The following Advisory Opinion is to advise the reader of the current position of the Kentucky Department of Insurance ("the Department") on the specified issue. The Advisory Opinion is not legally binding on either the Department or the reader.

Kentucky Department of Insurance

Advisory Opinion 99-06

In re: Claims Practice

RELEVANT FACTS AND STATUTES: Recently the Department has encountered noncompliance issues regarding the payment of health claims and issuing explanations of benefits ("EOB"). The statute and regulation involved are KRS 304.12-235 and 806 KAR 12:092. KRS 304.12-235(1) requires, "[a]ll claims arising under the terms of any contract of insurance shall be paid to the named insured person or health care provider not more than thirty (30) days from the date upon which notice and proof of claim, in the substance and form required by the terms of the policy, are furnished the insurer." KRS 304.12-235(2) states:

> If an insurer fails to make a good faith attempt to settle a claim within the time prescribed in subsection (1) of this section, the value of the final settlement shall bear interest at the rate of twelve percent (12%) per annum from and after the expiration of the thirty (30) day period.

806 KAR 12:092§3(4) restates the thirty (30) day time limit to settle claims found in KRS 304.12-235 (1) and instructs the insurer, "[i]f a portion or portions of the claim are in dispute, the insurer shall tender payment for any portion or portions of the claim which are not in dispute within thirty (30) days of receipt of due proof of loss." Finally, 806 KAR 12:0923(7) requires an insurer to provide an insured with a reasonable explanation of the delay if a claim remains unresolved for thirty (30) days. This subsection also provides, "[i]f the investigation remains incomplete, the insurer shall, forty-five (45) days from the date of initial notification and every forty-five (45) days thereafter, send the claimant a letter setting forth the reasons additional time is needed for the investigation."

KRS 304.38-200(7) states that all health maintenance organizations ("HMOs") are subject to Subtitle 12. KRS 304.17A-300(6) provides that all provider-sponsored integrated delivery networks ("PSNs") are subject to Subtitle 12. Additionally, House Bill 315§1(22), codified as KRS 304.17A-005(22), includes in the definition of "insurer" HMOs and PSNs. Therefore, HMOs and PSNs are subject to KRS 304.12-235 and 806 KAR 12:092 and any reference to "insurers " in this opinion includes HMOs and PSNs.

DEPARTMENT'S POSITION: The insurer must make a good faith attempt to settle all claims within thirty (30) days, from the date the claim is furnished to the insurer, or the claim will be subject to 12% per annum interest rate. The insurer is expected to make a good faith attempt to conduct a reasonable investigation on the claim. The insurer may extend the thirty (30) day period pursuant to 806 KAR 12:092§3(7), without incurring the 12% per annum interest rate, provided the investigation is reasonable and the notice requirements of 806 KAR 12:092 are met. 806 KAR 12:0923(7) requires the insurer to provide the insured or insured's beneficiary (the health care provider or debtor who has received assignment of the claim) a reasonable written explanation of why the claim is still unresolved if it is unresolved thirty (30) days from receipt of due proof of loss. If the investigation remains incomplete forty-five (45) days from the date of initial notification, and every forty-five (45) days thereafter, the

insurer must send the claimant a letter explaining why additional time is needed. The insurer must also include a notice of the availability of interest and attorney's fees.

806 KAR 12:0923(5) provides as follows:

> With each claim payment, the insurer shall provide to the insured an explanation of benefits which shall include the name of the provider of health care services covered, dates of service, and a reasonable explanation of the computation of benefits.

The Department has been made aware that some insurers only send an explanation of benefits ("EOBs") to the insured when the insurer does not cover the services 100% and that EOBs are rarely sent when the insurer pays a claim for prescription drugs. It is the Department's position, pursuant to 806 KAR 12:0923(5), that EOBs must be sent whenever the insurer pays a claim, including claims paid for prescription drugs. In the event the claim or coverage is denied, the insurer is also required to provide the enrollee with all information specified in KRS 304.17A-540, as well as all other applicable regulations and statutes.

Please note that the Department will be increasing its investigation efforts towards enforcement of the above-named statutes, in accordance with this Advisory Opinion. Any questions concerning this matter may be directed to Shaun T. Orme, Counsel for the Department at (502) 564-6032.

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George Nichols III, Commissioner

Kentucky Department of Insurance

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Date