BEFORE THE COMMISSIONER OF INSURANCE
OF THE STATE OF KANSAS

In the Matter of **KANSAS HEALTH** **INSURANCE ASSOCIATION**	)))	Docket No. 3798-MC

ORDER

Pursuant to the authority conferred upon the Commissioner of Insurance by K.S.A. §40-222, Sandy Praeger, the duly elected, qualified and service Commissioner of Insurance hereby adopts the Kansas Insurance Department's Report of Market Conduct Examination of the Kansas Health Insurance Association, as of December 30, 2006 (Attached herein as Attachment A) by incorporating the same in its entirety with specific findings stated below. This Order shall become effective as a Final Order, without further notice, upon the expiration of the fifteen (15) day period if no request for hearing is made, pursuant to K.S.A. 77-542.

Policy Reasons

It is the stated policy of the State of Kansas that whenever the Commissioner of Insurance deems it necessary, an examination of the affairs and financial condition of any insurance company in the process of organization, applying for admission, or doing business in the State of Kansas can be undertaken. In all cases, such an examination must occur once every five years. Through the examination process, the insurance consuming public will be served and protected.

Findings of Fact

1. The Commissioner of Insurance ("Commissioner") has jurisdiction over this matter pursuant to K.S.A. §40-222.
2. The Kansas Insurance Department ("KID") performed a targeted market conduct examination on Kansas Health Insurance Association ("KHIA") operations and

management, complaint handling, grievance procedures, TPA contracts, utilization review and claims processing from January 1, 2005 – December 31, 2006 to determine compliance with applicable statutes, regulations and bulletins of the State of Kansas.

3. On October 23, 2007, the Examiner-in-Charge provided KHIA with a draft of the Market Conduct Examination conducted by KID with request to KHIA to respond in the form of written comments, additions, or acceptance by November 26, 2007.

4. KHIA timely responded with written comments regarding the draft report on November 20, 2007 which is attached herein as Attachment B.

5. The Commissioner has since fully reviewed said Kansas report which is adopted herein as Attachment A.

Applicable Law

6. K.S.A. §40-222 states, in pertinent part:

   (a) Whenever the commissioner of insurance deems it necessary but at least once every five years, the commissioner may make, or direct to be made, an examination of the affairs and financial condition of any insurance company in the process of organization, or applying for admission or doing business in this state.

   (b) Also See K.S.A. §40-222(b) through (k)

Conclusions of Law

Based on the Findings of Fact enumerated in Paragraphs #1 through #5 and the Applicable Law above:

IT IS THEREFORE ORDERED BY THE COMMISSIONER OF INSURANCE THAT:

7. The Kansas Insurance Department's Report of Market Conduct Examination of Kansas Health Insurance Association as of December 30, 2006, is herein adopted in its entirety.

8. The Commissioner shall retain jurisdiction over this matter to issue any further Order(s) deemed appropriate or to take any further action deemed necessary.

Notice of Rights

Kansas Health Insurance Association ("KHIA") is entitled to a hearing pursuant to K.S.A. §77-537, the Kansas Administrative Procedure Act. If KHIA desires a hearing, it must file a written request for a hearing with:

John W. Campbell, General Counsel
Kansas Insurance Department
420 S.W. 9th Street
Topeka, Kansas 66612

This request must be filed within fifteen (15) days from the date of service of this Order. If KHIA requests a hearing, the Kansas Insurance Department will notify KHIA of the time and place of the hearing and information on the procedures, right of representation, and other rights of parties relating to the conduct of the hearing, before commencement of the same.

If a hearing is not requested in the time and manner stated above, this Order shall become effective as a Final Order upon the expiration of time for requesting a hearing, pursuant to K.S.A. §77-613. In the event KHIA files a Petition for Judicial Review, pursuant to K.S.A. §77-613(e), the agency officer to be served on behalf of the Kansas Insurance Department is:

John W. Campbell, General Counsel
Kansas Insurance Department
420 S.W. 9th Street
Topeka, Kansas

IT IS SO ORDERED THIS 4th DAY OF March, 2008, IN THE CITY OF TOPEKA, COUNTY OF SHAWNEE, STATE OF KANSAS.

Sandy Praeger
Commissioner of Insurance

BY:

John W. Campbell
General Counsel

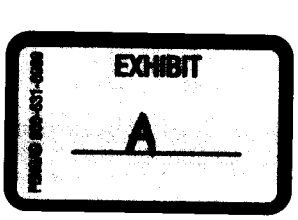
In the Matter of the
Kansas Health Insurance Association
3798-MC

Certificate of Service

The undersigned hereby certifies that above and foregoing **Order** was served via the United States Postal Service, first-class postage prepaid, on this 4th day of March, 2008, addressed to the following:

Mr. Ed Fonner, Executive Director
Kansas Health Insurance Association
c/o 14808 West 81st Place
Lenexa, KS 66215

Zachary J.C. Anshutz
Staff Attorney



REPORT OF MARKET CONDUCT EXAMINATION

KANSAS HEALTH INSURANCE ASSOCIATION
TOPEKA, KS

AS OF

DECEMBER 30, 2006

BY

KANSAS INSURANCE DEPARTMENT

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Honorable Sandy Praeger
Insurance Commissioner
Kansas Insurance Department
420 SW Ninth Street
Topeka, KS 66612-1678

Dear Commissioner Praeger:

In accordance with your respective authorization, and pursuant to K.S.A. 40-222, a market conduct examination has been conducted on the business affairs of:

Kansas Health Insurance Association
Topeka, KS

Hereafter referred to as KHIA or the "Plan", and the following report of such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM
Market Conduct Supervisor

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of the Kansas Health Insurance Plan (KHIA) operations and management, complaint handling, grievance procedures, TPA contracts, utilization review and claims processing from January 1, 2005 – December 31, 2006, to determine compliance with applicable statutes, regulations and bulletins of the state of Kansas.

The examination was conducted utilizing the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2006 (Handbook). The exam team selected 343 claim files and 35 complaint files to verify the Plan's procedures and practices. An acceptable tolerance standard as stated in the Handbook of 7% was used for claims and 10% was used for complaints. The report is written by test rather than by exception which means all standard tests are described and all results are reported.

The examination included, but was not **limited to the following:**

KHIA Operations and Management
TPA Contracts
Complaint Handling
Claims
Grievance Procedures
Utilization Review

EXECUTIVE SUMMARY

The Kansas Insurance Department (KID) performed a targeted market conduct examination of the Kansas Health Insurance Association (KHIA) claims and complaints from January 1, 2005 – December 31, 2006. The report is written by test and violations are listed within each category.

Although Kansas statutes do not require such an examination, KHIA requested this review as a means to determine its performance in serving its members. KID agrees with KHIA that a periodic review of the claims handled by this high-risk pool is in the best interests of Kansas citizens and policyholders. The examination was conducted utilizing the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2006 (Handbook) and K.S.A. 40-222. This examination differed from financial audits conducted in past years by the Kansas Insurance Department Financial Surveillance Division. While those audits reviewed the financial stability and accounting standards employed by the Association, the Market Conduct Exam reviewed the Association's claims processing, complaint handling, appeals and grievance processing and contracting for administrative duties.

KHIA employs a third party administrator (TPA) to perform typical services including: determine eligibility of applicants; process claims and appeals; maintain a billing procedure for premiums; maintain records covering claims and payments disbursed; provide customer service on claims and appeals; and report performance standards to the Board. An actuary is employed to assist with the development of premiums and plan benefits.

The Association passed most tests, and in terms of delivering good service to its insureds, the examiners note an overall positive and professional performance exhibited by the TPA staff and the KHIA Board and staff. However, the exam team made recommendations on the following issue:

MARKET CONDUCT RECOMMENDATIONS

TPA Performance Standards

The examiners recommend that all the criteria be spelled out in detail in this document or in the "KHIA Performance Standards Rule Sets" and include: a) definition of the starting date/time of a claim, e.g. electronic date stamp when received, not when received at a particular desk or by a particular person; b) deadlines as set in K.S.A. 40-2442(a) and (b) for clean claims and K.A.R. 40-1-34 for claims over 30 days; and c) details needed to interpret the report such as number of claims received that were clean and number of clean claims paid within 30 days during the reporting month.

Complaint Handling

Develop a more formalized procedure to track complaint files and to keep the claim information with the complaint file. While the examiners were on-site, a change in personnel created new supervisory and management duties within the complaint and claims areas. It appears these new supervisors recognize the need and such revisions are underway.

The specific areas the examiners recommend are:
a. Provide a system to record all KID and direct complaints in one central register as soon as they are received;
b. Maintain a central location for complaint files or develop a system that keeps the claim information with the complaint file;

Claim Handling

1. Conduct a current analysis to assure that claims processing timelines have improved during 2007.

2. Conduct a file review to assure that recent changes in claims processing have occurred, especially:
   a. letters acknowledging acceptance or denial of a claim is sent within 15 working days after receipt of properly executed proof of loss; (if not paid)
   b. claim investigations are completed within 30 days; and
   c. letters notifying claimants with reasons why more time is needed to conduct an investigation are sent within 15 working days after receiving properly executed proof of loss and every 45 days thereafter until the investigation is complete.

DESK EXAMINATION/ON-SITE EXAMINATION

PURPOSE AND SCOPE OF REVIEW

Although Kansas statutes do not require such an examination, KHIA requested this review as a means to determine its performance in serving its members. KID agrees with KHIA that a periodic review of the claims handled by this high-risk pool is in the best interests of Kansas citizens and policyholders. The examination was conducted utilizing the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2006 (Handbook) and K.S.A. 40-222. This examination differed from financial audits conducted in past years by the Kansas Insurance Department Financial Surveillance Division. While those audits reviewed the financial stability and accounting standards employed by the Association, the Market Conduct Exam reviewed the Association's claims processing, complaint handling, appeals and grievance processing and contracting for administrative duties.

The Kansas Insurance Department (KID) performed a targeted market conduct examination of the Kansas Health Insurance Association (KHIA) claims and complaints from January 1, 2005 – December 31, 2006. The report is written by test and violations are listed within each category.

OPERATIONS/MANAGEMENT

Tests for Operations Management

GENERAL EXAMINATION STANDARDS

Standard 1. Claim records are adequate, accessible, consistent and orderly and comply with state record retention requirements.

Claim records were available during the examination and are kept electronically both onsite and offsite. All records requested were available and provided.

The Association passed Standard 1.

Standard 2. TPA is licensed as a TPA in Kansas for the time under review.

The third party administrator has met the requirements to conduct TPA duties within the state of Kansas.

The Association passed Standard 2.

Standard 3. The TPA cooperates on a timely basis with examiners performing the examinations.

Generally, responses were timely but access to electronic files was delayed for a few days due to a claim system failure. New hardware and software installations delayed the exam timelines. Disaster recovery procedures were implemented and consumer representatives informed callers of potential delays and answered questions per normal procedures.

The Association passed Standard 3.

CONTRACTS AND WRITTEN AGREEMENTS
Tests for Contracts and Written Agreements

TPA EXAMINATION STANDARDS

Standard 1. Verify written agreement(s) are executed between the TPA and KHIA pertinent to the claim handling of KHIA.

A written Administrative Agreement with Exhibits and a Schedule of Fees was entered into on January 1, 2006 and will end as of midnight December 31, 2008.

The Association passed Standard 1.

Standard 2. The written agreement includes a statement of duties the TPA is expected to perform on behalf of the insurer or regulated, risk-bearing entity subject to the jurisdiction of the Department of Insurance and the lines, classes or types of insurance for which the TPA is authorized to administer.

The general administrative duties of the TPA regarding claims administration and payment of claims are stated in the Agreement. One exhibit enumerates the details required to handle claims, applications, premiums, internal audits, quarterly and annual reports, document storage and plan booklets and other consumer materials. The TPA is expected to implement the Action Plan for the Pool as detailed in another exhibit.

These duties also involve meeting with the Executive Director of the Pool, maintaining a payment fund, reviewing requests and appeals for denied claims and communicating with the Kansas Insurance Department on inquiries and complaints.

The measurement of performance standards is reported quarterly to the Board by the TPA and further documentation can be requested. Although the performance standards are clearly stated, it appears that the measurement criteria are left to the discretion of the TPA.

The examiners recommend that all the criteria be spelled out in detail in this document or in the "KHIA Performance Standards Rule Sets" and include: a) definition of the starting date/time of a claim, e.g. electronic date stamp when received, not when received at a particular desk or by a particular person; b) deadlines as set in K.S.A. 40-2442(a) and (b) for clean claims and K.A.R. 40-1-34 for claims over 30 days; and c) details needed to interpret the report such as number of claims received that were clean and number of clean claims paid within 30 days during the reporting month.

Other NAIC standards were contained within the TPA agreement, schedules and exhibits. Fees paid to the TPA are based upon services provided, not savings from claims settlements.

The Association passed Standard 2.

Standard 3. The TPA provides required written notices (approved by the client, applicable insurer or other related entity) to covered individuals in accordance with applicable statutes, rules and regulations pertinent to the claim handling process.

All written notices reviewed by the examiners for billing premiums, benefit updates, application requirements and pertinent periodic communications to participants were sent within required timelines and with the approval of the Association.

The Association passed Standard 3.

Standard 4. The TPA delivers materials and written communications pertinent to the claim handling process in a timely manner.

Individual requests for benefit schedules, cards, network information, etc. appeared to be met on a timely basis as well as distribution of notices requested by the Association.

The Association passed Standard 4.

Standard 5. Claim transactions are processed accurately and completely by the TPA.

Documentation to support claim payments, claim denials, medical record requests, participant requests and provider records were maintained in a consistent manner and were processed within privacy and confidentiality standards. Claim handling was based on the documentation received and occasionally required repeated requests for this information.

The Association passed Standard 5.

Recommendation:

The examiners recommend that all the criteria be spelled out in detail in this document or in the "KHIA Performance Standards Rule Sets" and include: a) definition of the starting date/time of a claim, e.g. electronic date stamp when received, not when received at a particular desk or by a particular person; b) deadlines as set in K.S.A. 40-2442(a) and (b) for clean claims and K.A.R. 40-1-34 for claims over 30 days; and c) details needed to interpret the report such as number of claims received that were clean and number of clean claims paid within 30 days during the reporting month.

COMPLAINT HANDLING

Complaint Handling Procedures

Complaints are divided into the categories or Claims Department Complaints, Premium Billing & Enrollment Department Complaints and Complaint, Appeals and Grievances for Medical Necessity or Experimental or Investigational Denials. Complaint procedures are carried out by claims processing personnel and management or the premium billing and enrollment personnel and supervisor.

Claims Complaints, Premium Billing & Enrollment Complaints

An examiner determines if claim should be reprocessed or if it was processed correctly according to the Plan Document. All complaint determinations and communications are documented into the Chronolog system. There is an expectation that complaints will be resolved within ten (10) days of receipt of the request and if more time is needed, the complainant shall receive an explanation for the delay.

If a processing error occurred in the original claim, it will be reprocessed and a corrected EOB will serve as the notification to the complainant that the decision was in his/her favor. For Billing Complaints, notification to the complainant will be either verbally or in writing. If the original processing did not contain an error and the original resolution is upheld, a letter is sent to the complainant explaining the reasons(s) for denial and instructions on appeal rights.

The complainant may file an appeal for an upheld denial within sixty (60) days after receiving denial notice.

Tests for Complaint Handling

GENERAL EXAMINATION STANDARDS

Standard 1. All complaints are recorded in the required format on the Association complaint register. K.S.A. 40-2404 (10).

Type	Sample	Errors	%Pass
KID	35	2	96%

The Association passed Standard 1.

Standard 2. The Association has adequate complaint handling procedures in place and communicates such procedures to policyholders. K.A.R. 40-1-34, Sections 5(a) & 6.

The examiners received the complaint handling procedures manual used by the customer service representatives. This document details the procedures to follow in handling various types of complaints and those procedures were followed by the TPA.

Comment: While the complaint log revealed details about the various complaints, it was not always possible to locate the actual files. The complaint files were kept by the last person who worked the file. Therefore, complaint files were not maintained in one central location.

The Association passed Standard 2.

Standard 3. The Association takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations, and contract language. K.A.R. 40-1-34, 4 and 6; K.S.A. 40-2442(a)(b)

Type	Sample	Errors	%Pass
KID	35	4	89%

- Three files did not have sufficient documentation to follow the sequence of events to resolve the complaints per K.A.R. 40-1-34,4.
- One complaint occurred because the original claim was not paid within 30 days per K.S.A. 40-2442(a)

The Association failed Standard 3.

Standard 4. The time frame within which the Association responds to complaints is in accordance with applicable statutes, rules and regulations. K.A.R. 40-1-34, Sections 6 & 8(a)&(c).

Type	Sample	Errors	%Pass
KID	35	1	97%

- One file did not have a response back to KID within 15 working days per K.A.R. 40-34, 6(b).

The Association passed Standard 4.

Recommendation:

The examination team recommends that procedures be written to ensure that all KID and direct complaint files are recorded in one central register as soon as they are received and a system be developed to keep the claim information with the complaint file in one designated area.

UTILIZATION REVIEW

Standard 1. The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

The Association follows URAC and NCQA standards in all utilization procedures and the Quality Assessment Committee reviews these procedures annually. Detailed procedures are in place for prospective, concurrent and retrospective reviews as well as adverse decision and case management programs. These reviews include pre-authorization for hospital admissions, medical necessity for surgical procedures, case management of mental health, chemical dependency, substance abuse and psychiatric care treatment and education for the maintenance of a healthy lifestyle and the prevention of illnesses and diseases.

Duties and timelines of the Medical Director (2nd Level Reviewer) and clinical peers (3rd Level Reviewer) are detailed when certification cannot be determined by the Medical Review Specialist or the Utilization Nurse Reviewer.

Letters sent to insureds in each of the programs listed above were provided to the examiners. Instructions to proceed with a program, denials for not medically necessary procedures, requests for medical records and appeal processes with deadlines are provided as appropriate.

The Association passed Standard 1.

Standard 3. The health carrier provides information about its utilization review program to members in a timely manner and in compliance with applicable statutes, rules and regulations.

The policy issued to insureds contains the process, definitions and timelines for all utilization review and appeal procedures. Also, specific procedures are outlined in an individual letter sent to each insured whenever they inquire about an issue or file a complaint about a claim.

The Association passed Standard 3.

GRIEVANCE PROCEDURES

Standard 1. The entity defines as a grievance any dissatisfaction expressed in writing with the administration, claims practices or provision of services concerning an issuer of a Medicare Select product or network.

The Association complies with the definitions of complaint and grievance.

The Association passed Standard 1.

Standard 2. The entity develops written grievance procedures that comply with applicable statutes, rules and regulations, and provides enrollees with a copy of its grievance procedures.

Part P. of the KHIA policy spells out the benefits, procedures and timelines to file a complaint, grievance and external review procedures. Additionally, letters are provided to insureds who request the procedures to file a complaint or grievance or who receive claim denial letters and include instructions on contacting the Kansas Insurance Department.

An addendum to the KHIA Plan of Action included the mission and function of the Grievance Committee became effective on January 2, 2007. The Chairman and two Directors appointed by the KHIA Board comprise this Grievance Committee. While this Committee has always existed and continues to review grievances, the Plan of Action now is in alignment with the procedures set for the in the Policy.

The Association passed Standard 2.

Standard 4. The company provides to any enrollee, who has filed a grievance, detailed information concerning its grievance and appeal procedures, how to use them and how to notify the department of insurance, if applicable.

The policy issued to insureds provides a step-by-step grievance procedure. Additionally, as complaints are received, individual letters are sent outlining the steps to follow for that specific issue.

The Association passed Standard 4.

Standard 5. The company reports its grievance procedures to the insurance commissioner on an annual basis.

The Association developed its grievance procedure with input from the Commissioner and is not required to report those procedures on an annual basis.

The Association passed Standard 5.

CLAIMS PROCESSING

Claims Testing Procedures

During the first three months of the 2006 examination period for claims, the TPA converted from one claims processing software system to another and experienced some delays as reflected in the No Pay and Paid claims listed below.

In an effort to obtain a more accurate picture of the normal claims payment processing time, the examiners sampled an additional 50 claims paid and denied outside the 30 days required by the Kansas health care Prompt Payment Act after July 1, 2006. The number of claims paid and denied beyond 30 days remained high and the examiners decided to sample paid and denied claims from January 1-June 30, 2005, to test the normal payment processing time prior to the conversion to the new claims processing system.

The error rates on claims paid and denied in the first half of 2005 were well within the tolerance levels recommended by the NAIC Market Regulation Handbook and adopted by the Kansas Insurance Department.

Tests for Claims

GENERAL EXAMINATION STANDARDS

Standard 1. The initial contact by the Association with the claimant is within the required time frame. K.A.R. 40-1-34 Section 6(a) & (d)

Type	Sample	Violations	%Pass
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 1.

Standard 2. Investigations are conducted in a timely manner. K.A.R. 40-1-34 Sections 7 & 8(a)(c), K.S.A. 2442 (a)(b)

Type	Sample	Violations	%Pass
No Pay	100	18	82%
Paid	100	14	86%
Over 30 after July 1	50	35	34%
2005 Claims	58	1	99%

- 18 No Pay files were not processed within 30 days per K.S.A. 40-2442(a) and additional information was not provided to explain the delay.
- 14 Paid files were not paid within 30 days per K.S.A. 40-2442(a) and additional information was not provided to explain the delay.
- 35 After July 1 files were not paid within 30 days per K.S.A. 40-2442(a) and additional information was not provided to explain the delay.
- 1 2005 Claims file was not paid within 30 days per K.S.A. 40-2442(a) and additional information was not provided to explain the delay.

The Association failed Standard 2 in three categories.

Standard 3. Claims are resolved in a timely manner. K.A.R. 401-34 Section 8 (a) & (c), K.S.A. 40-2442(a)(b)

Type	Sample	Violations	%Pass
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 3.

Standard 4. The regulated entity responds to claim correspondence in a timely manner. K.A.R. 40-1-34 Section 6 (a)(b)(c)(d), K.S.A. 40-2442(a)(b)

Type	Sample	Violations	%Pass
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 4.

Standard 5. Claim files are adequately documented. K.A.R.40-1-34 Section 4, K.A.R. 40-1-34 Section 8(f).

Type	Sample	Violations	%Pass
No Pay	100	0	100%
Paid	100	8	92%
Over 30 after July 1	50	0	100%
2005 Claims	58	2	97%

- Eight Paid files did not contain sufficient notes and work papers to adequately reconstruct the events of the claim file as required by K.A.R. 40-1-34, Section 4.
- Two 2005 Claims files did not contain sufficient notes and work papers to adequately reconstruct the events of the claim file as required by K.A.R. 40-1-34, Section 4.

The Association failed Standard 5 in one category.

Standard 6. Claims are properly handled in accordance with policy provisions and applicable statutes, (including HIPAA), rules and regulations. K.A.R. 40-1-34 Sections 5(a-f), 6(a-d), 7, 8(c,f,g,i), K.S.A. 40-2442(a)(b).

Type	Sample	Violations	%Pass
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 6.

Standard 7. Regulated entity claim forms are appropriate for the type of product.

The claim forms provided by the Association are appropriate for health plans.

The Association passed Standard 7.

Standard 8. Claims are reserved in accordance with the Association's established procedures.

This was not specifically tested. In the course of reviewing the sample, discriminatory practices would have been noticed by the examiner.

The Association passed Standard 8.

Standard 9. Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. KAR. 40-1-34 Section 8(a)

Type	Sample	Violations	%Pass
No Pay	100	0	100%

The Association passed Standard 9.

Standard 11. Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under policy.

Type	Sample	Violations	%Pass
No Pay	100	0	100%
Paid	100	0	100%
Over 30 after July 1	50	0	100%
2005 Claims	58	0	100%

The Association passed Standard 11.

HEALTH EXAM STANDARDS

Standard 1. Claim files are handled in accordance with policy provisions, HIPAA and state law.

This was not specifically tested. In the course of reviewing the sample, discriminatory practices would have been noticed by the examiner.

The Association passed Standard 1.

Standard 2. The Association complies with the requirement of the federal NewBorns' and Mothers' Health Protection Act of 1996. K.S.A. 40-2,102 (a)(b)

This was not specifically tested. In the course of reviewing the sample, discriminatory practices would have been noticed by the examiner.

The Association passed Standard 2.

Standard 3. The group health plan complies with the requirements of the Mental Health Parity Act of 1996 (MHPA). K.S.A. 40-2,105 (a)

This was not specifically tested. In the course of reviewing the sample, discriminatory practices would have been noticed by the examiner.

The Association passed Standard 3.

Standard 4. The Association complies with the requirements of applicable statutes, rules and regulations for group coverage replacements.

This was not specifically tested. In the course of reviewing the sample, discriminatory practices would have been noticed by the examiner.

The Association passed Standard 4.

Comment: During the review of claim files, the examiners discovered that notifications were not sent to claimants under K.A.R. 40-1-34, Sections 6(a)(c), 7 and 8(a)(c). After discussing this issue with the TPA staff, changes were made in the claims processing manual and their staff implemented immediate changes to comply with this regulation while the examiners were still onsite.

Recommendation:

1. Conduct a current analysis to assure that claims processing timelines have improved during 2007.

2. Conduct a file review to assure that recent changes in claims processing have occurred, especially:

- **a. letters acknowledging acceptance or denial of a claim is sent within 15 working days after receipt of properly executed proof of loss; (if not paid)**
- **b. claim investigations are completed within 30 days; and**
- **c. letters notifying claimants with reasons why more time is needed to conduct an investigation are sent within 15 working days after receiving properly executed proof of loss and every 45 days thereafter until the investigation is complete.**

MARKET CONDUCT RECOMMENDATIONS

TPA Performance Standards

The examiners recommend that all the criteria be spelled out in detail in this document or in the "KHIA Performance Standards Rule Sets" and include: a) definition of the starting date/time of a claim, e.g. electronic date stamp when received, not when received at a particular desk or by a particular person; b) deadlines as set in K.S.A. 40-2442(a) and (b) for clean claims and K.A.R. 40-1-34 for claims over 30 days; and c) details needed to interpret the report such as number of claims received that were clean and number of clean claims paid within 30 days during the reporting month.

Complaint Handling

Develop a more formalized procedure to track complaint files and to keep the claim information with the complaint file. While the examiners were on-site, a change in personnel created new supervisory and management duties within the complaint and claims areas. It appears these new supervisors recognize the need and such revisions are underway.

The specific areas the examiners recommend are:
a. Provide a system to record all KID and direct complaints in one central register as soon as they are received;
b. Maintain a central location for complaint files or develop a system that keeps the claim information with the complaint file;

Claim Handling

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   b. claim investigations are completed within 30 days; and
   c. letters notifying claimants with reasons why more time is needed to conduct an investigation are sent within 15 working days after receiving properly executed proof of loss and every 45 days thereafter until the investigation is complete.

Conclusion

The MC Exam Team acknowledges the cooperation and courtesy extended to the examination team by KHIA Director Ed Fonner and the TPA staff, especially Debbie McCormick, Sharon Manning and Chad Somers.

The following examiners of the Office of the Commissioner of Insurance in the State of Kansas participated in the review:

Market Conduct Division

Mary Lou Maritt	Tate Flott
Examiner-In-Charge	Market Conduct Examiner

Respectfully submitted,

Mary Lou Maritt
Examiner-In-Charge

APPENDIX 1

K.A.R. 40-1-34 - Unfair Claims Practices Act (Revised 1/03)

Table of Contents

Section 1. Authority

Section 1 is not adopted.

Section 2. Scope

This regulation applies to all persons and to all insurance policies and insurance contracts except policies of Workers' Compensation insurance. This regulation is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of K.S.A. 40-2404, and amendments thereto.

Section 3. Definitions

The definitions of "person" and of "insurance policy or insurance contract" contained in K.S.A. 40-2404, and amendments thereto shall apply to this regulation and, in addition, where used in this regulation:

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

(b) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

(c) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract;

(d) "Insurer" means a person licensed to issue or who issues any insurance policy or insurance contract in this State.

(e) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

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

(g) "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer; and

(h) Workers' Compensation" includes, but is not limited to, Longshoremen's and Harbor Workers' Compensation.

Section 4. File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

Section 5. Misrepresentation of Policy Provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(c) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(d) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(e) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

Section 6. Failure to Acknowledge Pertinent Communications

(a) Every insurer, upon receiving notification of a claim shall, within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(b) Every insurer, upon receipt of any inquiry from the insurance department respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within ten working days of notification of a claim shall constitute compliance with subsection (a) of this section.

Section 7. Standards for Prompt Investigation of Claims

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time.

Section 8. Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

(a) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim 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 to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(b) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the requirements of this subsection. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(c) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five days from the date of the initial notification and every forty-five days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(d) Section 8(d) is not adopted.

(e) An insurer shall not attempt to settle a loss with a first party claimant on the basis of a cash settlement which is less than the amount the insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

(f) If a claim is denied for reasons other than those described in section 8(a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(g) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(h) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or a contract time limit, without giving the

claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

(i) No insurer shall make statements which indicate the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

40-2440. Kansas health care prompt payment act; citation; effective date.
(a) K.S.A. 40-2440 through 40-2442 and amendments thereto shall be known as the Kansas health care prompt payment act and shall apply to any policy of accident and sickness insurance issued or renewed in this state.

(b) The provisions of the Kansas health care prompt payment act shall take effect and be in force on and after January 1, 2001.

40-2441. Same; definitions. As used in K.S.A. 40-2440 through 40-2442 and amendments thereto:
(a) The term "clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under the Kansas health care prompt payment act.

(b) The term "claim" means a written proof of loss as defined in paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto, or an electronic proof of loss which contains the information required by paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto.
(c) The term "policy of accident and sickness insurance" means any policy or contract insuring against loss resulting from sickness or bodily injury or death by accident, or both, any hospital or medical expense policy, health, hospital, medical service corporation contract issued by a stock or mutual company or association, a health maintenance organization or any other insurer, third party administrator or other entity which pays claims pursuant to a policy of accident and sickness insurance. The term policy of accident and sickness insurance does not include any policy or contract of reinsurance, life insurance, endowment or annuity contract, policies or certificates covering only credit, disability income, long-term care, medicare supplement, dental, drug, or vision-care only policy, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

40-2442. Same; claims; procedures; rules and regulations.
(a) Within 30 days after receipt of any claim, and amendments thereto, any insurer issuing a policy of accident and sickness insurance shall pay a clean claim for reimbursement in accordance with this section or send a written or electronic notice acknowledging receipt of and the status of the claim. Such notice shall include the date such claim was received by the insurer and state that:

(1) The insurer refuses to reimburse all or part of the claim and specify each reason for denial; or

(2) additional information is necessary to determine if all or any part of the claim will be reimbursed and what specific additional information is necessary.

(b) If any insurer issuing a policy of accident and sickness insurance fails to comply with subsection (a), such insurer shall pay interest at the rate of 1% per month on the amount of the claim that remains unpaid 30 days after the receipt of the claim. The interest paid pursuant to this subsection shall be included in any late reimbursement without requiring the person who filed the original claim to make any additional claim for such interest.

(c) After receiving a request for additional information, the person claiming reimbursement shall submit all additional information requested by the insurer within 30 days after receipt of the request for additional information. Failure to furnish such additional information within the time required shall not invalidate nor reduce the claim if it was not reasonably possible to give such information within such time, provided such proof is furnished as soon as possible as defined (within the time prescribed) in paragraph (7) of subsection (A) of K.S.A. 40-2203, and amendments thereto.

(d) Within 15 days after receipt of all the requested additional information, an insurer issuing a policy of accident and sickness insurance shall pay a clean claim in accordance with this section or send a written or electronic notice that states:

(1) Such insurer refuses to reimburse all or part of the claim; and

(2) specifies each reason for denial. Any insurer issuing a policy of accident and sickness insurance that fails to comply with this subsection shall pay interest on any amount of the claim that remains unpaid at the rate of 1% per month.

(e) The provisions of subsection (b) shall not apply when there is a good faith dispute about the legitimacy of the claim, or when there is a reasonable basis supported by specific information that such claim was submitted fraudulently.

(f) Any violation of this act by an insurer issuing a policy of accident and sickness insurance with flagrant and conscious disregard of the provisions of this act or with such frequency as to constitute a general business practice shall be considered a violation of the unfair trade practices act in K.S.A. 40-2401 et seq. and amendments thereto.

(g) The commissioner of insurance shall adopt rules and regulations necessary to carry out the provisions of the Kansas health care prompt payment act.

I, Mary Lou Maritt, being duly sworn do hereby state and depose: That I was the Examiner-In-Charge of the foregoing market conduct examination of the Kansas Health Insurance Association. The examination was performed in accordance with the provisions of K.S.A. 40-222 and other applicable laws and is hereby filed with the Kansas Insurance Department this the 23rd day of October, 2007.

Affiant saith not further.

Mary Lou Maritt
Examiner-In-Charge

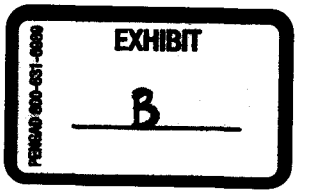
State of Kansas)
County of Shawnee)

Signed to before me on this 23rd day of Oct. 2007

By Mary Lou Maritt

JANA L. BEETHE NOTARY PUBLIC STATE OF KANSAS

Jana L. Beethe
Signature of Notary
Date Commission Expires 2-8-11



KANSAS HEALTH INSURANCE ASSOCIATION

NOV 26 10:22

November 20, 2007

Sandy Praeger, Commissioner
Kansas Insurance Department
420 SW 9th Street
Topeka KS 66612

Dear Sandy,

On behalf of the KHIA Board of Directors, we have reviewed and accept the findings of the examination conducted by your Department earlier in 2007. Itemized here are several comments on the report along with a summary of corrective actions taken to address those areas of concern cited by your claims auditors during the course of their study.

Corrective Actions. Here are the corrective actions being undertaken by KHIA in order of appearance in your October 23, 2007 report.

Complaint Handling – Prior to the audit the administrator did not have all correspondence relating to a KID complaint centralized into one location. During the audit the administrator was not able to produce all the documentation relating to a complaint and therefore failed the standard. As of November 16, 2007 the administrator has implemented the following corrective action plan:

> Centralized all correspondence related to all KID complaints. The administrator now centralizes all correspondence relating to KID complaints into one location. In addition, all paper files are digitally scanned and archived.

Claims Handling: Standard 2, Timely Payment – Prior to the audit the internal standard for the administrator had always been to process 100% of clean claims within 30-days. This key performance indicator was reviewed weekly by management and was met with regular consistency. This metric was also reported to the Association on a monthly basis. During the later part of the first quarter and into the second quarter of 2006 the administrator converted computer systems and as a result experienced delays in claim processing. In some cases the delays caused the administrator to fall below their internal standard of processing 100% of clean claims within 30-days. During the audit, after the administrator learned of the compliance requirement of the Kansas Health Care Prompt Payment Act, they immediately changed their claim handling procedure to a standard of processing 100% of clean claims within 10-days.

The delay in claim payments cited by the department were likely due to the fact that procedurally BMI cannot process a claim for a participant who has not paid their premium to a current status. In order to maintain coverage, the premium is due on the 1st of the month. Participants are given a 30-day grace period to make payment. All

payments are processed through a lockbox and which has an approximately 10-day lag from when the payment clears the bank to the time the administrator is notified. With a great deal of regularity, most participants who pay their premium via check take advantage of the grace period. Taking into mind the grace period, lock box processing and normal processing times for the administrator, in the current process, the administrator may not post a payment to a participant's account for as many as 45-days following the due date. During this time period any claims received, regardless of whether they are clean, are pended until the payment has been processed and their account in a current status.

As of November 16, 2007 the administrator has implemented the following corrective action plan:

Comply with K.A.R. 40-1-34 Sections 7 & 8(a)(c) and K.S.A. 2442(a)(b).

Generate and mail premium invoices 15-20 days prior to the due date. Historically the administrator generated and mailed the premium billing statements on the 20th of the month before the premium is due. They are now mailing the premium invoices out between the 10th and 15th of the month.

Encourage participants to pay their premium timely. The administrator changed the language on the premium billing statement in a way which strongly encourages the members to make their payment on the due date to avoid delays.

Encourage participants to pay their monthly premium using ACH. ACH payments are automatically withdrawn from the participants accounts each month therefore eliminate any delay in the administrator receiving payment.

Claims Handling: Standard 5, Adequate Documentation – It was determined that the administrator's claim analysts would sometimes perform work on a claim and not document such work. Examples of this would be pending a claim for PPO network re-pricing, for auditing and/or for payment of premium (as discussed in the failure of Standard 3). Proper documentation of the events was not always noted within their system. As of November 16, 2007 the administrator has implemented the following corrective action plan:

Training. Implemented focused training program to educate claim analysts about the need to document all activities as it relates to a claim.

Implementation of new system. The administrator is now utilizing a state of the art software system that is designed to capture and store all communications generated from the system. Any communications done outside of the system are digitally scanned and archived to the members file.

Comments. Here are several other comments made after reviewing the Report.

Grievance Committee – There was mention on page 11 of the Report under Grievance Procedures, Standard 2, that KHIA had a 'newly created' Grievance Committee effective on January 2, 2007. KID was inaccurate in stating that the Grievance Committee *began* in 2007. The Grievance Committee has been in existence since KHIA's inception. Bruce Witt, KHIA Vice Chairman, has been the Committee chair for the last seven years. The Committee has three other members - Dick Warner, MD, Bonnie Lowe, and Jeff Berry. It should also be noted that KHIA did revise and enhance the grievance procedures in 2006.

Claims Processing Timelines – There was mention on page 15 of the Report that a current analysis of claims processing timelines should be conducted in 2007 to ensure improvement in timely payments to enrollees. The KHIA actuary regularly generates a claims lag report to evaluate timely payments and calculate the IBNR reserves. The actuary noted prior to the October 2007 Board of Directors meeting that claims processing times had improved since the TPA's claims processing system conversion.

Performance Standards – This Report will be helpful to KHIA in the future as it itemizes and operationally defines the performance standards to be met by its third party administrators. For example, your recommendation to date stamp the start of a claims processing will be helpful in reviewing Clean Claims statistics cited in the TPA's monthly performance report.

'Claims Audit' – It was acknowledged by KID staff that a market conduct examination is normally triggered by some evidence of adverse performance by an insurer. We compliment the KID for its adherence to an explicit methodology for conducting its work, but wish to point out that the KHIA Board of Directors voluntarily requested this engagement primarily for the purpose of conducting a claims audit on its insurance operations. We hope this will not reflect poorly on KHIA or its TPA.

Thank you for the opportunity to work with the Insurance Department on this study. KHIA and its third party administrator strive to provide excellent and responsive insurance services to its enrollees. In that regard, the actions pointed out by your staff are constructive and are being addressed. Finally, your staff exhibited professionalism in undertaking its work on this assignment.

Sincerely yours,

BT-EF

Bill Tracy, Chairman

Ed Fonner Jr.

Edwin Fonner, Jr.
Executive Director

Kansas Health Insurance Association
c/o Benefit Management Inc.
P.O. Box 1090 / Great Bend KS 67530

Copy Bill Tracy (Chairman), Debbie McCormick, Julie Holmes, Llyle Behrens