



# LAWS OF ALASKA

2001

**Source**

SCS CSHB 113(HES)

**Chapter No.**

52

**AN ACT**

Relating to health care insurance payments for hospital or medical services; and providing for an effective date.

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

THE ACT FOLLOWS ON PAGE 1

**Approved by the Governor:** June 25, 2001

**Actual Effective Date:** January 1, 2002

AN ACT

1 Relating to health care insurance payments for hospital or medical services; and providing for  
2 an effective date.

3

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

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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 or deny 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 or is denied, the health care insurer shall give notice  
26 of the basis for denial or the specific items necessary for the claim to be adjudicated to  
27 the covered person and, if the claim was assigned or if the covered person elected  
28 direct payment under (e) of this section, to the provider of the hospital, nursing,  
29 medical, dental, or surgical services. Notice required under this subsection is required  
30 to be given within 30 calendar days after the health care insurer or third-party  
31 administrator receives the claim.

1 (c) For a claim that is made under this section on or after July 1, 2002, if  
2 notice of the specific items necessary for a claim to be adjudicated is not given as  
3 required in (b) of this section, the claim is presumed to be a clean claim, and interest  
4 accrues beginning on the day following the day notice is due and continues to accrue  
5 until the claim is paid. The rate of interest required under this subsection is the  
6 maximum rate provided for the financing of premiums under AS 06.40.120. If a claim  
7 made is only partially covered under the insurance contract, the interest accrued shall  
8 be based on the amount of the claim that is covered under the 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. For a claim that is made under this section on or after  
13 July 1, 2002, if payment is not made within the time period required under this  
14 subsection, the claim is presumed to be a clean claim, interest accrues at the rate  
15 allowed in (c) of this section, and the interest continues to accrue until the claim is  
16 paid. If a claim is only partially covered under the insurance contract, the interest  
17 accrued shall be based on the amount of the claim that is covered under the 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

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

22 (l) In this section,

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

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

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

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

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

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

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

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