RECEIVED

L.D. 891

Date: 5/29/2013 (Filing No. S- 147)

INSURANCE AND FINANCIAL SERVICES

Reproduced and distributed under the direction of the Secretary of the Senate.

STATE OF MAINE

SENATE

126TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT "A" to S.P. 312, L.D. 891, Bill, "An Act To Create Uniform Claims Paying Practices in Long-term Care Insurance Policies"

Amend the bill in the emergency preamble in the 4th paragraph in the last line (page 1, line 8 in L.D.) by striking out the following: "are" and inserting the following: 'is'

Amend the bill by striking out everything after the enacting clause and before the emergency clause and inserting the following:

'**Sec. 1. 24-A MRSA §2436, sub-§6** is enacted to read:

6. This section does not apply to a claim for payment of benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State.

Sec. 2. 24-A MRSA §5083 is enacted to read:

§5083. Payment of claims

1. Notice of claim for benefits; response by insured. Notwithstanding any other provision of this Title, upon receipt of a notice of claim for benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State, an insurer, whether actively marketing or renewing long-term care insurance in this State, shall provide the insured a written statement with sufficient detail to permit the insured to understand and respond with the documentation specified in subsection 2. The written statement must be provided by the insurer within 10 business days following receipt of the notice of claim. For purposes of this section, "insured" includes a person designated by the insured as the insured's representative.

2. Documentation. The documentation an insurer may require of an insured for the payment of a claim for benefits under a policy or certificate of long-term care insurance includes, but is not limited to:

A. A statement from the insured making the claim for benefits;

B. A signed release permitting the insurer to obtain personal health care information about the insured pursuant to the federal Health Insurance Portability and Accountability Act of 1996;

C. A statement from the insured's physician, including the appropriate diagnosis and a treatment and care plan for the insured;

D. A statement from the long-term care provider rendering services to the insured, including an itemized bill for services, the provider's license number and any daily nursing notes; and

E. A copy of any power of attorney executed by the insured.

Except for information solely in the possession of the insured, the burden is on the insurer to obtain any information other than that described in paragraphs A to E that is reasonably necessary to pay or continue paying the claim. The insured has a continuing obligation to cooperate with the insurer in order for the insurer to obtain needed information.

3. Payment of claim. A claim for payment of benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State is payable within 30 days after the documentation and information identified in subsection 2 as reasonably necessary to pay the claim for benefits have been received by the insurer. Within 30 days after receipt of that documentation and information, the insurer shall either pay the claim or issue a written notice to the insured declining to pay all or part of the claim and the specific reason for denial in accordance with this subsection.

A. An insurer may not extend the time for payment of a claim beyond 30 days after receipt of documentation and information related to a technical issue as designated in rules adopted by the bureau.

B. Except as provided in paragraph A, an insurer may delay payment of a claim and request additional documentation and information related to a substantive issue as designated in rules adopted by the bureau.

4. Ongoing claim. Except for information solely in the possession of the insured, if, during the course of an ongoing claim for benefits paid on a monthly or recurring basis, the insurer identifies the need for additional reasonable documentation to ensure the insured remains entitled to benefits under the policy or certificate of long-term care insurance, the burden is on the insurer to obtain that information. The insured has a continuing obligation to cooperate with the insurer in order for the insurer to obtain needed information.

5. Appeals of claims denials. An insured who receives a claims denial in accordance with this section has the right to internal appeal and, after exhausting an insurer's internal appeals process, the right to request an external review. The superintendent shall adopt rules to determine the standards for internal appeal and external review in a manner consistent with model legislation adopted by the National Association of Insurance Commissioners, or its successor organization. The written notice to the insured declining to pay all or part of the claim as required by subsection 3 must include a statement informing the insured of the insured's rights to internal appeal

and external review and a statement of the insured's right to seek assistance or file a complaint with the bureau and the toll-free telephone number of the bureau.

6. Interest on overdue claim. An undisputed claim that is not paid within 30 days is overdue. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date.

7. Attorney's fees. Reasonable attorney's fees for advising and representing a claimant on an overdue claim or action for an overdue claim must be paid by the insurer if overdue benefits are recovered in an action against the insurer or if overdue benefits are paid after receipt of notice of the attorney's representation.

8. No limitation on action by insured. This section does not prohibit or limit any claim or action for a claim that the insured has against the insurer.

9. Rules. The superintendent may adopt or amend rules in order to carry out the purposes of this section. Rules adopted pursuant to this section, including amendments to existing rules designated as major substantive, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 3. Bureau of Insurance report; rules. By March 1, 2014, the Department of Professional and Financial Regulation, Bureau of Insurance shall submit a report to the Joint Standing Committee on Insurance and Financial Services on the rules adopted by the bureau as required by the Maine Revised Statutes, Title 24-A, section 5083.'

SUMMARY

This amendment replaces the substantive provisions of the bill, but retains the emergency preamble and emergency clause. The amendment requires a long-term care insurer to pay a claim to an insured within 30 days of receipt of all necessary documentation identified by the insurer, which extends the time from 14 days as proposed in the bill. The amendment also provides that insurers may delay payment of claims and request additional information related only to substantive issues, which are required to be designated through rules.

FISCAL NOTE REQUIRED
(See attached)

Approved: 05/27/13 mac

126th MAINE LEGISLATURE

LD 891 **LR 1024(02)**

An Act To Create Uniform Claims Paying Practices in Long-term Care Insurance Policies

Fiscal Note for Bill as Amended by Committee Amendment "A" (S-147)
Committee: Insurance and Financial Services
Fiscal Note Required: Yes

Fiscal Note

Minor cost increase - Other Special Revenue Funds

Fiscal Detail and Notes

Additional costs for the Bureau of Insurance in the Department of Professional and Financial Regulation are expected to be minor and can be absorbed within existing budgeted resources.