
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

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

14 prompt payment of clean claims and for applicability.

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

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

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

4 * * *

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

14 * * *

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

17 decisions.

18 "Long-term care insurance." Any insurance policy or rider
19 advertised, marketed, offered or designed to provide
20 comprehensive coverage for each covered person on an expense-
21 incurred, indemnity, prepaid or other basis for functionally
22 necessary or medically necessary diagnostic, preventive,
23 therapeutic, rehabilitative, maintenance or personal care
24 services provided in a setting other than an acute care unit of
25 a hospital. The term includes a policy, rider or prepaid home
26 health or personal care service policy [which provides for
27 payment of benefits based upon cognitive impairment or the loss
28 of functional capacity]. The term includes group and individual
29 policies or riders issued by insurers, fraternal benefit
30 societies, nonprofit health, hospital and medical service
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1 corporations, health maintenance organizations or similar
2 organizations. The term does not include any insurance policy
3 which is offered primarily to provide basic Medicare supplement
4 coverage, basic hospital expense coverage, basic medical-
5 surgical expense coverage, hospital confinement indemnity
6 coverage, major medical expense coverage, disability income
7 protection coverage, accident-only coverage, specified disease
8 or specified accident coverage or limited benefit health
9 coverage.

10 * * *

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

12 Section 1111.1. Appealing An Insurer's Determination the

13 Benefit Trigger Is Not Met.--(a) An authorized representative

14 is authorized to act as the covered person's personal

15 representative within the meaning of 45 CFR § 164.502(g)

16 (relating to uses and disclosures of protected health

17 information: general rules) promulgated under the administrative

18 simplification provisions of the Health Insurance Portability

19 and Accountability Act of 1996 (Public Law 104-191, 110 Stat.

20 1936) and means the following:

21 (1) a person to whom a covered person has given express

22 written consent to represent the covered person in an external

23 review;

24 (2) a person authorized by law to provide substituted

25 consent for a covered person; or

26 (3) a family member of the covered person or the covered

27 person's treating health care professional only when the covered

28 person is unable to provide consent.

29 (b) If an insurer determines the benefit trigger of a long-

30 term care insurance policy has not been met, it shall provide a

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1 clear, written notice to the insured and the insured's

2 authorized representative, if applicable, of the following:

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

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

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

12 (c) The insured or the insured's authorized representative
13 may appeal the insurer's adverse benefit trigger determination
14 by sending a written request to the insurer, along with ANY <--
15 additional supporting information, within one hundred twenty
16 (120) calendar days after the insured and the insured's
17 authorized representative, if applicable, received the insurer's
18 benefit determination notice. The internal appeal shall be
19 considered by an individual or group of individuals designated
20 by the insurer provided the individual making the internal
21 appeal decision may not be the same individual who made the
22 initial benefit determination. The internal appeal shall be
23 completed and written notice of the internal appeal decision
24 shall be sent to the insured and the insured's authorized
25 representative, if applicable, within thirty (30) calendar days
26 of the insurer's receipt of the necessary information upon which

27 a final determination can be made and the following shall apply: <--

28 (1) If the insurer's original determination is upheld upon
29 internal appeal, the notice of the internal appeal decision
30 shall describe the additional internal appeal rights offered by <--
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1 the insurer. Nothing in this section shall require the insurer
2 to offer internal appeal rights other than those described in
3 this subsection.

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

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

14 We have determined that the benefit eligibility criteria
15 ("benefit trigger") of your (policy) (certificate) has not
16 been met. You may have the right to an independent review of
17 our decision conducted by long-term care professionals who
18 are not associated with us. Please send a written request for
19 independent review to us at (address). You must inform us, in
20 writing, of your election to have this decision reviewed

21 within 120 days of receipt of this letter. Listed below are
22 the names and contact information of the independent review
23 organizations approved or certified by your state insurance
24 department's office to conduct long-term care insurance
25 benefit eligibility reviews. If you wish to request an
26 independent review, please choose one of the listed
27 organizations and include its name with your request for
28 independent review. If you elect independent review, but do
29 not choose an independent review organization with your
30 request, we will choose one of the independent review

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

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

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

12 (d) (1) The insured or the insured's authorized
13 representative may request an independent review of the

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

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

24 (3) (i) Within five (5) business days of receiving a
25 written request for independent review, the insurer shall refer
26 the request to the independent review organization the insured
27 or the insured's authorized representative has chosen from the
28 list of certified or approved organizations the insurer has
29 provided to the insured. If the insured or the insured's
30 authorized representative does not choose an approved
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1 independent review organization to perform the review, the
2 insurer shall choose an independent review organization approved
3 or certified by the Commonwealth. The insurer shall vary its
4 selection of authorized independent review organizations on a
5 rotating basis.

6 (ii) The insurer shall refer the request for independent

7 review of a benefit trigger determination to an independent
8 review organization, subject to the following:

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

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

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

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

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

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

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

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

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

18 (v) Within five (5) business days of receipt of the request
19 for independent review, the independent review organization
20 assigned under this paragraph shall notify the insured and the
21 insured's authorized representative, if applicable, the insurer
22 and the department it has accepted the independent review
23 request and identify the type of licensed health care
24 professional assigned to the review. The assigned independent

25 review organization shall include in the notice a statement the
26 insured or insured's authorized representative may submit in
27 writing to the independent review organization within seven (7)
28 days following the date of receipt of the notice additional
29 information and supporting documentation the independent review
30 organization should consider when conducting its review.

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

11 (vii) The insured or the insured's authorized representative
12 may submit, at any time, new or additional information not
13 previously provided to the insurer but pertinent to the benefit
14 trigger denial. The insurer shall consider the information and
15 affirm or overturn its benefit trigger determination. If the
16 insurer affirms its benefit trigger determination, the insurer
17 shall promptly provide the new or additional information to the

18 independent review organization for its review along with the
19 insurer's analysis of the information.

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

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

26 (B) The independent review process shall immediately cease.

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

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

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

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

10 (C) For qualified long-term care insurance contracts,

11 provide a certification the insured is a chronically ill
12 individual. The certification shall be made only by a licensed
13 health care practitioner as defined in section 7702B(c)(4) of
14 the Internal Revenue Code of 1986 (Public Law 99-514, 26 U.S.C.
15 § 7702B(c)(4)).

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

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

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

1 (xiii) The department shall utilize the criteria established
2 by the National Association of Insurance Commissioners for its
3 guidelines for Long-Term Care Independent Review Entities in

4 certifying entities to review long-term care insurance benefit
5 trigger decisions.

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

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

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

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

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

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

27 (4) Shall not receive compensation of any type that is

28 dependent on the outcome of the review and shall not utilize a
29 licensed health care professional who receives compensation of
30 any type that is dependent on the outcome of the review.

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

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

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

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

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

19 (1) Maintain written documentation establishing the date it
20 receives a request for independent review, the date each review

21 is conducted, the resolution, the date the resolution was
22 communicated to the insurer and the insured, the name and
23 professional status of the reviewer conducting the review in an
24 easily accessible and retrievable format for the year in which
25 it received the information plus two calendar years.

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

30 (3) Report annually to the department by June 1 in the
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1 aggregate and for each long-term care insurer the following:

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

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

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

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

11 (v) The other information the department may require.

12 (4) Report immediately to the department a change in its
13 status which would cause it to cease meeting a qualification

14 required of an independent review organization performing
15 independent reviews of long-term care benefit trigger decisions.

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

19 (1) An insured's misrepresentation.

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

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

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

27 (i) This section shall not apply to long-term care insurance
28 claims made under a group long-term care insurance policy that
29 is governed by the Employee Retirement Income Security Act of
30 1974 (Public Law 93-406, 88 Stat. 829), referred to as ERISA.

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

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

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

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

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

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

1 (e) A violation of section 1111.1 or this section by an
2 insurer if committed flagrantly and in conscious disregard of
3 the provisions of this act or with frequency sufficient to
4 constitute a general business practice shall be considered a
5 violation of the act of July 22, 1974 (P.L.589, No.205), known
6 as the "Unfair Insurance Practices Act." A violation of section
7 1111.1 or this section is deemed an unfair method of competition
8 and an unfair deceptive act or practice pursuant to the "Unfair
9 Insurance Practices Act."

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

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

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

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

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

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