REPORT OF MARKET CONDUCT EXAMINATION
ETS# KS023- M029

Humana Group
Group # 119

Humana Insurance Company
NAIC # 73288

Humana Health Plans
NAIC # 95855

Humana, Inc.
201 W. Main Street
Louisville, KY 40202-1348

Humana Service Center
1100 Employers Road
De Pere, WI 54115-8187

AS OF

March 31, 2007

BY

KANSAS INSURANCE DEPARTMENT

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

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:

Humana Insurance Company
1100 Employers Blvd.
De Pere, WI 54115-8187

Humana Health Plans
201 West Main St.
Louisville, KY 40202-1348

Hereafter referred to as “HIC” or “HHP” or “Company” or “Companies” 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 Humana Health Plan and Humana Insurance Company was conducted pursuant to, but not limited to, K.S.A. 40-222. The exam team reviewed operations/management, complaints, claims, grievance/appeal procedures, and quality assessment to determine if the Company was in compliance with applicable statutes, regulations and bulletins of the State of Kansas.

The audit was conducted according to the guidelines and procedures recommended in the NAIC Market Regulation Handbook 2007. The exam team utilized the standards and tests recommended in the Handbook and its tolerances of 7% was used for claim procedures and 10% was used for all other categories. The examination report is written by test rather than by exception. This means all standard tests are described and results indicated.

The examination included a review of several samples of the Company's complaint files from January 1, 2005 to March 31, 2007 and closed claim files from January 1, 2006 to March 31, 2007.

Interrogatories were submitted to the Company prior to the on-site segment of the examination and the Company provided written responses. The responses received addressed the issues requested.

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

OPERATIONS/MANAGEMENT
History and Profile
Prior Market Conduct Examination Reports
Fines and/or Penalties
Company Operations and Management
Certificates of Authority
Internal Audit Procedures

COMPLAINT HANDLING
Record Keeping
Timely Response

CLAIMS
Claim Processing
Timeliness and Accuracy of Claim Payment
Proper Maintenance of Claim Files

GRIEVANCE AND APPEAL PROCEDURES

QUALITY ASSESSMENT

EXECUTIVE SUMMARY

The Kansas Insurance Department (KID) performed a market conduct examination of Humana Health Plan and Humana Insurance Company. The period of examination was January 1, 2005 through March 31, 2007.

The examiners reviewed the Companies' operations/management policies, complaint files, claim files, grievance and appeal procedures as well as the quality assessment process. The examination team reviewed these items in the administrative office in DePere, WI.

While the Company passed most tests, one major issue requires a thorough review. The Kansas Insurance Department believes the Company must revise its claim processing system to include the timelines from both the Prompt Pay Act and Unfair Claims Settlement Practices. Currently, the Company relies only on the Prompt Pay Act to adjudicate claims. An agreement was reached and timelines from both the Prompt Pay Act and Unfair Claims Settlement Practices are now used to adjudicate claims where appropriate. Additionally, the exam team has made recommendations on other issues.

LIST OF RECOMMENDATIONS

Grievances and Appeals

1. Several reviewed appeals concerned ER claims deemed to be contractual rather than medically necessary. Often the claimant was given conflicting information or incorrect information. Company letters appeared to address medically necessary issues but delayed the answer for up to 60 days. Others appeared to address contractual claims but were issued within 30 days. When the examiners questioned the Company, the consistent answer was that the customer representative had used the wrong letter.

   While errors do occur, the number appeared high for appeals of this magnitude. It appears that further training, more detailed manuals and greater supervisory control are needed to adjudicate these appeals with greater accuracy. Please provide evidence that steps are being implemented to eliminate such errors.

Claims Handling

1. The Company must review its claim practices and conduct the necessary training to assure that claimants are treated as 1st party claimants under all applicable sections of K.A.R. 40-1-34. During the examination, an argument was made by the company that claims submitted by providers were 3rd party claims and were not subject to K.A.R. 40-1-34. After a discussion, the Company and the examiners agreed that Humana policies were written as 1st party claims. Please provide evidence that claims are now being processed as 1st party claims.

2. The Company must amend its processing guidelines to include the timelines on all notices of coverage, investigations, acceptance and denial of claims, correspondences and payment of claims as found in K.S.A. 40-2442 and K.A.R. 40-1-34, Sections 6, 7 and 8. Training for customer representatives and supervisors must be delivered to ensure consistent and timely

claims processing. Please provide evidence that claims are now subject to both Kansas Unfair Settlement Act and the Prompt Payment Act.

Examiner's Note: This issue was resolved during the finalizing of the exam report and the company agrees to amend its processing guidelines to follow the Prompt Payment Act for all health claims until such claim is no longer deemed a clean claim and then follow the timelines associated with the Unfair Claims Settlement claims to complete further investigation and adjudication of the claim.

DESK EXAMINATION/ON-SITE EXAMINATION

Operations and Management

COMPANY OVERVIEW

History and Profile

HUMANA HEALTH PLAN, INC.

Humana Health Plan, Inc. ("HHP"), a Kentucky corporation, was incorporated on August 23, 1982. HHP is licensed as a health maintenance organization in the following states, followed by initial licensing dates:

Arizona (1/1/87); Colorado (6/25/87); Illinois (11/17/86); Indiana (10/21/86); Kansas (2/1/85); Kentucky (9/1/83); Missouri (3/30/87); Nebraska (3/19/87); Nevada (6/29/89) and Tennessee (8/24/87).

HHP is owned 100% by Humana Inc. ("HUMANA"), a Delaware corporation and an insurance and health maintenance organization holding company and the ultimate controlling entity. On August 3, 1984, HUMANA contributed 100% of the issued and outstanding shares of common stock of HHP to Group Health Insurance, Inc. ("GHI") which was insurance and health maintenance organization holding company and a wholly-owned subsidiary of HUMANA at that time. GHI merged with and into HUMANA on December 1, 1992.

HUMANA became an insurance and health maintenance organization holding company on December 1, 1992, when its wholly-owned subsidiary, GHI, merged into HUMANA. HUMANA was the survivor of the merger. HUMANA offers insurance and health maintenance organization plans through its subsidiaries.

HUMANA INSURANCE COMPANY

Humana Insurance Company ("HIC"), a Wisconsin corporation, was incorporated on December 18, 1968. HIC was licensed as a life and health insurance company on December 30, 1968 in the State of Wisconsin. HIC is licensed as a life and health insurance company in all states and DC except New York and New Hampshire. HIC is owned 100% by CareNetwowrk, Inc, a Wisconsin general business corporation and wholly-owned subsidiary of Humana Inc. ("HUMANA"), a Delaware corporation and insurance and health maintenance organization holding company and the ultimate controlling entity. HIC became an affiliate in the insurance holding company system

on October 13, 1995, when EMPHESYS Financial Group, Inc., a Delaware corporation, merged into HEW, Inc., a wholly-owned subsidiary of HUMANA. EMPHESYS Financial Group, Inc. ("EFG") was the survivor of the merger.

Effective December 31, 2001, as approved by the Wisconsin Office of the Commissioner of Insurance ("OCI"), Humana Insurance Company, a Missouri company, merged into Employers Health Insurance Company, and the Employers Health Insurance Company subsequently changed its name to Humana Insurance Company. Until June 30, 2002, HIC was owned 88.7% by EFG, as listed above, and owned 11.3% by Wisconsin Employers Group, Inc., a Wisconsin corporation. Wisconsin Employers Group, Inc. was a wholly-owned subsidiary of EFG. EFG was a wholly-owned subsidiary of Humana Inc.

On May 1, 2002, a Form A was submitted to the OCI that requested permission for several mergers, including the merger of Wisconsin Employers Group, Inc. into EFG and the subsequent merger of EFG into CareNetwork, Inc. The mergers were approved by OCI for an effective date of June 30, 2002. As a result of the above referenced mergers, which included the stockholders of HIC, HIC became a wholly-owned subsidiary of CareNetwork, Inc.

Certificate of Authority

The Kansas Certificates of Authority were reviewed and found to be in order.

Company Agreements

Humana does not employ an MGA nor does it utilize the services of a TPA.

Internal Audits

Humana's Internal Audit Group annually reviews four core areas of business for management of risk. A series of tests and comparisons are analyzed and reviewed to determine compliance with Company standards and objectives. Individual divisions perform periodic self-assessments that become part of the annual opinion. Findings are shared with the Audit Committee of the Board of Directors and Senior Management.

Prior Market Conduct Examination Report(s)

The Company provided the examiners with the market examination reports from the prior 2 years. There were no recommendations in these exams that required a follow up during this examination as any similar concerns were covered in our interrogatories.

Fines and/or Penalties

The NAIC I-Site database was reviewed. There was nothing noted that warranted follow-up by this exam team.

Tests for Company Operations/Management

Standard 1
The regulated entity has an up-to-date, valid internal or external audit program.

The Company submits an annual internal audit opinion to the Audit Committee of the Board of Directors and Senior Management regarding reliability and integrity of financial reporting and disclosure, effectiveness and efficiency of operations, safeguarding of assets and compliance with laws, regulations and contracts.

The auditing group conducts a series of claim tests, reviews supervisory meetings, analyzes data and monitors activities in claims, special investigations, payroll and communications. Checks and balances are reviewed to assure proper access, pending, and payment of claims as well as the integrity of payroll and communications.

The examiners requested and received reports for the years 2005 and 2006 which stated that the company maintains reasonable assurance that these four areas are effectively managed for risk.

The Company passed Standard 1.

Standard 5
Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as, but not limited to, MGAs, GAs, TPAs and management agreements must comply with applicable licensing requirements, statutes, rules and regulations.

The Company does not employ the services of an MGA or TPAs.

The Company passed Standard 5.

Standard 7
Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. K.S.A. 40-222 (a)(b)(c)(g)

> The Company maintained adequate records as required for a Market Conduct examination. However, they were not always accessible to the examiners in a timely manner as detailed in Standard 9 below.

The Company passed Standard 7.

Standard 8
The regulated entity is licensed for the lines of business that are being written.

The Kansas Certificate of Authority was reviewed and the company was in compliance with business written.

The Company passed Standard 8.

Standard 9
The regulated entity cooperates on a timely basis with examiners performing the examinations.

Examiners did not have electronic access to claim or complaint screens which caused both numerous delays in obtaining information and the expense of untold regular and overtime hours for Company employees making hard copies. In fact, the exam was suspended for one week to allow time for the company to provide the requested information. It appears the delays occurred in the Louisville facility, not in the DePere facility. The Examiner-In-Charge wrote a letter requesting prompt service and suggested that a Louisville employee be assigned to providing requested information on a daily basis. This suggestion resulted in a quicker response from the Louisville facility.

These delays prolonged the examination by approximately two weeks which resulted in increased costs to the company for the three examiners' expenses for airfare, lodging, meals, car rental, salaries, fringe benefits, and federal and state payroll taxes, not to mention paper, equipment and employee costs. Most of the information requested could have been verified electronically within a few seconds or minutes. We urge the Company Compliance and IT staff to develop a safe process for future examiners to have electronic access to the screens needed to complete an examination without being live in the system. Other companies have provided such access and those examinations were conducted swiftly and smoothly.

COMPLAINT HANDLING

Humana Procedures for handling general inquires or phone requests

All mail is received by a 3rd party vendor, Affiliated Computer Services (ACS), and they do an upfront prescreen. They assign the correspondence a doctype. It is scanned into their system and routed to the appropriate unit based on the doctype code.

The medical correspondence unit handles submissions for all medical products including Medicare and Medicaid programs. There is a correspondence unit in each of the three Service Centers.

The correspondence department handles all correspondence that is not a grievance, appeal or DOI complaint. Correspondence unit handles all unsolicited correspondence – submissions that were sent in with out a Humana request. Solicited correspondence is submitted as a result of a Humana request for information and is routed to the appropriate claims teams. The correspondence unit reviews the document to determine if they can complete the issue. If not, it is routed to the appropriate area. If the can handle it, they will follow through and complete the task including reprocessing the claim and performing any adjustment based upon the additional information provided.

The telephone CSU unit handles all calls that would include such requests as coverage explanations, deductible and co-pay information and provider eligibility. If the wrong information is given out on a benefit level question or other question that would affect a claim payment, the member's complaint will be handled at the grievance or appeal level.

Humana Complaint Procedures

The Critical Inquiry unit handles Humana complaints. The following are the steps that they follow to resolve a written complaint:

A. Humana has a formal matrix that they go through to identify and assign a complaint to an analyst the first day that a complaint is received.

1. Complaint received and forwarded to Critical Inquiry Unit.

2. The individual/entity is looked up in the Humana systems to determine what type of plan is involved and what Service Center is responsible for responding to the complaint.

3. The complaint is logged into the Customer Care Portal (CCP) with the date received. This is how Humana tracks the complaint.

4. The complaint is assigned to an analyst who is responsible for fact finding and researching the issue.

B. The analyst follows a formal process to research and respond to the complainant. This person is responsible for resolving the complaint and responding to individual who filed the complaint.

1. The analyst consults with the department that was originally involved in handling the issue that generated the complaint.

2. The analyst reviews the Humana systems and reads all notes, letters and calls that were pertinent to the events leading up to the complaint.

3. Analyst drafts the response to the consumer or department that sent in the complaint.

4. Analyst closes out the complaint in the CCP.

Critical Inquiry handles Presidential Complaints. Presidential Complaints are defined as a verbal or written inquires addressed to upper level management staff at Humana. Upper level management staff includes, but is not limited to associates in roles such as Chief Operating Officer, President, Vice President and members of the Board of Directors, Additionally, inquires received from Legislators, Congressmen or other governmental bodies would also be classified as Presidential Complaints for purposes of tracking. Presidential Complaints are responded to within 7 days of receipt.

Additionally, Critical Inquiry handles inquires received from the various state Insurance Departments and Attorney General's offices. Complaints submitted through various Better Business Bureau offices are also handled in the Critical Inquiry unit.

Grievance and Appeals Procedures

The following grids outline the criteria and time standards for handling grievances and appeals for both HIC and HHP.

	Commercial PPO 1st Level Grievance	Commercial PPO 1st Level Expedited Appeal	Commercial PPO 1st Level Appeal
Format	Follow informal complaint procedures	Oral or writing	Oral or writing
Acknowledgement		-	5 Bsns days
Time Frame Grievance/Appeal		-	180 Calendar Days
Reviewer		Specialty in the field & Not involved in the initial decision	Specialty in the field & Not involved in the initial decision
Decision Time Frame		No later than 1 Bsns day not to exceed 72 hours	30 calendar days
Extension		none	none
Notification Required		Initially orally & F/U in writing w/in 1 Bsns day	None specified
Notification Content		For medical necessity, experimental and investigative upholds or partial overturns 12 point type, name addresses of impacted parties & right to IRO review w/ DOI w/in 90 calendar days	For medical necessity, experimental and investigative upholds or partial overturns 12 point type, name addresses of impacted parties & right to IRO review w/ DOI w/in 90 calendar days
Definition		Adverse determination of "urgent care". Which is a treatment or services that if delayed in the opinion of the treating physician that could seriously jeopardize the life or health of member	Formal request to reconsider a determination not to certify an admission, extension or stay or other, health care service

Tests for Complaint Handling

Standard 1

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

> The company provided the exam team with a complaint log that met the required format specified by K.S.A. 40-2404 (10).

The Company passed Standard 1.

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

Company has complaint procedures documented. The member certificates have a section spelled out in the general section of the document that explains complaint and appeal procedures. However, a program with a defect originally was released into the complaint handling system. When it was discovered and ultimately corrected, three claims were allowed to stand and were not corrected which is a violation of K.A.R. 40-1-34 Section 5(a).

Type	Sample	Errors	%Pass
HIC	44	3	93%
HHP	9	0	100%
Total	53	3	94%

The Company passed Standard 2.

Standard 3
The regulated entity 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, 6.

Type	Sample	Errors	%Pass
HIC	44	6	86%
HHP	9	0	100%
Total	53	6	89%

- One file experienced a program loading error and benefits were not re-calculated when the error was corrected causing the company to fail to disclose all benefits and coverage per K.A.R. 40-1-34, 5(a)
- Five files did not pay interest per K.S.A. 40-2442(b).

While investigating one of the above files, the examiner discovered that 11 additional errors resulted from the program loading error:

- Eight files did not pay interest per K.S.A. 40-2442(b)
- Three files did not have benefits re-calculated when the program loading error was discovered causing the company to fail to disclose all benefits and coverages per K.A.R. 40-1-34, 5(a)

The Company failed Standard 3.

Standard 4
The time frame within which the regulated entity 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
HIC	44	1	98%
HHP	9	0	100%
Total	53	1	99%

- One file did not respond to KID within 15 business days per K.A.R. 40-1-34, 6(b).

The Company passed Standard 4.

HEALTH EXAM STANDARDS - GRIEVANCE PROCEDURES

Grievance and Appeals Procedures

The criteria and time standards for handling grievances and appeals in both HIC and HHP are found in the chart displayed on pages 12-13 of this report.

Standard 1
The health carrier treats as a grievance any written complaint submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the carrier.

HHP defines grievance as a "written complaint submitted in accordance with formal grievance procedures by (or on behalf) of a member regarding any aspect of HMO"

HIC (Commercial PPO) does not have a specific and distinct formal grievance process spelled out. There are no requirements in the Kansas Insurance code for PPOs to have a specific grievance procedure. The company follows their complaint requirements for handling an individual who writes in indicating dissatisfaction with the determination of a claim. If the member is still not satisfied after receiving a response to their complaint, the company handles it as an appeal.

The Company passed Standard 1.

Standard 2
The health carrier documents grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations.

1st Level grievance procedures for Commercial HMO meet K.S.A. 40-3228. There is no 1st Level grievance or appeal requirements for Commercial PPO. The policy certificate specifies the member's complaint and appeal process. It also advises the consumer of their rights under the external review process. For adverse grievance and appeal determinations, the denial letter spells out the process to go through for an external review and lists the Kansas Insurance Department as an alternate resource for dispute resolution.

Type	Sample	Errors	%Pass
HHP G&A	19	0	100%

HIC G&A	37	4	89%
Total G&A	56	4	93%

- Four files did not follow the company grievance and appeal procedures.

The Company passed Standard 2.

Standard 3
A health carrier files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

Not required by Kansas statute.

Standard 4
The health carrier conducts first-level reviews of grievances in compliance with applicable statutes, rules and regulations.

Not required by Kansas statute.

Standard 5
The health carrier conducts second-level reviews of grievances in accordance with statutes, rules and regulations.

Not required by Kansas statute.

Standard 7
The health carrier has procedures for and conducts expedited appeals in compliance with applicable statutes, rules and regulations.

There is no statutory requirement regarding a company's procedures to conduct an expedited appeal. The companies do have guidelines in place for an expedited appeal, and they track the statutory timing requirements of an expedited external review**.** (See chart on pages 12-13.)

Grievance and Appeals Recommendations:

1. Several reviewed appeals concerned ER claims deemed to be contractual rather than medically necessary. Often the claimant was given conflicting information or incorrect information. Company letters appeared to address medically necessary issues but delayed the answer for up to 60 days. Others appeared to address contractual claims but were issued within 30 days.

   When the examiners questioned the Company, the consistent answer was that the customer representative had used the wrong letter.

   While errors do occur, the number appeared high for appeals of this magnitude. It appears that further training, more detailed manuals and greater supervisory control are needed to

adjudicate these appeals with greater accuracy. Please provide evidence that steps are being implemented to eliminate such errors.

QUALITY ASSESSMENT AND IMPROVEMENT

Standard 1
The health carrier develops and maintains a quality assessment program in compliance with applicable statues, rules, and regulations. K.S.A. 40-3211(b)

> The company maintains a quality assessment program and follows the National Committee for Quality Assurance (NCQA) guidelines. The Corporate Quality Steering Committee is responsible for oversight of the quality improvement (QI) program. This oversight includes review and approval of the QI Program Description, QI Work Plans, annual QI Evaluations and the quarterly Work Plan Status Reports. The Service Committee is responsible for review and analysis of service related data in order to identify opportunities for improvement in service to customers.

The Company passed Standard 1.

Standard 2
The health carrier files a written description of the quality assessment program with the insurance commissioner in the prescribed format, which shall include a signed certificate by a corporate officer of the health carrier that the filling meets applicable statues, rules, and regulations. K.S.A. 40-3211(b)

> An accreditation survey was conducted by NCQA from November 3-5, 2003. The company was found to be in compliance with Kansas quality assurance guidelines. A letter indicating the findings of the review was sent to the Kansas Department on August 5, 2004. The next review is due to be conducted by July 1, 2007.

The Company passed Standard 2.

Standard 3
The health carrier develops and maintains a quality improvement program, in compliance with applicable statues, rules, and regulations. K.S.A. 40-3211(b)

> The Quality Improvement Work Plan prioritizes activities and helps to determine resource needs. The Work Plan also serves as the basis for the company's ongoing management of the QI process. The Work Plan is updated as needed, but at least quarterly, and is revised at least annually. The Quality Improvement Program Evaluation is an assessment of the Humana quality improvement program. The annual evaluation summarizes the program's performance for the year and includes recommendations for future initiatives and improvements.

The Company passed Standard 3.

Standard 4

The health carrier reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider. K.S.A. 40-3211(b)

> The Peer Review Committee's purpose is to review potential deviations from the standard of care, determine the severity of the issue and recommend quality improvements as appropriate. The committee has a process in place to handle provider terminations, although no providers have been terminated in the state of Kansas.

The Company passed Standard 4.

Standard 5
The health carrier documents and communicates information about its quality assessment program and its quality improvement program to covered persons and providers. K.S.A. 40-3211(b)

> There are guidelines established for both internal and external communications. The company has a committee structure in place and utilizes clinically focused committees as a forum for receiving feedback from network providers. Member communications include quarterly newsletters and/or bulletins, individual mailings, targeted e-mail communications, and the company's website.

The Company passed Standard 5.

Standard 6
The health carrier annually certifies to the insurance commissioner that its quality assessment and quality improvement program, along with the materials provided to the providers and consumers, meets applicable statues, rules, and regulations. K.S.A. 40-3211(b)

> An accreditation survey was conducted by NCQA from November 3-5, 2003. The company was found to be in compliance with Kansas quality assurance guidelines. A letter indicating the findings of the review was sent to the Kansas Department on August 5, 2004. The next review is due to be conducted by July 1, 2007.

The Company passed Standard 6.

Standard 7
The health carrier monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable state provisions equivalent to the NAIC Quality Assessment and Improvement Model Act and accompanying regulations are met. K.S.A. 40-3211(b)

> The company has procedures in place to address pre-delegation activities and the use of appropriate contractual language. The company states that "although the authority to perform a function may be delegated, the responsibility for the function being performed appropriately remains with Humana." Oversight activities consist of on-site visits, audits, and reviewing required reports.

The Company passed Standard 7.

CLAIM HANDLING

Tests for Claims Handling

GENERAL EXAM CLAIM STANDARDS

Standard 1
The initial contact by the regulated entity with the claimant is within the required time frame. K.A.R. 40-1-34, 6(a)&(d), K.S.A. 40-2442(a)(b)

> The Company and KID disagree about the use of the Unfair Claims Settlement (UCS), K.A.R. 40-1-34 Section 6, along with the Prompt Pay Act. The Company uses only the Prompt Pay Act and ignores the UCS. KID believes that the Prompt Pay Act is specific as to the company's actions within the first 30 days from when a claim is filed but is silent on any additional timelines a company must meet to adjudicate a claim. Therefore, we must look to the UCS for the other actions a company must follow to further handle a claim including initial notification.

Examiner's Note: This issue was resolved during the finalizing of the exam report and the company agrees to amend its processing guidelines to follow the Prompt Payment Act for all health claims until such claim is no longer deemed a clean claim, specifically K.S.A. 40-2442, and then follow the timelines associated with the Unfair Claims Settlement claims to complete further investigation and adjudication of the claim.

The Company failed Standard 1.

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

> The Company and KID disagree about the use of the Unfair Claims Settlement, K.A.R. 40-1-34 Sections 7 and 8(c), along with the Prompt Pay Act. The Company uses only the Prompt Pay Act and ignores the UCS. KID believes that the Prompt Pay Act is specific as to the company's actions within the first 30 days from when a claim is filed but is silent on any additional timelines a company must meet to adjudicate a claim. Therefore, we must look to the UCS for the other actions a company must follow to further handle a claim needing more time for the investigation.

Examiner's Note: This issue was resolved during the finalizing of the exam report and the company agrees to amend its processing guidelines to follow the Prompt Payment Act for all health claims until such claim is no longer deemed a clean claim and then follow the timelines associated with Unfair Claims Settlement, specifically K.A.R. 40-1-34, Sections 8(a) and 8(c) to complete further investigation and adjudication of the claim.

The Company failed Standard 2.

Standard 3
Claims are resolved in a timely manner. K.A.R. 40-1-34, 8(a), K.S.A. 40-2442(a)(b)

Type	Sample	Errors	%Pass
HIC Paid	102	4	96%
HHP Paid	100	1	99%
Total	202	5	98%

- Five files exceed 15 working days after proof of loss to notify a claimant of the acceptance of a claim which is a violation of K.A.R. 40-1-34 Section 8(a)

The Company passed Standard 3.

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

Type	Sample	Errors	%Pass
HIC Paid	102	0	100%
HIC No Pay	101	0	100%

Type	Sample	Errors	%Pass
HHP Paid	100	0	100%
HHP No Pay	100	0	100%
Total	403	0	100%

The Company passed Standard 4.

Standard 5
Claim files are adequately documented. K.A.R. 40-1-34, Sections 4, 6(a) & 8(c), K.S.A. 40-2442(a)(b)

Type	Sample	Errors	%Pass
HIC Paid	102	0	100%
HIC No Pay	101	1	99%

Type	Sample	Errors	%Pass
HHP Paid	100	0	100%
HHP No Pay	100	3	97%
Total	403	4	99%

- One file did not show evidence of reason for non- payment which is a violation of K.S.A. 40-2442(a)(b)
- One file lapsed 427 days with no documentation for the delay which is a violation of K.A.R. 40-1-34, Section 8(c)
- Two files did not contain EOBs which is a violation of K.A.R. 40-1-34 Section 4

The Company passed Standard 5.

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), 8, K.S.A. 40-3110 & K.S.A. 40-2-126

Type	Sample	Errors	%Pass
HIC Paid	102	0	100%
HIC No Pay	101	0	100%

Type	Sample	Errors	%Pass
HHP Paid	100	0	100%
HHP No Pay	100	0	100%
Total	403	0	100%

The Company passed Standard 6.

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

Nearly all claims are submitted electronically through the various contracted providers and are accepted by both companies. In the event that a claimant requests a paper claim form, the companies do send a standardized claim form.

The Company passed Standard 7.

Standard 8
Claim files are reserved in accordance with the company's established procedures.

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any reserving abnormalities would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 9
Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. K.A.R. 40-1-34, 8(a)(b)&(c)

Type	Sample	Errors	%Pass
HIC No Pay	101	4	96%
HHP No Pay	100	2	98%
Total	202	6	97%

- Six files exceed 15 working days after proof of loss to notify a claimant of the denial of a claim which is a violation of K.A.R. 40-1-34 Section 8(a)

The Company 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 the policy. K.S.A. 40-2404 (9) (f)&(g)

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any attempts to not settle a claim fair and promptly would have been reviewed, and the examiner would have noted it. There were no issues with the files that were reviewed.

HEALTH EXAM CLAIM STANDARDS

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

During the examination period, both HIC and HHP used only the timelines and notice requirements listed in the Kansas Prompt Pay Act when paying or denying claims. KID requires the continued use of the timelines and notices deadlines in the Unfair Claims Settlement Act for initial contact with the claimant, notices for extensions of time for investigations and resolutions in a timely manner as well as the requirements in the Prompt Pay Act in order to cover all claim situations. This requirement has been discussed with the Companies and written positions have been exchanged.

These violations are enumerated under Claim Handling, Standards 1, 2 and 3 found on pages 12-13 and are not repeated in this section of the report. The Companies failed General Exam Claim Standards 1 and 2.

Standard 2
The company complies with the requirements of the federal "Newborns and Mothers" Health Protection Act of 1996.

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any errors pertaining to this Act would have been written by the examiners. There were no issues within the file samples.

Standard 3
The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA).

The exam team did not specifically test for this standard. In the normal review of the sample claim files, any errors pertaining to this Act would have been written by the examiners. There were no issues within the file samples.

Standard 4
The company complies with applicable statutes, rules and regulations for group coverage replacements**.**

There were no replacements within the file samples.

Claim Handling Recommendations

1. The Company must review its claim practices and conduct the necessary training to assure that claimants are treated as 1st party claimants under all applicable sections of K.A.R. 40-1-34. During the examination, an argument was made by the company that claims submitted by providers were 3rd party claims and were not subject to K.A.R. 40-1-34. After a discussion, the Company and the examiners agreed that Humana policies were written as 1st party claims. Please provide evidence that claims are now being processed as 1st party claims.

2. The Company must amend its processing guidelines to include the timelines on all notices of coverage, investigations, acceptance and denial of claims, correspondence s and payment of claims as found in K.S.A. 40-2442 and K.A.R. 40-1-34, Sections 6, 7 and 8. Training for customer representatives and supervisors must be delivered to ensure consistent and timely claims processing. Please provide evidence that claims are now subject to both Kansas Unfair Claims Settlement Act and the Prompt Payment Act.

Examiner's Note: This issue was resolved during the finalizing of the exam report and the company agrees to amend its processing guidelines to follow the Prompt Payment Act for all health claims until such claim is no longer deemed a clean claim, specifically K.S.A. 40-2442, and then follow the timelines associated with the Unfair Claims Settlement, specifically K.A.R. 40-1-34 Sections 8(a) and 8(c), to complete further investigation and adjudication of claims.

SUMMARIZATION

This examination was conducted to review the operations/management policies, complaint files, claim files, grievance and appeal procedures as well as the internal review and quality assessment procedures utilized by this Company. The tests and standards were applied to create uniformity in the reporting of passes and failures. The examiners believe the recommendations are critical for the Company to implement as tools to treat all Kansas certificate and policyholders with uniformity and fairness. Our recommendations are listed below:

Grievances and Appeals

1. Several reviewed appeals concerned ER claims deemed to be contractual rather than medically necessary. Often the claimant was given conflicting information or incorrect information. Company letters appeared to address medically necessary issues but delayed the answer for up to 60 days. Others appeared to address contractual claims but were issued within 30 days. When the examiners questioned the Company, the consistent answer was that the customer representative had used the wrong letter.

While errors do occur, the number appeared high for appeals of this magnitude. It appears that further training, more detailed manuals and greater supervisory control are needed to adjudicate these appeals with greater accuracy. Please provide evidence that steps are being implemented to eliminate such errors.

Claims Handling

1. The Company must review its claim practices and conduct the necessary training to assure that claimants are treated as 1st party claimants under all applicable sections of K.A.R. 40-1-34. During the examination, an argument was made by the company that claims submitted by providers were 3rd party claims and were not subject to K.A.R. 40-1-34. After a discussion, the Company and the examiners agreed that Humana policies were written as 1st party claims. Please provide evidence that claims are now being processed as 1st party claims.

2. The Company must amend its processing guidelines to include the timelines on all notices of coverage, investigations, acceptance and denial of claims, correspondences and payment of claims as found in K.S.A. 40-2442 and K.A.R. 40-1-34, Sections 6, 7 and 8. Training for customer representatives and supervisors must be delivered to ensure consistent and timely claims processing. Please provide evidence that claims are now subject to both Kansas Unfair Claims Settlement Act and the Prompt Payment Act.

Examiner's Note: This issue was resolved during the finalizing of the exam report and the company agrees to amend its processing guidelines to follow the Prompt Payment Act for all health claims until such claim is no longer deemed a clean claim, specifically K.S.A. 40-2442, and then follow the timelines associated with the Unfair Claims Settlement, specifically K.A.R. 40-1-34 Sections 8(a) and 8(c), to complete further investigation and adjudication of claims.

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by Dan Haney, Craig Zimenk and Robin Verbruggen and the Claims, Complaint and Compliance staff in the DePere facility.

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

Market Conduct Division

Lyle Behrens Market Conduct Supervisor	Mary Lou Maritt Examiner-In-Charge	Tate Flott Market Conduct Examiner

Respectfully submitted,

_____

Mary Lou Maritt
Examiner-In-Charge

APPENDIX I

Related Kansas Insurance Statutes and Adminsitrative Regulations

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.

K.A.R. 40-4-41c - Utilization review organizations; written procedures
Each utilization review organization shall maintain the following written procedures.

(a) Written procedures to assure that reviews and second opinions are conducted in timely manner shall be maintained as follows.

(1) Each utilization review organization shall make prospective or concurrent certification determinations within two working days of receipt of the necessary information on a proposed admission or service requiring a review determination. Collection of the necessary information may necessitate a discussion with the health care provider, or based on the requirements of the health benefit plan, may involve a completed second opinion review.

(2) The utilization review organization may review ongoing inpatient stays, but shall not routinely conduct a daily review of all such stays. The frequency of the review for extension of the initial determination may vary, based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(3) Each utilization review organization shall make retrospective determinations, in the absence of any contractual agreement, within 30 days of the receipt of the necessary information.

K.S.A. 40-2,105. - Insurance coverage for services rendered in treatment of alcoholism, drug abuse or nervous or mental conditions; applicability or nonapplicability of section.
(a) On or after the effective date of this act, every insurer which issues any individual or group policy of accident and sickness insurance providing medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must provide for reimbursement or indemnity under such individual policy or under such group policy, except as provided in subsection (d), which shall be limited to not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or nervous or mental conditions in a medical care facility licensed under the provisions of K.S.A. 65-429 and amendments thereto, a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014 and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605 and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b and

amendments thereto or a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b and amendments thereto. Such individual policy or such group policy shall also provide for reimbursement or indemnity, except as provided in subsection (d), of the costs of treatment of such person for alcoholism, drug abuse and nervous or mental conditions, limited to not less than 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 in any year and limited to not less than $7,500 in such person's lifetime, in the facilities enumerated when confinement is not necessary for the treatment or by a physician licensed or psychologist licensed to practice under the laws of the state of Kansas.

(b) For the purposes of this section "nervous or mental conditions" means disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions:

(1) Not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, 1994); and

(2) defined as a mental illness in K.S.A. 2005 Supp. 40-2,105a and amendments thereto.

(c) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated.

(d) There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008 and amendments thereto or for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

(e) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

(f) The provisions of this section shall be applicable to the Kansas state employees health care benefits program developed and provided by the Kansas state employees health care commission.

(g) The outpatient coverage provisions of this section shall not apply to a high deductible health plan as defined in federal law if such plan is purchased in connection with a medical or health savings account pursuant to that federal law, regardless of the effective date of the insurance policy. After the amount of eligible deductible expenses have been paid by the insured, the outpatient costs of treatment of the insured for alcoholism, drug abuse and nervous or mental conditions shall be paid on the same level they are provided for a medical condition, subject to the yearly and lifetime maximums provided in subsection (a).

K.S.A. 40-2,126. - Interest Due On Insurance Settlements,

Except as otherwise provided by K.S.A. 40-447, 40-3110 and 44-512a, and amendments thereto, each insurance company, fraternal benefit society and any reciprocal or interinsurance exchange licensed to transact the business of insurance in this state which fails or refuses to pay any amount due under any contract of insurance within the time prescribed herein shall pay interest

on the amount due. If payment is to be made to the claimant and the same is not paid within 30 calendar days after the amount of the payment is agreed to between the claimant and the insurer, interest at the rate of 18% per annum shall be payable from the date of such agreement. If payment is to be made to any other person for providing repair or other services to the claimant and the same is not paid within 30 calendar days following the date of completion of such services and receipt of the billing statement, interest at the rate of 18% per annum shall be payable on the amount agreed to between the claimant and the insurer from the date of receipt of the billing statement.

K.S.A. 40-2404. - Unfair methods of competition or unfair and deceptive acts or practices; disclosure of nonpublic personal information; rules and regulations. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

K.S.A. 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.

K.S.A. 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.

K.S.A. 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.

K.S.A. 40-3228 - Procedures for resolving enrollee grievances (HMO)
A health maintenance organization shall provide in its certificate of coverage the procedures for resolving enrollee grievances. At a minimum, the certificate of coverage shall include the following provisions:

(a) The definition of a grievance;

(b) how, where and to whom the enrollee should file such enrollee's grievance; and

(c) that upon receiving notification of a grievance related for payment of a bill for medical services, the health maintenance organization shall:

(1) Acknowledge receipt of the grievance in writing within 10 working days unless it is resolved within that period of time;

(2) conduct a complete investigation of the grievance within 20 working days after receipt of a grievance, unless the investigation cannot be completed within this period of time. If the investigation cannot be completed within 20 working days after receipt of a grievance, the enrollee shall be notified in writing within 30 working days time, and every 30 working days after that, until the investigation is completed. The notice shall state the reasons for which additional time is needed for the investigation;

(3) have within five working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the decision of the health maintenance organization regarding the grievance and of any right to appeal. The notice shall explain the resolution of the grievance and any right to appeal. The notice shall explain the resolution of the grievance in terms which are clear and specific; and

(4) notify, if the health maintenance organization has established a grievance advisory panel, the enrollee of the enrollee's right to request the grievance advisory panel to review the decision of the health maintenance organization. This notice shall indicate that the grievance advisory panel is not obligated to conduct the review. This provision shall also state how, where and when the enrollee should make such enrollee's request for this review.

K.S.A. 40-2253. Universal accident and sickness insurance claim forms, design and use; acceptance of claims by insurer; uniform electronic data interchange formats and standards.

(a) The commissioner of insurance shall devise universal forms to be utilized by every insurance company, including health maintenance organizations where applicable, offering any type of accident and sickness policy covering individuals residing in this state for the purpose of receiving every claim under such policy by persons covered thereunder. In the preparation of such forms, the commissioner may confer with representatives of insurance companies, health maintenance organizations, trade associations and other interested parties. Upon completion and final adoption of such forms by the commissioner, the commissioner shall notify those companies affected by sending them a copy of such forms and an explanation of the requirements of this section. Every such company shall implement utilization of such forms not later than six months following the date of the commissioner's notification.

K.A.R. 40-4-40 - Accident and sickness insurance; claim forms; acceptance required.
(a) As used in this regulation:

(1) `Commissioner" means the commissioner of insurance, state of Kansas.

(2) `Claim form" shall mean any of the forms devised and promulgated by the commissioner pursuant to K.S.A. 1991 Supp. 40-2253.

(3) `Insurer" means insurance companies, health maintenance organizations, mutual non-profit medical and hospital service corporations, nonprofit dental service corporations, nonprofit optometric service corporations and nonprofit pharmacy service corporations.

(b) Insurers transacting business in this state shall accept and process any claim for benefits designated and submitted on a claim form as de- fined in subsection (a) of this regulation.

(c) Insurers shall not require health care providers, insureds or other persons to utilize a claim form promulgated by the commissioner if a simplified form will produce the information necessary to process the claim.

(d) This regulation does not prohibit an insurer from requesting additional information from a health care provider when such information is essential to a proper determination of benefit payments.

(e) Claim forms may be modified as necessary to accommodate the transmission and administration of claims by electronic means.

(f) The requirements imposed by this regulation shall take effect and be in force from and after 180 days following the regulation's effective date.

Bulletin 1992-20, K.A.R. 40-4-40; Universal Claim Forms, December 4 1992
Notified the insurance companies that KID had adopted form, HCFA 1500, as the standard medical form to be submitted by a hospital and form, UB82 and subsequent versions, as the approved form that a doctor or other medical provider should use to submit a claim to a carrier

<u>Mandated coverages</u>

Breast Reconstruction	K.S.A. 40-2,166
Dental anesthesia	K.S.A. 40-2,165

Diabetic supplies, education	K.S.A. 40-2,163
Emergency services	K.S.A. 40-4601 to 4608
Mammography screening	K.S.A. 40-2229 to 2230
Mental health, general	K.S.A. 40-2-105
Alcoholism treatment	K.S.A. 40-2,105
Drug abuse treatment	K.S.A. 40-2,105
Mental health parity	K.S.A. 40-2,105a
	K.S.A. 40-2,105b
	K.S.A. 40-2,105c
	K.S.A. 40-2,105d
Minimum maternity stays	K.S.A. 40-2,160
New Born & Mothers Health Protection Act	K.SA.A. 40-2,102
OB-GYN access	K.S.A. 2001 Supp. 40-4609
Off-label drug use	K.S.A. 40-2,103
	K.S.A. 40-19c09
Osteoporosis diagnosis & treatment	K.S.A. 40-2,166a
Pap smear coverage	K.S.A. 40-2229-2230
Prostate cancer screening	K.S.A. 40-2,164