HOUSE BILL NO. 638

4

INTRODUCED BY HANSEN, WALDRON

IN THE HOUSE

February 4, 1983	Introduced and referred to Committee on Business and Industry.
February 17, 1983	Committee recommand 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.
I	n 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

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

INTRODUCED By Tall Read Hancen Wald 1 2 3

A BILL FOR AN ACT ENTITLED: MAN ACT PROVIDING THAT THE INSURANCE COMMISSIONER NAY IMPOSE AN ADMINISTRATIVE PENALTY 5 UPON AN INSURER FOR FAILING TO PROMPTLY PAY CLAIMS: 6 7 PROVIDING THAT ANY INSURER FAILING TO PAY A CLAIN WITHIN 20 WORKING DAYS AFTER RECEIPT OF PROOF OF LOSS SHALL NOTIFY THE 8 9 INSURED AND ANY ASSIGNEE IN WRITING OF THE REASON FOR FAILING TO MAKE SUCH PAYMENT; PROVIDING FOR THE PROCESSING 10 11 AND PAYMENT OF CLAIMS BY AN INSURER WITHIN 20 WORKING DAYS 12 AND NO LONGER THAN 30 WORKING DAYS AFTER RECEIPT OF REQUIRED 13 DOCUMENTS OR INFORMATION; PROVIDING THAT INSURERS SHALL PAY 14 THE INSURED INTEREST ON CLAINS THAT ARE NOT PAID IN A TIMELY 15 NANNER: DEFINING "PROOF OF LOSS" AND "INSURER"; AND 16 ESTABLISHING THE USE OF A UNIFORM BILLING FORM."

17

18 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA: 19 Section 1. Definitions. In [this act] the following 20 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.

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

Section 2. Proof of loss forms -- availability --9 10 type. Each insurer shall provide to Montana hospitals an 11 ample supply of the insurer's standard proof of loss form 12 for hospitalization and shall, effective January 1, 1985, 13 adopt and implement the national uniform billing form or its 14 replacement identified as the UB-82 form authorized by the 15 federal office of management and budget and adopted by the 16 federal health care financing administration of the United 17 States department of health and human services.

18 Section 3. Time for payment of claims. [1] All 19 benefits payable by an insurer under a policy, other than 20 benefits for loss of time, are payable immediately upon 21 receipt of proof of loss. If an insurer does not pay the 22 benefits payable under its policy, other than benefits 23 payable for loss of time, upon receipt of proof of loss, the 24 insurer has a maximum of 20 working days after receipt of 25 proof of loss to notify the insured or subscriber and

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assignee, in writing, stating the reasons for failing to pay 1 2 the claim, either in whole or in part. The notification must 3 include a written itemization of any documents or other information needed to process the claim or any portions 4 thereof. When all of the listed documents or other 5 information needed to process the claim have been received. 6 7 the insurer has a maximum of 10 working days to process the 8 claim and either pay it or deny it, in whole or in part. The 9 insurer must notify the insured and assignee of the reasons for denying any claim or any portion of a claim. 10

11 (2) Subject to proof of loss, all accrued benefits 12 payable under a policy for loss of time must be paid not 13 later than the expiration of each 30-day period during the 14 continuance of the time for which the insurer is liable. Any 15 balance remaining unpaid at the termination of such time 16 must be paid immediately upon receipt of such proof.

17 (3) For failure to comply with the requirements of 18 this section, an insurer must pay interest to the insured or 19 subscriber at the rate of 18% a year on the benefits due 20 under the terms of the policy.

21 Section 4. Administrative penalty for failure to pay 22 promptly. (1) The commissioner may, after a hearing, impose 23 an administrative fine as set forth in subsection (2) on an 24 insurer if he finds that the insurer as a general course of 25 business practice in this state fails to: (a) use due diligence in processing all claims;

(b) pay claims in a timely manner;

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3 (c) provide proper notice when required with respect
4 to the reasons for the insurer's failure to make claim
5 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.

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

15 (3) If an insurer can demonstrate that it has 16 consistently paid 90% of the total amount outstanding in 17 claims within 20 working days and all of the amount within 18 30 working days of receipt of claims during the 6-month 19 period immediately preceding the hearing date+ the insurer 20 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-

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STATE OF MONTANA

REQUEST NO. 474-83

FISCAL NOTE

Form BD-15

In	compliance with a writ	ten request received	February 17,	19 <u>83</u> ,	there is hereby su	ibmitted a Fiscal Note	,
for	House Bill 63	18 pursuant	to Title 5, Chapter 4, Pa	art 2 of the M	Vontana Code Ann	otated (MCA).	
Ba	ckground information us	ed in developing this Fisc	al Note is available from	the Office of	Budget and Program	m Planning, to member	5
of	the Legislature upon rec	quest.					

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:	1	
Personal Complexe	<u>FY 84</u>	<u>FY 85</u>
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		<u> </u>
to General Fund	\$23,747	<u>\$21,347</u>

COMMENTS:

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

FISCAL NOTE 14:EE/1

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 <u>March 25</u>, 19<u>83</u>, there is hereby submitted a Fiscal Note for <u>House Bill 638</u>, <u>Amended</u> 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:

	<u>FY 84</u>	<u>FY 85</u>
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	<u> </u>	<u> </u>
to General Fund	\$24,747	<u>\$21,847</u>

FISCAL NOTE 14:EE/2

BUDGET DIRECTOR Office of Budget and Program Planning Date: 3-2-6-83

STATEMENT	ΠĒ	TNTENT

HOUSE	BILL	638
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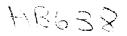
3 House Business and Industry Committee

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5 A statement of intent is required for [House Bill 638] because it gives rulemaking power to the commissioner of 6 7 insurance. In section 5, the commissioner is authorized to 8 establish rules to determine if a health or medical insurer 9 is meeting his contractual obligation in a timely manner, to provide for administrative penalties against insurers who 10 11 fail to fulfill those obligations, and to make the determinations necessary for insured persons whose benefit 12 13 payments are unnecessarily delayed to be eligible to collect 14 interest on the late payments.

SECOND READING



Approved by Committee on <u>Business and Industry</u>

1	HOUSE BILL NO. 638
2	INTRODUCED BY HANSEN, WALDRON
3	
4	A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT THE
5	INSURANCE COMMISSIONER MAY IMPOSE AN ADMINISTRATIVE PENALTY
6	UPON AN INSURER FOR FAILING TO PROMPTLY PAY MEDICAL
7	HEALTH CLAIMS IN A TIMELY MANNER; PROVIDING THAT ANY-INSURER
8	F&1L\$NG T0-PAY-A-ELAIN-WITHIN-20-WORKING-DAY5-AFTER -REGEIPT
9	OF-PR88F-8F-L855-SHALL-N&TIFY-THE-INSURED-ANDANYASSIGNEE
10	±NWR±Ŧ ÌN6-+8F -ŦHE- REASBN-FOR -FA I LING-TO-HAKE-SUCH-PA¥MENŦŧ
11	PROVIRING-FOR-THE-PROCESSING-AND-PAYMENTOFELAIMSBYAN
12	INSURER-WITHIN~20-WORKING-DAYS-AND-NO-LONGER-THAN-30-WORKING
13	DAYSAFTER-REGEIPT-OF-REQUIRED-DOGWNENTS-OR-INFORMATION IME
14	COMMISSIONER_MAY_INQUIRE_INTOTHECAUSEDECERTAINLAIE
15	PAYMENIS; PROVIDING THAT INSURERS SHALL PAY THE INSURED
16	INTEREST ON CERIAIN CLAIMS THAT ARE NOT PAID IN A TIMELY
17	MANNER; DEFINING "PROOF OF LOSS" AND "INSURER"+AND
18	E\$T#8LISHING-THE-USE-8F-A-UNIF8RM-BILLING-F8RM."
19	
20	DE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
21	Section 1. Definitions. In [this act] the following

22 definitions apply:

(1) "Insurer" means any insurer as that term is
 defined by this title, including any fraternal benefit
 society, hospital service nonprofit corporation, <u>HEALTH</u>

1 SERVICE CORPORATIONs nonprofit medical service corporation, 2 nonprofit health care corporation, health maintenance 3 organization, self-insurer, or third-party administrator or 4 any other public or private, profit or nonprofit, 5 governmental or nongovernmental individual. Group. or 6 organization that sells or offers for sale insurance 7 policies, subscriber contracts, certificates, or agreements 8 by which the offerer promises to pay medical benefits in any 9 form in this state. 10 (2) "Proof of loss" means any document accepted by an 11 insurer upon which payment of benefits is made. 12 5ection-2u-+Proof-of--toss--for#s-----avaitabitity-----13 typew---Each--insurer--shail-provide-to-Nontana-hospitals-an 14 ample-supply-of-the-insurer*s-standard-proof--of--loss--form 15 for--hospitalization--and--shally-offective-January-1--1985* 16 adopt-and-implement-the-national-uniform-billing-form-or-its 17 replacement-identified-as-the-UB-82-form-authorized--by--the 18 federat--office--of-management-and-budget-and-adopted-by-the 19 federal-health-care-financing-administration-of--the--United 20 States-department-of-health-and-human-services. 21 Section-3u--- Fime---- for--payment--of--elaimsu---- (1)--+++ 22 benefits-payable-by-an-insurer-under-a--policyy--other--than

- 23 benefits--for--loss--of--timey--are-payable-immediately-upon
- 24 receipt-of-proof-of-loss-lf-an-insurer--does--not--psy--the
- 25 benefits--payable--under--its--policyy--other--than-benefits

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1	payable-for-loss-of-timey-upon-receipt-of-proof-of-lossy-the
2	insurer-has-a-maximum-of-20-working-daysafterreaciptof
3	proofoftosstonotifytheinsuredor-subscriber-and
4	assigneey-in-writingy-stating-the-reasons-for-failing-to-pay
5	the-claimy-cither-in-whole-or-in-parts-The-notification-must
6	include-a-written-itemizetionofanydocumentsorother
7	informationneededtoprocesstheclaim-or-any-portions
8	thereofyWhanallofthelisteddocumentsorother
9	informationneeded-to-process-the-claim-have-been-receivedy
10	the-insurer-hos-a-maximum-of-10-working-doys-to-processthe
11	cloim-and-cither-pay-it-or-deny-ity-in-whole-or-in-party-The
12	tnsurermust-notify-the-insured-and-assignee-of-the-reasons
13	for-denying-any-claim-or-any-portion-of-a-claimy
14	{}}Subject-to-proof-of}ossya}}-accruzdbenafits
15	peyebteunderapottcyfor-toss-of-time-must-be-paid-not
16	later-than-the-expiration-of-each-30-day-periodduringthe
17	continuance-of-the-time-for-which-the-insurer-is-liabler-Any
18	balancaremainingunpaidatthe-termination-of-such-time
19	must-be-psid-immediately-upon-receipt-of-such-proofw
20	t3jFor-failurs-to-complywiththerequirementsof
21	this-sectiony-an-insurer-must-pay-interest-to-the-insured-or
22	subscriberattherateof-10%-a-year-on-the-benefits-due
23	under-the-terms-of-the-policy-
24	IHERE_IS_A_NEW_MCA_SECTION_IHAT_READS:
25	Section 2. Time for payment of claims. (1) If within

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1 30 days after receipt of a proof of loss, the insurer has 2 not paid the claim for benefits provided in the policy or 3 contract or notified the insured or the insured's assignee 4 of the reasons for failure to pay the claim in full and has 5 not requested additional information or documents, the 6 insured or the assignee may report the delay to the 7 commissioner, who may then investigate to determine if the 8 insurer has failed to pay the claim within 30 days of its 9 receipt without good reason and, if so, whether such delay 10 is a general course of business practice of the insurer. 11 (2) Upon the commissioner's determination that the 12 delay is a general course of business practice and for a year thereafter unless earlier rescinded by 13 the 14 commissioner, all claims for benefits not paid by that insurer within 30 working days after receipt by the insurer, 15 without good reason as determined by the commissioner, shall 16

obligate the insurer to pay interest at 18% a year from the
date the commissioner determines that the delay became
unreasonable.

20 Section 3. Administrative penalty for failure to pay 21 promptly. (1) The commissioner may, after a hearing, impose 22 an administrative fine as set forth in subsection (2) on an 23 insurer if he finds that the insurer as a general course of 24 business practice in this state fails to:

25 (a) use due diligence in processing all claims;

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(b) pay claims in a timely manner;

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

5 (d) pay, without just cause, proper claims arising 6 under coverage provided by its policies, whether such claims 7 are in favor of an insured, in favor of a third person with 8 respect to the liability of an insured to such third person, 9 or in favor of any other person entitled to the benefits of 10 a policy.

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

14 (3) If an insurer can demonstrate that it has 15 consistently paid 90% of the total amount outstanding in 16 claims within 20 working days and all of the amount within 17 30 working days of receipt of claims during the 6-month 18 period immediately preceding the hearing date, the insurer 19 is not subject to the fine imposed under subsection (2).

IHEBE_IS_A_NEW_MCA_SECTION'THAT_READS:

20

21 Section 4. Right of privacy guaranteed. Nothing in 22 [this act] requires the commissioner to disclose information 23 in violation of the Insurance Information and Privacy 24 Protection Act.

25 IHERE IS A NEW MCA SECTION THAT READS:

- 1 Section 5. Rulemaking authority. The commissioner
- 2 shall make rules, under the Montana Administrative Procedure
- 3 Acty necessary to implement [this act].
- 4 Section 6. Codification instruction. This act is
- 5 intended to be codified as an integral part of Title 33, and
- 6 the provisions of Title 33 apply to this act.

-End-

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HOUSE BILL 638

House Business and Industry Committee

5 A statement of intent is required for [House Bill 638] 6 because it gives rulemaking power to the commissioner of 7 insurance. In section 5, the commissioner is authorized to 8 establish rules to determine if a health or medical insurer 9 is meeting his contractual obligation in a timely manner, to provide for administrative penalties against insurers who 10 11 fail to fulfill those obligations, and to make the 12 determinations necessary for insured persons whose benefit payments are unnecessarily delayed to be eligible to collect 13 14 interest on the late payments.

THIRD READING

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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 <u>MEDICAL</u>OR HEALIH CLAIMS IN_A_IIMELY_MANNER; PROVIDING THAT ANY-INSURER FAILING--TO-PAY-A-GLAIM-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 OATS--AFTER-RECEIPT-OF-REQUIRED-DOCUMENTS-OR-INFORMATION IHE COMMISSIONER MAY_INQUIRE_INTO_THE_CAUSE_OR_CERTAIN_LAIE PAYMENIS; PROVIDING THAT INSURERS SHALL PAY THE INSURED INTEREST ON CERIAIN CLAIMS THAT ARE NOT PAID IN A TIMELY

 17
 MANNER; DEFINING "PROOF OF LOSS" AND "INSURER";--AND

 18
 ESTABLISHING-THE-USE-OF-A-UNIFORM-BILLING-FORM;"

19

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1 SERVICE CORPORATION: nonprofit medical service corporation; 2 nonprofit health care corporation, health maintenance 3 organization, self-insurer, or third-party administrator or 4 any other public or private, profit or nonprofit, 5 governmental or nongovernmental individual, group, or 6 organization that sells or offers for sale insurance 7 policies, subscriber contracts, certificates, or agreements by which the offerer promises to pay medical benefits in any 8 9 form in this state. 10 (2) "Proof of loss" means any document accepted by an

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25 benefits--payable--under--its--policyy--other--than-benefits

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HB 638

THIRD READING

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1	payable-for-loss-ef-timey-upon-receipt-of-proof-of-lossv-the
2	insurer-has-a-moximum-of-20-working-daysafterreeaiptof
3	proofoflosstonotifytheinsuredor-subscriber-and
4	azzigncey-in-writingy-stating-the-reasons-for-failing-to-pay
5	the-claimy-either-in-whole-or-in-party-The-notification-must
6	include-a-written-itemizationofanydocumentsorather
7	informationneededtoprocesstheclaim-or-any-portions
8	thereofoWhenofthelisteddocumentsorother
9	informationneeded-to-process-the-claim-hove-been-receivedy
10	the-insurer-has-a-maximum-of-l8-working-days-to-processthe
11	claim-and-either-pay-it-or-deny-ity-in-whole-or-in-parto-The
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14	{}}Subject-to-proof-oflossvallaccrusdbenafits
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20	{3} Fo r-foilure-to-comply-withtherequirementsof
21	this-sectiony-an-insurer-must-pay-interest-to-the-insured-or
2 Z	subscriberattherateof-18%-a-year-on-the-benefits-due
23	under-the-terms-of-the-policys
24	IHERE_IS_A_NEW_MCA_SECTION_THAT_READS:
25	Section 2. Time for payment of claims. (1) If within

-3-

1

1 30 days after receipt of a proof of loss, the insurer has 2 not paid the claim for benefits provided in the policy or contract or notified the insured or the insured's assignee 3 4 of the reasons for failure to pay the claim in full and has 5 not requested additional information or documents, the insured or the assignee may report the delay to the 6 7 commissioner, who may then investigate to determine if the 8 insurer has failed to pay the claim within 30 days of its 9 receipt without good reason and, if so, whether such delay is a general course of business practice of the insurer. 10 (2) Upon the commissioner's determination that the

11 12 delay is a general course of business practice and for a year thereafter unless earlier rescinded by the 13 commissioner, all claims for benefits not paid by that 14 15 insurer within 30 working days after receipt by the insurer, 16 without good reason as determined by the commissioner, shall obligate the insurer to pay interest at 18% a year from the 17 18 date the commissioner determines that the delay became 19 unreas onable.

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25 (a) use due diligence in processing all claims;

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1 (b) pay claims in a timely manner;

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3 to the reasons for the insurer's failure to make claim
4 payments when due; or

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IHERE_IS_A_NEW_MCA_SECTION: THAT_READS:

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Section 4. Right of privacy guaranteed. Nothing in
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25 IHERE_IS_A_NEW_MCA_SECTION_THAT_BEADS:

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Section 5. Rulemaking authority. The commissioner

2 shall make rules, under the Montana Administrative Procedure

3 Act, necessary to implement [this act].

4 Section 6. Codification instruction. This act is

5 intended to be codified as an integral part of Title 33, and

6 the provisions of Title 33 apply to this act.

-End-

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1	STATEMENT OF INTENT
2	HOUSE BILL 638
3	House Business and Industry Committee
4	
5	A statement of intent is required for [House Bill 638]
6	because it gives rulemaking power to the commissioner of
7	insurance. In section 5, the commissioner is authorized to
8	establish rules to determine if a health or medical insurer
9	is meeting his contractual obligation in a timely manner, to
10	provide for administrative penalties against insurers who
11	fail to fulfill those obligations, and to make the
12	determinations necessary for insured persons whose benefit
13	payments are unnecessarily delayed to be eligible to collect
14	interest on the late payments.

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HB 0638/02

1	HOUSE BILL NO. 638	1	SEBVICE_CORPORATION: nonprofit medical service corporation;
2	INTRODUCED BY HANSEN, WALDRON	2	nonprofit health care corporation, health maintenance
Э		3	organization, self-insurer, or third-party administrator or
4	A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT THE	4	any other public or private, profit or nonprofit,
5	INSURANCE COMMISSIONER MAY IMPOSE AN ADMINISTRATIVE PENALTY	5	governmental or nongovernmental individual, group, or
6	UPON AN INSURER FOR FAILING TO promptly pay <u>medical or</u>	6	organization that sells or offers for sale insurance
7	HEALTH CLAIMS IN A TIMELY HANNER; PROVIDING THAT ANY-INSURER	7	policies, subscriber contracts, certificates, or agreements
8	FAILINGFO-PAY-A-CLAIM-WITHIN-20-WORKING-DAYS-AFTER-RECEIPT	8	by which the offerer promises to pay medical benefits in any
9	OF-PROBF-BF-LOSS-SHALL-NOTIFY-THE-INSURED-ANDANYASSIGNEE	9	form in this state.
10	ŧN~~₩RITIN6~-OF~THE~REA\$ON-FOR-FAILING-TO~MAKE-SUCH-PAYMENT\$	10	(2) "Proof of loss" means any document accepted by an
11	PROVIDING-FOR-THE-PROCESSING-AND-PAYMENTOFGLAINSBY AN	11	insurer upon which payment of benefits is made.
12	INSURER-WITHIN-20-WORKING-DAY5-AND-NO-LUNGER-THAN-30-WORKING	12	Section-2=Proof-oftossformsavaitabitity
13	BatsAfter-Regeipt-of-Requi red- Documents-or-Information <u>The</u>	13	typesEachinsurershail-provide-to-Montana-hospitals-an
14	COMMISSIONER_MAY_INDUIRE_INTOTHECAUSEDECERTAINLATE	14	ample-supply-of-the-insurer*s-standard-proofoflossform
15	PAYMENIS; PROVIDING THAT INSURERS SHALL PAY THE INSURED	15	forhospitalizationondshally-effective-January-ly-1985v
16	INTEREST ON <u>CERTAIN</u> CLAINS THAT ARE NOT PAID IN A TIMELY	16	adopt-and-impiement-the-national-uniform-billing-form-or-its
17	MANNER; DEFINING "PROOF OF LOSS" AND "INSURER"+ANO	17	replacement-identified-es-the-U8-82-form-authorizedbythe
18	ESTABLISHING-THE-USE-OF-A-UNIFORM-BILLING-FORM."	18	federalofficeof-monogement-and-budget-and-adopted-by-the
19		19	feders]-health-care-financing-administration-oftheUnited
20	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:	20	States-department-of-heolth-and-humon-services.
21	Saction 1. Definitions. In [this act] the following	21	Section-3vTimeforpaymentofclsimsv(1)All
22	definitions apply:	22	benefits-payable-by-an-insurer-under-a-policyyotherthan
23	(1) "Insurer" means any insurer as that term is	23	benefitsfortossoftimesare-poyable-immediately-upon
24	defined by this title, including any fraternal benefit	24	receist-of-proof-of-lossw-if-an-insurerdoesnotpaythe
25	society, hospital service nonprofit corporation, <u>HEALIH</u>	25	benefitspayabteunderitspoticyotherthan-benefits

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1	payable-for-toss-of-timey-upon-receipt-of-proof-of-lossy-the			
2	insure r-has-a -ma ximum-of-20-working-daysafterreceiptof			
3	proofaf loss to not ifythe- -insuredor -subscriber-and			
4	assign eer-in-writingr-stating-the-reasons-for-failing-ta-pay			
5	the-claimy-either-in-whole-or-in-party-The-notification-must			
6	include-a-written-it em izationaf a ny documentsor other			
7	informationneededtoprocesstheeloim-or-any-portions			
8	thereofyKhenallofthelisteddocumentsorother			
9	informationneeded-to-process-the-claim-have-been-receiveds			
10	the-insurer-has-a-maximum-of-10-working-days-to-processthe			
11	clais-and-aither-pay-it-or-dany-ity-in-whol e-or-in-party-The			
12	insurermust-notify-the-insured-and- assign ee -of-the-reasons			
13	for-denying-any-claim-or-eny-portion-of-a-claim-			
14	{2}~-5ubject-ta-proof-of}ossy- - a }}accra adbenef tts			
15	payableunderapolicyfor-loss-of-time-must-be-pold-nat			
16	later-than-the- expiration-of-each-30-day-periodduringthe			
17	continuance-of-the-time-for-which-the-insurer-is-liabler-Any			
18	balanceremainingunpoidatthe-termination-of-such-time			
19	must-be-paid-immediately-upon-receipt-of-such-proof-			
20	{3}For-fa ilure-to-complywiththerequirementsof			
21	this-sectiony-an-insurer-must-pay-interest-to-the-insured-or			
22	subscriberattherateof-184-a-year-on-the-benefits-due			
23	under-the-terms-of-the-policy-			
24	IHERE_IS_A_NEW_MCA_SECTION_THAT_BEADS:			
25	Section 2. Time for payment of claims. (1) If within			
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30 days after receipt of a proof of loss, the insurer has L 2 not paid the claim for benefits provided in the policy or contract or notified the insured or the insured's assignee 3 of the reasons for failure to pay the claim in full and has 4 not requested additional information or documents, the 5 insured or the assignee may report the delay to the 6 commissioner, who may then investigate to determine if the 7 insurer has failed to pay the claim within 30 days of its 8 9 receipt without good reason and, if so, whether such delay is a general course of business practice of the insurer. 10

11 (2) Upon the commissioner's determination that the 12 delay is a general course of business practice and for a 13 year thereafter unless earlier rescinded by the commissioner, all claims for benefits not paid by that 14 insurer within 30 working days after receipt by the insurer, 15 16 without good reason as determined by the commissioner, shall obligate the insurer to pay interest at 18% a year from the 17 18 date the commissioner determines that the delay became 19 unreas onable.

20 Section 3. Administrative penalty for failure to pay 21 promptly. (1) The commissioner may, after a hearing, impose 22 an administrative fine as set forth in subsection (2) on an 23 insurer if he finds that the insurer as a general course of 24 business practice in this state fails to:

(a) use due diligence in processing all claims;

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(b) pay claims in a timely manner;

1

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

5 (d) pay, without just cause, proper claims arising 6 under coverage provided by its policies, whether such claims 7 are in favor of an insured, in favor of a third person with 8 respect to the liability of an insured to such third person, 9 or in favor of any other person entitled to the benefits of 10 a policy.

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

14 (3) If an insurer can demonstrate that it has 15 consistently paid 90% of the total amount outstanding in 16 claims within 20 working days and all of the amount within 17 30 working days of receipt of claims during the 6-month 18 period immediately preceding the hearing date, the insurer 19 is not subject to the fine imposed under subsection (2).

20 IHERE_IS_A_NEW_MCA_SECTION_THAT_READS:

21 Section 4. Right of privacy guaranteed. Nothing in 22 [this act] requires the commissioner to disclose information 23 in violation of the Insurance Information and Privacy 24 Protection Act.

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25 IHERE IS A NEW MCA SECTION_IMAT_BEADS:

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

4 Section 6. Codification instruction. This act is 5 intended to be codified as an integral part of Title 33, and

6 the provisions of Title 33 apply to this act.

-End-

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