HOUSE BILL NO. 130

INTRODUCED BY LEWIS

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE PROMPT PAY PROVISIONS FOR INSURERS; MODIFYING THE ~~DEFINITIONS OF "INSURER" AND~~ DEFINITION OF "PROOF OF LOSS"; DEFINING "CLAIM DOCUMENTATION"; REVISING THE TIME PERIOD FOR PAYMENT OF CLAIMS BY AN INSURER; REQUIRING PROMPT PAYMENT OF MOTOR VEHICLE DAMAGE CLAIMS; REVISING THE ADMINISTRATIVE PENALTY PROVISIONS FOR FAILURE OF AN INSURER TO PROMPTLY PAY CLAIMS; PROVIDING THAT COMPLIANCE OR NONCOMPLIANCE WITH PROMPT PAYMENT REQUIREMENTS MAY NOT BE USED AS A BASIS FOR PRIVATE CAUSE OF ACTION OR ADMISSIBLE AS EVIDENCE IN A PRIVATE ACTION; AND AMENDING SECTIONS 33-18-231, 33-18-232, AND 33-18-233, MCA."

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

Section 1. Section 33-18-231, MCA, is amended to read:

"33-18-231. State administrative process to provide timely payment of ~~medical benefits~~ ~~CLAIMS~~ MEDICAL BENEFITS -- definitions. In 33-18-231 through 33-18-235 the following definitions apply:

(1) "CLAIM DOCUMENTATION" MEANS STANDARD CLAIMS FORMS OR OTHER DOCUMENTATION ROUTINELY ACCEPTED BY INSURERS AS PROOF OF LOSS.

~~(1)~~(2) "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~~

~~(a) a property insurer;~~

~~(b) a casualty insurer, EXCLUDING WORKERS' COMPENSATION COVERAGE AND PROFESSIONAL LIABILITY INSURANCE;~~

~~(c) a farm mutual insurer;~~

~~(d) a health service corporation;~~

~~(e) a health maintenance organization;~~

~~(f) a self-insurer, EXCLUDING WORKERS' COMPENSATION COVERAGE;~~

~~(g) a third-party administrator who settles claims in connection with property, casualty, or disability insurance; or~~

~~(h) a disability insurer that covers medical expenses or indemnifies an insured for sickness AND ACCIDENT~~ 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)~~(3) "Proof of loss" means any ~~document accepted~~ CLAIM DOCUMENTATION received by an insurer upon which payment of ~~benefits~~ claims is ~~made~~ REQUESTED."

Section 2. Section 33-18-232, MCA, is amended to read:

"33-18-232. Time for payment of claims. (1) ~~If~~ An insurer shall pay OR DENY a claim 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~~ unless the insurer makes a reasonable request for additional information or documents in order to evaluate the claim. If an insurer makes a reasonable request for additional information or documents, the insurer shall pay OR DENY the claim within 60 days of receiving the proof of loss unless the insurer HAS NOTIFIED THE INSURED, THE INSURED'S ASSIGNEE, OR THE CLAIMANT OF THE REASONS FOR FAILURE TO PAY THE CLAIM IN FULL OR UNLESS THE INSURER has a reasonable belief that insurance fraud has been committed and the insurer has reported the possible insurance fraud to the commissioner. THIS SECTION DOES NOT ELIMINATE AN INSURER'S RIGHT TO CONDUCT A THOROUGH INVESTIGATION OF ALL THE FACTS NECESSARY TO DETERMINE PAYMENT OF A CLAIM.

(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.~~ If an insurer fails to ~~pay a claim as required by~~ COMPLY WITH this section AND THE INSURER IS LIABLE FOR PAYMENT OF THE CLAIM, the insurer shall pay an amount equal to the amount of the claim DUE plus ~~18%~~ 10% annual interest calculated from the date on which the claim was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after the insurer's receipt of the proof of loss or 60 days after receipt of the proof of loss if the insurer made a reasonable request for information or documents. Interest payments must be made to the person who receives the claims payment.

(3) A PRIVATE CAUSE OF ACTION UNDER 33-18-201 OR 33-18-242 MAY NOT BE BASED ON THE COMPLIANCE OR NONCOMPLIANCE WITH THE REQUIREMENTS OF THIS SECTION AND EVIDENCE OF COMPLIANCE OR NONCOMPLIANCE WITH THIS SECTION IS NOT ADMISSIBLE IN ANY PRIVATE ACTION BASED ON 33-18-201 OR 33-18-242."

Section 3. Section 33-18-233, MCA, is amended to read:

"33-18-233. Administrative penalty for failure to pay promptly. (1) The commissioner may, after a hearing, impose an administrative fine as ~~set forth in subsection (2)~~ provided in 33-1-317 on an insurer if ~~he~~ the commissioner 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~~ the claims are in favor of an insured, in favor of a third person with respect to the liability of an insured to ~~such~~ the third person, or in favor of any other person entitled to the benefits of a policy; or

(e) pay interest pursuant to 33-18-232(2).

~~(2) The administrative penalty imposed for violations of 33-18-231 through 33-18-235 may not exceed $1,000 for each separate violation.~~

~~(3)~~(2) If an insurer can demonstrate that it has consistently paid 90% of the total dollar amount outstanding in claims to each claimant 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)~~ described in subsection (1)."

NEW SECTION. **SECTION 4. PROMPT PAYMENT OF MOTOR VEHICLE DAMAGE CLAIMS.** (1) EXCEPT FOR PROVIDERS WHO ARE PREPAID OR AGREE TO A DIFFERENT PAYMENT SCHEDULE, AN INSURER SHALL MAKE AN OFFER TO PAY OR SHALL PAY ALL APPROVED CLAIMS FOR COVERED SERVICES OR DAMAGES THAT SOLELY INVOLVE THE RECOVERY OF PROPERTY DAMAGES IN AN AMOUNT OF $2,500 OR LESS ARISING OUT OF THE OWNERSHIP, MAINTENANCE, OR USE OF A MOTOR VEHICLE WITHIN 30 WORKING DAYS OF RECEIPT OF A PROOF OF LOSS THAT IS CORRECTLY COMPLETED AND SUBMITTED TO THE INSURER.

(2) SUBSECTION (1) DOES NOT APPLY TO AN INSURER WHO HAS NOTIFIED THE INSURED OR THE INSURED'S ASSIGNEE OF THE REASONS FOR THE INSURER'S FAILURE TO PAY THE CLAIM IN FULL OR TO AN INSURER THAT HAS MADE A REASONABLE REQUEST FOR ADDITIONAL INFORMATION OR DOCUMENTS.

NEW SECTION. **SECTION 5. CODIFICATION INSTRUCTION.** [SECTION 4] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 18, AND THE PROVISIONS OF TITLE 33, CHAPTER 18, APPLY TO [SECTION 4].

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