Title 210 - NEBRASKA DEPARTMENT OF INSURANCE

Chapter 61 - UNFAIR LIFE, SICKNESS AND ACCIDENT CLAIMS SETTLEMENT PRACTICES RULE

001. Authority. This rule is adopted under the authority of the Unfair Insurance Claims Settlement Practices Act, pursuant to Neb.Rev.Stat. §§44-1536 through 44-1544.

002. Purpose. This rule sets forth minimum standards for the investigation and disposition of life, sickness and accident claims occurring in the State of Nebraska and arising under insurance policies or certificates which, if violated with such frequency as to indicate a general business practice or is committed flagrantly and in conscious disregard would constitute a violation of the Unfair Insurance Claims Settlement Practices Act and any rule or regulation promulgated thereunder. Various provisions of this rule are intended to define procedures and practices which constitute unfair insurance claims practices. This rule is not exclusive and other acts, not herein specified, may also be found to constitute such practices.

Nothing herein shall be construed to create nor imply a private cause of action for violation of this rule. This is merely a clarification of original intent and does to indicate any change of position.

003. Definitions. All definitions contained in the Unfair Insurance Claims Settlement Practices Act are hereby incorporated by reference. As otherwise used in this regulation:

003.01 "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

003.02 "Beneficiary" means a party entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured but shall not include a medical services provider receiving an assignment of proceeds;

003.03 "Claim file" means any retrievable electronic file, microfilm/microfiche file, paper file, or any combination thereof;

003.04 "Claimant" means an insured, or the beneficiary and includes a designated legal representative or a member of the insured’s immediate family as designated by the insured, making a claim under a policy.

003.05 "Days" means working days;

003.06 "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

003.07 "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or certificate;

003.08 "Notification of claim" means any notification by a claimant, whether in writing or by other means acceptable under the terms of an insurance policy or certificate, to an insurer or its agent which reasonably apprises the insurer of the facts pertinent to a claim;

003.09 "Proof of loss" means written proofs, such as claim forms, medical bills, or other reasonable evidence of the claim that is ordinarily required of persons submitting the claim(s);

003.10 "Reasonable explanation" means information reasonably sufficient to enable the insured or beneficiary to compare the allowable benefits with policy or certificate provisions and determine whether proper payment has been made;

003.11 "Written communications" includes all correspondence, regardless of source or type, that is related to the handling of the claim. Written communications shall be effectively communicated when placed in the mail with adequate first class postage.

004. File and record documentation. Each insurer's claim files are subject to examination by the Director or by the Director's duly appointed designees. To aid in such examination:

004.01 The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed files for the current year and the two preceding years.

004.02 Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

004.03 Each relevant document within the claim file shall be noted as to date received, date processed or date mailed.

004.04 For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT), Video Display Terminal (VDT) or micrographics and be capable of duplication to hard copy.

005. Misrepresentation of policy provisions.

005.01 Not agent or insurer shall knowingly misrepresent or conceal from claimants, any pertinent benefits, coverages, or other provisions of any insurance policy or certificate when such benefits, coverages or other provisions are pertinent to a claim.

005.02 No insurer shall indicate to a claimant on a payment draft, check or in any accompanying letter that said payment is "final" or is "a release" of any claim(s) unless such is the case, or the policy limit has been paid, or there has been a compromise settlement agreed to by the claimant and the insurer as to coverage and amount payable under the insurance policy or certificate.

005.03 No insurer shall issue checks or drafts in partial settlement of a claim under a specific coverage that contains language purporting to release the insurer from total liability.

006. Failure to acknowledge pertinent communications.

006.01 Every insurer shall, within fifteen (15) days of receipt, acknowledge and respond to any written communication relating to a claim and to all other pertinent communications from a claimant which reasonably suggest that a response is expected. Communication to an agent of an insurer shall be communication to the insurer.

006.02 Every insurer, upon receipt of any inquiry from the Director respecting a claim shall furnish the Department, in duplicate, an adequate response to the inquiry or request additional reasonable time to respond within fifteen (15) days of receipt of such inquiry.

006.03 Every insurer, upon receiving notification of claim, shall provide, within fifteen (15) days, the necessary claim forms, instructions and reasonable assistance so the insured can comply with the insurer's reasonable requirements and also comply with the policy conditions. Compliance with this paragraph shall constitute compliance with Subsection 006.01.

007. Standards for the prompt investigation of claims.

007.01 Every insurer shall, within fifteen (15) days of receipt of proof of loss from a claimant, initiate investigation of the claim.

007.02 The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under

similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability.

008. Standards for prompt, fair and equitable settlements.

008.01 When a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) days of the determination. No insurer shall deny a claim, or portion thereof, on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given in writing, with reasonable and accurate explanation. The claim file of the insurer shall contain documentation of the denial as required by Section 004.

008.02 If a claim remains unresolved for fifteen (15) days from the date proof of loss is received, the insurer shall provide the insured a reasonable written explanation for delay. If the investigation remains incomplete, the insurer shall, thirty (30) days from the date of initial notification the claim is unresolved and every thirty (30) days thereafter, send to the insured a reasonable written explanation setting forth the reasons additional time is needed for investigation.

008.03 The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within fifteen (15) days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved or portions of the claim are in dispute, payments to a known payee which are not in dispute should be tendered within fifteen (15) days after receipt by the insurer of settlement information if such payment would terminate the insurer's known liability under that individual coverage or portion of the claim which was not in dispute. This is notwithstanding the existence of disputes as to other portions of coverage.

008.04 With each claim payment, the insurer shall provide to the insured an Explanation of Benefits that shall include, if applicable, the name of the provider or services covered, amount charged, dates of service, and a reasonable explanation of the computation of benefits.

008.05 An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for pre-certification and/or concurrent review unless such penalty is specifically and clearly set forth in the policy.

008.06 No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

008.07 Insurers offering cash settlements of first party long-term disability income claims, except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability, shall develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies such as mortality, morbidity, and interest rates assumptions, etc. appropriate to the risk. A copy of the amount so calculated shall be given to and attested to by the insured at settlement time.

008.08 If, after an insurer rejects a claim or portion thereof, the claimant objects to such rejection and the rejection is maintained, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the Nebraska Department of Insurance, and the insurer shall provide the claimant with the Department's address and phone number.

009. Standards for overpayment recovery.

009.01 No insurer shall withhold any portion of any benefit payable, on the basis that the sum withheld is an adjustment or correction of an overpayment made on a prior claim arising under the same policy unless:

009.01(A) The insurer has within its files clear, documented evidence of an overpayment and written authorization from the claimant permitting such withholding procedure, or

009.01(B) The insurer has within its files clear, documented evidence that:

009.01(B)(1) The overpayment was clearly erroneous under the provisions of the policy. If the overpayment is the subject of a reasonable dispute as to facts, this procedure may not be used; and

009.01(B)(2) The error which resulted in the overpayment is not a mistake of law; and

009.01(B)(3) The insurer has notified the claimant within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants, the insurer notifies the claimant within fifteen (15) days after the date that clear, documented evidence of discovery of such error is included in its file; and

009.01(B)(4) Such notice states clearly the nature of the error, the amount of the overpayment, and the three year limitation as provided in subsection 009.01(C).

009.01(C) An insurer may use the procedure set forth in Section 009.01(B) provided that the claim used to adjust the first overpayment is made no later than three years after the date of the error.

009.01(D) For the purpose of Section 009, the date of the error shall be the day on which the draft for benefits is issued.

010. Severability. If any section or portion of this Rule of the application thereof to any person or circumstance is held invalid by a court, the remainder of the rule shall not be affected thereby.

011. Effective date. This rule shall become operative on September 1, 1992.