

REPORT OF MARKET CONDUCT EXAMINATION
ETS# KS 023-M35

Trustmark Ins. Group
NAIC Group #276

Trustmark Life Ins. Co.
IL Domiciled Co.
NAIC # 62863,

Trustmark Ins. Co.
IL Domiciled Co.
NAIC # 61425

Trustmark Companies
400 Field Dr.
Lake Forest, IL 60045-2581

AS OF

June 30, 2009

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:

Trustmark Life Ins. Co.
And
Trustmark Ins. Co.
400 Field Dr.
Lake Forest, IL 60045-2581

Hereafter referred to as the “Company” or “Companies” and the following report of such examination is respectfully submitted,

Lyle Behrens, CPCU, CIE, FLMI, ARM, ARe
Market Conduct Supervisor

PURPOSE AND SCOPE OF REVIEW

A targeted market conduct examination of Trustmark Life Ins. Co. (TLIC) and Trustmark Ins. Co. (TIC) was conducted by the Kansas Insurance Department (KID) pursuant to K.S.A. 40-222. The exam team reviewed operations/management, complaints, grievance/appeal procedures, claims, quality assessment and utilization review programs 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 (MRH). 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 standards used are described and results indicated. Not all standards listed in the MRH were used in this exam, and therefore the reader will notice gaps in the numbering of these standards throughout the report.

The examination included a review of several samples of the Company's complaint and appeal files from January 1, 2007 to June 30, 2009 and closed claim files from July 1, 2008 to June 30, 2009.

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:

COMPANY OPERATIONS AND MANAGEMENT

- History and Profile
- Management Agreements
- Fines and/or Penalties
- Certificates of Authority
- Internal Audit Procedures
- TPA

COMPLAINT HANDLING/GRIEVANCE PROCESS

- Consumer Complaints
- Appeal Process
- Grievance Process

QUALITY ASSESSMENT & IMPROVEMENT PLAN

- Quality Assessment Plan
- Quality Improvement Plan

CLAIMS PRACTICES

- Policy Forms and Filings
- Paid Claims
- Declined Claims
- TPA Claims

EXECUTIVE SUMMARY

The Kansas Insurance Department (KID) performed a market conduct examination of Trustmark Life Insurance Company (TLIC) and Trustmark Insurance Company (TIC). The period of examination was January 1, 2007 through June 30, 2009.

The number of complaints received at KID for these two companies combined was 20 in 2007, 12 in 2008, and 20 during the first half of 2009. Because of these complaints, KID undertook this targeted market conduct exam. The complaints filed with KID were primarily claims related. In discussions with the Company about the significant increase in their complaint ratio, they felt it was centered in a book of business that was administered by a third party administrator (TPA), Harrington Health (HH). The company had been working with this TPA to resolve the problems that contributed to this issue. Both the Company and the TPA indicated that they had made significant strides in 2009 to correct what they felt was the problem.

As part of the testing process, the exam team divided the HH claim review into separate samples of claims processed in last the half of 2008 and the first six months of 2009. This was done to determine if there was in fact an improvement in the timeliness of the claim handling by HH for 2009. Overall the 2008 HH claims sampled averaged a 12.3% error rate, while the 2009 HH claims sampled averaged a 6.3% error rate. This shows an overall improvement; however, some 2009 claims standards still exceeded the 7% error tolerance level recommended in the NAIC Market Regulation Handbook (MRH). All other claims sampled (other than HH administered claims) averaged only a 2.3% error rate. Further detail on the individual errors can be found in the exam report.

Summary of errors that failed Standards within the Market Regulation Handbook:

Grievances & Appeals

Failure to conduct first-level appeals properly – 53 total appeals in violation (55% error rate)

- not acknowledging within 10 days per K.A.R. 40-1-34, 6 - 45 appeals
- not handling within 30 days per K.S.A. 40-2442(a) – 44 appeals
- giving incorrect information regarding appeal rights – 2 appeals
- not making decision within 15 days of receiving additional information – 1 appeal

Failure to conduct second-level appeals properly – 13 total appeals in violation (87% error rate)

- not acknowledging within 10 days per K.A.R. 40-1-34, 6 - 13 appeals
- not paying interest on claims that took over 30 days per K.S.A. 40-2442 (a)&(b) – 4 appeals
- not maintaining adequate claim file documentation per K.A.R. 40-1-34, 4 – 1 appeal
- not notifying of rights to external review per K.A.R. 40-4-42a – 6 appeals

Failure to notify insureds of right to waive second level review per K.S.A. 40-22a09a(a)

Claims

Failure to contact claimant timely per K.A.R. 40-1-34, 6(a) - 112 claims (25% error rate)

Failure to resolve claims in timely manner per K.S.A. 2442 (a)(b) – 40 claims (16% error rate)

Failure to handle claims properly – 34 claims (17% error rate)

- not paying interest as required by K.S.A. 40-2442 (b)(d)(2) – 33 claims
- not paying correct benefit amount, K.A.R. 40-1-34, 5(a) – 1 claim

LIST OF RECOMMENDATIONS

Complaint, Grievance and Appeals Recommendations

1. The Company needs to review their complaint handling process to insure that complaints from KID are handled within 15 working days of receipt of the complaint. Per K.A.R. 40-1-34, 6(b).
2. The Company needs to review their appeal process to insure that all Level 1 and Level 2 appeal timelines are met. This would include acknowledging the appeal within 10 working days and responding with a decision to the appeal within the timelines spelled out in their procedures and the Kansas statute. Per K.S.A. 40-2442 and K.A.R. 40-1-34, 6(a).
3. The Company needs to follow up with HH to insure that they are meeting all Level 1 and Level 2 timelines. This would include acknowledging the appeal within 10 working days and responding with a decision to the appeal within the timelines spelled out in their procedures and Kansas statute. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to KID insurance code. Per K.S.A. 40-2442 and K.A.R. 40-1-34, 6(c).
4. The Company needs to follow up with HH on all Level 1 and Level 2 appeals where it takes longer than 30 days to reprocess the claim to ensure interest is being paid appropriately. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to Kansas insurance code. Per K.S.A. 40-2442 (a)(b).
5. The Company needs to follow up with HH to ensure insureds are notified of their right to waive the second level review. Per K.S.A. 40-22a09a(b)
6. The Company needs to follow up with HH on all Level 2 appeals that when a denial is upheld the insured is advised of their right to an external review. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to Kansas insurance code. Per K.A.R. 40-4-42a.
7. The Company needs to follow up with HH on their complaint, Level 1 Appeal and Level 2 Appeal logs to insure that the TPA is accurately coding and documenting complaints and appeals. Within 30 days the company should provide documentation that HH is monitoring and accurately coding their complaint and appeal logs. Per K.S.A. 40-2404 (10) and K.S.A. 40-2405.

Claims Handling Recommendations

1. Both the Company and HH need to review their procedures to insure there is a confirmation letter sent to the insured within 10 working days of receipt of a claim per K.A.R. 40-1-34, 6(a). Within 30 days the company should provide documentation that the Company and HH are sending out acknowledgement letters within 10 days of receipt of a claim.

2. The Company and HH met with KID after the time period of the exam to restate their commitment and plan to monitor HH's improvement in their claim processing. Within 30 days the Company needs to provide KID with a year end 2009 report of their monitoring process to substantiate that HH is now adjudicating claims within 30 days. Per K.S.A. 40-2442.

3. Within 30 days the Company needs to provide KID with a report showing the status of HH going back and paying interest on the claims in 2007, 2008 and 2009 that took over 30 days to pay and interest was not included in the settlement payment. Per K.S.A. 40-2442 (b)(d)(2).

4. Within 30 days the Company needs to provide KID with some documentation that HH has in place a process to pay interest on future claims that take over 30 days to pay. Per K.S.A. 40-2442 (b)(d)(2).

DESK EXAMINATION/ON-SITE EXAMINATION

OPERATIONS AND MANAGEMENT

History and Profile

Trustmark Life Insurance Company
Date Incorporated: 01/25/1925
Domicile: IL

TLIC was originally incorporated in 1925 in Minnesota as the Employees Mutual Benefit Association of Saint Paul. In 1985 they changed their name to Horizon Life Insurance Company. The following year the title was again changed to Trustmark Life Insurance Company. TLIC re-domesticated to Illinois in 1991.

Source: **AMB Credit Report - Insurance Professional**, Report Revision Date: 02/02/2009

Trustmark Insurance Company
Date Incorporated: 01/18/1913
Domicile: IL

In 1913, four enterprising railroad employees decided that "passing the hat" no longer adequately provided financial security for an injured or disabled coworker. They formed a fraternal association, known as the Brotherhood of All Railway Employees, offering insurance benefits. Ten years after its founding, it became a mutual insurance company, managed for the benefit of its policyholders. The company was renamed Benefit Trust Life Insurance Company in 1963. In 1985, the company acquired mutual insurer EMBA, converted it to a stock company and renamed it Trustmark Life. The name Trustmark was subsequently adopted for the entire company in 1994.

Source: Company website.

Certificate of Authority

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

Internal Audits

The company shared with the examiners their claims auditing procedures. They also provided five audits of business units that were completed during the exam period.

Due to an increase on complaints and inquiries from KID, the Company conducted an audit of their TPA, HH, in May of 2009. As a result of these findings they conducted a follow-up audit in August 2009.

The audit summaries were shown to KID prior to the commencement of the exam. There were no audit reports on HH presented to the exam team prior to the May 2009 report.

Prior Market Conduct Examination Report(s)

The Company provided the examiners with the market examination reports from the prior two years. There were no recommendations in these exams that required a follow-up during this examination.

Fines and/or Penalties

The NAIC I-Site database was reviewed. There was nothing noted that warranted a follow-up by the 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 shared with the examiners their claims auditing procedures. They also provided 5 audits of business units that were completed during the exam period.

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.

As a result of an increase in complaints over a period of time and inquiries from KID, the Company conducted an extensive audit of their TPA, HH, in May of 2009. As a result of these findings they conducted a follow up audit in August 2009. The company presented these findings to KID along with a remediation plan put together by the Company and HH.

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.

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.

The Company provided the exam team with the necessary records and documents in a timely fashion.

The Company passed Standard 9.

COMPLAINT HANDLING, GRIEVANCE AND APPEAL PROCEDURES

The company defines a complaint as “any written communication primarily expressing a grievance.”

For terminology purposes, the Company calls any written correspondence from KID as a complaint. Any written request received directly from a member, provider or representative is an appeal which is defined as a formal request to reconsider a determination not to certify an admission, extension of stay or other health care service. These are categorized as Level 1, Level 2 and External Review.

The following is the Company’s notice of grievance procedures:

Notice of Grievance Procedures for Kansas Residents

If You have questions about any decisions related to Your coverage, You may call Us and a Customer Service Representative will assist You.

[LEVEL 1: You, Your medical provider, or Your personal representative may submit a written request for a formal grievance review, if You have a complaint about any of the following:

- Trustmark’s decisions, policies, or actions related to coverage of health care services;
- Claims payment or handling;
- The contractual relationship between a Covered Person and Trustmark;
- The outcome of an appeal on a denial of certification of an admission or service, or continued stay or treatment.

Your written request should contain the issues and comments which are pertinent and should be sent or faxed to:]

Trustmark Life Insurance Company
[Grievance and Appeal]
[8324 South Avenue]
[Boardman, OH 44512]
[Fax (330) 965-7599]

You may contact the Commissioner of Insurance for assistance at:

Kansas Department of Insurance
420 SW 9th Street

Topeka, Kansas 66612-1678
1-800-432-2484

You are not required to exhaust all levels of grievance review prior to requesting an External Review upon the occurrence of any of the following:

- Our failure to make a decision on a final internal grievance within the 60 day time frame required;
- Our mutual agreement with You to bypass the internal grievance procedure;
- A medical condition which seriously jeopardizes Your life or health; or
- Your death.

Within 10 working days after receiving Your written request for a review of Your grievance, We will send a notification of the investigation process, if the complaint has not already been resolved. A status report will be sent to You or Your representative every 30 days until resolution.

After a review is completed, a written decision, including reason, will be sent to You within 30 calendar days after receipt of the complaint. If there are special circumstances requiring an extensive review, the final decision will be made within 90 calendar days after receipt of the complaint. You will be notified if it will take longer than 30 days, why additional time is needed, and when final resolution can be expected.

[LEVEL 2: If You are dissatisfied with the results of the Level I review of Your grievance, You, Your medical provider or Your personal representative, on Your behalf, may request a second level grievance review.

We will, within 10 working days after receiving Your Level 2 review request, send a notification of the investigation process.

We will provide You, Your medical provider or Your personal representative with a written decision providing the relevant facts and conclusions supporting our decision within:

Seventy-two (72) hours if the Level 2 review involves an emergency medical condition as defined by Kansas law; or

Fifteen (15) business days if the Level 2 review involves a pre-service claim; or

Thirty (30) days if the Level 2 appeal involves a post-service claim.

If We deny Your claim for medical services at the Level 2 review, We will advise You that Our decision is a final adverse decision and advise You of Your right to request an External Review and provide the information necessary to file a request for an External Review.

You, Your medical provider or Your personal representative have the right to appear in person before the Grievance Review Committee for a Level 2 review of your claim. A written request to appear must be submitted within 5 days of the scheduled review meeting, except in the case of an

emergency medical condition, such request must be made no less than 24 hours prior to the scheduled meeting.

If for some reason, the majority of the designated representatives of the Grievance Review Committee cannot be present in person or by other electronic means during the Level 2 review, then at least one of the designated representatives of the Committee who will be making the determination will be a physician, who will be present in person or by telephone or other electronic means. No physician or health care provider serving as a reviewer in the Level 2 review shall be liable in damages to the insured or the health plan for any opinion rendered as part of the Level 2 review.

You, Your medical provider or Your personal representative have the right to: receive, upon request, copies of records that are not confidential or privileged relevant to your request for benefits; and a reasonable and adequate amount of time to present Your case to the Grievance Review Committee and to submit written comments and documents relevant to your request for benefits at the Level 2 review before, or during the Level 2 review; and ask questions prior to or during the Level 2 review, to the Committee. The Committee may respond verbally if questions are asked during the review or in writing if such questions are submitted in writing, within 30 days of receipt of the questions.

You, Your medical provider or Your personal representative has the right to record the Level 2 review, at Your expense.

You, Your medical provider or Your personal representative may voluntarily waive your right to a Level 2 appeal by sending us written notification of the decision to do so. Such a waiver constitutes the exhaustion of all available levels of internal appeal.

EXTERNAL REVIEW: If You feel that the Level 1 review and the Level 2 review decision does not comply with the terms of Your Certificate, You or Your authorized representative have the right to request an External Review by an independent review organization. Your right to an External Review may be based on an adverse decision during the Levels 1 and 2 reviews including when a health care service or treatment that would otherwise be covered under Your plan was determined to be experimental, investigational or not medically necessary, and such determination leaves You with a financial obligation to the provider(s) of such services or prevents You from receiving such services. A request for an External Review may be filed by You or Your authorized representative and must be made within 90 days after the date You receive Our final adverse determination. The Commissioner of Insurance will review Your, or Your authorized representative's request for an External Review and notify You, or your authorized representative and Us within 10 days if:

- the request for External Review is complete and has been accepted;
- the request for External Review is not complete; or
- the request for External Review is not accepted.

If your request for External Review is accepted, Your claim will be assigned to an Independent Review Organization for review. The External Review determination is the final determination for purposes of this adverse decision and these grievance procedures.

EXPEDITED REVIEW: If You have an emergency medical condition, and have received a final adverse determination from Us, You or Your authorized representative, may write the Commissioner of Insurance and request an expedited External Review. If the request is complete and is accepted by the Commissioner, Your claim will be assigned to an Independent Review Organization. An Expedited Review decision and notice thereof will be made expeditiously as Your medical condition or circumstances requires, but not more than 7 days after the receipt of the request. Written confirmation of the decision will be provided within 2 working days of notice of the decision. Expedited external reviews are not provided for retrospective adverse decisions.

CLAIM REVIEW AND APPEALS PROCEDURE NOTICE

1. Rights of Review and Appeals

If a claim for benefit payment is denied, in whole or part for any reason, your Plan's claim procedures provide you or your authorized representative the opportunity to appeal the denial. A complete copy of your Plans Claim Procedures is contained in your Plan Document and is also available from your Plan Administrator.

2. Appeal Procedures

The request for review must be submitted in writing to the Plan Administrator within 180 days, or as outlined in your plan document, after the date of the claim payment or notification of denial of benefits.

A request for expedited review of Urgent Care claims may be made orally to the Plan Administrator. All required information, as well as the determination of the request for review, may be made between the covered person or their representative and the Plan Administrator through telephone, facsimile, email or other expeditious methods.

3. Appeal Decision

You will be notified of the Plan Administrator's final decision on appeals, according to plan guidelines, as follows:

- Urgent care claims - 72 hours after receipt of the request for review
- Pre-service claims - 30 calendar days after receipt of the request for review
- Post-service claims - 60 calendar days after receipt of the request for review
- Disability claims - 45 calendar days after receipt of the request for review

Additional time for review may be allowed in accordance with plan provisions and applicable regulations. You will be notified in writing of any extension required to respond to your appeal. If the appeal concerns a benefit determination

involving medical necessity or appropriateness, experimental treatments or other medical judgments, an appropriate health care professional will be consulted.

4. Governing Law

ERISA Plans - You have the right to bring a civil action under section 502(a) of ERISA following the appeal of a claim denial. To determine whether ERISA applies to your plan, please contact your Plan Administrator.

Non-ERISA plans (generally government and church plans) may not have the same rights as described above and may be subject to different state and/or federal rules. Please see your plan document for further information.

Insured Plans - If your plan is governed by the insurance laws of your state, your state may have different requirements than those shown above. Please see your plan document for the appropriate appeal process.

While HH's "Complaints, Grievances and Appeals" procedures call for one level of appeal, HH's log indicates that there is a 2nd level of appeals, and there are numerous references in their files about a 2nd level of appeal. The written appeal process to the certificate holder must include reference to these procedures per K.S.A. 40-22a09a:

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 their complaint log and HH's 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.

The Company has complaint procedures documented and provided KID with copies of their complaint logs for both their company-administered business and the business handled by their TPA, HH.

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.

For the most part the Company corrected the situation when the complaint was filed and it was determined that the member was entitled to additional benefits.

There was one claim that the examiner required the Company to go back on and pay additional interest per K.S.A. 40-2442.

The Company passed 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).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
DOI Complaints	57	5	91%

- Five DOI complaints were not responded to within 15 working days. This is a violation of K.A.R. 40-1-34, 6.

The Company passed Standard 4.

Tests for Grievance and Appeals Procedures

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.

See the comments under complaint handling regarding how the Company defines and handles grievances and appeals.

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.

The Company has Level 1 and 2 appeal procedures in place for their large group, small group (Starmark), individual medical and affinity market business that meet K.S.A. 40-3228. The policy certificate spells out the member's complaint and appeal process. It also advises the consumer of their rights under the external review process. For adverse appeal

determinations, the denial letter explains the process to go through for an external review and lists the Kansas Insurance Department as an alternate resource for dispute resolution.

While HH’s “Complaints, Grievances and Appeals” procedures call for one level of appeal, HH’s log indicates that there is a 2nd level of appeals, and there are numerous references in their files about a 2nd level of appeal. The appeal process to the insured holder must include reference to these procedures per K.S.A. 40-22a09a:

HH does maintain a log for Level 1 and 2 appeals. The control of this document and review by management to insure its accuracy and use as a quality control and training tool appears deficient. Out of the nineteen Level 2 appeals reviewed by the exam team, HH subsequently indicated that five of them should not have been coded as Level 2 Appeals. The exam team removed four of them from the Level 2 list of reviewed items. This is a violation of K.S.A. 40-22a09a as referenced above.

The Company failed 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.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Company Level 1 Appeals	48	12	75
HH Level 1 Appeals	<u>48</u>	<u>41</u>	<u>15</u>
Total	96	53	45

Company Level 1

- Four appeals did not have an acknowledgement sent to the certificate holder within 10 working days. This is a violation of K.A.R. 40-1-34, 6.
- Five appeals took over 30 days from the receipt of the appeal till the EOB was issued showing the final claim payment amount. This is a violation of K.S.A. 40-2442 (a).
- One file did not have a decision to either uphold or reverse the claim denial within 15 days after receipt of the additional information. This is a violation of K.S.A. 40-2442 (a)(d).
- Two files had the wrong information provided to the insured regarding their appeals rights. This is a violation of K.A.R. 40-1-34, 5.

HH Level 1

- Forty-one files did not have contact with the certificate holder or provider within 10 days of receipt of the appeal. This is a violation of K.A.R. 40-1-34, 6.

- Thirty-eight files did not have a response to the certificate holder within 30 days of receipt of the appeal. This is a violation of K.S.A. 40-2442 (a).

The Company failed Standard 4.

Standard 5

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

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Company Level 2 Appeals	2	0	100
HH Level 2 Appeals	<u>15</u>	<u>13</u>	<u>13</u>
Total	17	13	24

HH Level 2

- Thirteen files did not have contact with the certificate holder or provider within 10 days of receipt of the appeal. This is a violation of K.A.R. 40-1-34, 6.

- Eight files did not have a response to the certificate holder within 30 days of receipt of the appeal. This is a violation of K.S.A. 40-22a09a.

- Four Level 2 appeals were reprocessed and the money was paid to the provider on behalf of the certificate holder; interest was not paid on the claims that took over 30 days to reprocess from the date of receipt of the Level 2 appeal per K.S.A. 40-2442 (a) & (b):

- One claim had no documentation to substantiate HH’s final decision and communication to the certificate holder. This is a violation of K.A.R. 40-1-34, 4.

- Six 2nd level appeals had the denial of the claim upheld and did not advise the certificate holder in the 2nd level denial letter of their right to file for an external review. This is a violation of K.A.R. 40-4-42a.

The Company failed Standard 5.

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.

Complaint, Grievance and Appeals Recommendations

1. The Company needs to review their complaint handling process to insure that complaints from KID are handled within 15 working days of receipt of the complaint. Per K.A.R. 40-1-34, 6(b).
2. The Company needs to review their appeal process to insure that all Level 1 and Level 2 appeal timelines are met. This would include acknowledging the appeal within 10 working days and responding with a decision to the appeal within the timelines spelled out in their procedures and the Kansas statute. Per K.S.A. 40-2442 and K.A.R. 40-1-34, 6(a).
3. The Company needs to follow up with HH to notify insureds of their right to waive the second level review. Per K.S.A. 40-22a09a(b)
4. The Company needs to follow up with their TPA to insure that the TPA is meeting all Level 1 and Level 2 timelines. This would include acknowledging the appeal within 10 working days and responding with a decision to the appeal within the timelines spelled out in their procedures and Kansas statute. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to KID insurance code. Per K.S.A. 40-2442 and K.A.R. 40-1-34, 6(c).
5. The Company needs to follow up with their TPA on all Level 1 and Level 2 appeals where it takes longer than 30 days to reprocess the claim and insure that they are paying interest. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to Kansas insurance code. Per K.S.A. 40-2442 (a)(b).
6. The Company needs to follow up with their TPA on all Level 2 appeals that when a denial is upheld the member is advised of their right to an external review. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to Kansas insurance code. Per K.A.R. 40-4-42a.
7. The Company needs to follow up with their TPA on their complaint, Level 1 Appeal and Level 2 Appeal logs to insure that the TPA is accurately coding and documenting complaints and appeals. Within 30 days the company should provide documentation that HH is monitoring and accurately coding their complaint and appeal logs. Per K.S.A. 40-2404 (10) and K.S.A. 40-2405.

QUALITY ASSESSMENT AND IMPROVEMENT

Trustmark Life Insurance Company and Trustmark Insurance Company participate in a voluntary Quality Assessment program administered by CoreSource, Inc. The purpose is to promote objective and systematic measurement, monitoring and evaluation of services and to implement activities designed to create improvement in areas based on findings obtained through this program. While the Quality Management Committee conducts monthly meeting of to review the progress on Quality Improvement Projects, activities and goals, an annual report is provided to Trustmark's Executive

Board which has final oversight responsibility. Their TPA, Harrington, Inc., also conducts its own Quality Assurance program on timeliness and accuracy of all its contracted administrative functions.

Standard 1

The health carrier develops and maintains a quality assessment program in compliance with applicable statutes, rules, and regulations.

Trustmark Life Insurance Company and Trustmark Insurance Company are not required to submit Quality Assessment reports to the Kansas Insurance Department for health insurance policies not organized under an HMO. However, these companies do participate in a voluntary Quality Assessment program administered by CoreSource, Inc. The purpose is to promote objective and systematic measurement, monitoring and evaluation of services and to implement activities designed to create improvement in areas based on findings obtained through this program. Their TPA, Harrington, Inc., also conducts its own Quality Assurance program on timeliness and accuracy of all its contracted administrative functions.

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 filing meets applicable statutes, rules, and regulations. K.S.A. 40-3211(b).

Not applicable to the Trustmark Insurance Group

Standard 3

The health carrier develops and maintains a quality improvement program, in compliance with applicable statutes, rules, and regulations.

CoreSource, Inc. has established QI program goals through its HCM Department which is reviewed, evaluated and revised by the Quality Management Committee. These goals include the areas of: consumer complaints, physician peer review, measurements and timeliness, certification of professionals, staff orientation and internal performance review.

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).

Not applicable to the Trustmark Insurance Group

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).

Not applicable to the Trustmark Insurance Group

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).

Not applicable to the Trustmark Insurance Group

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.

Monthly meeting of the Quality Management Committee are conducted to review the progress on Quality Improvement Projects, activities and goals. A report is sent annually to Trustmark’s Executive Board which has final oversight responsibility.

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).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Large Group Paid	50	1	98
Large Group No Payment	50	2	96
Small Group Paid	100	15	85
Small Group No Payment	50	13	74
Individual Paid	13	0	100
Individual No Payment	48	0	100
Harrington TPA 2008 Paid	100	36	64
Harrington TPA 2009 Paid	99	23	77
Harrington TPA 2008 No Payment	50	17	66
Harrington TPA 2009 No Payment	<u>50</u>	<u>8</u>	<u>84</u>
Total	610	115	81

Large Group Paid Claims

-One claim did not have an acknowledgement letter sent within 10 working days after receipt of a claim. This is a violation of K.A.R. 40-1-34, 6(a).

Large Group No Payment Claims

-Two claims did not have an acknowledgement letter sent within 10 working days after receipt of a claim. This is a violation of K.A.R. 40-1-34, 6(a).

Small Group Paid Claims

-Fifteen claims did not have an acknowledgement letter sent within 10 working days after receipt of a claim. This is a violation of K.A.R. 40-1-34, 6(a).

Small Group No Payment Claims

- Thirteen claims did not have an acknowledgement letter sent within 10 working days after receipt of a claim. This is a violation of K.A.R. 40-1-34, 6(a).

Harrington TPA 2008 Paid Claims

- Thirty-six claims did not have an acknowledgement of the receipt of claim within 10 working days after receipt of a claim. This is a violation of K.A.R. 40-1-34, 6(a).

Harrington TPA 2009 Paid Claims

- Twenty-three claims did not have an acknowledgement of the receipt of claim within 10 working days after receipt of a claim. This is a violation of K.A.R. 40-1-34, 6(a).

Harrington TPA 2008 No Payment Claims

- Seventeen claims did not have an acknowledgement of the receipt of claim within 10 working days after receipt of a claim. This is a violation of K.A.R. 40-1-34, 6(a).

Harrington TPA 2009 No Payment Claims

- Eight claims did not have an acknowledgement of the receipt of claim within 10 working days after receipt of a claim. This is a violation of K.A.R. 40-1-34, 6(a).

The Company did indicate that they have a process in place to send out acknowledgement letters for all product lines. In some cases the letters were not sent because the parameters that their system looks at to generate the acknowledgement letter were not met. For example, the type of information scanned into their system must be coded as a HCFA, UB92, Superbill or Prescription in order to trigger the letter. If the information is coded as something else, such as medical records (in error), the acknowledgement letter won't be sent. There were also a few instances where the claim was not received timely from our PPO network and in those cases the acknowledgement letter would not have been sent timely.

The above statement does not apply to the HH book of business. The errors noted for the other books of business pertain to the documentation provided to the exam team by the Company.

The Company failed Standard 1.

Standard 2

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

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Large Group Paid	50	0	100
Large Group No Payment	50	0	100
Small Group Paid	100	0	100
Small Group No Payment	50	0	100
Individual Paid	13	0	100
Individual No Payment	48	0	100
Harrington TPA 2008 Paid	100	0	100
Harrington TPA 2009 Paid	99	2	98
Harrington TPA 2008 No Payment	50	0	100
Harrington TPA 2009 No Payment	<u>50</u>	<u>0</u>	<u>100</u>
Total	610	2	99

Harrington 2009 No Payment Claims

- Two claims had no follow up with the insured advising them that there were delays in processing the claim. This is a violation of K.A.R. 40-1-34, 8(c).

The Company passed 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)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Large Group Paid	50	1	98
Large Group No Payment	50	3	94
Small Group Paid	100	2	98
Small Group No Payment	50	0	100
Individual Paid	13	0	100
Individual No Payment	48	3	94
Harrington TPA 2008 Paid	100	23	77
Harrington TPA 2009 Paid	99	9	91
Harrington TPA 2008 No Payment	50	8	84
Harrington TPA 2009 No Payment	<u>50</u>	<u>3</u>	<u>94</u>
Total	610	52	91

Large Group Paid Claim

- One claim took over 30 days to pay a claim. This is a violation of K.S.A. 40-2442(a)(b).

Large Group No Payment Claims

- Three claims took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442(a)(b).

Small Group Paid Claim

- Two claims took over 30 days to pay a claim. This is a violation of K.S.A. 40-2442(a)(b).

Individual Member No Payment Claim

- Three claims took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442(a)(b).

Harrington TPA 2008 Paid Claims

- Twenty-three claims took over 30 days to pay the claim. This is a violation of K.S.A. 40-2442 (a)(b).

Harrington TPA 2009 Paid Claims

- Nine claims took over 30 days to pay the claim. This is a violation of K.S.A. 40-2442 (a)(b).

Harrington TPA 2008 No Payment Claims

- Eight claims took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442 (a)(b).

Harrington TPA 2009 No Payment Claims

- Three claims took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442 (a)(b).

The Company failed 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).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Large Group Paid	50	0	100
Large Group No Payment	50	0	100
Small Group Paid	100	0	100
Small Group No Payment	50	0	100
Individual Paid	13	0	100
Individual No Payment	48	0	100
Harrington TPA 2008 Paid	100	0	100
Harrington TPA 2009 Paid	99	0	100
Harrington TPA 2008 No Payment	50	0	100

Harrington TPA 2009 No Payment	<u>50</u>	<u>0</u>	<u>100</u>
Total	610	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).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Large Group Paid	50	0	100
Large Group No Payment	50	0	100
Small Group Paid	100	0	100
Small Group No Payment	50	0	100
Individual Paid	13	0	100
Individual No Payment	48	0	100
Harrington TPA 2008 Paid	100	0	100
Harrington TPA 2009 Paid	99	0	100
Harrington TPA 2008 No Payment	50	0	100
Harrington TPA 2009 No Payment	<u>50</u>	<u>0</u>	<u>100</u>
Total	610	0	100

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.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Large Group Paid	50	2	96
Large Group No Payment	50	0	100
Small Group Paid	100	0	100
Small Group No Payment	50	1	98
Individual Paid	13	0	100
Individual No Payment	48	0	100
Harrington TPA 2008 Paid	100	24	76
Harrington TPA 2009 Paid	99	10	90
Harrington TPA 2008 No Payment	50	1	98

Harrington TPA 2009 No Payment	<u>50</u>	<u>1</u>	<u>98</u>
Total	610	39	94

Large Group Paid Claim 1

- One claim did not have interest paid when there was a delay in processing. This is a violation of K.S.A. 40-2442.
- One claim did not have interest paid when it was re-adjudicated due to an earlier processing error. This is a violation of K.S.A. 40-2442.

Small group No payment Claims

- One claim had all benefits misapplied to the deductible. This is a violation of K.S.A. 40-2,105.

Harrington TPA 2008 Paid Claims

- Twenty-three claims were not adjudicated within 30 days, and interest was not paid to the insured. This is a violation of K.S.A. 40-2442 (b) (d)(2).
- One claim was reprocessed due to an error, but interest was not included on the additional amount paid to the insured. This is a violation of K.S.A. 40-2442 (b) (d)(2).

Harrington TPA 2009 Paid Claims

- Nine claims were not adjudicated within 30 days, and interest was not paid to the insured. This is a violation of K.S.A. 40-2442 (b) (d)(2).
- One claim had incorrect benefit limits applied to the claim. This is a violation of K.A.R. 40-1-34, 5(a)

Harrington TPA 2008 No Payment Claims

- One claim had incorrect benefit limits applied to the claim. This is a violation of K.A.R. 40-1-34, 5(a)

Harrington TPA 2009 No Payment Claims

- One claim had the co-pay misapplied. This is a violation of K.A.R. 40-1-34, 5(a)

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 the Company. 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).

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Large Group No Payment	50	0	100
Small Group No Payment	50	0	100
Individual No Payment	48	3	94
Harrington TPA 2008 No Payment	50	8	84
Harrington TPA 2009 No Payment	<u>50</u>	<u>3</u>	<u>94</u>
Total	248	14	94

Individual Member No Payment Claim

- Three claims took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442(a)(b).

Harrington TPA 2008 No Payment Claims

- Eight claims took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442 (a)(b).

Harrington TPA 2009 No Payment Claims

- Three claims took over 30 days to adjudicate. This is a violation of K.S.A. 40-2442 (a)(b).

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.

One of the triggers of this exam was a number of complaints relating to claims handling and delays in the claim adjudication process. Problem areas have been noted in the General Exam Claim Standards section above.

Standard 2

The company complies with the requirements of the federal “Newborns and Mothers” Health Protection Act of 1996.

As a result of a complaint filed with KID, the Company had previously agreed to go back and review their maternity claims. They provided the examiners with documentation that the project was completed.

Standard 3

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

As the result of one claim having all benefits mis-applied to the deductible, the Company went back and reviewed all other mental health claims for that group to confirm that this was an isolated error. There were no other claims identified that were not paid in accordance with K.S.A. 40-2,105.

Claims Handling Recommendations

1. Both the Company and their TPA need to review their procedures to insure there is a confirmation letter sent to the insured within 10 working days of receipt of a claim per K.A.R. 40-1-34, 6(a). Within 30 days the company should provide documentation that the Company and HH are sending out acknowledgement letters within 10 days of receipt of a claim.
2. The Company and the TPA met with KID after the time period of the exam, 2008 through the first 6 months of 2009, to restate their commitment and plan to monitor HH’s improvement in their claim processing. Within 30 days the Company needs to provide KID with a year end 2009 report of their monitoring process to substantiate that HH is now adjudicating claims within 30 days. Per K.S.A. 40-2442.
3. Within 30 days the Company needs to provide KID with a report showing the status of HH going back and paying interest on the claims in 2007, 2008 and 2009 that took over 30 days to pay and interest was not included in the settlement payment. Per K.S.A. 40-2442 (b)(d)(2).
4. Within 30 days the Company needs to provide KID with some documentation that HH has in place a process to pay interest on future claims that take over 30 days to pay. Per K.S.A. 40-2442 (b)(d)(2).

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:

Complaint, Grievance and Appeals Recommendations

1. The Company needs to review their complaint handling process to insure that complaints from KID are handled within 15 working days of receipt of the complaint. Per K.A.R. 40-1-34, 6(b).
2. The Company needs to review their appeal process to insure that all Level 1 and Level 2 appeal timelines are met. This would include acknowledging the appeal within 10 working days and responding with a decision to the appeal within the timelines spelled out in their procedures and the Kansas statute. Per K.S.A. 40-2442 and K.A.R. 40-1-34, 6(a).
3. The Company needs to follow up with HH to notify insureds of their right to waive the second level review. Per K.S.A. 40-22a09a(b).
4. The Company needs to follow up with their TPA to insure that the TPA is meeting all Level 1 and Level 2 timelines. This would include acknowledging the appeal within 10 working days and responding with a decision to the appeal within the timelines spelled out in their procedures and Kansas statute. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to KID insurance code. Per K.S.A. 40-2442 and K.A.R. 40-1-34, 6(c).
5. The Company needs to follow up with their TPA on all Level 1 and Level 2 appeals where it takes longer than 30 days to reprocess the claim and insure that they are paying interest. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to Kansas insurance code. Per K.S.A. 40-2442 (a)(b).
6. The Company needs to follow up with their TPA on all Level 2 appeals that when a denial is upheld the member is advised of their right to an external review. Within 30 days the Company should provide documentation that HH's complaint and appeal process is conforming to Kansas insurance code. Per K.A.R. 40-4-42a.
7. The Company needs to follow up with their TPA on their complaint, Level 1 Appeal and Level 2 Appeal logs to insure that the TPA is accurately coding and documenting complaints and appeals. Within 30 days the company should provide documentation that HH is monitoring and accurately coding their complaint and appeal logs. Per K.S.A. 40-2404 (10) and K.S.A. 40-2405.

Claims Handling Recommendations

1. Both the Company and their TPA need to review their procedures to insure there is a confirmation letter sent to the insured within 10 working days of receipt of a claim per K.A.R. 40-1-34, 6(a). Within 30 days the company should provide documentation that the Company and HH are sending out acknowledgement letters within 10 days of receipt of a claim.
2. The Company and the TPA met with KID after the time period of the exam, 2008 through the first 6 months of 2009, to restate their commitment and plan to monitor HH's improvement in their claim processing. Within 30 days the Company needs to provide KID with a year end 2009 report of their monitoring process to substantiate that HH is now adjudicating claims within 30 days. Per K.S.A. 40-2442.
3. Within 30 days the Company needs to provide KID with a report showing the status of HH going back and paying interest on the claims in 2007, 2008 and 2009 that took over 30 days to pay and interest was not included in the settlement payment. Per K.S.A. 40-2442 (b)(d)(2).
4. Within 30 days the Company needs to provide KID with some documentation that HH has in place a process to pay interest on future claims that take over 30 days to pay. Per K.S.A. 40-2442 (b)(d)(2).

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by Lisa Sayerstad, Robin Rodbro, the staff of Trustmark Insurance Companies and the claims staff of Harrington Health.

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
Market Conduct Examiner

Tate Flott
Market Conduct Examiner

Respectfully submitted,

Lyle Behrens
Examiner-In-Charge

APPENDIX I

Related Kansas Insurance Statutes and Administrative Regulations

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

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Section 1.	Authority
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Section 8.	Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers:
Section 9.	Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

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.

K.A.R. 40-4-42a Notice requirements of adverse decisions.

(a) A written notification of an adverse decision shall be printed in clear, legible type and in at least 12-point type.

(b) The notice of adverse decision shall explain the principal reason for the adverse decision in language easily

understood by a person with an eighth-grade reading level. An insurer may meet this requirement by omitting medical terminology that describes an insured's medical condition. The notice shall include the proper names of all impacted parties, telephone numbers, and addresses.

(c) The notice of adverse decision shall explain how an insured, as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, can initiate an external review with the commissioner. If an insured is eligible for an expedited review due to an emergency medical condition as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, then the notice shall explain how an insured can initiate an expedited review.

(d) The notice shall explain that an insured may file for an external review with the commissioner within 90 days of receipt of a final adverse decision. The notice shall also list the Kansas insurance department's toll-free number.

(e) The notice of adverse decision shall describe how the insured can request a written statement of the clinical rationale and clinical review criteria used to make the adverse decision.

(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.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 defined 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.

K.S.A. 40-22a09a. Same; internal review procedure. (a) Every health insurance plan for which utilization review is performed shall include a description of the health insurance plan's procedures for an insured to obtain an internal appeal or review of an adverse decision. This description shall include all applicable time periods, contact information, rights of the insured and available levels of appeal. If the health insurer uses a utilization review organization, the insured shall be notified of the name of such utilization review organization. The health insurance plan shall provide an insured with written or electronic notification of any adverse decision, and a description of the health insurance plan's

internal appeal or review procedure, including the insured's right to external review as provided in K.S.A. 40-22a14 and amendments thereto. The health insurance plan also shall notify the insured of the insured's right to waive the second appeal or internal review and proceed directly to the external review as provided in K.S.A. 40-22a14 and amendments thereto.

(b) If the health insurance plan contains a provision for two levels of internal appeal or review of a health care decision which is adverse to the insured, the health insurance plan shall allow the insured to voluntarily waive such insured's right to the second internal appeal or review. Such waiver shall be made in writing to the health insurance plan and shall constitute the exhaustion of all available internal appeal or review procedures within the meaning of subsection (d) of K.S.A. 40-22a14 and amendments thereto.

(c) If an insured elects to request the second internal appeal or review of a health care decision which is adverse to the insured, the insured shall have the right to appear in person before a designated representative or representatives of the health insurance plan or utilization review organization at the second internal appeal or review meeting. If a majority of the designated representatives of the health plan or utilization review organization who will be deciding the second internal appeal or review cannot be present in person, by telephone or by other electronic means, at least one of those designated representatives who will be deciding the second internal appeal or review shall be a physician and shall be present in person, by telephone or by other electronic means. No physician or other health care provider serving as a reviewer in an internal appeal or review of an adverse decision shall be liable in damages to the insured or the health insurance plan for any opinion rendered as part of the internal appeal or review.

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.

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 provide

