

REPORT OF MARKET CONDUCT EXAMINATION

COVENTRY HEALTH CARE OF KANSAS, INC.

8320 WARD PARKWAY

KANSAS CITY, MO 64114

AS OF MARCH 31, 2004

BY

KANSAS INSURANCE DEPARTMENT

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

Dear Commissioner Praeger:

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

Coventry Health Care of Kansas, Inc

8320 Ward Parkway

Kansas City, MO 64114

hereafter referred to as “CHC” or “the Company”, and the following report of such examination is submitted.

Respectfully,

Lyle Behrens, CPCU, CIE, ARM
Market Conduct Supervisor
Examiner in Charge

EXECUTIVE SUMMARY

The Kansas Insurance Department performed a market conduct examination of the Coventry Health Care of Kansas, Inc. (CHC). The examiners reviewed the company general procedures, complaints and grievances, CSR training, UR and claims manuals. The exam team reviewed claim and complaint files in company's Administrative office in Kansas City, MO. A series of meetings were held with CHC staff that focused on their current operations. To supplement and verify the understanding of how the company does business, a series of samples were selected for review to verify their procedures and practices in claims, complaint and grievance handling and UR review.

The company passed most tests; and in terms of delivering good service to its insureds, the examiners were impressed with the overall positive and very professional performance by the CHC staff and management to their policyholders. The exam team made recommendations on several issues.

LIST OF RECOMMENDATIONS

Complaint Handling

1. While the response times were within KID's tolerances, many were near the end of the fifteen (15) working days allowed by K.A.R. 40-1-34, 6(b). The company should review their complaint handling procedures to ensure that response times remain in compliance.

Grievance Procedures

1. The Company needs to review their grievance procedures to ensure that responses are timely and within Department guidelines and Company policy. Acknowledgement letters must be sent within ten (10) working days per Kansas statute and within five (5) working days per Company policy. The enrollee should be notified of the decision on an appeal within five (5) working days after the investigation is complete.

2. The Company needs to review their grievance procedures to ensure that grievance/appeal files that are overturned or reversed are processed and claims are adjudicated in a timely fashion and interest is applied when applicable per K.S.A. 40-2404 (9)(f) and K.S.A. 40-2442 (d)(2).

Utilization Review

1. The company must amend the language for retrospective reviews to comply with URAC Health Utilization Management Standards, Version 4.1. Retrospective review determinations must include written notification to the claimant and must be sent within thirty (30) days per K.A.R. 40-4-41c(a)(3) and URAC Standard UM 25.

SCOPE OF REVIEW

A targeted market conduct examination of CHC's, claims and complaints was completed to determine compliance with applicable statutes and regulations of the state of Kansas. The examination was conducted according to the guidelines and procedures recommended in the NAIC Market Conduct Examiners Handbook.

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

COMPANY OVERVIEW

Certificates of Authority

COMPLAINT HANDLING

Record Keeping

Timely Response

GRIEVANCE PROCEDURES

Record Keeping

Procedures

Timely Response

UTILIZATION REVIEW

Record Keeping

Procedures

Timely Response

CLAIMS

Claim Processing

Use of Outside Pricing Entities

Timeliness and Accuracy of Claim Payment

Proper Maintenance of Claim Files

SUMMARY OF REVIEW

The market conduct examination focused on CHC. The testing and file review consisted of sampling from the Company's complaints and settled claim files in Kansas City, MO.

The examination included a review of the Company's complaints January 1, 2003 to March 31, 2004 and settled claim files from October 1, 2003 to March 31, 2004.

General topics were covered in Interrogatories submitted to the Company for its written response. Subjects covered were CSR training, UR review, complaints and grievances, and claims. The response received adequately addressed the issues presented.

DESK EXAMINATION/ON-SITE EXAMINATION

COMPANY OVERVIEW

History & Organization

History of Coventry Health Care of Kansas, Inc.

Coventry Health Care of Kansas, Inc. was founded in 1988 as Principal Health Care of Kansas City, Inc. This organization was a Missouri incorporated Health Maintenance Organization whose parent company was Principal Health Care, headquartered in Bethesda, Maryland. Principal Health Care was a Health Maintenance Organization wholly-owned by The Principal Financial Group in Des Moines, Iowa.

Principal Health Care of Kansas City, Inc. ("Principal") held Certificates of Authority from both the Missouri and Kansas Departments of Insurance. With approval of a standard HMO product and a Kansas City metropolitan service area, Principal set its marketing focus on group employers. Principal expanded its service area to include counties in the Wichita area and completed an acquisition of a Cigna HMO in Wichita. By the end of its ninth year, membership had grown to 86,659 with a premium volume of \$125 million.

Coventry Health Care, Inc. acquired Principal Health Care in April 1998. In the fall of 1998, Coventry Health Care, Inc. was looking to expand its holdings in the area and set about to secure the assets and membership of a failing HMO in Wichita, Health America Plans, Inc. ("HAPI"). The acquisition of HAPI was approved when Coventry agreed to the Kansas Insurance Department's condition of surrendering their Principal Certificate of Authority and assuming the HAPI Certificate thus changing their state of incorporation to Kansas. This made Coventry Health Care, d/b/a Principal Health Care of Kansas City, a Kansas domiciled Health Maintenance Company. The acquisition of HAPI was successfully completed in December of 1998.

The desire to grow market share included the continued expansion of new service areas in Kansas and Missouri and the addition of a Medicare + Choice plan. The company applied for and was approved to offer a Medicare + Choice, known as Advantra in July of 1999.

The name Principal remained until January 1, 2000, when the Principal name was retired and the plan became known as Coventry Health Care of Kansas, Inc. The focus became designing plans that were affordably priced yet attractive in benefits to local employer groups.

In 2001, Coventry finalized a plan to acquire the membership of the Kaiser Foundation HealthCare Plan of Kansas City, Inc. The local membership included 50,000 commercial lives and 5,000 Medicare lives in the Senior Advantage programs. Coventry assumed responsibility for all members in the Kaiser Plan as of April 1, 2001. Kaiser physicians were recruited into the Coventry network. With the Kaiser acquisition membership of Coventry of Kansas, Inc. totaled 187,132.

In September 2002, Coventry Health Care announced their intent to purchase Mid America HealthCare (formerly Health Net), a local health plan owned by several shareholder hospitals in the Kansas City area. Coventry's intent was to acquire the organization including plans, assets, liabilities and membership. The acquisition did not include the purchase of the Senior Excel program, a Medicare +Choice program that Mid America had already notified the Centers for Medicare and Medicare Services of their intent to leave the market on December 31, 2002. The acquisition closed on December 3, 2002. The resulting Coventry Health Care of Kansas, Inc. membership after the final acquisition was 258,223.

[See Table 1 for an organization chart of Coventry Health Care of Kansas, Inc.](#)

Tests for Company Operations/Management

Standard 1

The company has an up-to-date, valid internal, or external, audit program.

The exam team reviewed the Company's internal audit procedures.

Standard 5

The company is adequately monitoring the activities of any entity (MGA, GA, and TPA) that contractually assumes a business function or is acting on behalf of the company.

The exam team reviewed and audit of UBH, who is a third party administrator handling CHC mental health claims.

Standard 6

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

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

Standard 7

The company is licensed for the lines of business that are being written. K.S.A. 40-216

The Certificate of Authority was reviewed and found to be in order and the company was complying with it.

Standard 8

The company cooperates on a timely basis with examiners performing the examinations. K.S.A. 40-222, (c)(g)

The company was very cooperative and provided the exam team with the items requested within the time frames established for this exam.

COMPLAINT HANDLING

Company Complaint Handling Procedures

Per the Company's policies and procedures, a complaint is "Any dissatisfaction expressed by a Member or a Member's Authorized Representative regarding an issue in the Health Plan, which may be resolved by the Customer Service Representative in the CSO." There is a distinction between Department of Insurance (DOI) complaints, other complaints, and appeals (discussed separately under grievances). The Company has detailed procedures in place for handling both DOI complaints and other complaints.

Department of Insurance Complaints

When DOI complaints are received within the Compliance Department, they are first date stamped and then logged into the Customer Service Console (CSC). It is noted in the procedures that with Kansas DOI complaints, a resolution is due within fifteen working days of the Company receiving the complaint. The date the response is due back to the DOI is written down to ensure timeliness. After the complaint is investigated, a letter is sent to the DOI via certified mail with a copy of the original complaint and any pertinent attachments. Finally, the file is closed in the appeals database and a resolution comment is made to the CSC. If the issue involves a medical necessity determination, a Coventry Medical Director would review the file. If the issue involves mental health, it would be forwarded to UBH to gather information. A written log is kept of all DOI complaints including at least all information required by Kansas statute.

Direct Consumer Complaints

There are detailed procedures for the Customer Service Specialists in the Customer Service Organization to follow when handling complaints. Coventry has broken down complaints into three types: quality of care, quality of service, and service center specific. The steps for handling complaints as described in the training manual are: identification, initial system documentation, investigation, resolution, and closure. First, the type is identified from the three choices listed above. Then, it is initially documented in the system with an appropriate reason code, a brief description, and provider ID if applicable. There are eight steps highlighted in the manual to provide for thorough investigation and documentation. The Customer Service Specialists are responsible for resolving quality of service and service center specific resolutions. Regarding quality of care complaints, Customer Service Specialists are instructed to refer the complaint to the Quality Management Department for closure and investigation. QM staff should close quality of care complaints within 24 hours of receipt from the Customer Service Specialist. If the member/provider is not satisfied after the above process, the Customer Service Specialist should inform the member/provider of their right to appeal. Appeals can be made by telephone or in writing (preferred method). The appeal process is discussed further under the grievance section of this report.

Tests for Complaint Handling (See Appendix I for the appropriate statute or regulation.)

Standard 1

All complaints are recorded in the required format on the company complaint register.

K.S.A. 40-2404 (10)

The Company did provide a complaint register. However, eleven Kansas Insurance Department complaints did not appear on the register. Seven complaints were located as Mid America Health complaints and occurred during the first half of 2003. Coventry states that the integration of responding to KID complaints involving MAH members was not completed until early summer 2003. Since that time all KID complaints have been entered into the complaint log. Four complaint files were not found.

Standard 2

The company has adequate complaint handling procedures in place and communicates such procedures to policyholders.

The detailed procedures written into the company policies are adequate and generally work quite well.

Standard 3

The company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

K.S.A. 40-2442 (a)(b)(d)(2); K.S.A. 40-2404 9(f)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
DOI Complaints	49	2	93.9%

- One DOI complaint contained a claim that was not accurately paid per K.S.A. 40-2442 (a)(b).
- On another DOI complaint, Coventry agreed to pay a claim per the request of the Kansas Insurance Department. The claim was not paid until 67 days later. This was not paid promptly, and was in violation of K.S.A. 40-2404, 9(f) and K.S.A. 40-2442, (d)(2).

The company passed Standard 3.

Standard 4

The time frame within which the company responds to complaints is in accordance with applicable statutes, rules and regulations. K.A.R. 40-1-34 6(b)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
DOI Complaints	49	4	91.8%

On four occasions, the company failed to respond to DOI complaints within the fifteen working days allowed by K.A.R. 40-1-34 6(b). They were responded to in 17, 19, 23 and 48 working days.

The company passed Standard 4.

Recommendations:

1. While the response times were within KID's tolerances, many were near the end of the fifteen (15) working days allowed by K.A.R. 40-1-34 6(b). The company should review their complaint handling procedures to ensure that response times remain in compliance.

GRIEVANCE PROCEDURES

Company Grievance Handling Procedures

Per the Company's policies/procedures, an appeal is a "request by the Member of the Member's Authorized Representative for consideration of an Adverse Benefit Determination of a health service request or benefit that the member believes he or she is entitled to receive." When an adverse determination is made, the member is sent instructions on various appeal rights. The appeal procedures are divided into pre-service, post-service, and urgent care. These types of appeals can also be subdivided into first and second levels. The Company has detailed procedures in place for the handling of appeals. A written log containing the total number, type, nature, and resolution of all appeals is kept in a grievance register as required by Kansas statute. The Appeals Coordinator (AC) is responsible for the acknowledgment, documentation, and resolution of all appeals. The AC for an appeal shall not be involved in the circumstances giving rise to the appeal in question.

With all appeals, the member or the member's authorized representative is notified of their right to receive copies of all documents and information pertinent to the appeal. Also, a standard form is sent upon all appeal decisions and ABDs notifying the member of the various levels of appeals. Since late 2003, an Appeal Tracking Form is used with all appeals to document pertinent information, including rationale for decision, names of committee members, authorization for member representative, type of appeal, etc.

Pre-Service Appeals

The pre-service appeal is available for either a member or member's authorized representative when dissatisfied with an adverse benefit determination (ABD) on a service that has not yet been rendered. The request for such appeal must be made within one hundred eighty (180) calendar days of receipt of the ABD. For both first-level and second-level appeals, an acknowledgement letter is sent within five working days explaining the member's rights and the appeal process. If the appeal is second level, the acknowledgement letter should contain information regarding an anticipated date and time for the hearing and the member's right to attend. For both levels, the appeal must be resolved within fifteen calendar days. If the Company needs more time, they can request a thirty calendar day delay by sending a letter to the member requesting additional time and including reasons more time is needed and what information is needed if any. Also for both levels of a pre-service appeal, the member should be notified of the decision within five business days after the investigation is completed.

The pre-service first level appeal committee is comprised of one to three health plan senior manager(s) not involved in the ABD and not the subordinate(s) of the individual who made the ABD. If the decision involves medical judgment, the committee must meet above-mentioned

requirements plus include the consultation of a health care professional with the same or similar area of expertise. This can be met by the health plan Medical Director if above criteria is met.

The pre-service second level appeal continues the appeal process for insured persons who are not satisfied with the outcome at the first level appeal. A request for a second level appeal must be made within thirty-one calendar days of receipt of the first level appeal committee's decision. The appeal committee is comprised of one to three health plan senior managers not involved in previous reviews or decisions. If the decision is based in part or in whole on medical judgment, the committee must also include the written opinions of at least three health care professionals with appropriate training and experience. For both administrative and medical judgment reviews, the committee must include other enrollees of the health plan.

Post-Service Appeals

The post-service appeal is an appeal available for those in which an ABD has been rendered for a service that has already been provided. Like the pre-service appeal, this type of appeal must be requested within one hundred eighty (180) calendar days after receipt of initial ABD. This type of appeal can also go through a first and second level. With both levels, an acknowledgment letter must be sent to the member or the member's authorized representative within five working days. The policy also states that the member or the member's authorized representative must be notified of the appeal committee's decision within five business days of a decision being made.

The post-service first level appeal committee is comprised of the same criteria as the pre-service first level appeal committee. The post-service second level appeal must be requested within thirty-one calendar days of receipt of the decision of the first level committee. The appeal committee is comprised of the same criteria as the second level pre-service appeal committee. The member or the member's authorized representative may participate in the second level hearing.

Urgent Appeals

An urgent appeal is an appeal for which a requested service requires pre-authorization, an ABD has been rendered, the requested service has not been provided, and the application of non-urgent care appeal time frames could seriously jeopardize the life/health of the member or the member's unborn child, or the member's ability to regain maximum function. The urgent care appeal committee must be scheduled within twenty-four hours of the receipt of the appeal request. The appeal must be resolved and a decision must be provided to the member or authorized representative within thirty-six hours of receipt of the appeal request for both first and second level urgent appeals. If the decision is adverse, the notification will include further appeal rights. Second level urgent care appeals must be submitted within thirty-one days after the member received the ABD of the first level committee. There were no urgent appeals for Kansas residents during the exam period.

Member and provider appeals are analyzed by the health plan through review by the multi-disciplinary committee used for first level member appeals and by the Quality Improvement Committee (QIC). Appeal analysis, including but not limited to categorization of the top 5 reasons for appeals, provider appeal trends, overturn rates and an analysis of the reasons for overturn are done on at least a monthly basis. Analyses are trended over time. Corrective

action plans are reviewed and approved by the QIC until resolution. The Company has quality assessment audits done by URAC to ensure compliance.

A random sample of fifty appeal files was taken from the grievance/appeal register that was provided by the Company. Upon further review of these files, it turned out that forty-five of the files were for first-level appeals and five files were regarding second-level appeals.

Tests For Grievance Procedures (See Appendix I for the appropriate statute or regulation.)

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. (Health Carrier Grievance Procedures Model Act (HCGPMA), Section 3Q.) K.S.A. 40-3202(k)

The Company has written definitions of inquiries, complaints, and appeals that are defined and explained thoroughly in policies and procedures. Complaints are divided into three types: quality of care, quality of service, and service center specific. Appeals are generally the result of an adverse benefit determination.

Standard 2

The health carrier documents grievances and establishes and maintains grievance procedures in compliance with statute, rules, and regulations. K.S.A. 40-3228

The company has developed a detailed and precise complaint procedures manual used by personnel as they handle grievances. A written log containing the total number, type, nature, and resolution of all appeals is kept in a grievance register.

Standard 4

The health carrier conducts first level reviews of grievances in compliance with statutes, rules, and regulations. K.S.A. 40-3228(c)(1-3); K.S.A. 40-2404(9)(f); K.S.A. 40-2442(d)(2)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>Passed</u>
Grievances/Appeals	45	6	86.7%

- Two Grievance/Appeal files failed to notify the complainant of a written decision within 5 working days of the investigation being completed per K.S.A. 40-3228 (c)(3)
- Two Grievance/Appeal files failed to acknowledge receipt of the grievance in writing within 10 working days per K.S.A. 40-3228 (c)(1). One of these files also failed to complete the investigation within 30 days and failed to notify the enrollee every 30 days thereafter of the reasons additional time was needed as required by K.S.A. 40-3228 (c)(2)

- Two Grievance/Appeal files concluded with overturn decisions to pay claims that were not paid after the Company accepted this liability until 211 days and 58 days later respectively. Neither appeal was paid promptly or with interest per K.S.A. 40-2404, (9)(f) & K.S.A. 40-2442, (d)(2). The company has now paid interest on both claims.

The company failed Standard 4.

Standard 5

The health carrier conducts second level reviews of grievances in accordance with statutes, rules, and regulations. (HCGPMA, Section 8A.) K.S.A. 40-3228(c)(1-3)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>Passed</u>
Grievances/Appeals	5	0	100%

The company passed Standard 5.

Standard 6

The health carrier handles grievances involving adverse utilization review determinations in compliance with statutes, rules, and regulations.

All grievances/appeals reviewed involved adverse utilization review determinations. Grievance handling errors are noted in specific standards.

Standard 7

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

The list of sample grievances/appeals did not reveal any expedited appeals filed during the exam period.

Recommendations:

1. The Company needs to review their grievance procedures to ensure that responses are timely and within Department guidelines and Company policy. Acknowledgement letters must be sent within ten (10) working days per Kansas statute and within five (5) working days per Company policy. The enrollee should be notified of the decision on an appeal within five (5) working days after the investigation is complete.
2. The Company needs to review their grievance procedures to ensure that grievance/appeal files that are overturned or reversed are processed and claims are adjudicated in a timely fashion and interest is applied when applicable per K.S.A. 40-2404 (9)(f) and K.S.A. 40-2442 (d)(2).

MARKETING AND SALES

Standard 1

All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

The exam team reviewed the membership package that was given to each new member. General advertising materials and the company's web site were also reviewed.

Standard 5

Outline of coverages are in compliance with all applicable statutes, rules and regulations.

The company provided the exam team with coverage summaries for review. The member has their own personal site with their own PIN number that they use to access their account via the Internet. This site is confidential, and only the member can access it. Therefore the exam team was not able to review any specific member coverage summaries.

NETWORK ADEQUACY

Standard 7

The health carrier's arrangements with participating providers comply with statutes, rules, and regulations.

	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Contracts Reviewed	9	0	100%

The Company passed Standard 7.

UTILIZATION REVIEW

For Covered Services that require pre-Authorization from Coventry Health Care of Kansas, Inc, Coventry uses the following procedures:

Initial Determinations

For initial determinations, Coventry will make the determination within two (2) working days of obtaining all necessary information regarding a proposed Admission, procedure or service requiring a review determination. For purposes of this section, "Necessary Clinical Information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an Admission, procedure or service, Coventry will notify the Provider rendering the service by telephone within twenty-four (24) hours of making the initial determination, and provide written or electronic confirmation of the telephone notification to the Member and the Provider within two (2) working days of making the initial determination.

In the case of an Adverse Determination, Coventry will notify the Provider rendering the service by telephone within twenty-four (24) hours of making the Adverse Determination, and will provide written or electronic confirmation of the telephone notification to the Member and the Provider within one (1) working day of making the Adverse Determination.

Concurrent Review Determinations

For Concurrent Review determinations, Coventry will make the determination within one (1) working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, Coventry will notify by telephone the Provider rendering the service within one (1) working day of making the determination, and provide written or electronic confirmation to the Member and Provider within one (1) working day after the telephone notification. The written notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of Admission or initiation of services.

In the case of an Adverse Determination, Coventry will notify by telephone the Provider rendering the service within twenty-four (24) hours of making the Adverse Determination, and provide written or electronic notification to the Member and the Provider within one (1) working day of the telephone notification. The service will be continued without liability to the Member until the Member has been notified of the determination.

Notification of Adverse Determinations

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including review criteria used to make the determination.

Reconsideration

In the case of an initial determination or a concurrent review determination, the Provider may request, on behalf of the Member, a reconsideration of an Adverse Determination. This reconsideration will occur within one (1) working day of the receipt of the request. The reconsideration will be conducted between the Provider rendering the service and the reviewer who made the Adverse Determination or a clinical peer designated by the reviewer if the reviewer who made the Adverse Determination is not available within one (1) working day. If the difference of opinion is not resolved, the Member or the Provider on behalf of the Member may appeal an Adverse Determination.

Retrospective Review Determinations

For Retrospective Review Determinations, Coventry will make the determination within thirty (30) days of receiving all necessary information. Coventry will provide notice in writing of the determination to the Member within ten (10) working days of making the determination.

Post Emergency Services

Coventry Health Care of Kansas, Inc. will cover Emergency Services necessary to screen and stabilize a Member and will not require Pre-Authorization of such services. If immediate

post-evaluation or post-stabilization services are required, Coventry will notify the Provider within the time frame required by law.

Denials of Claims

The Medical Director shall make all medical necessity denials of claims. Notice of claim denials shall include information regarding the basis of the decision and further appeal rights.

Tests For Utilization Review (See Appendix I for the appropriate statute or regulation.)

Standard 1

The health carrier establishes and maintains a utilization review program in compliance with statutes, rules, and regulations. K.A.R. 40-4-41c (a)(3)

The Coventry Utilization Review procedures allow the Medical Director 30 days to reach a retrospective decision and 10 working days to notify the member after making a decision. This is a violation of both statute and the contractual agreement with URAC under their Health Utilization Management Standards & Program Guide v. 4.1. Both require the receipt of the request, the decision and the notification to happen within thirty (30) days. The company procedure allows another ten (10) days to notify the member.

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 a timely manner shall be maintained as follows:
- (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.

URAC Standard UM 25 states: For *retrospective review*, the *organization* issues a determination within 30 calendar days of the request for a *utilization management* determination.... And the Interpretive Information/Commentary on p. 99 of the Program Guide states that the time frames provided in these standards are inclusive of the entire UM process, from the receipt of the request for a UM decision to the issuance of the decision...

The Company failed Standard 1.

Standard 2

The health carrier files with the commissioner an annual summary report of its utilization review activities. K.S.A. 40-3211(b)

Quality of care assessments are required every three years and the last one was filed with the Kansas Department on October 23, 2003. External review requests are provided to the commissioner upon request. The commissioner has not requested these reviews during the exam period.

The Company passed Standard 2.

Standard 3

The health carrier provides information about its utilization review program to members in a timely manner and in compliance with statutes, rules, and regulations. K.S.A. 40-3209, (9)(d)

Information is provided initially in the Member Handbook and Evidence of Coverage; a toll free number is published in the Handbook and on the membership card.

The Company passed Standard 3.

Standard 4

The health carrier conducts provider related utilization review activities in a timely manner and in compliance with statutes, rules, and regulations. K.A.R. 40-4-42(a)(1)(B)(3)

The Quality Management Committee reviews clinical issues and accepts recommendations from physicians for the Quality Management Program and providers are allowed to ask for a review on behalf of insured members. Provider review requests are included in Standards 5-10.

The Company passed Standard 4.

Standard 5

The health carrier makes utilization review decisions in a timely manner and as required by state statutes, rules, and regulations and the provisions of HIPAA. K.A.R. 40-4-41c(a)(1)(2)(3)

Initial determinations are made within 2 working days for admission, service and procedures and the Company notifies the provider within 24 hours by phone and 2 working days. Prospective and concurrent reviews are conducted within two working days of receipt of all information. Retrospective reviews are conducted within 30 days of receipt of all information.

Twenty-five (25) Utilization Review files were examined for 1/13/2004 and twenty-four (24) were examined for 4/13/2004.

<u>Date</u>	<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>% Pass</u>
1/13/2004	Prospective	14	0	100%
1/13/2004	Concurrent	3	0	100%
1/13/2004	Retrospective	8	0	100%

<u>Date</u>	<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>% Pass</u>
4/13/2004	Prospective	9	0	100%
4/13/2004	Concurrent	7	0	100%
4/13/2004	Retrospective	8	0	100%

The Company passed Standard 5.

Standard 6

The health carrier provides written notice in compliance with statutes, rules, and regulations for an adverse determination.

K.A.R. 40-4-42a; K.A.R. 40-4-41c(b)(4)(B)(C)(D); K.A.R. 40-4-41c(b)(5)

Adverse determinations are made within 24 hours and reported to providers by telephone. Written communications are sent to members and providers within 1 working day and written procedures include principal reasons for the determination, procedures for further appeal and statements that clinical rationale used in making a non-certification decision shall be provided in writing upon request.

The Company passed Standard 6.

Standard 7

The health carrier makes reconsideration decisions in a timely manner and in compliance with state statutes, rules, and regulations. K.A.R. 40-4-41c(b)(4)(A)(i)&(ii)

The attending health care provider or other ordering provider and original reviewer can meet within 1 working day to further discuss the decision. If the issue still is not resolved, the attending health care provider or other ordering provider has the right to initiate an expedited appeal or standard appeal.

Only one sample item from the population of the 50 Utilization Review files was for reconsideration and it was handled in a timely manner.

<u>Date</u>	<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
4/13/2004	Reconsideration	1	0	100%

The Company passed Standard 7.

Standard 9

The health carrier conducts expedited appeals in a timely manner and in compliance with applicable statutes, rules, and regulations. K.A.R. 40-4-41d(a)

A health care provider or other ordering provider shall have an opportunity to appeal over the telephone or via facsimile with a peer clinical reviewer within one working day and a decision shall be made and the provider notified within one working day.

The selected sample did not include expedited appeals.

Standard 10

The health carrier conducts utilization review activities and provides for emergency services in compliance with statutes, rules, and regulations. K.A.R. 40-4-42g(b)(1)(A)

Emergency Services are provided to screen and stabilize the patient without pre-authorization but post-emergency services must be pre-authorized.

The selected sample did not include emergency service appeals.

Standard 11

The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with K.A.R. 40-4-41h.

The health plan President/CEO has the authority to delegate utilization review activities to an outside entity and consults with the QIC (Quality Improvement Committee), Utilization Management Committee (UMC), QMC (Quality Management Committee), the Medical Director or other appropriate plan staff prior to a delegation decision.

The health plan must complete at least 2 audits per year, one of which must be done on-site. The last audit was conducted on September 16 and 17, 2003.

The Company passed Standard 11.

Standard 12

Companies covered under the act will be in compliance with the following procedures and criteria as well as with other applicable statutes, rules and regulations. K.A.R. 40-4-41(b)

The decision as to what treatment to prescribe shall remain that of the health care provider and the determination of covered benefits remains the responsibility of the claims administrator or health benefit plan.

The Company passed Standard 12.

Standard 13

In states that choose the Option 1 or Option 2 under the act for providing an external review process, companies will be in compliance with the following requirements whether the request for the review is for a standard, expedited, or experimental/investigational review. K.A.R. 40-4-42, 42b-42g

The Company policy meets the standards required by Kansas regulations.

The Company passed Standard 13.

Recommendations:

The company must amend the language for retrospective reviews to comply with URAC Health Utilization Management Standards, Version 4.1. Retrospective review determinations must include written notification to the claimant and must be sent within thirty (30) days per K.A.R. 40-4-41c(a)(3) and URAC Standard UM 25.

CLAIMS

Tests for Claims (See Appendix I for the appropriate statute or regulation.)

Standard 1

The initial contact by the company with the claimant is within the required time frame.
 K.A.R. 40-1-34, 6(a)(d); KSA 40-2442, (a) (1)(2), (b)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
General Claims			
Pd	96	0	100%
No Pay	41	0	100%
Mental Health			
Pd	37	0	100%
No Pay	36	0	100%
<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
ER Claims			
Pd	99	0	100%
No Pay	50	0	100%

The Company passed Standard 1.

Standard 2

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

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
General Claims			
Pd	96	0	100%
No Pay	41	0	100%
Mental Health			
Pd	37	0	100%
No Pay	36	0	100%
ER Claims			
Pd	99	0	100%
No Pay	50	0	100%

The Company passed Standard 2.

Standard 3

Claims are resolved in a timely manner. K.A.R. 40-1-34, 8(a)(c); KSA 40-2442, (a) (1)(2), (b)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
General Claims			
Pd	96	1	99%
No Pay	41	0	100%
Mental Health			
Pd	37	0	100%
No Pay	36	0	100%
<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
ER Claims			
Pd	99	1	99%
No Pay	50	0	100%

The Company passed Standard 3.

Standard 4

The company responds to claim correspondence in a timely manner. K.A.R. 40-1-34, 6(a)(6); KSA 40-2442, (a) (1)(2), (b)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
General Claims			
Pd	96	0	100%
No Pay	41	0	100%
Mental Health			
Pd	37	0	100%
No Pay	36	0	100%
ER Claims			
Pd	99	0	100%
No Pay	50	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(b)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
General Claims			
Pd	96	0	100%
No Pay	41	0	100%
Mental Health			
Pd	37	0	100%
No Pay	36	0	100%
ER Claims			
Pd	99	0	100%
No Pay	50	0	100%

The Company passed Standard 5.

Standard 6

Claims are properly handled in accordance with policy provisions HIPA and state law. K.A.R. 40 -1-34 Sections 5(a), 8, 9; K.S.A. 40-3110; K.S.A. 40-2,126; K.S.A. 40-2442, (a) (1)(2), (b)

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
General Claims			

	Pd	96	3	96%
	No Pay	41	0	100%
Mental Health				
	Pd	37	1	97%
	No Pay	36	0	100%
ER Claims				
	Pd	99	1	99%
	No Pay	50	0	100%

The Company passed Standard 6.

Standard 7

Company claim forms are appropriate for the type of product.

The company accepts standard HCFA paper forms and electronic transmittals.

Standard 8

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

The exam team did not specifically test for this standard.

Standard 9

Denied and closed-without-payment claims are handled in accordance with policy provisions, HIPA 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>	
General Claims				
	No Pay	41	0	100%
Mental Health				
	No Pay	36	0	100%
ER Claims				
	No Pay	50	0	100%

The Company passed Standard 9.

Standard 10

Cancelled benefit checks and drafts reflect appropriate claim handling practices.

<u>Type</u>	<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
General Claims	20	0	100%
ER Claims	10	0	100%
MH	15	0	100%

The Company passed Standard 10.

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)

<u>Type</u>		<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
General Claims				
	Pd	96	0	100%
	No Pay	41	0	100%

<u>Type</u>		<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Mental Health				
	Pd	37	0	100%
	No Pay	36	0	100%
ER Claims				
	Pd	99	0	100%
	No Pay	50	0	100%

The Company passed Standard 11.

Standard 12

The company complies with the requirements of The Newborns' and Mothers' Health Protection Act of 1996. KSA 40-2,102

The exam team did not specifically test for this standard. In the normal review of the 100 denied and 99 paid claims, any maternity claims would have been reviewed and the examiner would have noted it. There were no issues with the files that were reviewed.

Standard 13

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

<u>Type</u>		<u>Sample</u>	<u>Errors</u>	<u>%Pass</u>
Mental Health				
	Pd	37	1	97%
	No Pay	36	0	100%

The Company passed Standard 13.

GENERAL COMMENTS

Complaint Handling

1. While the response times were within KID's tolerances, many were near the end of the fifteen (15) working days allowed by K.A.R. 40-1-34, 6(b). The company should review their complaint handling procedures to ensure that response times remain in compliance.

Grievance Procedures

1. The Company needs to review their grievance procedures to ensure that responses are timely and within Department guidelines and Company policy. Acknowledgement letters must be sent within ten (10) working days per Kansas statute and within five (5) working days per Company policy. The enrollee should be notified of the decision on an appeal within five (5) working days after the investigation is complete.
2. The Company needs to review their grievance procedures to ensure that grievance/appeal files that are overturned or reversed are processed and claims are adjudicated in a timely fashion and interest is applied when applicable per K.S.A. 40-2404 (9)(f) and K.S.A. 40-2442 (d)(2).

Utilization Review

1. The company must amend the language for retrospective reviews to comply with URAC Health Utilization Management Standards, Version 4.1. Retrospective review determinations must include written notification to the claimant and must be sent within the thirty (30) days per K.A.R. 40-4-41c(a)(3) and URAC Standard UM 25.

CONCLUSION

I would like to acknowledge the cooperation and courtesy extended to the examination team by Mr. Steve Robino and the staff of Coventry Health Care of Kansas.

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
Supervisor

Michael Grover
Market Conduct Examiner

Mary Lou Maritt
Market Conduct Examiner

Stacy Rinehart
Market conduct Examiner

Respectfully submitted,

Lyle Behrens, CPCU, CIE, ARM

APPENDIX I

A. **K.A.R. 40-1-34** - Unfair claims practices provides for the following guidelines to be met in the processing and investigation and settlement/denial of a claim:

- Definitions, Sec. 3
- File and Record Documentation, Sec. 4
- Misrepresentation of Policy Provisions, Sec. 5
- Failure to Acknowledge to Pertinent communication, Sec. 6
- Standards for Prompt Investigation of Claims, Sec. 7
- Standards for Prompt, Fair and Equitable Settlements Applicable to all Insurers, Sec. 8
- Standards for Fair and Equitable Settlements Applicable To Auto Insurance, Sec. 9

- Kansas Automobile Injury Reparations Act (Payment of Benefits). K.S.A. 40-3110
- Unfair methods of competition or unfair and deceptive acts or practices. KSA 40-2404
- Interest Due On Insurance Settlements. KSA 40-2,126

1. K.A.R. 40-1-34 Sec. 3. Definitions

The definitions of "person" and of "insurance policy or insurance contract" contained in section 2 of the Unfair Trade Practice Act 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 insure 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, or 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" mean 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) "Worker's Compensation" includes, but is not limited to, Longshoremen's and Harbor Worker's Compensation.

2. K.A.R. 40-1-34 Sec. 4 - File and Record Documentation

The insurer's claim files shall be subject to examination by the (Commissioner) or by his/her 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.

3. K.A.R. 40-1-34 Sec. 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.

4. K.A.R. 40-1-34 Sec. 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.

5. K.A.R. 40-1-34 Sec. 7 - Failure to Acknowledge Pertinent Communications

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.

6. K.A.R. 40-1-34 Sec. 8 - Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers

(a) Within 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.

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

(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) 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.

(e) 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 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.

(f) No insurer shall make statements which indicate that 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.

(g) 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.

7. K.A.R. 40-1-34 Sec. 9 - Standards for Prompt, Fair, and Equitable Settlements Applicable to 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 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, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. 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 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.

(B) One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the 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 (a)(2) of this section*, the deviation must be supported by documentation giving particulars of the automobile 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. K.A.R. 40-1-34 – Unfair Claims Practices Act (Revised 1/03)

Table of Contents

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Section 2.	Scope
Section 3.	Definitions
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Section 5.	Misrepresentation of Policy Provisions.
Section 6.	Failure to Acknowledge Pertinent Communications.
Section 7.	Standards for Prompt Investigation of Claims.
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.

Section 9. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance

(a) When the insurance policy provides, for the adjustment and settlement of automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one 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 claimant, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect to pay 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 incident to transfer of evidence of ownership of a comparable automobile. Such cost shall be determined by any source or method for determining statistically valid fair market value that meets both of the following criteria:

(A) The source or method's database, including nationally recognized automobile evaluation publications, shall provide values for at least eighty-five percent (85%) of all makes and models of private passenger vehicles for the last fifteen (15) model years taking into account the values for all major options for such vehicles; and

(B) The source, method, or publication shall provide fair market values for a comparable automobile based on current data available for the local market area as defined in subsection (j)(2).

(3) When an automobile total loss is settled on a basis which deviates from the methods and criteria described in subsection (a)(1) and (a)(2)(A) and (B) of this section, the deviation must be supported by documentation giving the particulars of the automobile condition and the basis for the deviation. Any deviations from such cost, including deductions 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 claimant.

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

(c) Insurers shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(d) Insurers shall, upon the claimant's request, 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) 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 or more conveniently located repair shops.

(f) 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.

(g) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(h) Insurers shall include consideration of applicable taxes, license fees, and other fees incident to transfer of evidence of ownership in third party automobile total losses and shall have sufficient documentation relative to how the settlement was obtained in the claim file. A measure of damages shall be applied which will compensate third party claimants for the reasonable loss sustained as the proximate result of the insured's negligence.

(i) A claimant has the right of recourse if the claimant notifies the insurer, within thirty (30) days after the receipt of the claim draft, that claimant is unable to purchase a comparable automobile for the amount of the claim draft. Upon receipt of this notice, the insurer shall reopen its claim file within five (5) business days, and one of the following actions shall apply.

(1) the Insurer shall either pay the claimant the difference between the market value as determined by the insurer and the cost of the comparable vehicle of like kind and quality which the claimant has located, or negotiate and effect the purchase price of this vehicle for the claimant; or

(2) the insurer may elect to offer a replacement in accordance with provisions of subsection 9(a)(1).

(j) As used in this regulation the following terms shall have the following meanings:

- (1) comparable automobile means a vehicle of the same make, model, year, style and condition, including all major options of the claimant vehicle;
- (2) local market area means the fifty (50) mile area surrounding the place where the claimant vehicle was principally garaged.

C. KSA 40-3110 Payment of PIP benefits

(a) Except for benefits payable under any workmen's compensation law, which shall be credited against the personal injury protection benefits provided by subsection (f) of K.S.A. 40-3107, personal injury protection benefits due from an insurer or self-insurer under this act shall be primary and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued in compliance with this act. An insurer or self-insurer may require written notice to be given as soon as practicable after an accident involving a motor vehicle with respect to which the insurer's policy of motor vehicle liability insurance affords the coverage required by this act. No claim for personal injury protection benefits may be made after two (2) years from the date of the injury.

(b) Personal injury protection benefits payable under this act shall be overdue if not paid within thirty (30) days after the insurer or self-insurer is furnished written notice of the fact of a covered loss and of the amount of same, except that disability benefits payable under this act shall be paid not less than every two (2) weeks after such notice. If such written notice is not furnished as to the entire claim, any partial amounts supported by written notice is overdue if not paid within thirty (30) days after such written notice is furnished. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within thirty (30) days after such written notice is so furnished: Provided, That no such payment shall be deemed overdue where the insurer or self-insurer has reasonable proof to establish that it is not responsible for the payment, notwithstanding that written notice has been furnished. For the purpose of calculating the extent to which any personal injury protection benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of eighteen percent (18%) per annum.

D. KSA 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.

E. KSA 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.