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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1251 Session of 2009

INTRODUCED BY D. COSTA, BARRAR, BRADFORD, BRENNAN, CALTAGIRONE, CASORIO, COHEN, CONKLIN, DEASY, DeLUCA, FREEMAN, GEORGE, GOODMAN, GRUCELA, HALUSKA, HARKINS, HENNESSEY, JOSEPHS, MAHONEY, MANN, MELIO, M. O'BRIEN, PASHINSKI, READSHAW, SIPTROTH, K. SMITH, SOLOBAY, J. TAYLOR, VULAKOVICH, WALKO, BELFANTI, FRANKEL, SEIP AND KORTZ, APRIL 13, 2009

AS RE-REPORTED FROM COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES, AS AMENDED, FEBRUARY 8, 2010

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," in long-term care, further providing for definitions; and providing for appealing an insurer's determination the benefit trigger is not met, for prompt payment of clean claims and for applicability.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The definition of "long-term care insurance" in section 1103 of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, amended July 17, 2007 (P.L.134, No.40) is amended and the section is amended by adding definitions to read:

Section 1103. Definitions.--As used in this article, the following words and phrases shall have the meanings given to them in this section:

* * *

"Benefit trigger." A contractual provision in the insured's policy of long-term care insurance conditioning the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. For the purposes of a qualified long-term care insurance contract as defined in section 7702B of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 7702B), the term shall include a determination by a licensed health care practitioner the insured is a chronically ill individual.

* * *

"Independent review organization." An organization that conducts independent reviews of long-term care benefit trigger decisions.

"Long-term care insurance." Any insurance policy or rider advertised, marketed, offered or designed to provide comprehensive coverage for each covered person on an expense-incurred, indemnity, prepaid or other basis for functionally necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. The term includes a policy, rider or prepaid home health or personal care service policy [which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity]. The term includes group and individual policies or riders issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service

corporations, health maintenance organizations or similar organizations. The term does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage or limited benefit health coverage.

* * *

Section 2. The act is amended by adding sections to read:

Section 1111.1. Appealing An Insurer's Determination the Benefit Trigger Is Not Met.--(a) An authorized representative is authorized to act as the covered person's personal representative within the meaning of 45 CFR § 164.502(g) (relating to uses and disclosures of protected health information: general rules) promulgated under the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936) and means the following:

(1) a person to whom a covered person has given express written consent to represent the covered person in an external review;

(2) a person authorized by law to provide substituted consent for a covered person; or

(3) a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

(b) If an insurer determines the benefit trigger of a long-term care insurance policy has not been met, it shall provide a

clear, written notice to the insured and the insured's authorized representative, if applicable, of the following:

(1) The reason the insurer determined the insured's benefit trigger has not been met.

(2) The insured's right to internal appeal under subsection (c) and the right to submit new or additional information relating to the benefit trigger denial with the appeal request.

(3) The insured's right to have the benefit trigger determination reviewed under the independent review process under subsection (d) after the exhaustion of the insurer's internal appeal process.

(c) The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with ANY ←
additional supporting information, within one hundred twenty (120) calendar days after the insured and the insured's authorized representative, if applicable, received the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer provided the individual making the internal appeal decision may not be the same individual who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within thirty (30) calendar days of the insurer's receipt of the necessary information upon which a final determination can be made ~~and the following shall apply~~: ← ←

(1) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe ~~the~~ additional internal appeal rights offered by ←

the insurer. Nothing in this section shall require the insurer to offer internal appeal rights other than those described in this subsection.

(2) If the insurer's original determination is upheld after the internal appeal process has been exhausted and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in subsection (d) to the insured and the insured's authorized representative, if applicable.

(3) As part of the written description of the insured's right to request an independent review, an insurer shall include the following or substantially equivalent language:

We have determined that the benefit eligibility criteria ("benefit trigger") of your (policy) (certificate) has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at (address). You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance department's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review

organizations for you and refer the request for independent review to it.

(4) If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured, the insured's authorized representative, if applicable, and the department in writing and include in the notice the reasons for its determination of independent review ineligibility.

(5) The appeal process described in this subsection does not include a notice requirement as to the availability of new long-term care services or providers.

(d) (1) The insured or the insured's authorized representative may request an independent review of the insurer's benefit trigger determination after the internal appeal process outlined in subsection (c) has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the insurer within one hundred twenty (120) calendar days after the insurer's written notice of the final internal appeal decision is received by the insured and the insured's authorized representative, if applicable.

(2) The cost of the independent review shall be borne by the insurer.

(3) (i) Within five (5) business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization the insured or the insured's authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved

independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the Commonwealth. The insurer shall vary its selection of authorized independent review organizations on a rotating basis.

(ii) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

(A) The independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this section.

(B) The independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer.

(C) The review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.

(iii) If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, the information shall first be considered in the internal review process, as set forth in subsection (c).

(A) While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.

(B) The insurer shall complete its review of the information

and provide written notice of the results of the review to the insured and the insured's authorized representative, if applicable, and the independent review organization within five (5) business days of the insurer's receipt of the new or additional information.

(C) If the insurer maintains its denial after such review, the independent review organization shall continue its review and render its decision within the time period specified in subparagraph (ix). If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.

(iv) The insurer shall acknowledge in writing to the insured, the insured's authorized representative, if applicable, and the department the request for independent review has been received, accepted and forwarded to an independent review organization for review. The notice will include the name and address of the independent review organization.

(v) Within five (5) business days of receipt of the request for independent review, the independent review organization assigned under this paragraph shall notify the insured and the insured's authorized representative, if applicable, the insurer and the department it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement the insured or insured's authorized representative may submit in writing to the independent review organization within seven (7) days following the date of receipt of the notice additional information and supporting documentation the independent review organization should consider when conducting its review.

(vi) The independent review organization shall review all of the information and documents received under subparagraph (v) that have been provided to the independent review organization. The independent review organization shall provide copies of the documentation or information provided by the insured or the insured's authorized representative to the insurer for its review if it is not part of the information or documentation submitted by the insurer to the independent review organization. The insurer shall review the information and provide its analysis of the new information under subparagraph (viii).

(vii) The insured or the insured's authorized representative may submit, at any time, new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. The insurer shall consider the information and affirm or overturn its benefit trigger determination. If the insurer affirms its benefit trigger determination, the insurer shall promptly provide the new or additional information to the independent review organization for its review along with the insurer's analysis of the information.

(viii) If the insurer overturns its benefit trigger determination:

(A) The insurer shall provide notice to the independent review organization and the insured, the insured's authorized representative, if applicable, and the commissioner of its decision.

(B) The independent review process shall immediately cease.

(ix) The independent review organization shall provide the insured, the insured's authorized representative, if applicable, the insurer and the department written notice of its decision within thirty (30) calendar days from receipt of the referral

referenced in paragraph (3)(ii). If the independent review organization overturns the insurer's decision, it shall:

(A) Establish the precise date within the specific period of time under review the benefit trigger was deemed to have been met.

(B) Specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met.

(C) For qualified long-term care insurance contracts, provide a certification the insured is a chronically ill individual. The certification shall be made only by a licensed health care practitioner as defined in section 7702B(c)(4) of the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C. § 7702B(c)(4)).

(x) The decision of the independent review organization regarding whether the insured met the benefit trigger shall be subject to appeal to a court of competent jurisdiction within sixty (60) days of receipt of notice of the independent review organization's decision. There shall be a rebuttable presumption in favor of the decision of the independent review organization.

(xi) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions and is intended to be admissible in a proceeding only to the extent it establishes the eligibility of benefits payable.

(xii) Nothing in this section shall restrict the insured's right to submit a new request for benefit trigger determination after the independent review decision, if the independent review organization upholds the insurer's decision.

(xiii) The department shall utilize the criteria established by the National Association of Insurance Commissioners for its guidelines for Long-Term Care Independent Review Entities in certifying entities to review long-term care insurance benefit trigger decisions.

(xiv) The department shall accept another state's certification of an independent review organization, provided the state requires the independent review organization to meet substantially similar qualifications as those established by the National Association of Insurance Commissioners.

(xv) The department shall maintain and periodically update a list of approved independent review organizations.

(e) The department shall certify or approve a qualified long-term care insurance independent review organization, provided the independent review organization demonstrates to the satisfaction of the commissioner that it is unbiased and meets the following qualifications:

(1) Has on staff or contracts with a qualified and licensed health care professional in an appropriate field, such as physical therapy, occupational therapy, neurology, physical medicine or rehabilitation, for determining an insured's functional or cognitive impairment to conduct the review.

(2) Shall not be related to or affiliated with an entity previously providing medical care to the insured.

(3) Utilizes a licensed health care professional who is not an employe of the insurer or related to the insured.

(4) Shall not receive compensation of any type that is dependent on the outcome of the review and shall not utilize a licensed health care professional who receives compensation of any type that is dependent on the outcome of the review.

(5) Is approved or certified by the Commonwealth to conduct the reviews if the Commonwealth requires the approvals or certifications.

(6) Provides a description of the fees to be charged by it for independent reviews of a long-term care insurance benefit trigger decision. The fees shall be reasonable and customary for the type of long-term care insurance benefit trigger decision under review.

(7) Provides the name of the medical director or health care professional responsible for the supervision and oversight of the independent review procedure.

(8) Has on staff or contracts with a licensed health care practitioner as defined under section 7702B(c)(4) of the Internal Revenue Code of 1986 who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

(f) Each certified independent review organization shall comply with the following:

(1) Maintain written documentation establishing the date it receives a request for independent review, the date each review is conducted, the resolution, the date the resolution was communicated to the insurer and the insured, the name and professional status of the reviewer conducting the review in an easily accessible and retrievable format for the year in which it received the information plus two calendar years.

(2) Be able to document measures taken to appropriately safeguard the confidentiality of the records and prevent unauthorized use and disclosures under applicable Federal and State law.

(3) Report annually to the department by June 1 in the

aggregate and for each long-term care insurer the following:

(i) The total number of requests received for independent review of long-term care benefit trigger decisions.

(ii) The total number of reviews conducted and the resolution of the reviews such as the number of reviews that upheld or overturned the long-term care insurer's determination the benefit trigger was not met.

(iii) The number of reviews withdrawn prior to review.

(iv) The percentage of reviews conducted within the prescribed timeframe set forth in subsection (c)(3).

(v) The other information the department may require.

(4) Report immediately to the department a change in its status which would cause it to cease meeting a qualification required of an independent review organization performing independent reviews of long-term care benefit trigger decisions.

(g) Nothing in this section shall limit the ability of an insurer to assert rights an insurer may have under the policy related to:

(1) An insured's misrepresentation.

(2) Changes in the insured's benefit eligibility.

(3) Terms, conditions and exclusions of the policy other than failure to meet the benefit trigger.

(h) The department shall compile and maintain a list of certified, qualified long-term care insurance independent review organizations and shall publish the list on its Internet website and annually in the Pennsylvania Bulletin by July 1.

(i) This section shall not apply to long-term care insurance claims made under a group long-term care insurance policy that is governed by the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829), referred to as ERISA.

Section 1111.2. Prompt Payment of Clean Claims.--(a) Within thirty (30) business days after receipt of a claim for benefits under a long-term care insurance policy or certificate, an insurer shall pay the claim if it is a clean claim or send a written notice acknowledging the date of receipt of the claim and one of the following:

(1) the insurer is declining to pay all or part of the claim and the specific reason for denial; or

(2) additional information is necessary to determine if all or part of the claim is payable and the specific additional information that is necessary.

(b) Within thirty (30) business days after receipt of the requested additional information, an insurer shall pay a claim for benefits under a long-term care insurance policy or certificate if it is a clean claim or send a written notice the insurer is declining to pay all or part of a claim and the specific reason or reasons for denial.

(c) If an insurer fails to comply with subsection (a) or (b), the insurer shall pay interest at the rate of one per centum (1%) per month on the amount of the claim that should have been paid but remains unpaid forty-five (45) business days after the receipt of the claim with respect to subsection (a) or all requested additional information with respect to subsection (b). The interest payable under this subsection shall be included in a late reimbursement without requiring the person who filed the original claim to make an additional claim for the interest.

(d) The provisions of this section shall not apply to where the insurer has reasonable basis supported by specific information the claim was fraudulently submitted.

(e) A violation of section 1111.1 or this section by an insurer if committed flagrantly and in conscious disregard of the provisions of this act or with frequency sufficient to constitute a general business practice shall be considered a violation of the act of July 22, 1974 (P.L.589, No.205), known as the "Unfair Insurance Practices Act." A violation of section 1111.1 or this section is deemed an unfair method of competition and an unfair deceptive act or practice pursuant to the "Unfair Insurance Practices Act."

(f) As used in this section the following words and phrases shall have the meanings given to them in this subsection:

"Claim" means a request for payment of benefits under a policy in effect regardless of whether the benefit claimed is covered under the policy or terms or conditions of the policy have been met.

"Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

Section 3. The provisions of this act shall apply to benefit trigger requests made on or after 60 days after the effective date of this act.

Section 4. This act shall take effect in 60 days.