HB164

ACT No. 2001-445

36325-4

By Representatives Johnson and Carothers

RFD: Health

First Read: 06-FEB-2001

Enrolled, An Act,

Relating to the prompt payment of claims for health care services by insurers and health plans; to amend Section 27-1-17, Code of Alabama 1975, to require insurers and health plans to pay health care providers within 30 calendar days for electronic claims and 45 calendar days for written claims and would further define certain terms relating to payment of claims; to require that insurers and health plans notify health care providers within a certain period of time if a claim is pending for additional information; to require that claims not paid within the limits prescribed in this act shall be subject to interest prorated daily; to provide for exceptions to the requirements of this act; to provide that the Commissioner of Insurance may assess administrative fines against insurers and health plans where there has been established a pattern of overdue payments; to provide for the adoption of regulations to implement the provisions of this act; to amend Section 27-21A-23, Code of Alabama 1975, to require that the provisions of this act shall apply to health maintenance organizations; to amend Section 27-1-19, Code of Alabama 1975, relating to reimbursement of health care providers; to amend Section 10-4-115, Code of Alabama 1975, relating to the applicability of insurance laws to certain

health care service plans; and to provide for the effective date.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. Sections 27-1-17, 27-1-19, 27-21A-23, and 10-4-115, Code of Alabama 1975, are amended to read as follows:

"§27-1-17.

"(a) ~~All persons, firms, corporations or associations issuing health and accident insurance policies within this state shall consider claims made thereunder and, if found to be valid and proper, shall pay such claims within 45 days after the receipt of proof of loss under such policies. Benefits due under the policies and claims are to be considered overdue if not paid within 45 days after the insurer receives reasonable proof of the fact and amount of loss sustained. If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof shall be considered overdue if not paid within 45 days after such proof is received by the insurer. Any part or all of the remainder of the claim that is later supported by reasonable proof shall be considered overdue if not paid within 45 days after such proof is received by the insurer. For the purposes of calculating the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the claimant or beneficiary in a~~

~~properly addressed, postpaid, envelope, or, if not so posted, on the date of delivery.~~ Each insurer, health service corporation, and health benefit plan that issues or renews any individual policy of accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for services rendered by Alabama health care providers within 45 calendar days upon receipt of a clean written claim or 30 calendar days upon receipt of a clean electronic claim. If the insurer, health service corporation, or health benefit plan is denying or pending the claim, the insurer, health service corporation, or health benefit plan shall, within 45 calendar days for a written claim and 30 calendar days for an electronic claim notify the health care provider or certificate holder of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. Any undisputed portion of the claim shall be paid in accordance with the foregoing schedule. If the insurer, health service corporation or health benefit plan fails to provide the notice to the health care provider of the reason for denying pending the claim, then any such claim, if and when determined to be payable, shall accrue interest at the rate as provided herein, from the date such notice should have been given in accordance with this provision. Upon receipt of the necessary information, the claim must be paid, denied or otherwise adjudicated within 21

calendar days from the receipt of the requested information. The failure of an insurer, health service corporation, or health benefit plan to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment to providers. For the purposes of this section, an insurer, health service corporation, or health benefit plan domiciled outside of the State of Alabama is deemed to be subject to the provisions of this section if it receives, processes, adjudicates, pays, or denies claims for health care services submitted by or on behalf of patients, insureds, or beneficiaries who reside in the State of Alabama or who receive health care services in the State of Alabama.

"(b) ~~If the claim is not denied for valid and proper reasons by the end of said 45 day period, the insurer must pay the insured one and one-half percent per month on the amount of said claim until it is finally settled or adjudicated.~~ As used in this section, the following terms shall have the following meanings:

"(1) CLEAN ELECTRONIC CLAIM. The transmission of data for purposes of payment of covered health care expenses that is submitted to an insurer, health service corporation, or health benefit plan which contains substantially all of the

required data elements necessary for accurate adjudication without obtaining additional information from the provider of the service or from a third party in an electronic data format specified by the insurer's, health service corporation's, or health benefit plan's published filing requirements. In no event shall an insurer, health service corporation, or health benefit plan require that the health care provider submit data elements in excess of those required on the standard electronic health insurance claim format designated by Section 27-1-16 as a condition to the acceptance and processing of an initial claim as a clean claim.

"(2) CLEAN WRITTEN CLAIM. A claim for payment of covered health care expenses that is submitted to an insurer, health service corporation, or health benefit plan on the claim form of the insurer, health service corporation, or health benefit plan which contains substantially all of the required data elements necessary for accurate adjudication without obtaining additional information from the provider of the service or from a third party. In no event shall an insurer, health service corporation, or health benefit plan require that the health care provider submit information or data elements in excess of those required on the standard health insurance claim form designated by Section 27-1-16 as a condition to the acceptance and processing of an initial claim as a clean claim.

"(3) INSURER, HEALTH SERVICE CORPORATION, AND HEALTH BENEFIT PLAN. Include health care insurers, health maintenance organizations, accident and sickness insurers, fraternal benefit societies, non-profit hospital service corporations, or non-profit medical service providers that pays for, purchases, or furnishes health care services to patients, insureds, or beneficiaries in this state.

"(4) POLICY OF ACCIDENT OR HEALTH INSURANCE. Any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, renewed in this state by a health care insurer, health maintenance organization, accident and sickness insurer, fraternal benefit society, non-profit hospital service corporation, or non-profit medical service corporation that pays for, purchases, or furnishes health care services to patients, insureds, or beneficiaries in this state.

"(5) NOTICE or NOTIFY. Where the provider files an electronic claim or where the provider has electronic media available, as used herein the following terms shall mean:

"NOTICE. In addition to all forms of paper notice, includes electronic notice whereby the insurer, health services corporation or the health benefit plan makes claims status, eligibility and payment and remittance advice information which is available to the provider via electronic media.

"NOTIFY. In addition to all forms of paper notification, includes the posting or updating of an electronic record or data set with the claims status, eligibility and payment and remittance advice information which is available to the provider via electronic media.

"In all other instances, except where the provider has agreed to accept notice by electronic media, notice shall mean written notice delivered or mailed to the provider.

"This provision is intended to be and shall be applied in a manner consistent with the standardized transaction and code set requirements for administrative simplification pursuant to the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191.

"(c) ~~In the event that the insurer fails to pay such benefits when due, the person entitled to such benefits may bring an action to recover them.~~ Any claim which has not been denied with notice, made pending with notice, or paid to the provider by the insurer, health service corporation, or the health benefit plan shall be overdue if the notice or payment is not received by the provider within the time periods specified in subsection (a). No further notice by the provider to the insurer, health service corporation, or health benefit plan shall be required under this section. If the insurer, health service corporation, or health benefit plan fails to

deny or pay a clean written claim or clean electronic claim within the time periods, then the following shall occur:

"The amount of the overdue claim shall include an interest payment of 1.5 percent per month prorated daily which shall accrue from the date the payment was overdue and which shall be payable at the time that the claim is paid.

"(d) The following are exceptions to the requirements of this section:

"(1) No insurer, health service corporation, or health benefit plan shall be in violation of this section for a claim submitted by a health care provider if any of the following circumstances apply:

"a. Failure to comply is caused by a directive from a court or a federal or state agency.

"b. The insurer, health service corporation, or health benefit plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation.

"c. Compliance by the insurer, health service corporation, or health benefit plan is rendered impossible due to matters beyond its control which were not caused by such insurer, health service corporation, or health benefit plan or caused by any third party vendor, agent, or contracting party furnishing services to the insurer, health service corporation, or health benefit plan which are related directly

or indirectly to the processing of claims by such insurer, health service corporation, or health benefit plan.

"(2) No insurer, health service corporation, or health benefit plan shall be in violation of this section for any claim submitted more than 180 days after the service was rendered.

"(3) No insurer, health service corporation, or health benefit plan shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an external review process.

"(e) The commissioner may assess an administrative fine against any insurer, health service corporation, or health benefit plan or may suspend or revoke the license or certificate of authority of any insurer, health service corporation, or health benefit plan after determining that the insurer, health service corporation, or health benefit plan has established a pattern of overdue payments and that the contemplated enforcement action would not promote the deterioration of the financial condition of an at-risk insurer, health service corporation, or health benefit plan. Such fine shall be up to one thousand dollars ($1,000) for each day that the claim or claims remained unpaid, not to exceed one hundred thousand dollars ($100,000) per violation. All fines recovered by the Department of Insurance shall be

deposited in the General Fund and shall become available for use by the Department of Insurance for administration of the department.

"(f) The State Department of Public Health is authorized to adopt regulations implementing those provisions of this act that apply to health maintenance organizations. The commissioner is authorized to adopt such regulations as may be required to implement the provisions of this act that apply to insurers and regulations governing the assessment of administrative fines authorized by this section.

"§27-1-19.

~~"(a) All persons, firms, corporations, associations, health maintenance organizations, health insurance service, or preferred provider organizations, non-profit health service organizations, and any employer sponsored health benefit company providing health, accident, dental, or workmen's compensation insurance coverage, either directly or indirectly through an agent, shall reimburse health care providers, including physicians, dentists, pharmacists, podiatrists, chiropractors, optometrists, durable medical equipment and home care providers, or subscribers for covered services within 25 working days of receipt of a proper claim or invoice at the office of the insurer or its designated office.~~

~~"(b) If a provider of insurance coverage fails to comply with subsection (a), then interest shall be payable on~~

~~the claim commencing on the 26th day of receipt of the claim at a rate of 1.5 percent per month or any part of a month thereof until the claim has been paid, without any further action by the provider being required except as provided in subsection (c).~~

"~~(c) This section does not apply to claims where there is a dispute regarding the legitimacy of the claim, and the company or agency does both of the following:~~

"~~(1) Notifies the provider within 2 weeks of the receipt of the claim that the claim is in dispute, and specifies which items of the claim are in dispute.~~

"~~(2) Pays any undisputed portion of the claim within 30 days of receipt of the claim and makes a timely, good faith effort to resolve differences.~~

"~~(d)~~ (a) The insured, or health or dental plan beneficiary may assign reimbursement for health or dental care services directly to the provider of services. Health benefits include medical, pharmacy, podiatric, chiropractic, optometric, durable medical equipment and home care services. The company or agency, when authorized by the insured, or health or dental plan beneficiary, shall pay directly to the health care provider the amount of the claim, under the same criteria and payment schedule that would have been reimbursed directly to the contract provider, and any applicable interest. This amount only applies to assigned claims. Any

company or agency making a payment to the insured, or health or dental plan beneficiary, after the rights of reimbursement have been assigned to the provider of services, shall be liable to the provider for the payment. If the company or agency fails to reimburse the provider in accordance with the terms of the provider contract as provided in this section, then the provider shall be entitled to recover in the circuit or district courts of this state from the company or agency responsible for the payment of the claim an amount equal to the value of such claim plus interest and a reasonable attorney's fee to be determined by the court.

"~~(e)~~ (b) Nothing in this section shall be construed to limit any insurer, health maintenance organization, preferred provider organization, health care service corporation, or other third party payor from determining the scope of its benefits or services or any other terms of its group and/or individual insured, subscriber or enrollee contracts nor from negotiating contracts with licensed providers on reimbursement rates or any other lawful provisions, except that the contract providing coverage to an insured may not exclude the right of assignment of benefits to any provider at the same benefit rate as paid to a contract provider.

"~~(f)~~ (c) This section shall not apply to any persons covered under a state administered health benefit plan.

"§27-21A-23

"(a) Except as otherwise provided in this chapter, provisions of the insurance law and provisions of health care service plan laws shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision shall not apply to an insurer or health care service plan licensed and regulated pursuant to the insurance law or the health care service plan laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

"(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

"(c) Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and shall be exempt from the provisions of Section 34-24-310, et seq., relating to the practice of medicine.

"(d) No person participating in the arrangements of a health maintenance organization other than the actual provider of health care services or supplies directly to enrollees and their families shall be liable for negligence,

misfeasance, nonfeasance or malpractice in connection with the furnishing of such services and supplies.

"(e) Nothing in this chapter shall be construed in any way to repeal or conflict with any provision of the certificate of need law.

"(f) Notwithstanding the provisions of subsection (a), a health maintenance organization shall be subject to Section 27-1-17.

"§10-4-115

"No statute of this state applying to insurance companies shall be applicable to any corporation organized under the provisions of this article and amendments thereto or to any contract made by such corporation unless expressly mentioned in this article and made applicable; except as follows:

"(1) ~~Such~~ The corporation shall be subject to the provisions regarding annual premium tax to be paid by insurers on insurance premiums.

"(2) The corporation shall be subject to the provisions of Chapter 55, Title 27, regarding the prohibition of unfair discriminatory acts by insurers on the basis of an applicant's or insured's abuse status.

"(3) ~~Such~~ The corporation shall be subject to the provisions regarding Medicare Supplement Minimum Standards set forth in Article 2 of Chapter 19 of Title 27, and long-term

care insurance policy minimum standards set forth in Article 3 of Chapter 19 of Title 27.

"(4) The corporation shall be subject to the provisions of Section 27-1-17, requiring insurers and health plans to pay health care providers in a timely manner."

Section 2. This act shall become effective on the first day of the third month following its passage and approval by the Governor, or its otherwise becoming law.

Speaker of the House of Representatives

President and Presiding Officer of the Senate

House of Representatives

I hereby certify that the within Act originated in and was passed by the House 20-MAR-2001, as amended.

Greg Pappas
Clerk

Senate 03-MAY-2001 Passed

APPROVED 5/10/01
TIME 12:50 pm
GOVERNOR

Alabama Secretary Of State
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