requiring patients to pay for treatment before treatment is given so as not to create a barrier to receiving appropriate medical care; and
2. assurance that at least some portions of the charges for medical care will be paid to the medical care provider.

Most group disability insurance contracts will allow the choice of direct payment to medical care providers to be made by the individual persons covered under the group contract. This election is required to be made in writing and may only be changed by a subsequent written request received before claim payment is made. However, many insurers do retain the contractual option of whether paying direct to the person covered or to a medical care provider. If the covered person has made the written election for direct payment to a provider, the insurer will pay to the provider. If the covered person does not make the written election for direct payment, the insurer must pay any benefits to the covered person.

However, if no direct payment election is made and the amount of the claim is substantial, many insurers will require the covered person to provide proof that the medical care provider has been paid. (An insurer will do this because, if a covered person is paid but the provider ultimately is not paid, those reimbursed charges will be factored into and result in higher charges being made for future medical service.

The new language removes the insurer's discretion in regard to making direct payment to a provider. If the insurer allows for the election of direct payment, then the direct payment must be made unless the election is revoked in writing. It's assumed that the term "insured" means the covered person and not the group policyholder (e.g. the employer, association, union, or trust). If it does include the group policyholder, the policyholder may also make the election of whether or not direct payment must be made. If that is the case, it would seem if the group policyholder made the decision that all payments would be made direct, the covered person would not have the option. Additionally, in such a circumstance, if a provider required full payment before rendering service, the provider would receive double payment and would have to reimburse the covered person the amount in excess of the total charges.

Included in the new language is reference to blanket disability policies. This reference provides conflict with AS 21.54.050 which pertains to payment of benefits under disability policies. This reference either needs to be removed or AS 21.54.050 needs to be amended.

The same 30-day criteria for payment of claims and the double payment features are evident in this amended provision as are in the section pertaining to individual disability contracts.

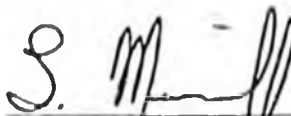
It should also be noted that group subscriber contracts issued by a hospital or medical service association that provide indemnity benefits would not be affected by this Act. Additionally, it should be noted that this Act would not have any effect on self-insureds nor on group contracts issued in another state even though coverage is provided to Alaska residents.

The department's position is neutral.

Amendments Proposed

1. If it is the sponsor's intent to include both individual and group subscriber contracts issued by a hospital or medical service corporation that provide indemnity benefits, then AS 21.87 would need to be amended. This could be accomplished by adding references to AS 21.51.120 and AS 21.54.020 to the list of other applicable provisions found in AS 21.87.340.
2. AS 21.54.050 needs to be amended so it does not conflict with the proposed language in AS 21.87.340.

3. AS 21.54.020 should be amended to clarify that the option of the election of direct payment is up to each covered person as opposed to the group policyholder if that is the intent. This is required because technically the "insured" is the group policyholder.
4. In both AS 21.51.120 and AS 21.54.020, the proposed language would trigger the 30-day claim payment upon the insurer receiving a "complete and final billing." Technically this is but one element of the required "proof of loss." For example, other elements include whether or not the person was an eligible group member at the time the loss was incurred either through being employed full time or having premiums paid up-to-date. Therefore, it is recommended that the term "complete and final billing" be replaced with the term "proof of loss."



Larry Mercuriello, Commissioner

Date: 4/12/89

LM/JB/3829D
041289a



Official Business

Alaska State Legislature

Pouch V
State Capitol
Juneau, Alaska 99811

April 4, 1989

MEMORANDUM

TO: Representative Johnny Ellis
Chair, House HESS Committee

FROM: Representative Max Gruenberg *MG*

RE: House Bill 225

HB 225 provides that an insured under a disability insurance policy can require the insurer to pay a provider of health services directly. Under current law, direct payments are at the insurer's option. The bill adds that if an insured asks for direct payments and the insurer instead pays the insured, the insurer remains liable to the provider.

These minor changes in the current law will make insurance payments responsive to the needs of consumers.

I would appreciate your scheduling HB 225 as soon as possible.
Thank you.

6-1033E
Ford
4/17/89

Original sponsors: Gruenberg and Menard

1 IN THE HOUSE

2 CS FOR HOUSE BILL NO. 225 ()

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to payment of disability insurance
7 claims."

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

9 * Section 1. AS 21.51.120 is repealed and reenacted to read:

10 Sec. 21.51.120. PAYMENT OF CLAIMS. (a) A disability policy
11 delivered or issued for delivery must contain the following provi-
12 sions:

13 (1) indemnity for loss of life shall be paid according to
14 the beneficiary designation and payment provisions contained in the
15 policy that are effective at the time of payment; if a beneficiary has
16 not been designated, indemnity shall be paid to the estate of the
17 insured; accrued indemnities unpaid at the insured's death shall be
18 paid to either the beneficiary or the estate, at the option of the
19 insurer; all other indemnities shall be paid to the insured;

20 (2) the insurer may, and upon request of the insured shall,
21 within 30 days after receiving a proof of loss statement, pay indemni-
22 ties for hospital, nursing, medical, dental, or surgical services
23 directly to the provider of the services; an insurer who pays indemni-
24 ties to an insured, after the insured has given the insurer written
25 notice in the proof of loss statement of an election of direct payment
26 of indemnities to the provider of the services, shall also pay indem-
27 nities to the provider of the services; this paragraph does not
28 require that services be provided by a particular hospital or person.

29 (b) A disability policy delivered or issued for delivery may, at

1 the option of the insurer, require that an indemnity in an amount not
2 to exceed \$1,000 that is payable to the estate of the insured, an
3 insured or beneficiary who is a minor, or an insured who is not compe-
4 tent to give a valid release, be paid to a relative by blood or mar-
5 riage, or a beneficiary that the insured determines is equitably
6 entitled to the payment. A good faith payment by the insurer under
7 this subsection fully discharges the insurer to the extent of the
8 payment.

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

10 Sec. 21.54.020. DIRECT PAYMENT OF HOSPITAL, MEDICAL SERVICES.
11 An insurer may, and upon request of the covered person shall, within
12 30 days after receiving a proof of loss statement, pay indemnities
13 under a group disability policy directly to the provider of the hospi-
14 tal, nursing, medical, dental, or surgical services. The policy may
15 not contain a provision requiring that services be provided by a
16 particular hospital or person. If the insurer pays indemnities to the
17 covered person after the covered person has given the insurer written
18 notice in the proof of loss statement of an election of direct payment
19 of indemnities to the provider of the service, the insurer shall also
20 pay those indemnities to the provider of the service.

21 * Sec. 3. AS 21.54.050 is repealed and reenacted to read:

22 Sec. 21.54.050. PAYMENT OF BLANKET DISABILITY POLICY BENEFITS.
23 All benefits under a blanket disability policy shall be paid to (1)
24 the person insured; (2) the designated beneficiary or beneficiaries of
25 the person insured; (3) the estate of the person insured; (4) the
26 parent, guardian, or other person actually supporting the person
27 insured, if the person insured is a minor or otherwise not competent
28 to give a valid release; or (5) the employer, if the entire cost of
29 the insurance has been paid by the employer. An insurer may, and upon

1 request of the covered person shall, within 30 days after receiving a
2 proof of loss statement, pay benefits directly to the provider of the
3 hospital, nursing, medical, dental, or surgical services. The policy
4 may not contain a provision requiring that services be provided by a
5 particular hospital or person. If the insurer pays indemnities to the
6 insured after the covered person has given the insurer written notice
7 in the proof of loss statement of an election of direct payment of
8 indemnities to the provider of the service, the insurer shall also pay
9 those indemnities to the provider of the service.

10 * Sec. 4. AS 21.87.340 is amended to read:

11 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to
12 the provisions contained or referred to previously in this chapter,
13 the following chapters and provisions of this title also apply with
14 respect to service corporations to the extent applicable and not in
15 conflict with the express provisions of this chapter and the reason-
16 able implications of the express provisions, and for the purposes of
17 the application the corporations shall be considered to be mutual
18 "insurers":

- 19 (1) AS 21.03
20 (2) AS 21.06
21 (3) AS 21.09, except AS 09.090
22 (4) AS 21.18.010
23 (5) AS 21.18.030
24 (6) AS 21.18.040
25 (7) AS 21.18.120
26 (8) AS 21.21.321
27 (9) AS 21.36
28 (10) AS 21.69.400
29 (11) AS 21.69.520

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(12) AS 21.69.600, 21.69.620, and 21.69.630

(13) AS 21.78

(14) AS 21.90

(15) AS 21.42.345 - 21.42.365

(16) AS 21.89.040

(17) AS 21.89.060;

(18) AS 21.51.120.

* Sec. 5. This Act applies to policies of disability insurance entered into or renewed after the effective date of this Act.