

**HB**

**113**

22-LS0418\O  
Ford  
3/19/01

**CS FOR HOUSE BILL NO. 113( )**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**TWENTY-SECOND LEGISLATURE - FIRST SESSION**

BY

Offered:  
Referred:

Sponsor(s): REPRESENTATIVES GREEN, Dyson

**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 AS 21.54.020 is repealed and reenacted to read: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 health maintenance organization under AS 21.86. If the health care  
23 insurer makes a claim payment to the covered person after the covered person has  
24 given written notice electing direct payment to the provider of the service, the health  
25 care insurer shall also pay that amount to the provider of the service.

26 (f) A covered person may revoke an election of direct claim payment made  
27 under (e) of this section by giving written notice of the revocation to the health care  
28 insurer and to the provider of the service. The written notice of revocation to the  
29 health care insurer must certify that the covered person has given written notice of  
30 revocation to the provider of the service. Revocation of an election of direct claim  
31 payment is not effective until the notice of revocation is received by the health care

1 insurer and the provider of the service, whichever date is later.

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

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

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

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

18 (k) In this section, "clean claim" means a claim that does not have a defect,  
19 impropriety, or circumstance requiring special treatment that precludes timely  
20 payment on the claim.

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

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

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

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

1           that is applicable to those provisions.

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





# Alaska State Legislature

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DEPT. OF LAW

Representative Joe Green  
District 10

## MEMORANDUM

To: The Honorable Fred Dyson, Chair  
House Health, Education and Social Services Committee

From: Representative Joe Green

Date: March 2, 2001

Subject: HB 113  
"Prompt pay for health care insurance payments"

I respectfully request that you schedule HB 113 for a hearing before the House Health, Education and Social Services Committee at your earliest convenience.

Attached are:

1. CS for House Bill 113 (L&C)
2. Sponsor Statement
3. Back-up materials

Thank you for your consideration of this request.

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## SPONSOR STATEMENT

### HOUSE BILL 113

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

House Bill 113 builds upon a national trend to develop fair payment provisions that enable health insurance companies to make sound business decisions while ensuring that patients receive benefit payments in an appropriate time frame. This concept of "prompt pay" legislation has been successfully adopted and implemented by 39 states.

House Bill 113 requires health insurers to pay benefits within thirty calendar days of receiving a "clean claim". If a payment is not made on time, the insurer is charged interest on the outstanding claim. HB 113 also establishes a definition for "clean claim" that recognizes an insurance company's need to make payment decisions based upon complete and accurate information.

**CS FOR HOUSE BILL NO. 113( )**

**IN THE LEGISLATURE OF THE STATE OF ALASKA  
TWENTY-SECOND LEGISLATURE - FIRST SESSION**

**BY**

**Offered:  
Referred:**

**Sponsor(s): REPRESENTATIVES GREEN, Dyson**

**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 21.06.087(a) is amended to read:**

5 (a) The director shall require reporting of and shall compile information  
6 necessary to

7 (1) evaluate the effect of the measures enacted in chapter 26, SLA  
8 1997, on the availability and cost of insurance in the state; and

9 (2) implement the claims reporting requirements under  
10 AS 21.54.020(i).

11 **\* Sec. 2. AS 21.06.110 is amended to read:**

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

1 with respect to the preceding calendar year,

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

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

7 (3) the name of each insurer authorized to do business in this state  
8 against which delinquency or similar proceedings were instituted and, if against an  
9 insurer domiciled in this state, a concise statement of the facts with respect to each  
10 proceeding and its present status;

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

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

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

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

20 [AND]

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

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

25 \* Sec. 3. AS 21.54.020 is repealed and reenacted to read:

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

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(b) If a claim is not paid as required under (a) of this section, the health care insurer shall give notice of 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 by the date specified for payment of an indemnity under (a) of this section.

(c) 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 shall be added to the claim 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. 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 shall be added to the claim 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 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.

1 (f) A covered person may revoke an election of direct claim payment made  
2 under (e) of this section by giving written notice of the revocation to the health care  
3 insurer and to the provider of the service. The written notice of revocation to the  
4 health care insurer must certify that the covered person has given written notice of  
5 revocation to the provider of the service. Revocation of an election of direct claim  
6 payment is not effective until the notice of revocation is received by the health care  
7 insurer and the provider of the service, whichever date is later.

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

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

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

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

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

28 (l) In this section,

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

30 (2) "clean claim" means a claim that does not have a defect,  
31 impropriety, or circumstance requiring special treatment that precludes timely

1 payment on the claim.

2 \* Sec. 4. AS 25.24.160(b) is amended to read:

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

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

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

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

# FISCAL NOTE

STATE OF ALASKA  
2001 LEGISLATIVE SESSION

Fiscal Note Number: 2  
Bill Version: CSHB 113(L&C)  
(H) Publish Date: 3/7/01

Revision Date/Time (Note if correction): \_\_\_\_\_ Dept. Affected: Administration  
Title: An Act relating to health care insurance BRU: Centralized Administrative Services  
payments for hospital or medical... Component: Retirement and Benefits  
Sponsor: Representative Green  
Requester: L&C Component Number: 64

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	*	*	*	*	*	*

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
<b>TOTAL</b>	*	*	*	*	*	*

Estimate of any current year (FY2001) cost: \_\_\_\_\_

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

This legislation requires an insurer to pay "clean claims" within 10 or 20 working days of receipt, depending on filing method. If not, interest is assessed. The bill would also require an insurer who mistakenly pays a member instead of the provider to make a second payment to the provider and then attempt recovery from the member. These changes could increase administrative overhead and claims costs. We currently require Aetna, our third party administrator, to pay 80% of claims within 12 calendar days. If not, penalties are assessed on Aetna for late payment. The penalties come to the plan (not providers).

Continued on page 2

Prepared by: Guy Bell, Director Phone 465-4471  
Division: Retirement and Benefits Date/Time February 23, 2001  
Approved by: Commissioner Jim Duncan Date February 23, 2001  
Agency: Department of Administration

For distribution information, call the Governor's Legislative Office

## **Fiscal Note HB 113 (L & C) – Continued**

In addition, the bill does not clearly define a "clean claim." Without a clear definition, we are concerned about added administrative overhead.

The State's contribution as an employer is capped by collective bargaining agreements and by statute for non covered employees. Any increase in cost will be borne by employees.

