ACT No. 2001-1060

SB29

43538-2

By Senators Butler, Barron, Waggoner, Denton, Biddle, Means, Dixon, Callahan, and Lindsey

RFD: Health

First Read: 04-DEC-2001

Enrolled, An Act,

To amend Section 27-1-17, Code of Alabama 1975, as amended by Act No. 2001-445, H.164, 2001 Regular Session, relating to prompt payment of certain medical claims, to clarify a possible ambiguity in the current law.

BE IT ENACTED BY THE LEGISLATURE OF ALABAMA:

Section 1. This bill is declaratory of existing law and does not constitute a change.

Section 2. Section 27-1-17, Code of Alabama 1975, as amended by Act No. 2001-445, H.164, 2001 Regular Session, is amended to read as follows:

"§27-1-17.

"(a) Each insurer, health service corporation, and health benefit plan that issues or renews any 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 or 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) 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, nonprofit hospital service corporations, or nonprofit medical service providers that pay for, purchase, or furnish health care services to patients, insureds, or beneficiaries in this state.

"(4) 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.

"(5) 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, nonprofit hospital service corporation, or nonprofit medical service corporation that pays for, purchases, or furnishes health care services to patients, insureds, or beneficiaries in this state.

"(c) 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 section and Sections 27-1-19, 27-21A-23, and 10-4-115 that apply to health maintenance organizations. The commissioner is authorized to adopt such regulations as may be required to implement the provisions of this section and Sections 27-1-19, 27-21A-23, and 10-4-115 that apply to insurers and regulations governing the assessment of administrative fines authorized by this section."

Section 3. This act shall become effective immediately upon its passage and approval by the Governor, or its otherwise becoming a law.

President and Presiding Officer of the Senate

Speaker of the House of Representatives

SB29

Senate 06-DEC-2001
I hereby certify that the within Act originated in and passed the Senate.

McDowell Lee
Secretary

House of Representatives
Passed: 13-DEC-2001

By: Senator Butler

APPROVED 12/20/01
TIME 6:17 PM
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Alabama Secretary Of State
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