§2436. Interest on overdue payments

1. A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue. If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim is not overdue until 30 days following receipt by the insurer of the additional required information; except that:

A. The time period applicable to a standard fire policy and to that portion of a policy providing a combination of coverages, as described in section 3003, insuring against the peril of fire must be 60 days, as provided in section 3002; and [PL 2009, c. 244, Pt. H, §1 (NEW).]

B. The time period applicable to individual life insurance must be 2 months as provided in section 2513. [PL 2009, c. 244, Pt. H, §1 (NEW).]

[PL 2009, c. 244, Pt. H, §1 (AMD).]

1-A. A claimant, including a health care provider, may submit simultaneously a claim for payment with all carriers potentially liable for payment of the claim whether primary or secondary. Payment or denial of a claim by each carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim whether or not another carrier with which it is attempting to coordinate has acted on the claim. Any payment made must be in accordance with rules adopted by the superintendent relative to coordination of benefits.

[PL 2005, c. 58, §1 (NEW).]

2. An insurer may dispute a claim by furnishing to the insured or beneficiary, or a representative of the insured or beneficiary, a written statement that the claim is disputed with a statement of the grounds upon which it is disputed. The statement must be based upon a reasonable investigation of the claim and must include sufficient detail to permit the insured or beneficiary to understand and respond to the insurer's position. For purposes of this subsection, a claim for payments under a policy or certificate providing health care coverage is disputed if the insurer has denied the claim or has requested further information that is consistent with Bureau of Insurance Rule Chapter 850.

[PL 1999, c. 256, Pt. I, §1 (AMD).]

2-A. For a claim submitted by a health care provider or health care facility with respect to a health plan as defined in section 4301-A, subsection 7, for purposes of this section, "undisputed claim" means a timely claim for payment of covered health care expenses that is submitted to a carrier in conformity with the following requirements.

A. The claim must be submitted on one of the following claims forms:

(1) For a health care facility claim submitted on paper, the standard claim form, using standards approved by a national uniform billing committee;

(2) For a health care provider claim submitted on paper, the standard claim form, using standards approved by a national uniform claim committee; and

(3) For health care facility and health care provider claims submitted electronically, an electronic form using standards approved by an accredited standards committee of the American National Standards Institute. [PL 2009, c. 613, §9 (NEW).]

[PL 2009, c. 613, §9 (RPR).]

2-B. If a claim does not conform to the requirements specified in subsection 2-A and payment is denied to a health care provider or health care facility by a carrier, the health care provider or health

care facility may not request payment from the insured or beneficiary and shall attempt to rectify the deficiencies with the claim and resubmit the claim to the carrier.
[PL 2009, c. 613, §10 (NEW).]

3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date. Notwithstanding this subsection, the superintendent shall adopt rules that establish a minimum amount of interest payable on an overdue undisputed claim to a health care provider before a payment must be issued. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2005, c. 50, §1 (AMD).]

4. A reasonable attorney's fee for advising and representing a claimant on an overdue claim or action for an overdue claim must be paid by the insurer if overdue benefits are recovered in an action against the insurer or if overdue benefits are paid after receipt of notice of the attorney's representation.
[PL 1999, c. 256, Pt. I, §1 (AMD).]

5. Nothing in this section prohibits or limits any claim or action for a claim that the claimant has against the insurer.
[PL 1999, c. 256, Pt. I, §1 (AMD).]

6. This section does not apply to a claim for payment of benefits under a policy or certificate of long-term care insurance delivered or issued for delivery in this State.
[PL 2013, c. 278, §1 (NEW).]

SECTION HISTORY

PL 1973, c. 480 (NEW). PL 1975, c. 157 (AMD). PL 1975, c. 321 (AMD). PL 1977, c. 357 (RPR). PL 1987, c. 344 (RPR). PL 1999, c. 256, §I1 (AMD). PL 2001, c. 569, §1 (AMD). PL 2003, c. 218, §§3, 4 (AMD). PL 2003, c. 469, Pt. D, §4 (AMD). PL 2003, c. 469, Pt. D, §9 (AFF). PL 2005, c. 50, §1 (AMD). PL 2005, c. 58, §1 (AMD). PL 2009, c. 244, Pt. H, §1 (AMD). PL 2009, c. 613, §§9, 10 (AMD). PL 2013, c. 278, §1 (AMD).