HOUSE BILL NO. 638

INTRODUCED BY HANSEN, WALDRON

IN THE HOUSE

February 4, 1983	Introduced and referred to Committee on Business and Industry.
February 17, 1983	Committee recommend bill do pass as amended. Report adopted.
	Statement of Intent attached.
February 18, 1983	Bill printed and placed on members' desks.
February 19, 1983	Second reading, do pass.
February 21, 1983	Considered correctly engrossed.
February 22, 1983	Third reading, passed. Transmitted to Senate.

IN THE SENATE

March 1, 1983	Introduced and referred to Committee on Business and Industry.
March 16, 1983	Committee recommend bill be concurred in. Report adopted.
March 18, 1983	Second reading, concurred in.
March 21, 1983	Third reading, concurred in. Ayes, 48; Noes, 0.

IN THE HOUSE

March 21, 1983	Returned to House.
March 22, 1983	Sent to enrolling.
	Reported correctly enrolled.

House BILL NO. 638

INTRODUCED BY Stella Jean Hansen Walker

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT THE INSURANCE COMMISSIONER MAY IMPOSE AN ADMINISTRATIVE PENALTY UPON AN INSURER FOR FAILING TO PROMPTLY PAY CLAIMS; PROVIDING THAT ANY INSURER FAILING TO PAY A CLAIM WITHIN 20 WORKING DAYS AFTER RECEIPT OF PROOF OF LOSS SHALL NOTIFY THE INSURED AND ANY ASSIGNEE IN WRITING OF THE REASON FOR FAILING TO MAKE SUCH PAYMENT; PROVIDING FOR THE PROCESSING AND PAYMENT OF CLAIMS BY AN INSURER WITHIN 20 WORKING DAYS AND NO LONGER THAN 30 WORKING DAYS AFTER RECEIPT OF REQUIRED DOCUMENTS OR INFORMATION; PROVIDING THAT INSURERS SHALL PAY THE INSURED INTEREST ON CLAIMS THAT ARE NOT PAID IN A TIMELY MANNER; DEFINING "PROOF OF LOSS" AND "INSURER"; AND ESTABLISHING THE USE OF A UNIFORM BILLING FORM."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Definitions. In [this act] the following definitions apply:

(1) "Insurer" means any insurer as that term is defined by this title, including any fraternal benefit society, hospital service nonprofit corporation, nonprofit medical service corporation, nonprofit health care corporation, health maintenance organization, self-insurer, or third-party administrator or any other public or private, profit or nonprofit, governmental or nongovernmental individual, group, or organization that sells or offers for sale insurance policies, subscriber contracts, certificates, or agreements by which the offerer promises to pay medical benefits in any form in this state.

(2) "Proof of loss" means any document accepted by an insurer upon which payment of benefits is made.

Section 2. Proof of loss forms -- availability -- type. Each insurer shall provide to Montana hospitals an ample supply of the insurer's standard proof of loss form for hospitalization and shall, effective January 1, 1985, adopt and implement the national uniform billing form or its replacement identified as the UB-82 form authorized by the federal office of management and budget and adopted by the federal health care financing administration of the United States department of health and human services.

Section 3. Time for payment of claims. (1) All benefits payable by an insurer under a policy, other than benefits for loss of time, are payable immediately upon receipt of proof of loss. If an insurer does not pay the benefits payable under its policy, other than benefits payable for loss of time, upon receipt of proof of loss, the insurer has a maximum of 20 working days after receipt of proof of loss to notify the insured or subscriber and

assignee, in writing, stating the reasons for failing to pay the claim, either in whole or in part. The notification must include a written itemization of any documents or other information needed to process the claim or any portions thereof. When all of the listed documents or other information needed to process the claim have been received, the insurer has a maximum of 10 working days to process the claim and either pay it or deny it, in whole or in part. The insurer must notify the insured and assignee of the reasons for denying any claim or any portion of a claim.

(2) Subject to proof of loss, all accrued benefits payable under a policy for loss of time must be paid not later than the expiration of each 30-day period during the continuance of the time for which the insurer is liable. Any balance remaining unpaid at the termination of such time must be paid immediately upon receipt of such proof.

(3) For failure to comply with the requirements of this section, an insurer must pay interest to the insured or subscriber at the rate of 18% a year on the benefits due under the terms of the policy.

Section 4. Administrative penalty for failure to pay promptly. (1) The commissioner may, after a hearing, impose an administrative fine as set forth in subsection (2) on an insurer if he finds that the insurer as a general course of business practice in this state fails to:

(a) use due diligence in processing all claims;

(b) pay claims in a timely manner;

(c) provide proper notice when required with respect to the reasons for the insurer's failure to make claim payments when due; or

(d) pay, without just cause, proper claims arising under coverage provided by its policies, whether such claims are in favor of an insured, in favor of a third person with respect to the liability of an insured to such third person, or in favor of any other person entitled to the benefits of a policy.

(2) The administrative penalty imposed for violations of [this act] may not exceed $1,000 for each separate violation.

(3) If an insurer can demonstrate that it has consistently paid 90% of the total amount outstanding in claims within 20 working days and all of the amount within 30 working days of receipt of claims during the 6-month period immediately preceding the hearing date, the insurer is not subject to the fine imposed under subsection (2).

Section 5. Codification instruction. This act is intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to this act.

-End-

STATE OF MONTANA

REQUEST NO. 474-83

FISCAL NOTE

Form BD-15

In compliance with a written request received February 17, , 19 83 , there is hereby submitted a Fiscal Note for House Bill 638 pursuant to Title 5, Chapter 4, Part 2 of the Montana Code Annotated (MCA). Background information used in developing this Fiscal Note is available from the Office of Budget and Program Planning, to members of the Legislature upon request.

DESCRIPTION OF PROPOSED LEGISLATION:

House Bill 638 would impose investigatory requirements on the Insurance Department to determine if all companies were making their required payments in a timely manner.

ASSUMPTIONS:

1) An additional FTE, personal benefits, space, and equipment would be required.

FISCAL IMPACT:

	FY 84	FY 85
Personal Services		
Under Current Law	$ -0-	$ -0-
Under Proposed Law	20,471	20,471
Increase	$ 20,471	$ 20,471
Operating Expenses		
Under Current Law	$ -0-	$ -0-
Under Proposed Law	876	876
Increase	$ 876	$ 876
Capital Outlay		
Under Current Law	$ -0-	$ -0-
Under Proposed Law	2,400	-0-
Increase	$ 2,400	$ -0-
Total Expenditures to General Fund	$23,747	$21,347

COMMENTS:

The additional requirements could increase the workload of the entire current staff in addition to necessitating another FTE.

FISCAL NOTE 14:EE/1

David M Lewis

BUDGET DIRECTOR

Office of Budget and Program Planning

Date: 2-19-83

STATE OF MONTANA

REQUEST NO. 517-83

FISCAL NOTE

Form BD-15

In compliance with a written request received March 25, 19 83, there is hereby submitted a Fiscal Note for House Bill 638, Amended pursuant to Title 5, Chapter 4, Part 2 of the Montana Code Annotated (MCA). Background information used in developing this Fiscal Note is available from the Office of Budget and Program Planning, to members of the Legislature upon request.

DESCRIPTION OF PROPOSED LEGISLATION:

House Bill 638, amended, provides the Insurance Commissioner may impose an administrative penalty upon an insurer for failing to pay health or medical claims in a timely manner and may inquire into the cause of late payments.

ASSUMPTIONS:

1) An additional FTE, personal benefits, space, and equipment would be required to investigate late payments and administer bill.
2) Hearings to establish rules to implement the bill would have to be held.

FISCAL IMPACT:

	FY 84	FY 85
Personal Services		
Under Current Law	$ -0-	$ -0-
Under Proposed Law	20,471	20,471
Increase	$ 20,471	$ 20,471
Operating Expenses		
Under Current Law	$ -0-	$ -0-
Under Proposed Law	1,876	1,376
Increase	$ 1,876	$ 1,376
Capital Outlay		
Under Current Law	$ -0-	$ -0-
Under Proposed Law	2,400	-0-
Increase	$ 2,400	$ -0-
Total Expenditures to General Fund	$24,747	$21,847

FISCAL NOTE 14:EE/2

David McLaurin

BUDGET DIRECTOR
Office of Budget and Program Planning
Date: 3-26-83

STATEMENT OF INTENT

HOUSE BILL 638

House Business and Industry Committee

A statement of intent is required for [House Bill 638] because it gives rulemaking power to the commissioner of insurance. In section 5, the commissioner is authorized to establish rules to determine if a health or medical insurer is meeting his contractual obligation in a timely manner, to provide for administrative penalties against insurers who fail to fulfill those obligations, and to make the determinations necessary for insured persons whose benefit payments are unnecessarily delayed to be eligible to collect interest on the late payments.

SECOND READING

HB638

Approved by Committee
on Business and Industry

HOUSE BILL NO. 638

INTRODUCED BY HANSEN, WALDRON

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT THE INSURANCE COMMISSIONER MAY IMPOSE AN ADMINISTRATIVE PENALTY UPON AN INSURER FOR FAILING TO ~~PROMPTLY~~ PAY MEDICAL OR HEALTH CLAIMS IN A TIMELY MANNER; PROVIDING THAT ~~ANY INSURER FAILING TO PAY A CLAIM WITHIN 20 WORKING DAYS AFTER RECEIPT OF PROOF OF LOSS SHALL NOTIFY THE INSURED AND ANY ASSIGNEE IN WRITING OF THE REASON FOR FAILING TO MAKE SUCH PAYMENT; PROVIDING FOR THE PROCESSING AND PAYMENT OF CLAIMS BY AN INSURER WITHIN 20 WORKING DAYS AND NO LONGER THAN 30 WORKING DAYS AFTER RECEIPT OF REQUIRED DOCUMENTS OR INFORMATION~~ THE COMMISSIONER MAY INQUIRE INTO THE CAUSE OF CERTAIN LATE PAYMENTS; PROVIDING THAT INSURERS SHALL PAY THE INSURED INTEREST ON CERTAIN CLAIMS THAT ARE NOT PAID IN A TIMELY MANNER; DEFINING "PROOF OF LOSS" AND "INSURER"; ~~AND ESTABLISHING THE USE OF A UNIFORM BILLING FORM.~~"

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Definitions. In [this act] the following definitions apply:

(1) "Insurer" means any insurer as that term is defined by this title, including any fraternal benefit society, hospital service nonprofit corporation, HEALTH SERVICE CORPORATION, nonprofit medical service corporation, nonprofit health care corporation, health maintenance organization, self-insurer, or third-party administrator or any other public or private, profit or nonprofit, governmental or nongovernmental individual, group, or organization that sells or offers for sale insurance policies, subscriber contracts, certificates, or agreements by which the offerer promises to pay medical benefits in any form in this state.

(2) "Proof of loss" means any document accepted by an insurer upon which payment of benefits is made.

~~Section 2. Proof of loss forms availability types. Each insurer shall provide to Montana hospitals an ample supply of the insurer's standard proof of loss form for hospitalization and shall, effective January 1, 1985, adopt and implement the national uniform billing form or its replacement identified as the UB-82 form authorized by the federal office of management and budget and adopted by the federal health care financing administration of the United States department of health and human services.~~

~~Section 3. Time for payment of claims. (1) All benefits payable by an insurer under a policy, other than benefits for loss of time, are payable immediately upon receipt of proof of loss. If an insurer does not pay the benefits payable under its policy, other than benefits~~

SECOND READING

~~payable for loss of time upon receipt of proof of loss the insurer has a maximum of 20 working days after receipt of proof of loss to notify the insured or subscriber and assignee in writing stating the reasons for failing to pay the claim either in whole or in part The notification must include a written itemization of any documents or other information needed to process the claim or any portions thereof When all of the listed documents or other information needed to process the claim have been received the insurer has a maximum of 10 working days to process the claim and either pay it or deny it in whole or in part The insurer must notify the insured and assignee of the reasons for denying any claim or any portion of a claim~~

~~(2) Subject to proof of loss all accrued benefits payable under a policy for loss of time must be paid not later than the expiration of each 30 day period during the continuance of the time for which the insurer is liable Any balance remaining unpaid at the termination of such time must be paid immediately upon receipt of such proof~~

~~(3) For failure to comply with the requirements of this section an insurer must pay interest to the insured or subscriber at the rate of 10% a year on the benefits due under the terms of the policy~~

THERE IS A NEW MCA SECTION THAT READS:

Section 2. Time for payment of claims. (1) If within 30 days after receipt of a proof of loss, the insurer has not paid the claim for benefits provided in the policy or contract or notified the insured or the insured's assignee of the reasons for failure to pay the claim in full and has not requested additional information or documents, the insured or the assignee may report the delay to the commissioner, who may then investigate to determine if the insurer has failed to pay the claim within 30 days of its receipt without good reason and, if so, whether such delay is a general course of business practice of the insurer.

(2) Upon the commissioner's determination that the delay is a general course of business practice and for a year thereafter unless earlier rescinded by the commissioner, all claims for benefits not paid by that insurer within 30 working days after receipt by the insurer, without good reason as determined by the commissioner, shall obligate the insurer to pay interest at 18% a year from the date the commissioner determines that the delay became unreasonable.

Section 3. Administrative penalty for failure to pay promptly. (1) The commissioner may, after a hearing, impose an administrative fine as set forth in subsection (2) on an insurer if he finds that the insurer as a general course of business practice in this state fails to:

(a) use due diligence in processing all claims;

(b) pay claims in a timely manner;

(c) provide proper notice when required with respect to the reasons for the insurer's failure to make claim payments when due; or

(d) pay, without just cause, proper claims arising under coverage provided by its policies, whether such claims are in favor of an insured, in favor of a third person with respect to the liability of an insured to such third person, or in favor of any other person entitled to the benefits of a policy.

(2) The administrative penalty imposed for violations of [this act] may not exceed $1,000 for each separate violation.

(3) If an insurer can demonstrate that it has consistently paid 90% of the total amount outstanding in claims within 20 working days and all of the amount within 30 working days of receipt of claims during the 6-month period immediately preceding the hearing date, the insurer is not subject to the fine imposed under subsection (2).

THERE IS A NEW MCA SECTION THAT READS:

Section 4. Right of privacy guaranteed. Nothing in [this act] requires the commissioner to disclose information in violation of the Insurance Information and Privacy Protection Act.

THERE IS A NEW MCA SECTION THAT READS:

Section 5. Rulemaking authority. The commissioner shall make rules, under the Montana Administrative Procedure Act, necessary to implement [this act].

Section 6. Codification instruction. This act is intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to this act.

-End-

STATEMENT OF INTENT

HOUSE BILL 638

House Business and Industry Committee

A statement of intent is required for [House Bill 638] because it gives rulemaking power to the commissioner of insurance. In section 5, the commissioner is authorized to establish rules to determine if a health or medical insurer is meeting his contractual obligation in a timely manner, to provide for administrative penalties against insurers who fail to fulfill those obligations, and to make the determinations necessary for insured persons whose benefit payments are unnecessarily delayed to be eligible to collect interest on the late payments.

THIRD READING

HB 638

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(2) Upon the commissioner's determination that the delay is a general course of business practice and for a year thereafter unless earlier rescinded by the commissioner, all claims for benefits not paid by that insurer within 30 working days after receipt by the insurer, without good reason as determined by the commissioner, shall obligate the insurer to pay interest at 18% a year from the date the commissioner determines that the delay became unreasonable.

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