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Name of Agency Arkansas Insurance Department

Department Legal Division

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Statutory Authority for Promulgating Rules ACA§§23-61-108, 23-66-207, 23-76-125, 23-94-107, 25-15-202, 23-76-125, 23-76-118(b)(2)

Reg. 43

Intended Effective Date		Date
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_____ 10 Days After Filing	Final Date for Public comment . . .	_____
_____ Other	Filed with Legislative Council	[illegible]
3/1/2000	Reviewed by Legislative Council .	2/3/00
	Adopted by State Agency	2/7/00

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended

Booth Rand
Signature

(501) 371-2820
Phone Number

Associate Counsel
Title

2/8/2000
Date

Rule and Regulation 43

UNFAIR CLAIMS SETTLEMENT PRACTICES

Sections

Section 1. Purpose

The purpose of this rule is to define certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute unfair claims settlement practices as well as to provide minimum standards which govern claims handling procedures of insurers, health maintenance organizations, risk retention groups, and any other persons hereafter defined in this rule, without regard to a general business practice where so specified in this rule. Ark. Code Ann. §§ 23-66-201(1987), et seq., and 23-76-103 (1987), 23-76-119 (1987) and 23-94-204 (Supp. 1987) prohibit insurers, health maintenance organizations and risk retention groups doing business in the State of Arkansas from engaging in unfair claims settlement practices; and provide that, if any insurer or health maintenance organization or risk retention group performs any of the acts or practices proscribed by those sections with such frequency as to indicate a general business practice, then those acts shall constitute an unfair or deceptive act or practice in the business of insurance.

Section 2. Authority

This rule is issued pursuant to the authority vested in the Commissioner by Ark. Code Ann. §§ 23-61-108(1987), 23-66-207(1987), 23-76-125(1987), 23-94-107(Supp. 1987), 25-15-202(1987), Ark. Code Ann. §23-76-125 to enforce Ark. Code Ann. §23-76-118(b)(2) related to prohibiting balance billing in Section 6 C (4) of this Rule, and other applicable provisions of Arkansas law.

Section 3. Applicability and scope

This rule applies to all persons, to all insurance policies and insurance contracts and to all contracts, certificates, subscriber agreements, or other evidences of coverage issued by insurers, health maintenance organizations and risk retention groups, as applicable, except policies of Workers' Compensation and Employer's Liability. This rule is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of Ark. Code Ann. §§ 23-66-201(1987), et seq., and 23-76-103(1987), and 23-76-119(1987). Unless otherwise expressly stated in this Rule,

to constitute a violation of any section of this Rule, there shall be required the finding of a pattern or general business practice as described in Ark. Code Ann. §23-66-201(1987), et seq.

Section 4. Effective date

The effective date of this rule shall be March 1, 2000 for all provisions of this rule except for Sections VI. B. 2. and VI. C. 2. which shall be effective on July 1, 2000.

Section 5. Definitions

The definitions of "person," "evidence of coverage," and of "insurance policy or insurance contract" contained in the Trade Practices Act, Ark. Code Ann. § 23-66-203(1987), and in Ark. Code Ann. § 23-76-102 (1987), shall apply to this regulation and, in addition, where used in this regulation:

(a) "Agent" or "Representative" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer, health maintenance organization, or risk retention group with respect to a claim;

(b) "Automobile insurance" includes, but is not limited to, insurance as defined under Ark. Code Ann. § 23-89-301(1987);

(c) "Claimant" means an enrollee, a first party claimant, and/or a third party claimant, and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

(d) "Complaint" means a written communication primarily expressing a grievance;

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

(f) "Insurance Department Complaint" means a written communication regarding a complaint transmitted by the Arkansas Insurance Department;

(g) "Non-Disability Insurer" means any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this State as described in Ark. Code. Ann §§23-62-101, 23-62-102, 23-62-104, 23-62-105, 23-62-106, 23-62-107, 23-62-107, 23-62-108. "Non-Disability Insurer" includes a risk retention group as defined in Ark. Code Ann. §23-94-201 as well an automobile liability insurer providing medical and hospital benefits coverage under Ark. Code Ann. §23-89-202(1).

(h) "Investigation" means all activities of an insurer directly or indirectly related to determination of liabilities or obligations under coverages afforded by a policy, contract, or Health Care Plan;

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

(j) "Risk retention group" means a group as defined under Ark. Code Ann. § 23-94-102 (10) (Supp. 1987);

(k) "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; and

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

(m) "Health Care Insurer" means an insurer that issues policies or contracts providing coverage for expenses associated with the treatment of an illness or injury. For purposes of this regulation, unless otherwise stated, the term "Health Care Insurer" shall include a self-insured governmental or church plan, as well as third party administrators which administer or adjust disability benefits for a health care insurer. A Health Care Insurer does not include an automobile insurer paying medical or hospital benefits under Ark. Code Ann. §23-89-202(1) nor shall it include a self insured employer health benefits plan. A Health Care Insurer also does not include any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this State as described in Ark. Code Ann. §§23-62-104, 23-62-105, 23-62-106, and 23-62-107 providing medical or hospital benefits for accidental injury or disability.

(n) "Health Maintenance Organization" means any person or organization defined as a health maintenance organization under Ark. Code Ann. §23-76-102(6).

(o) "Health Care Claimant" means a person who has made a request to a Health Care Insurer or Health Maintenance Organization for a coverage determination, a request for payment of medical benefits, or a request for preauthorization or approval of a health or medical benefit in accordance with the terms of the insurance contract or health care plan of the Health Care Insurer or Health Maintenance Organization. "

(p) "Clean Claim" means a claim by a Health Care Claimant for payment of medical benefits from a Health Care Insurer or Health Maintenance Organization, which is submitted to a Health Care Insurer or Health Maintenance Organization on a claim form [AIDFORM# Provider & HF1500] with all of the required fields correct and completed in accordance with the filing requirements of the Health Care Insurer or Health Maintenance Organization. A "Clean Claim" does not include the following claims: (1) a claim which is not received by the Health Care Insurer or Health Maintenance Organization within forty-five (45) calendar days after the date of treatment by the medical provider or clinic, or, if incurred in a hospital or facility, after the date of discharge; (2) a claim which requires the Health Care Insurer or Health Maintenance

Organization to obtain additional information from a provider or Health Care Claimant to initiate claims processing; (3) a claim which requires the Health Care Insurer or Health Maintenance Organization to obtain information on student eligibility or on over age dependents; (4) a claim which requires the Health Care Insurer or Health Maintenance Organization to obtain medical records from a provider in order to determine if the services rendered by the provider are covered under the terms of the insurance contract; and (5) a claim which is related to a Health Care Insurer's or Health Maintenance Organization's investigation of possible fraud.

(q) "Health Care Claim" means a claim by a Health Care Claimant to a Care Insurer or Health Maintenance Organization for a coverage determination, a request for payment of medical benefits, or a request for preauthorization or approval from a Health Care Insurer in accordance with the terms of the Plan.

(r) "Urgent Care Claim" means a Health Care Claim by a Health Care Claimant to a Health Care Insurer or Health Maintenance Organization for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Health Care Claimant or the ability of the Health Care Claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim. In addition, any claim that a physician with knowledge of the Health Care Claimant's medical condition determines as claim involving urgent care under this section of the rule shall be treated as a claim involving urgent care.

Section 6. File and record documentation

The claim files of non-disability insurers, and Health Care Insurers 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.

A. Claims Handling Requirements for Non-Disability Insurers

1. Failure to acknowledge pertinent communications

(a) Every Non-Disability Insurer, upon receiving notification of a claim shall, within fifteen (15) 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 in 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. Pursuant to Ark. Code Ann. § 23-79-126(1987), insurers shall furnish forms for proof of loss within twenty (20) working days after a loss has been reported, or thereafter waive proof of loss requirements. Insurers shall not require a claimant to calculate depreciated value of personal property on forms for proof of loss.

(b) Every Non-Disability Insurer upon receipt of any inquiry from the Arkansas Insurance Department respecting a claim shall within fifteen (15) working days of such inquiry furnish the Department with a reasonably adequate response to the inquiry.

(c) An appropriate reply shall be made within fifteen (15) working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every Non-Disability Insurer, upon receiving notification of a claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance to claimants so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements.

2. Standards for prompt investigation of claims

Every Non-Disability Insurer shall complete investigation of a claim within forty-five (45) working days after notification of claim, unless such investigation cannot reasonably be completed within such time. If an investigation cannot be completed within the forty-five (45) day time period, insurers shall notify claimants that additional time is required and include with such notification the reasons therefore.

3. Standards for prompt, fair and equitable settlements applicable to Non-Disability Insurers

The provisions of this section shall apply to claims handling and practices of Non-Disability insurers, except those of surety and fidelity insurance, mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(a)(1) Within fifteen (15) 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.

(2) 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 in writing within fifteen (15) working days after receipt of the proofs of loss, stating the reasons more time is needed. If the investigation remains incomplete, the insurer shall, forty-five (45) working days from the date of the initial notification and not more than every forty-five (45) working days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(b) Where there is a reasonable basis supported by specific information available for review by the Arkansas Insurance Department that the first party claimant has fraudulently caused or contributed to the loss by arson, the insurer is relieved from the

requirements of subsection (a)(1). The claimant shall be advised of the acceptance or denial of the claim within a reasonable time following a full investigation after receipt by the insurer of a properly executed proof of loss. The insurer shall comply with the provisions of the Arson Reporting-Immunity Statute, Ark. Code Ann. §§ 12-13-301(1987) - 12-13-305(1987).

(c) Insurers shall not refuse 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.

(d) Insurers shall not continue or prolong 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 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 (30) working days and to third party claimants sixty (60) working days before the date on which such time limit may expire.

(e) 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 applicable provision of a statute of limitations, as provided in subsection (d) of this section.

(f) Insurers shall mail or deliver claim checks or drafts to claimants within ten (10) working days after the claims are processed, all claim investigations are completed and said claim files are closed and ready for payment.

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

(h) 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.

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

(j) 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 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.

(k) 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.

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

(m) No insurer shall delay payment of any claim under specific coverages under a contract in an attempt to settle all or a portion of the claims under other coverages provided by the policy.

4. Standards for prompt, fair and equitable settlements applicable to private passenger automobile insurance

(a) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one (1) of the following methods must apply:

(1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured. All applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile must be paid at no cost to the insured other than the policy deductible. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile, including all applicable taxes, license fees and other fees actually incurred incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by:

(A) The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area; or

(B) Use of one (1) of two (2) or more quotations obtained by the insurer from two (2) or more qualified dealers or appraisal services located within the local market area when a comparable automobile is not available in the local market area.

(3) When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections (a)(1) and (2) of this section, the deviation must be supported by documentation giving particulars of the automobile's condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.

(b) Where liability and damages are reasonably clear, insurers shall not recommend or require that third party claimants make a claim under their own policies solely to avoid paying claims under such insurer's policy or contract.

(c) Insurers shall not require a claimant to travel an unreasonable distance to inspect a replacement automobile, to obtain a repair estimate, or to have the automobile repaired at a specific repair shop. Insurers shall not require a claimant to have the automobile repaired at a specific repair shop as a condition of recovery.

(d) Insurers shall include the first party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

(e) When the insurer elects to repair, and, with the insured's written consent, a specific repair shop is selected, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at the estimate cost with no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(f) If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one (1) or more conveniently located repair shops.

(g) When the amount claimed is reduced because of betterment or depreciation all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

B. Claims Handling Requirements for Health Care Insurers.

1. Standards for prompt, fair and equitable settlements applicable to Health Care Insurers.

(a) Notification of Benefit Determinations by Health Care Insurers.

(1) A Health Care Insurer shall notify a Health Care Claimant in writing of the benefit determination within forty-five (45) calendar days after receipt of the Health Care Claim by the Health Care Insurer unless the Health Care Claimant has failed to submit sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or insurance contract. In the case of such a failure, the Health Care Insurer shall notify the Health Care Claimant or medical provider with a written request for the items necessary for it to make a benefit determination within ten (10) calendar days after receipt of the claim by the disability insurer. After receipt of the information requested, the Health Care Insurer shall have no longer than forty-five (45) calendar days after receipt of the information to notify the Health Care Claimant in writing of the benefit determination. No Health Care Insurer shall make unreasonable requests for information from a medical provider or claimant for the sole purpose of delaying the payment of a Health Care Claim. If the Health Care Insurer has

made an unreasonable request for information from a medical provider or claimant for the sole purpose of delaying the payment of the claim, the Health Care Insurer's period to provide to the Health Care Claimant a benefit determination in writing shall not be extended as a result of such a request.

(2) A Health Care Insurer shall notify the Health Care Claimant of the benefit determination in writing within thirty (30) calendar days after receipt of a Health Care Claim which meets the standards of a clean claim under Section 5. (p) of this rule.

(3) A Health Care Insurer shall notify the Health Care Claimant of the benefit determination in writing within seventy-two (72) hours after receipt of a Health Care Claim which meets the standards of an urgent care claim under Section 5. (r) of this rule.

(b) Payment of Benefits by Health Care Insurers.

(1) For Health Care Claims admitted to be paid by a Health Care Insurer in the notice under Section B.1. (a) of this rule, the Health Care Insurer shall make payment on a Health Care Claim within five (5) calendar days after the Health Care Insurer was required to notify the Health Care Claimant of the benefit determination.

(2) A Health Care Claim which has been received by a Health Care Insurer for which no notification of benefit determination was made in violation of Section B. 1. (a) of this rule shall be deemed admitted by the Health Care Insurer ten (10) calendar days after the date a notification of benefit determination was required to be made to the Health Care Claimant. A Health Care Insurer's admission of a claim under this section is not an admission of contractual liability by the Health Care Insurer to pay the claim but rather is an admission by the Health Care Insurer that it has not complied with this section of the regulation.

2. Reporting Standards for prompt, fair and equitable settlements applicable to Health Care Insurers this section shall require Health Care Insurers to file on a quarterly basis with the Arkansas Insurance Department a health claims processing report.

(a) Every Health Care Insurer in this state shall submit to the Arkansas Insurance Department each quarterly period a health claims processing report which shall contain all of the following:

(1) A report describing the percentage of claims, separately categorized into clean claims as defined in Section 5. (p) of this rule, and all other claims processed within fifteen days (15) days following receipt by the Health Care Insurer;

(2) A report describing the percentage of claims, separately categorized into clean claims as defined in Section 5. (p) of this rule, and all other claims processed within thirty (30) days following receipt by the Health Care Insurer;

(3) A report describing the percentage of claims, separately categorized into clean claims as defined in Section 5. (p) of this rule, and all other claims processed within forty-five (45) days following receipt by the Health Care Insurer;

(4) A report describing for each clean claim and all other claims not paid within forty-five (45) days describing why the claim was delayed for payment.

(5) A report providing, for each clean claim and other claim, the time or date between the date of service or treatment by a medical provider and the time or date the claim was reported to the Health Care Insurer.

(6) A report attaching the Health Care Insurer's Health Plan Employer Data and Information Set (HEDIS®) performance results if performed and published in written form for the Health Care Insurer during that quarter.

(b) The optimal standards for claim processing shall be:

(1) Percentage of claims processed within fifteen (15) calendar days shall be fifty percent (50%).

(2) Percentage of claims processed within thirty (30) calendar days shall be eighty-five percent (85%).

(3) Percentage of claims processed within forty-five (45) calendar days shall be ninety-eight percent (98%).

(c) If a Health Care Insurer's claim processing falls below any of the following "regulatory action standards," the Health Care Insurer shall be subject to the requirements in subsections 6 B. 2. (d) through (h) of this Rule:

(1) In fifteen (15) calendar days is less than twenty-five percent (25%);

(2) In thirty (30) calendar days is less than sixty percent (60%);

(3) In forty-five (45) calendar days is less than eighty-five percent (85%).

(d) The Health Care Insurer shall be required to submit to the Arkansas Insurance Department a remediation action play setting forth how and when its claim processing shall be brought above regulatory action standards.

(e) Depending upon the insurer's response, the Insurance Department, may require the insurer to provide notice to its members and providers of delays in claims processing and the steps being taken to improve this status.

(f) A Health Care Insurer that has failed to meet the regulatory action standards would be required to provide information to the Arkansas Insurance Department a claim

processing report on a monthly basis until the insurer meets the fifty percent (50%), eighty-five percent (85%) and ninety-eight percent (98%) standards for two consecutive quarters.

(g) A Health Care Insurer may be temporarily relived from the claims payment standards under Section 6 B. 2. of this Rule, if its claims processing system is seriously impacted by an internal reorganization, by a computer system conversion or system conversion, in such case, the Health Care Insurer must notify the Commissioner prior to commencing such action, specify when the reorganization or conversion shall be completed, and commit to submitting periodic progress reports to the Commissioner. In the case of a natural disaster, the Health Care Insurer shall notify the Commissioner as soon as possible after the event, specify when the claims system will be restored and commit to submitting periodic progress reports to the Commissioner.

(h) Nothing in this Rule shall limit or restrict the Arkansas Insurance Department from pursuing any other remedy or action against the Health Insurer under Ark. Code Ann. § 23-66-201(1987), nor act to limit any other administrative action against an Health Care Insurer under the Arkansas insurance code.

C. Claims Handling Requirements for Health Maintenance Organizations.

1. Standards for prompt, fair and equitable settlements applicable to Health Maintenance Organizations.

(a) Notification of Benefit Determinations Health Maintenance Organizations.

(1) A Health Maintenance Organization shall notify a Health Care Claimant in writing of the benefit determination within forty-five (45) calendar days after receipt of the Health Care Claim by the Health Maintenance Organization unless the Health Care Claimant has failed to submit sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or insurance contract. In the case of such a failure, the Health Maintenance Organization shall notify the Health Care Claimant or medical provider with a written request for the items necessary for it to make a benefit determination within ten (10) calendar days after receipt of the claim by the disability insurer. After receipt of the information requested, the Health Maintenance Organization shall have no longer than forty-five (45) calendar days after receipt of the information to notify the Health Care Claimant in writing of the benefit determination. No Health Maintenance Organization shall make unreasonable requests for information from a medical provider or claimant for the sole purpose of delaying the payment of a Health Care Claim. If the Health Maintenance Organization has made an unreasonable request for information from a medical provider or claimant for the sole purpose of delaying the payment of the claim, the Health Maintenance Organization's period to provide to the Health Care Claimant a benefit determination in writing shall not be extended as a result of such a request.

(2) A Health Maintenance Organization shall notify the Health Care Claimant of the benefit determination in writing within thirty (30) calendar days after receipt of a Health Care Claim which meets the standards of a clean claim under Section 5. (p) of this rule.

(3) A Health Maintenance Organization shall notify the Health Care Claimant of the benefit determination in writing within seventy-two (72) hours after receipt of a Health Care Claim which meets the standards of an urgent care claim under Section 5. (r) of this rule.

(b) Payment of Benefits by Health Maintenance Organizations.

(1) For Health Care Claims admitted to be paid by a Health Maintenance Organization in the notice under Section B.1. (a) of this rule, the Health Maintenance Organization shall make payment on a Health Care Claim within five (5) calendar days after the Health Maintenance Organization was required to notify the Health Care Claimant of the benefit determination.

(2) A Health Care Claim which has been received by a Health Maintenance Organization in which no notification of benefit determination was made in violation of Section B. 1. (a) of this rule shall be deemed admitted by the Health Maintenance Organization ten (10) calendar days after the date a notification of benefit determination was required to be made to the Health Care Claimant. A Health Maintenance Organization's admission of a claim under this section is not an admission of contractual liability by the Health Maintenance Organization to pay the claim but rather is an admission by the Health Maintenance Organization that it has not complied with this section of the regulation.

2. Reporting Standards for prompt, fair and equitable settlements applicable to Health Maintenance Organizations

This section shall require Health Maintenance Organizations to file on a quarterly basis with the Arkansas Insurance Department a health claims processing report.

(a) Every Health Maintenance Organization in this state shall submit to the Arkansas Insurance Department each quarterly period a health claims processing report which shall contain all of the following:

(1) A report describing the percentage of claims, separately categorized into clean claims as defined in Section 5. (p) of this rule, and all other claims processed within fifteen days (15) days following receipt by the Health Maintenance Organization;

(2) A report describing the percentage of claims, separately categorized into clean claims as defined in Section 5. (p) of this rule, and all other claims processed within thirty (30) days following receipt by the Health Maintenance Organization;

(3) A report describing the percentage of claims, separately categorized into clean claims as defined in Section 5. (p) of this rule, and all other claims processed within forty-five (45) days following receipt by the Health Maintenance Organization;

(4) A report describing for each clean claim and all other claims not paid within forty-five (45) days describing why the claim was delayed for payment.

(5) A report providing, for each clean claim and other claim, the time or date between the date of service or treatment by a medical provider and the time or date the claim was reported to the Health Maintenance Organization.

(6) A report attaching the Health Maintenance Organization's Health Plan Employer Data and information Set (HEDIS®) performance results if performed and published in written form for the Health Maintenance Organization during that quarter.

(b) The optimal standards for claim processing shall be:

(1) Percentage of claims processed within fifteen (15) calendar days shall be fifty percent (50%).

(2) Percentage of claims processed within thirty (30) calendar days shall be eighty-five percent (85%).

(3) Percentage of claims processed within forty-five (45) calendar days shall be ninety-eight percent (98%).

(c) If a Health Maintenance Organization's claim processing falls below any of the following "regulatory action standards," the Health Maintenance Organization shall be subject to the requirements in subsections 6 B. 2. (d) through (h) of this Rule:

(1) In fifteen (15) calendar days is less than twenty-five percent (25%);

(2) In thirty (30) calendar days is less than sixty percent (60%);

(3) In forty-five (45) calendar days is less than eighty-five percent (85%).

(d) The Health Maintenance Organization shall be required to submit to the Arkansas Insurance Department a remediation action play setting forth how and when its claim processing shall be brought above regulatory action standards.

(e) Depending upon the organization's response, the Insurance Department, may require the organization to provide notice to its enrollees and providers of delays in claims processing and the steps being taken to improve this status.

(f) A Health Maintenance Organization that has failed to meet the regulatory action standards would be required to provide information to the Arkansas Insurance Department a claim processing report on a monthly basis until the organization meets the fifty percent (50%), eighty-five percent (85%) and ninety-eight percent (98%) standards for two consecutive quarters.

(g) A Health Maintenance Organization may be temporarily relived from the claims payment standards under Section 6 B. 2. of this Rule, if its claims processing system is seriously impacted by an internal reorganization, by a computer system conversion or system conversion, in such case, the Health Maintenance Organization must notify the Commissioner prior to commencing such action, specify when the reorganization or conversion shall be completed, and commit to submitting periodic progress reports to the Commissioner. In the case of a natural disaster, the Health Maintenance Organization shall notify the Commissioner as soon as possible after the event, specify when the claims system will be restored and commit to submitting periodic progress reports to the Commissioner.

(h) Nothing in this Rule shall limit or restrict the Arkansas Insurance Department from pursuing any other remedy or action against the Health Maintenance Organization under Ark. Code Ann. § 23-66-201(1987), nor act to limit any other administrative action against an Health Maintenance Organization under the Arkansas insurance code.

3. Minimum standards for pre-certification or pre-authorization reviews as to disability coverage by Health Maintenance Organizations.

(a) The purpose of this section is to define certain minimum standards for Health Maintenance Organizations utilizing pre-certification or pre-authorization reviews to ensure that such cost-containment procedures of disability insurers and health care plans are reasonable and do not unduly delay, or interfere with or impede the authorized practice of medicine and delivery of reasonable medical care. For purposes of this rule, acts of the claims administrator in performing pre-certification reviews shall be deemed to be acts of the Health Maintenance Organization.

From and after one hundred and eighty (180) days from the effective date of this rule, Health Maintenance Organizations utilizing such reviews shall establish reasonable procedures to:

(1) Ensure that pre-certification reviews are completed in a prompt and timely manner;

(b) Avoid excessive, repetitious and duplicative requests for information to claimants and their health care providers;

(c) Provide for reconsideration or medical reviews following disapproval or denial of pre-certification requests of insureds and claimants; and

(d) Provide for prompt peer medical review following disapproval or denial of pre-certification requests of insureds or claimants as to medically-necessary and/or life-threatening major surgical procedures.

4. Balance Billing Prohibited

(a) No participating provider of a Health Maintenance Organization shall bill an enrollee or subscriber for amounts due the participating provider by the Health Maintenance Organization knowingly in violation of a hold harmless agreement defined in Ark. Code Ann. §23-76-118 (b)(1).

(b) Wrongful billing of subscribers or enrollees in violation of Section 4(a) of this Rule, when committed knowingly or intentionally by the participating provider in violation of a provider agreement hold harmless clause, shall constitute a violation of this rule by the Health Maintenance Organization, for each violation, without regard to finding a frequency as to indicate a general business practice in violation of Ark. Code Ann. §23-66-205.

(c) If the commissioner finds after a hearing conducted in accordance with §23-61-301, et seq that any person or insurer subject to this rule has violated Section C. 4 of this rule, the commissioner may order:

(1) For each separate violation, a penalty in an amount up to two thousand ($2,000) dollars or, if the commissioner has found willful misconduct or willful violation, a penalty in an amount up to ten thousand ($10,000) dollars;

(2) Revocation or suspension of the applicable licensure or certificate of authority of the person, agent, adjuster or insurer with the Arkansas Insurance Department;

(3) For multiple violations by a "person" as defined in Ark. Code Ann. §23-66-203(1), the fines, penalties and injunctive relief for violations constituting a trade practice under Ark. Code Ann. §23-66-201 et seq.

(4) Nothing contained in this rule shall affect the right of the commissioner to impose any other penalties otherwise permitted in the insurance law.

(5) Nothing contained in this rule is intended to or shall in any manner limit or restrict the rights of policyholders or claimants.

Section 7. Severability

Any section or provision of this rule held by a court to be invalid or unconstitutional will not affect the validity of any other section or provision of this rule.

MIKE PICKENS
INSURANCE COMMISSIONER

2/7/2000

DATE