Senate Bill 88

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires Director of Department of Consumer and Business Services to adopt internal and external review procedures for denial of long term care insurance claims. Requires insurer to notify insured of review procedures. Extends prompt payment requirements and interest on unpaid claims for health benefit plans to long term care insurers.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to long term care insurance; creating new provisions; amending ORS 743.655 and 743.911; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 743.655 is amended to read:

743.655. (1)(a) The Director of the Department of Consumer and Business Services shall adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, program for public understanding, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, underwriting at time of application, requirements for replacement, recurrent conditions and definitions of terms **and that include required procedures for internal and external review of denied claims**.

(b) In adopting rules [*setting standards*] under this section, the Director **of the Department of Consumer and Business Services** must give timely notice to, and shall consider recommendations from the Director of Human Services.

(2) A long term care insurance policy may not:

(a) Be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

(d) Exclude coverage for Alzheimer's disease and related dementias;

(e) Be nonrenewed or otherwise terminated for nonpayment of premiums until 31 days overdue and then only after notice of nonpayment is given the policyholder prior to expiration of the 31 days,

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

except as otherwise provided by rule; or

(f) Be sold to provide less than 24 months' coverage.

(3)(a) A long term care insurance policy or certificate other than a policy or certificate issued to a group described in ORS 743.652 (3)(a), (b) or (c) may not use a definition of "preexisting condition" that is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(b) A long term care insurance policy or certificate other than a policy or certificate thereunder issued to a group described in ORS 743.652 (3)(a), (b) or (c) may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

(c) The Director of the Department of Consumer and Business Services may extend the limitation periods set forth in paragraphs (a) and (b) of this subsection as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, over the 10 years immediately prior to the date of application, and, on the basis of the answers on the application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) of this subsection expires. A long term care insurance policy or certificate may not exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b) of this subsection.

(4) A long term care insurance policy may not be delivered or issued for delivery in this state if the policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium or post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(5)(a) A long term care insurance policy containing post-confinement, post-acute care or recuperative benefits must clearly label in a separate paragraph of the policy or certificate titled "Limitations or Conditions of Eligibility for Benefits" all such limitations or conditions, including any required number of days of confinement.

(b) A long term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

(6) Individual long term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group described in ORS 743.652

(3)(a), the applicant is not satisfied for any reason. This subsection also applies to denials of applications. Any refund must be made within 30 days of the return or denial.

(7)(a)(A) An outline of coverage shall be delivered to a prospective applicant for long term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(B) The Director **of the Department of Consumer and Business Services** by rule must prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(C) In the case of solicitations by an insurance producer, the insurance producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(D) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(E) In the case of a policy issued to a group described in ORS 743.652 (3)(a), an outline of coverage is not required to be delivered as long as the information described in paragraph (b) of this subsection is contained in other materials related to the enrollment. Upon request, these other materials must be made available to the Director **of the Department of Consumer and Business Services**.

(b) The outline of coverage must include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) A statement of the principal exclusions, reductions and limitations contained in the policy;

(C) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(D) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(E) A description of the terms under which the policy or certificate may be returned and premium refunded;

(F) A brief description of the relationship of cost of care and benefits; and

(G) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be qualified long term care insurance as defined in ORS 743.652.

(8) A certificate issued pursuant to a group long term care insurance policy if the policy is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(c) A statement that the group master policy determines governing contractual provisions.

(9) If an application for a long term care insurance policy or certificate is approved, the insurer must deliver the policy or certificate to the applicant no later than 30 days after the date of approval.

(10) At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy that provides long term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer must deliver the policy summary upon the applicant's request, but regardless of request must make delivery not later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary must also include the provisions required in this subsection. The required provision may be incorporated into a basic illus-

tration or into the life insurance policy summary if required by rule. The following provisions must be included in the summary:

(a) An explanation of how the long term care benefit interacts with other components of the policy, including deductions from death benefits;

(b) An illustration of the amount of benefits, the length of benefits and the guaranteed lifetime benefits, if any, for each covered person;

(c) Any exclusions, reductions and limitations on benefits of long term care;

(d) A statement that any long term care inflation protection option required by rule is not available under the policy; and

(e) If applicable to the policy type, the following:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(11) When a long term care benefit that is funded through a life insurance policy by an acceleration of the death benefit is in benefit payment status, the insurer must provide a monthly report to the policyholder. The report must include:

(a) Any long term care benefits paid out during the month;

(b) An explanation of any changes in the policy, such as death benefits or cash values, owing to payment of long term care benefits; and

(c) The amount of long term care benefits existing or remaining.

(12) If a claim under a long term care insurance policy is denied, then not later than the 60th day after the date of a written request by the policyholder or certificate holder, or a **personal or authorized** representative of either, the insurer must:

(a) Provide a written explanation of the reasons for the denial; [*and*]

(b) Make available all information directly related to the denial**; and**

(c) Provide a written explanation in a form approved by the Director of the Department of Consumer and Business Services of the internal and external review procedures for contesting the denial of a claim.

(13) A policy may not be advertised, marketed or offered as long term care or nursing home insurance unless it complies with the provisions of ORS 743.650 to 743.664.

(14) Rules adopted pursuant to ORS 743.650 to 743.664 shall be in accordance with the provisions of ORS chapter 183.

(15) This section is exempt from ORS 743A.001.

SECTION 2. ORS 743.911 is amended to read:

743.911. (1) Except as provided in this subsection, when a **health benefit plan or long term care insurance** claim [*under a health benefit plan*] is submitted to an insurer by a provider on behalf of an [*enrollee*] **insured**, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the [*enrollee*] **insured** and the provider in writing and give the [*enrollee*] **insured** and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.

(2) A contract between an insurer and a provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section and

ORS 743.913 or has the effect of relieving either party of their obligations under this section and ORS 743.913.

(3) An insurer shall establish a method of communicating to providers the procedures and information necessary to complete claim forms. The procedures and information must be reasonably accessible to providers.

(4) This section does not create an assignment of payment to a provider.

(5) Each insurer shall report to the Director of the Department of Consumer and Business Services annually on its compliance under this section according to requirements established by the director.

(6) The director shall adopt by rule a definition of "clean claim" and shall consider the definition of "clean claim" used by the federal Department of Health and Human Services for the payment of Medicare claims.

SECTION 3. The amendments to ORS 743.911 by section 2 of this 2011 Act apply to long term care insurance policies issued or renewed on or after the effective date of this 2011 Act.

SECTION 4. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.
